The reality of introducing advanced nurse practitioners into practice

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The senior level gained by advanced nurse practitioners (ANPs) means they are in a strong position when it comes to representing the population. Nurses have had to educate themselves beyond post registration with Masters and Doctorates to support the client group, because of the growing population and 24-hour healthcare requirements. This is in support of the NHS’s commitment to care for patients from the cradle to the grave. There have been obstacles to the ANP’s advancement, but the five drivers of health care are firm and supportive and likely to have a great impact in the future for ANPs as service deliverers.

KEYWORDS: Advanced nurse practitioners Education Skill mix

There is a strong support within education for the essential role of advanced practice and advanced nurse practitioners (ANPs), which helps to positively represent advanced nursing roles to healthcare professionals and the public alike, meaning that they can better deliver health care. Although the title advanced nurse practitioner has been debated by the Association of Advanced Nurse Practitioner Educators (2014), advancing practice has finally been described as a level of nursing, not a role, which is in line with UK, European and international literature (Royal College of Nursing [RCN], 2008). The RCN’s competencies for ANPs are mapped against the NHS Knowledge and Skills Framework (NHS KSF) and are linked to the NHS career framework (Skills for Health, 2006), with endorsement by the Nursing and Midwifery Council (NMC). These competencies were devised and researched with higher education institutions (HEIs), service providers and professional organisations (RCN, 2012), with recommendations at Masters level for entry from the International Council of Nurses (ICN, 2008a).

ANPs have been described by the ICN (2008a) as registered nurses who have acquired expert knowledge, complex decision-making skills and clinical competencies for expanded practice; the characteristics of which are shaped by the context and or country in which they are permitted to practice. However, some countries have not differentiated the role of advanced practice due to their limited empirical research which has delineated the activity, role and responsibilities (Baldwin et al, 2013).

The introduction and development of the ANP role has been facilitated by:

- Demand from nurse associations
- Support from healthcare managers
- Training from education systems
- Patient and public interests (DH, 2009; Delamare and Lafortune, 2010).

Contrary to this, those who have a general professional interest with doctors and concerns about liability of malpractice may hinder the introduction of ANPs into practice and subsequently require further educating (Wallsten, 2004). This confusion is not restricted to the UK, as even countries such as Hong Kong have seen their greatest challenges associated with the ANP role coming from other healthcare professionals, along with the public’s traditional attitudes to healthcare provision (Christiansen et al, 2013). Requirements for further education in the role of the ANP have been suggested, along with more clinical support and system management (Dalton, 2013). However, despite attempts by medical boards to limit practice authority, as seen in the US (Phillips, 2013), there have been accomplishments for advanced practice, such as improving access for healthcare to use ANPs (Phillips 2013), or ANPs ordering of X-ray films if suitably trained.

Other obstacles to ANPs include:

- Organisation of care and funding mechanisms
- Legislation and regulation of scope of practice and education
- Training opportunities (Delamare and Lafortune, 2010).

However, the five drivers in healthcare could help to counteract these negative effects, namely:

- Healthcare needs of the population
- Education
- Workforce
- Practice patterns
- Legal and health policy framework (DeGeest et al, 2008).

These drivers can be used to educate and support healthcare professionals and the public as follows.

Driver 1 identifies the healthcare needs of the population and is
probably the most significant, as it is this that gives the impetus to take healthcare delivery forward. Various issues have influenced change in health care. They appear not only at local level, but also at national and international levels. Continued technological advances, changing healthcare needs (ICN, 2008b), and the structural changes in healthcare delivery are but a few reasons. All have influenced the professional (nursing and medical) bodies and governmental policies in this rapidly changing healthcare environment.

A glance back in history leading to the development of the ANP reflects upon the NHS’s purpose in the 1940s to promise to care for all from the cradle to the grave (Warden, 1995), but this has seen much ongoing and public debate. The Government wanted patients to have a continuation of care 24 hours a day, seven days a week, which meant that general practitioners (GPs) had a 24-hour, on-call commitment. GP recruitment decreased and the Government tried to find ways to deal with this. The Government wanted better teamwork, better access for patients and quality of care. They wanted to improve services while reducing GP workload. The Labour Party promised to create an NHS for the 21st century, investing huge sums to try and achieve its vision of a dynamic publicly funded, consumer-driven health service (Milburn, 2003). Milburn (2003) went on to say: ‘We’ve got to move down from the one size fits all, take it or leave it, top down health service of the 1940s towards an NHS which embraces devolution, diversity and choice.’ This followed the NHS Plan (DH, 2000) which proposed ending postcode lottery of care, investing in staff development and recruitment, as well as general practice, medical equipment and hospitals.

The general consensus of opinion was that nurses should hold greater role flexibility in primary care to meet the needs of patients more effectively, and should become the first point of call for the healthcare population, especially while many GPs were opting out of the 24-hour on-call commitment (Horrocks, 2002).

Thus, other ‘out of hours’ services developed, including the ‘one stop’, walk-in centres and NHS Direct — both nurse-led initiatives. With nurses performing some of the roles previously undertaken by doctors and the roles of other healthcare professional such as pharmacists developing in primary care, GPs were able to devote time to specialising in a selection of secondary care skills, such as minor surgery to reduce waiting lists (British Medical Association [BMA], 2009).

Blurring the roles of nurses, and working in different ways to adopt new responsibilities and displaying greater flexibility was suggested by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC, 1992). The NHS Management Executive report (1994) also identified many opportunities for nurses in primary care in exercising autonomy in diagnosis and treatment of certain conditions/problems. They also suggested nurses should take the lead by being the first point of contact.

Presently, care of chronic diseases is one of the most important areas to consider in primary care, especially with their increase. In 1990, 50% of the population had a chronic disease, but now the literature suggests that it has increased to 80% (World Health Organization [WHO], 2002). It is self-management of such diseases (WHO, 2002) that puts ANPs in great stead to care for these patients. In fact, ANPs are well-positioned to develop care models for chronically ill patients (Bodenheimer et al, 2005), making every contact count with compassion and the six Cs (Chief Nursing Officer [CNO], 2012).

The six Cs encompass:
- Care
- Compassion
- Courage
- Communication
- Competence
- Commitment.

In short, they amount to the new vision for nursing care, and have been incorporated within Cadman’s Change Model (2012), which provides evidence, models and measurements for healthcare delivery and discusses leadership change, spread of innovation, improvement methodology, rigorous delivery, transparent measurement, system drivers, engagement to mobilise, and our shared purpose. This is the education required in driver 2. Innovative solutions prepare ANPs to fill the gaps of healthcare today and of the future with development of the Doctor of Nursing Practice programme (Instone and Palmer, 2013). However, in the author’s opinion, all education needs to be followed up with audit and research to identify barriers and improvements within the system.

In the author’s clinical experience, ANPs are agents for health care and are well-equipped to use the evidence of various models available to implement evidence-based practice for change. This may include working with changing the behaviour of specific types of individuals, understanding their stages of readiness for change and reviewing strengths, weaknesses, opportunities and threats (SWOT) analysis (Hamer, 1999).

Driver 3, which promotes ANPs, includes workforce planning and highlights the problems of primary care GP shortages (MacDonald et al, 2005) with European working time directive regulations reducing junior doctors’ working time (Imison et al, 2008). Promoting ANPs here is often seen as being a substitution of doctors by nurses (Richardson et al, 1998). However, this is not surprising with the increasing numbers of nurses taking their education forward to higher levels, such as doctoral, and is provided at the highest bid for the lowest cost. Possibly, the future will see the ANP offering their services and competing on an international market for the health care of the British public. They are certainly in a good position to deliver a service at a comparable level of care as their healthcare colleagues, and should definitely be utilised within the system appropriately. Collaboration with GPs or working independently are both
considered to be as important, and is dependent upon the skill mix of the health care provided.

Other obvious factors driving the promotion of the ANP include the increasing demand for the aging population (Simeons et al, 2005) and the competencies/skill mix fitting with chronic patients (Buchan and Calman, 2004). The nurse has always been the healthcare professional most likely to see the patients with elderly care issues or chronic disease more frequently than other healthcare professionals, due to the nature of the work. Having advanced assessment skills of prescribing and clinical examination and diagnosis are extremely helpful in providing holistic care for these patients. Therefore, these opportunities need to be celebrated, with nurses being allowed to work alongside GPs in order that any issues of safety can be dispelled. Currently, in the author’s opinion, there is a greater emphasis on team work and integration with a need to work to government guidelines.

Protocols and computer templates help nurse-led clinics exercise autonomy in the diagnoses and treatment of certain conditions/problems as a first point of contact (NHS Management Executive, 1994). It is fortunate that these high level nurse posts were developed to try to keep nurses in clinical work and away from management (DH, 1998), as the concept is proving successful and needs to be properly supported in practice. Post-registration education and practice projects were set up to keep nurses updating themselves, especially as they move towards advanced levels.

Driver 4 focuses on practice patterns/models of care. The skill mix stimulated by changing healthcare needs include triage, walk-in centres, primary care centres, call centres, nurse-led clinics, transitional care models, etc. The ANP took the lead in developing these models which showed reduced readmissions (Naylor et al, 1999) and its effectiveness. They have managed to fill gaps of health care such as rural residency where services are few and far between. They have also been identified in some countries as being the safety net to the public who are underserved, replacing fragmented care with fuller coordinated care as they practice their variety of skills (Burke and Schwartz, 2012). In the US, there is new consideration of a doctor of nursing practice in orthopaedic residency, as the increasing numbers of this area of interest is a growing concern in an aging population (Instone and Palmer, 2013).

Driver 5 is an interesting legal and policy context. Outdated laws, regulations and policies have prevented other countries from maximising on their skilled workforce of ANPs and they are campaigning for action to eliminate these barriers in providing primary care to their public (Brassard, 2013). In the US, the Federal Trade Commission prevents unfair restriction of competition and challenges limitations to ANP’s work (US Federal Trade Commission, 2011). This is of importance as various healthcare models are developed to serve the public and should not be restricted for fear of competition from another healthcare professional.

The Francis Report (2012) discusses a culture of secrecy and defensiveness in health care and calls for better patient care with regulations of healthcare workers. He discusses the importance of the revalidation of the nurse under ‘ensuring staff are trained and motivated’. This is of concern because the Command Paper (2007) suggested that regulating ANPs was too costly a process and possibly a merge with other advanced practitioners would be a better option. The Francis Report added that rating healthcare providers as well as appointing a chief inspector for primary care (RCCGP Summary, 2013) would be of interest to the public. These recommendations may be helpful with the future regulation of ANPs, as they strengthen the debate around accountability of health care and safety to the public. More work on the variation of the ANP role is possibly required to aid with regulation for licensure, practice and education through a consensus model which identifies ANP’s prescribing medication, ordering tests and clinically examining patients, as is confirmed by the National Council of State Boards of Nursing (2012).

In essence, when reflecting on the reality of introducing ANPs into practice, the role of education needs to be central. Educating the public, GPs and other healthcare professionals who collaborate with ANPs to deliver the dynamic care of the public needs to be the prime focus. Other countries realise that preventing health care being accessed from this skilled workforce is not only detrimental for the public, but is also unfairly restrictive as a means of competition (US Federal Trade Commission, 2011).

The five drivers of health care should be used as a guide to promote ANPs’ involvement with:

- Healthcare needs of the population
- Education
- Workforce
- Practice patterns
- Legal and healthcare policy


Overall, in the author’s opinion, this is an exciting time for ANPs to serve the public in every arena.

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KEY POINTS

- Nurses have had to educate themselves beyond post registration with Masters and Doctorates to support the client group, because of the growing population and 24-hour healthcare requirements.

- ANPs are well-positioned to develop care models for chronically ill patients.

- ANPs are change agents for health care and are well-equipped to use the evidence of various models available to implement evidence-based practice for change.

- Having advanced assessment skills of prescribing and clinical examination and diagnosis are extremely helpful in providing holistic care for patients with elderly care issues or chronic disease.

‘There is a fine line between madness and magic.’

It is 1989 and community care is about to reboot the industry of psychiatry. In a soon-to-be-closed asylum a bruised nurse, Adam Sands, is feeling less like a purveyor of kindness and more like a concentration camp guard with every passing drink. Years later, Adam has got used to the quiet life when his past finds him. Maybe this time he can do some good. Even make a difference. But redemption, like magic, can come from the strangest of places.

‘Stranger than Kindness is funny, poignant, intelligent and compelling. I believe books are like stepping into little alternative worlds floating in your mind and this world was one I wanted to stay in much longer.’

JO BRAND
Scope of Practice: The scope of practice entails the cognitive, integrative and technical abilities of the qualified nurse to put into practice ethical and culturally safe acts, procedures, protocols and practice guidelines.