Résumé

Cadre de travail pour évaluer l'intégration du rôle de l'infirmière praticienne dans les soins de santé primaires

Judith Burgess, Alietha Martin, Wayne Senner

Dans la province canadienne de la Colombie-Britannique, le rôle d'infirmière praticienne (IP) est officiellement entré en vigueur en 2005. Une recherche-action participative (RAP) a été menée auprès d'IP pour déterminer comment la collaboration fait progresser l'intégration du rôle des IP dans les soins de santé primaires. Les auteurs présentent les résultats de cette recherche, qui explore la signification de l'intégration du rôle des IP. L'étude a porté sur cinq aspects de cette intégration : l'autonomie, la reconnaissance, l'inclusion, la contribution et l'alliance. Ces aspects, jumelés à d'autres indicateurs, ont informé une démarche soutenant l'intégration du rôle des IP dans le cadre des soins de santé primaires. L'importance de la collaboration pour faciliter la progression de l'intégration du rôle des IP a fait l'objet d'une discussion. L'intégration du rôle des IP est liée aux politiques de la réforme des soins de santé primaires et à la promesse d'une approche holistique de la santé promouvant des soins pour la clientèle et la collectivité. Le cadre de travail peut aider les concepteurs de politiques, les décideurs et les chercheurs à cerner les obstacles freinant l'intégration du rôle des IP, à soutenir un processus de mise en place et d'évaluation d'un tel rôle, et d'en assurer la continuité.

Mots-clés : infirmière praticienne, intégration du rôle, collaboration, recherche-action participative

A Framework to Assess Nurse Practitioner Role Integration in Primary Health Care

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In the Canadian province of British Columbia, the nurse practitioner (NP) role was formally introduced in 2005. A participatory action research study was undertaken with NPs to examine how collaboration advances NP role integration in primary health care (PHC). The authors report on the study, in which the meaning of NP role integration was explored. The study uncovered 5 dimensions of NP role integration: autonomy, recognition, inclusion, contribution, and alliance. These dimensions, along with sample indicators, informed development of the NP Role Integration in PHC Framework. The significance of collaboration for advancing NP role integration is discussed; NP role integration is linked to the politics of PHC reform and the promise of holistic health promoting care for clients and communities. The framework has utility for policy leaders, decision-makers, and researchers in addressing barriers to role integration, supporting role evaluation, and securing and safeguarding the NP role.

Keywords: nurse practitioner, role integration, collaboration, participatory action research

All Canadian provinces and territories have introduced the nurse practitioner (NP) role through legislative, regulatory, and educational initiatives (http://NPCanada.ca). The NP role is intended to increase access to primary clinical care, preventive screening and early detection of disease, wellness and health promotion, health education and counselling, and outreach to vulnerable populations (DiCenso et al., 2007). The formal introduction of NPs is significant, because the NP role has suffered from a discontinuous history (Haines, 1993; McDonald & McIntyre, 2010). Limitations with regard to policy structures, role clarification, team relations, accountability measures, and leadership have been reported. Enabling legislation, regulation, and education have remedied the earlier restrictions on NP scope of practice (Canadian Nurses Association [CNA], 2006). However, role ambiguity continues to cause confusion for health consumers and for other disciplines, even nursing, particularly in areas of limited NP supply (Bryant-Lukosius, DiCenso, Browne, & Pinelli, 2004). Team relations are challenged by historical interprofessional tensions and territorialism, limited organizational support to teams, and slow-to-change systems — for example, interprofessional education has yet to be formalized (Hall, 2005). Accountability is problematic due to

insufficient tools for measuring the value-added contributions of NPs (Browne & Tarlier, 2008). Leadership support and insufficient funding, resulting in poor utilization of NPs, remain concerns in many jurisdictions (Stevenson & Sawchenko, 2010). Research on NP role integration will help to address existing barriers, support role evaluation, and further secure and safeguard the NP role.

In the province of British Columbia, NP legislation was introduced in 2005. This study, undertaken in 2008, examined, from the perspective of NPs, the question of how collaboration advances role integration in primary health care (PHC). Collaboration was viewed by the researcher, and substantiated in the literature, as a key enabler of team-based care, and role integration was thought to occur at the point of care in PHC team settings, although the literature lacked clarity on the meaning of role integration. The researcher brought to the study her experience as director of a community health centre in which she championed an NP pioneer and weathered the ups and downs of team-based practice, health promotion and holistic care, and the politics of PHC reform. As a result, participatory action research (PAR) was employed in the study to foster relations with and amongst NPs, share and generate practice knowledge, and engage in collective visioning and action to enhance NP role status (Reason & Bradbury, 2001).

True to PAR, this article is written by the researcher and two NP participants. Our purpose is to report on the study's findings with respect to the meaning of NP role integration and its various dimensions. The participatory inquiry uncovered five dimensions of NP role integration: autonomy, recognition, inclusion, contribution, and alliance. These dimensions, along with sample indicators, informed development of the NP Role Integration in PHC Framework. In this article we outline the British Columbia context of NP role development, the study's methodology, the findings, including the NP Role Integration in PHC Framework, application of the framework by the two co-author participants, and a discussion of the significance of collaboration in advancing NP role integration.

NP Role Development in British Columbia

Provincial NP role *introduction* was guided by a stakeholder consultation process (College of Registered Nurses of British Columbia [CRNBC], 2005) and an early research study (MacDonald, Schreiber, & Davis, 2005). Strategic planning fostered stakeholder consensus of graduate-level entry and NP scope of practice. Provincial legislation gave NPs title protection and the CRNBC provided the regulatory mandate for NP practice oversight (CRNBC, 2008). The province funded British Columbia universities to initiate NP graduate programs and provided 3-year funding to regional

Health Authorities (HAs) for NP role start-up (Ministry of Health Services, 2006).

Regional NP role *implementation* undertaken by all six HAs varied in approach. According to the literature, role implementation is contingent upon a systematic evidence-based approach, to ascertain health-service needs, design relevant NP positions, set operative policies, and allocate resources (Bryant-Lukosius et al., 2004; CNA, 2006, 2008; DiCenso & Matthews, 2005). The HAs were given limited time and direction by the province to prepare NP implementation; as a result the regions tended to be more reactive than systematic in their planning. The 3-year funding enabled each HA to plan for and implement 10 to 15 NP positions in various PHC settings.

Program NP role *integration* within PHC practice settings also varied. The literature indicates that role integration is fostered by proactive leadership, clarification of NP autonomy, education in team roles and scopes, collaborative team planning, and technology to support shared care (Almost & Laschinger, 2002; Jones & Way, 2004; Reay, Golden-Biddle, & Germann, 2003). HA leadership was inconsistent in terms of adequately preparing program sites and community partners, which for some NPs brought significant start-up challenges. A few of the HAs used the strategy of NP communities of practice (CoP) to promote role integration (Sawchenko, 2009; Wenger, McDermott, & Snyder, 2002). CoP enhanced NP relations, role integration strategies and alliances, and NP collective capacity.

System NP role *sustainability* was contingent upon incremental and ongoing funding of NP positions; the province's funding commitment was limited to 3 years. The securing of long-term commitments calls for strategic political and policy leaders to champion the NP role (McDonald & McIntyre, 2010), research partners to produce evidence of role effectiveness (Horrocks, Anderson, & Salisbury, 2002), and wide public support of NPs. To achieve sustainability, the NP role must be viewed as integral to system efficacy (Pogue, 2007). Now, 5 years post-legislation, the NP role is at risk in British Columbia due to inadequate provincial/regional funding mechanisms and inadequate political/policy support for health-system change.

Methodology: Participatory Action Research

Study Design

The researcher employed a PAR approach and, to guide the study, drew upon Hall's (2001) definition of PAR as "an integrated three-pronged process of social investigation, education and action to support those with less power in their organizational or community setting" (p. 171). This

definition also provided three-point criteria for later validation of the quality and integrity of the study (Bradbury & Reason, 2001). Social investigation was intended to foster a participatory stage for NPs to share stories, engage in critical and collective reflection, and become co-constructors of everyday worklife (Burgess, 2006). Education was meant to produce an informative stage when ideas and theorizing of collaboration would give new meaning to role integration. Action was expected to generate a transformative stage at which to address power relations and advance NP role integration.

Participant Recruitment

A strategic sampling approach was used for recruitment (Mason, 2002). Two HAs were targeted because of similarities in population size and urban/rural geography; also, both had already initiated a CoP to support NP role development. To protect the anonymity of those involved, HA demographics are not reported. Ethics approval was obtained from the university and each of the HAs. Approval by each Chief of Professional Practice was also obtained, to ensure employment release time for NP participation. A notice, prepared by the researcher and e-mailed by each HA, invited all NPs to an introductory research meeting (in fact, they were asked to participate in the study as co-researchers) at which the research questions were introduced, consent forms reviewed, and future meeting dates and locations set. Consent was obtained from 11 of the 12 NPs employed in one HA and 6 of the 12 employed in the other. The variance in NP recruitment rates was later attributed to CoP maturation; the CoP that had been active for 18 months had nurtured a collective enthusiasm for discovery, while the other CoP had begun 3 months prior to the study and was still at the relationship-forming stage.

Participant Engagement

The NPs in each HA requested that the study sessions be held in conjunction with their scheduled CoP meetings, which served to streamline rural travel. Over a 6-month period, five data-collection sessions and two action sessions were held for each HA group; this produced a combined total of 22 hours of audiorecorded data. The researcher prepared evolving questions for each session to facilitate group dialogue about the current status of NP collaborative practice in PHC, enablers of and barriers to collaboration, the meaning of role integration, enablers of and barriers to NP integration, and collaborative strategies to advance role integration.

Data Collection

At the social investigation (participatory) stage, the study's principles were collectively developed, journal articles shared for the grounding of group

knowledge, the inquiry process described, and trusting interactions and relations nurtured. The education (informative) stage focused on discussion of NPs' patterns of everyday PHC practice, experiences of role development, and factors contributing to collaboration and role integration. The action (transformative) stage unfolded as two action strategies. The first was to invite HA leaders responsible for NP role implementation to an audiorecorded "action interview" to discuss the NP planning processes adopted in each HA. The second was to host a research action day in each HA, with an evaluation expert designing a research template for NPs to initiate inquiry and analysis within their practice settings. Action strategies have subsequently included publication and dissemination of research findings.

Data Analysis

Following each session, the audiorecording was transcribed and preliminary analysis undertaken. Data analysis was carried out through a process of constant comparison drawn from the analytic techniques of grounded theory (Charmaz, 2005; Schwandt, 2001). QSR NVivo 7 software was used to index data into initial codes, create sub-themes, formulate themes, and make conceptual correlations (Mason, 2002). Interpretations were taken to NP study meetings, in the form of text and PowerPoint presentations, to spark further discussion and analysis. HA data sets were initially kept separate to allow for comparison of group results and were later integrated to capture common themes and findings. Participants commented on draft summaries and took part in dissemination and joint publication; this is consistent with the role of PAR in fostering enduring consequences (Bradbury & Reason, 2001).

Results: Explicating a Meaning for Role Integration

Only a few sources found in the literature used the term role integration, and a definition or description was not clearly articulated (CNA, 2006; DiCenso & Matthews, 2005; IBM Business Consulting Services, 2003). Therefore, as part of the study, the meaning of role integration was collectively explicated. Five dimensions emerged from the data analysis to describe the meaning of NP role integration in PHC. NPs would attain role *autonomy* to fully enact their scope of practice, gain role *recognition* in delivering holistic health promoting care for clients and communities, achieve role *inclusion* as vital PHC team members, establish role *contribution* by measuring value-added effects in care delivery, and develop role *alliances* to enable strategic capacity in PHC improvements. In addition, the data revealed stories about NP practice, which served as indicators of role integration. These five dimensions and related indicators formed the

Table 1 *NP Role Integration in PHC Framework*

Dimensions	Partners	Practice Indicators	Program Indicators	System Indicators
Role autonomy	Management leadership	NPs enabled to assess client/population needs and service gaps and to design responsive role	NPs enact full scope in delivery of relevant practice and programs	Practice policies and procedures modified to enable NPs to deliver effective care
Role recognition	Clients and communities	Clients understand and utilize NP role; client confidence/satisfaction in holistic health promoting care	Communities utilize NP programs; service access increased to marginalized populations	Public awareness and recognition of NP role, including public awareness campaigns
Role inclusion	Intra– and interprofessional colleagues	Informal and formal team-building strategies to improve NP and team experiences	Team modifications to enhance NP role value; additional team requests for NP roles	Utilization of the NP role by PHC network and intersectoral partners
Role contribution	Researchers and evaluators	Increased NP participation in practice, research, and evaluation	Surveillance systems to track client care, program results, and value–added effects	Instruments and tools to measure and produce evidence of NP health outcome contributions
Role alliance	Organization stewards and policy leaders	NPs engaged in and contributing to local practice innovations	NP representation in health program/HA strategic planning	NPs and their organizations participate in provincial and national initiatives

basis of the NP Role Integration in PHC Framework, as outlined in Table 1.

Role Autonomy

The NPs noted the importance of building collaborative relations with site managers and HA leaders to achieve role autonomy and fully enact the scope of practice within their various positions and settings. Role autonomy enabled the NPs to determine client population needs, identify gaps in care, and design their practice and programs accordingly. It meant that the NPs had the flexibility to determine the best use of their expertise and time. One NP said:

> *Each day is different. I have some days set aside strictly for clinical . . . yesterday I was at the Aboriginal centre . . . then another day it's paperwork, meetings . . . then I might have another day when I'm travelling somewhere to do a clinic . . . so each day is different!*

However, the clinic schedules of a few NPs left little time for the upstream work of health promotion and care innovation. Within the groups, NPs spoke of ways to preserve flexibility and fluidity in order to provide responsive care and address health-care inequities. The absence of regional policies and procedures created tensions for some of the NPs; for instance, referral forms still stated "most responsible physician," practice guidelines referenced only the role of physicians, and electronic health records and billing codes did not adequately reflect NP practice. The freedom of NPs to assess client/population needs and design responsive practice was an indicator of autonomy, as were policies and procedures to support the effectiveness of NP practices.

Role Recognition

NPs discussed collaborating with clients and the community to provide holistic health promoting care, increase care access, and address health gaps among marginalized populations. By combining advanced clinical practice with health promotion and preventive education strategies, holistic health promoting care contributed to NP role clarity. One NP stated:

> *NPs focus their practice [on] particular client health conditions, populations, et cetera. I think the whole concept of wellness and health promotion is something that's really important in what we do, because we bring that into every client encounter and interaction.*

NPs also gave examples of community partnerships that enhance holistic care, such as outreach clinics, group client visits, and women's wellness and screening services. As clients and communities used the services of NPs, role recognition was acquired. The following indicators

were noted: client understanding of and confidence in NP holistic health promoting care, community utilization of NP programs, and public awareness of the NP role — a public awareness campaign was mentioned as a strategy for increasing overall public recognition.

Role Inclusion

NPs saw collaboration as foundational to their everyday nursing practice. They discussed collaboration and team-building strategies as ways to foster role inclusion within their various team settings. For the NPs, role inclusion meant that they were perceived as vital team members who made a real difference to the quality of care provided by the team. One NP shared a comment made by a physician:

> *A physician said, "Can you chat with us? [I am seeing] a patient who has diabetes, poorly controlled . . ." At lunchtime the physician said, "That was so good . . . that makes my day. Like, everything else could go wrong today, but that interaction we had [together] with that patient was so good."*

The NPs also discussed collaborating with a range of practitioners and resources in order to plan and coordinate complex patient care. In fostering informal team-sharing of client information and facilitating broader formal case reviews, NPs cultivated relationships within their teams and across professions and sectors, thus strengthening their role as essential team members. Role-inclusion indicators identified were team-building to improve NP and team experiences, team modifications to enhance the value of the NP role, and utilization of the NP role by the PHC network and intersectoral partners.

Role Contribution

NPs acknowledged the importance of collaborating with researchers and evaluators to capture NPs' unique value-added contributions to client and community care. However, the lack of tools and resources to measure NP contributions presented a real challenge. One NP reported fewer emergency room visits and hospital admissions from her clinic, which was attributed to having an NP; however, this was viewed as anecdotal evidence only. Another NP commented:

> *You're not going to see what I do tomorrow, but hopefully you'll be able to see [it] in 10 to 20 years, when people are healthier, not smoking, exercising, and doing our health screening.*

NPs expressed concern about the lack of tools to track and measure their advanced nursing practice. Billing codes used to track clinical services did not fully capture the holistic care provided to clients and com-

munities through health preventive education and harm-reduction services. Collaboration with research partners would thus help NPs to produce evidence of their contributions. Indictors identified were increased NP participation in research and evaluation; design of surveillance systems to track client care, program results, and value-added effects; and design of instruments and tools to measure NPs' contribution to health outcomes.

Role Alliance

NPs spoke of collaborating with local and provincial stewards and leaders to foster role alliances and thus more effectively participate in practice innovations, health improvements, and policy initiatives. They discussed how to attain status as a "go to" group with political power, so that their expertise would be sought after and they would be included in strategic policy initiatives. Mentorship by policy leaders was identified as a way to increase leadership capacity and advance political aspirations. Yet not all NPs had political interests:

> We're in our infancy. We're only 64 bodies. It's hard to spread all that work out amongst only 64 people. So I think we'll get there, and those people will step up who have a stronger political interest; however, some [NPs] aren't really interested in the politics . . . that doesn't fit for all of us.

Cultivating role alliances was seen as essential for role integration. Indicators included NP involvement in local practice innovations, NP representation in HA organizational planning, and participation of NPs and their organizations in provincial and national strategic initiatives.

Knowledge Transfer:
Application of the Role Integration in PHC Framework

PAR constructs inquiry as a dynamic process to encourage a high degree of participation, in which members are co-researchers, co-learners, and co-activists (Reason & Bradbury, 2001). The credibility of our results is measured by enhanced social relations; generated education and knowledge; actions to improve practice, policies, and systems; application of results to the local setting; and knowledge transfer for enduring outcomes and wider applicability (Herr & Anderson, 2005). The results are made evident here by the two NP co-authors who apply the NP Role Integration in PHC Framework to assess their unique positions and thus determine their role status and the dimensions that require improvement for successful role integration.

Discussion: NP Collaboration and the Politics of PHC

This study focused on the how collaboration serves to advance NP role integration, because collaboration was known to be a key enabler of team-based care and role integration was seen to occur in team settings. Recent research, however, has depicted collaboration as multilevel and complex (Canadian Health Services Research Foundation, 2007; World Health Organization [WHO], 2008, 2010). The results substantiate this broader view of collaboration. The discussions revealed role integration to be inextricably linked to collaborative relations and initiatives at practice, program, and system levels. To achieve role integration, NPs developed collaborative relations, at these multiple levels, with managers, clients and community, colleagues, researchers, and policy leaders. Advancing role integration required NPs to cultivate partners at all levels of the health–care system and to be well grounded in the dynamics of change in order to navigate the power and politics of PHC reform (Burgess & Purkis, in press).

The NP role in PHC is decidedly political, because it represents a new way of delivering PHC to clients and communities. The NP is the first formal profession to be adopted by Canada's provinces/territories to augment physician primary care, and has significance for the realization of team-based PHC. The World Health Organization (2008) has reframed the work of Alma Ata (WHO, 1978) to highlight PHC reforms that emphasize health access, equity, and social justice; socially relevant and responsive services; collaboration of public health and primary care; and participatory leadership. The NP role is well positioned to align with WHO reforms (Browne & Tarlier, 2008; WHO, 2010). However, government and health-system commitment to comprehensive PHC and integrated health teams is at times questionable. Reticence can be analyzed as power relations, where patriarchal health systems limit public participation, organizational hierarchies constrain practitioner involvement, and traditional protective disciplines confine collaborative relations (Burgess & Purkis, in press; McDonald & McIntyre, 2010). The NP role sparks conflicts and controversies associated with PHC reform, because it contests traditional primary care services and is a catalyst for holistic health promoting care. Assessment of NP role integration is thus valuable for monitoring both advancement of the NP role and progress of PHC reform. Further research is needed to explicate these political implications.

Validation and Limitations

Validation criteria were derived from Hall's (2001) PAR definition to evaluate the quality and integrity of the study. The social investigation opened up communicative space for NPs to collectively investigate their experiences and foster more democratic relations (Reason & Bradbury,

2001). Education was constituted as NP stories that fostered learning and theorizing of the NP world, and thereby co-conceptualized collaboration in everyday worklife (Reason, 2006). Action enabled NPs to generate a meaning for role integration, articulate steps forward, and gain confidence in co-constructing role sustainability (Bradbury & Reason, 2001). Through discussion of power relations, NPs came to realize the importance of cultivating strategic capacity; thus the emergent nature of PAR created potential for enduring consequences.

The credibility of PAR is enhanced by managing the unexpected and taking a study's limitations into account (Reason, 2006). The HA with the more longstanding CoP actively helped to recruit NPs; as a result, the study groups were not equally represented and this may have compromised comparative analysis. Both the newness of the NP role and the limited experience of NPs in the politics of the role may have constrained dialogue. The study was centred on the NP role in PHC and was specific to the health-care context in British Columbia, which may limit its generalizability; according to Friedman (2001), however, knowledge can be applied as a template for evaluating similarities and differences, and thus can be translated for broader application.

Conclusion: Potential for Broad Use

The NP Role Integration in PHC Framework outlines dimensions of role integration and provides a tool for NPs to self-assess role integration within their own unique practice settings. The framework could be developed further as an evaluation instrument for policy leaders, decision-makers, and researchers to determine the status of NP role integration within a health-care setting or area and to identify deficiencies and strategies for role advancement. The discussion of NP collaboration as multilevel and complex and the NP role as politically significant for PHC reform illustrate the need to make collaboration everyone's business in order for NP role integration to be realized. Because NP collaborative processes are not yet fully understood and NP role integration in Canada is still uncertain, further research in these areas is indicated.

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Appendix 1 *Assessments of NP Role Integration*

Alietha's Assessment

Role Autonomy

In October 2005, Alietha, educated and licensed in British Columbia as a Family Nurse Practitioner, began in a newly created role with the Renal Program. With management support, she assessed the gaps in renal care. By collaborating with providers in a program review, she prioritized patients with early stage chronic kidney disease (CKD) and determined that her renal expertise would be best utilized by complementing family physicians in primary care settings. With leadership support, she expanded her role to include renal outreach to urban and rural communities, including the use of telehealth technology. In all sites, she collaborates with family physicians and nephrologists in shared care of CKD patients. Alietha's actions to determine the needs of the renal patient population, design a responsive role with the support of management, and bring about program changes to enable her contributions indicate that she has achieved advanced role autonomy.

Role Recognition

For Alietha, chronic disease management, health promotion, and injury/illness prevention are key to holisic care. Discussion of immunizations, falls–reduction strategies, and medication safety are embedded in each patient encounter. The care that she provides is focused not simply on the kidneys but on all aspects of the patient's health and well-being. However, many patients, families, and care providers lack awareness and understanding of the NP role and this create challenges. Alietha commented:

> *Patients hear the language differently. Some patients hear family "practitioner" and think I am a physician. . . . other patients hear the word "nurse" practitioner and think I have just basic nursing skills.*

Alietha notes that new clients are mostly accepting of her role. Ongoing care fosters client understanding and satisfaction with her role in renal care. But there is still much educating to be done with local communities and the general public. Role recognition is hindered by the small number of NPs available to provide holistic care and the lack of public awareness about the NP role.

Role Inclusion

Alietha notes that collaboration with family physicians and nephrology specialists has slowly improved through shared care. Some sites and teams collaborate more effectively than others, which reinforces the need for efforts in this area. Alietha has engaged in opportunities to formally describe her unique role to key stakeholders, such as family physicians, nursing staff, the hospital board, and the provincial renal community. However, she feels that team collaboration and inclusion of the NP role require further attention to enhance NP role integration.

Role Contribution

Alietha was keen to be included in the PAR study and she asked to participate in publications. She is actively tracking client and program results and exploring ways to evaluate program effectiveness. Evidence of role integration could be strengthened by improved tools and measures to show her contributions to PHC outcomes in the CKD population she serves.

Role Alliance

Alietha has strategically aligned her role to local, regional, and provincial renal programs. Over 4 years, she has received consistent support from local nephrologists and organization leaders. The integration of the NP role into HA renal programs has influenced changes to the existing BC Provincial Renal Agency. For instance, the NP role has been included in the care-provider database and NP-followed renal patients are now part of renal program funding. From the perspective of strategic alliances, she is advancing well in role integration.

Overall, Alietha remarked that these first 4 years of role development have been a time of tremendous growth and learning for her and many others. She commented:

> *I have really enjoyed the autonomy and flexibility to design my role around the needs of the community and my own expertise. Integration of my role into the existing health-care system has not been without its challenges, but I really believe it has been well worth the effort in terms of narrowing the gap in health care for British Columbians.*

Wayne's Assessment

Role Autonomy

Wayne was also educated and registered in British Columbia as an NP. He accepted a new position in 2008 in the Thoracic Surgery Program. The thoracic surgeons had lobbied for an NP who could provide primary care and chronic care continuity to patients with acute illness. The surgeons were delighted with Wayne's vast family practice experience in chronic care and facilitated his further learning of thoracic and radiology procedures through daily patient rounds, conferences, and linking with other thoracic programs. Wayne's autonomy was initially limited due to a lack of understanding of the NP role and the complexity of the specialty. By cultivating collaborative relations with surgeons, unit leaders, and other providers, as well as demonstrating a high standard of care and motivation to learn, he secured the trust of these stakeholders. Wayne's unique role in assessing the chronic care needs of acutely ill patients, navigating acute and PHC systems, and providing advanced nursing care has resulted in surgeons and unit staff modifying daily routines and policies to accommodate the NP role. He has achieved moderate role autonomy.

Role Recognition

Wayne has gained the competence to deliver holistic care to patients and their families. Clients accept and understand the NP role because they are prepared for a "team approach" from the outset. The surgeons explain, in their consultation with new patients, that once admitted to hospital they will be attended to by four thoracic surgeons and an NP who coordinates primary care and chronic health issues, along with unit staff to provide acute care. The NP care coordination gives clients an increased sense of security and confidence. The surgeons are keen advocates of NPs and publicly speak about their collaborative approach, although public awareness of the NP role is not yet evident.

Role Inclusion

Wayne sees acutely ill patients several times a day, first during rounds to deal with immediate surgical or chronic health needs and later to discuss a new diagnosis, meet with family members, provide discharge teaching, or consult with staff on managing co-morbid conditions. He notes:

> *Thoracic surgeons do not need to see their patients daily after surgery if all health and post-operative issues can be managed by an NP. In reality, issues such as hypertension, diabetes, heart disease, or smoking cessation, which are often associated with this patient population, are more appropriately left to providers who can provide a holistic approach and [make a] greater impact.*

Wayne's presence has enhanced team capacity. He and the surgeons meet each day to review the critical care needs of patients and draw up care plans. He is present in the thoracic unit on a daily basis, to complete team rounds, support decision-making, and provide education to staff, patients, and families; he is considered a vital team member. Through his direct and ready access to the thoracic surgeons, he mediates relations between the surgeons and the staff and has become a conduit for interdisciplinary management of the urgent and chronic needs of patients. Wayne has achieved role inclusion and is consulted by others in surgical and PHC networks.

Role Contribution

Wayne understands the importance of documenting his value-added contributions in order to advance role integration. He notes that there is early evidence in this program of NP role benefits to patients, mentoring of other staff, and savings to the system; however, this needs formalized measurement to determine NP health outcome contributions.

Role Alliance

Wayne has cultivated strategic alliances with the thoracic surgeons to develop a new NP role in which the acute and primary care needs of clients are holistically addressed. He has HA leader support and is recognized for innovations in advancing the NP role. His role success has elicited the interest of other specialist programs, the British Columbia Medical Association, and nursing leaders, indicating that role alliance is well advanced.

A surgeon commented:

> *We have changed the culture of care in our facility. The success of the Thoracic Surgery Program, the NP integration, and the impact on staff and patient care are evident, as every service (vascular, cardiology, orthopedics, hospitalists) has expressed interest in collaborative care and integrating an NP into their service for primary care. This is significant not only in terms of benefits to patient care but also for cost containment and savings to the system.*