Rural nurse to nurse practitioner: an ad hoc process

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ABSTRACT

INTRODUCTION: Despite a 10-year history of nurse practitioner (NP) development in New Zealand (NZ) there is no formalised or universal process for ensuring the transition of willing nurses to NP status. This unmet need is of particular interest in the rural context where workforce issues are paramount. The aim of this study was to explore the transition from rural nurse to NP in NZ.

METHOD: A qualitative descriptive survey was sent to all NZ nurses with a rural address. Ninety-two questionnaires were returned, of which 21 respondents were working in a rural location and aiming to become an NP. Data analysis included description of demographic data and thematic analysis of open-ended question responses.

FINDINGS: Four themes encompassed the experiences of the 21 potential NP candidates: uncertainty about opportunities for employment as an NP and legislative and funding barriers for NP practice; support or resistance from GPs and nurse colleagues, self-doubt, and the importance of mentoring; difficulties with the NP authorisation process; and meeting the NP competencies within the challenges imposed by rural location.

CONCLUSION: At the systems level of workforce design, stronger linkages between policy development, investment, employment creation, funding streams, professional regulation and overall communication require attention.

KEYWORDS: Rural health; nurse practitioners; workforce; health policy

Introduction

In February 2010 the New Zealand (NZ) National Health Committee released a report entitled *Rural Health: Challenges of Distance; Opportunities for Innovation*.[1] This report outlines particular challenges for rural services and notes the need to provide rural communities with comprehensive primary health care. A requirement for innovation is noted, especially with respect to creating new workforce roles and making existing role deployment flexible. The nurse practitioner (NP) role was established in NZ in 2001 to deliver an increased level of service to manage full episodes of care in an expanded range of settings.[2] An NP in NZ (as in the United States, Canada and Australia) is a nurse who has completed a clinical master's degree, had at least four to five years' clinical experience and been formally authorised as an NP by the Nursing Council of New Zealand. The authorisation process includes preparation of an extensive portfolio which is audited against the NP competencies and attendance at a three to four hour oral viva in front of a multidisciplinary panel.

In response to the specific need in rural settings, between 2004 and 2007 a number of substantial scholarships were awarded to identified NP candidates whose aim was to practise in rural settings. Nearly 10 years after the introduction of the role there are 74 NPs in New Zealand, but few in areas designated as rural.

There is currently a rural health workforce shortage and forthcoming depletion due to retirement

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will exacerbate the pressure. The 2005 Rural Health Workforce Survey found that 73% of GPs (n=358) were aged over 40 and nearly 35% had an intention to leave general practice within the next five years. For nurses (n=445), 72% were over 40 and 25% expressed their intention to leave within the next five years.[3]

Whilst there are many ways for rural nurses to increase the level and breadth of their contribution to rural health, the NP role remains the professionally-agreed and policy-supported process for legitimating, remunerating and undertaking agreed clinical and educational preparation to support advanced nursing practice. We conducted qualitative descriptive survey research eliciting how the experience of intending NPs from rural areas can increase understanding of why this development has not progressed more rapidly or successfully.

Method

Ethical approval for the study was received from the Massey University Human Ethics committee and participants were informed that the completion and return of the questionnaire implied consent.

In carrying out the study, the first problem we encountered was identifying rural nurses with an interest in the NP track. We first aimed to recruit the nurses who had received funding via the Ministry of Health specifically to enable them to complete NP preparation, but no accurate recipient records could be found. We then placed the questionnaire on the Internet and advertised its presence through professional nursing organisation websites. Next we asked the Nursing Council of New Zealand (NCNZ) to send out a questionnaire on our behalf to all nurses who were identified as living in a rural location (the category of rural nurse is not included in their database) and who had agreed to take part research. This meant that surveys (n=650) were posted to a large number of ineligible nurses as rural addresses in NZ do not guarantee a rural work location. We received 91 surveys back, 21 from nurses who met our study criteria of working in a rural location and aiming to become a NP. Other respondents (n=70) had considered the idea and for various reasons not progressed but decided to respond anyway, adding data of interest as to why they were not actively pursuing the pathway.

The study materials consisted of an information sheet, a questionnaire and reply paid envelope for its return. The questionnaire contained demographic questions, a section on current status with respect to postgraduate qualifications and progress towards attaining NP status, a section on barriers and supports for postgraduate education and a section on barriers and supports for becoming an NP. This paper focuses particularly on the final section and the questions included in this section are presented in Appendix A in the web version of this paper. Via the information sheet the nurses were asked to participate by completing the questionnaire and returning it in the envelope provided.

Data analysis

Data analysis (n=21) included categorisation of the demographic data. The open-ended questions in the descriptive survey were subjected to thematic analysis looking for patterns, repetitions and commonalities between and across participant reports. Data excerpts were sorted into broad categories and refined as per agreed processes for thematic analysis.

Findings

Of the 21, there was one authorised NP, one unsuccessful application and one application pending. Of the remaining 17, 11 had completed a master's degree but not yet submitted an application, two had commenced but not completed a master's degree and five had not started a master's degree.

The surveys (n=70) of nurses not on the NP pathway were not formally analysed, but we noted a range of very diverse reasons for not committing, including cost, lack of support from employers, investment of time and concomitant stress not being worth the outcome, family commitments, perceived lack of job opportunities and difficulties of studying in a rural location.

There was remarkable consistency and four clear themes surfaced from participant data. Themes which characterised the experience of the 21

potential NP candidates were: uncertainty, support or resistance, concern with process issues and concerns about meeting the NP competencies within the challenges imposed by rural location.

Uncertainty

There is no guarantee of employment as an NP at the end of the long journey through education and authorisation and uncertainty emerged as a key theme. Some respondents did have positions ready and waiting for them, and these nurses tended to have more positive attitudes about their NP journey in general. Others have valid concerns; as one nurse said 'these employment opportunities do not actually exist yet' and another noted 'there is no planning by the DHB [District Health Board] to employ NPs'. Yet a further nurse added 'there seems to be a disheartening number of NPs unable to find employment as such—they are still working and paid as practice or general nurses'.

Being on a formal development pathway within the current employment position removes uncertainty. For example, one respondent noted '[I have] a contract set up to aid the journey with study days factored in, a financial commitment to study such that accommodation, travel, books etc. are paid for by the organisation I work for. Supervision is accounted for and I have easy access to the Director of Nursing.'

Uncertainty is further increased by a general awareness that, despite the NP role having existed for nearly 10 years, the many legislative and funding barriers have not been actively addressed to facilitate full use of NP potential. The already qualified NP said that the DHB management 'refuses to allow the ordering of radiology investigations' despite this issue having been addressed and clarified on a national basis. Another comment related to employment: 'Remuneration for NPs needs to be clear and how this is to be funded so GPs don't feel their income is threatened if they employ a nurse who wants to upskill to NP.'

Resistance and support

NP candidates experienced varying degrees of resistance and support. Considerable opposition was described as coming from GPs who were not prepared to support nurses in becoming NPs as they 'generally don't understand the role—it is new' or 'do not believe such a role is necessary', have a 'lack of vision for the NP role in general practice' and because they 'feel threatened by the thought of NPs'. One nurse described GPs as having 'separatist and elitist attitudes. NPs are not viewed on the same career/hierarchical level. Attitudes of GPs (are) reflected in their often condescending 'support'.'

Nurse colleagues or leaders were found to be as much or even more of a challenge 'It seems that many colleagues don't understand the NP process'. One nurse respondent said that her colleagues state that 'I am doing the job now so why do you need to be called a nurse practitioner?'. Self-doubt is also an issue for some nurses. Two nurses identified themselves as the most significant barrier to their progress so far, but in both cases the doubt was linked to a lack of support and not knowing how to proceed.

Where support was formally or informally available it made a considerable difference. The importance of mentoring was evident with most mentors being GPs or NPs. One said 'I was mentored for a year by GP who is now teaching general practice. This was invaluable.' Another example was 'by working closely with two GPs in particular who respect my opinion and diagnosis. I have been encouraged to explore this role with the view to becoming more clinically competent and developing more skills in assessing and diagnosing'.

Fewer than half of the respondents have managed to receive mentoring from a practising NP,

WHAT GAP THIS FILLS

What we already know: New Zealand has had nurse practitioners for a decade, but there is no formal process for nurses transitioning to nurse practitioner status. This is of particular interest in rural primary health care where there are significant workforce issues.

What this study adds: Developing stronger links between policy development, investment, employment creation, funding streams and professional regulation could assist the design of future workforce systems.

but it is not easy as the small number of NPs in NZ means they are likely to be geographically distant, working within a different scope of practice or already mentoring and too busy. Several respondents had made efforts to contact NPs and while some have agreed to help, many are 'too busy to help those who want to become an NP'.

Several nurses mentioned that the support they had received from the community motivated them to keep going as they saw the need for more advanced nursing services. One nurse described assistance towards becoming an NP as 'rural clients who really are interested and value the "specially trained nurse" '; another said she was in a 'community that shares the vision for me'.

Difficulties with the NP authorisation process

Many barriers along the career pathway were perceived to be related to preparation for the authorisation process itself. The portfolio (submitted to the Nursing Council of NZ as a part of the authorisation process) loomed large, attracting comments such as 'I am unsure whether my portfolio will be of a high enough standard—my colleague's wasn't'. Lack of knowledge about how to develop a portfolio was mentioned by several nurses and some also expressed concern about the stress involved in applying and being interviewed and possibly rejected. The form of the interview (an oral viva conducted as a part of the authorisation process) was another perceived barrier, described as the 'scariest' part of the process. The application process in general was viewed by many respondents as a real struggle, resulting in 'horror' or 'war stories from nurses who have applied, both successful and unsuccessful'. One nurse described her most significant barrier as: 'having to take on too many battles... and at the end of it I will have to fight to get employment as an NP'. Yet another stated 'not only are you studying, but I have been fighting for change, e.g. through local MP, deputy Minister of Health, rural PHO [Public Health Organisation], DHB [District Health Board], organising an employment contract with minimal help from NZNO [NZ Nurses Organisation] and at the end of it no guarantee of employment as an NP'.

Meeting Nursing Council competencies for nurse practitioner authorisation in a rural location

General descriptions and perceptions of the rural nursing role were proposed by the respondents. The broad scope of rural practice was alluded to by several of them, one noting that 'it is a challenge to study towards [becoming] an NP when the scope of practice is very wide—lifespan—and my focus is ultimately on 'rurality' as the defining community.' The degree of community enmeshment described was viewed both positively as support and negatively as endless demand for availability.

With respect to meeting five of the six NP competencies required by the Nursing Council, the nurse respondents held quite varied views. Meeting the first competency, advanced clinical skill, was reported to be achievable by most of the nurses. The second competency, collaborative practice across settings and disciplines, in the rural setting appeared to provide some barriers as well as some advantages. One nurse described it as 'no problem. [It is] inherent in practice as I usually work alone and therefore it is crucial for safe and best practice'; another 'this is difficult. There may not be other disciplines in the rural environment'. A general theme was that while the opportunities were there and collaboration was part of day-to-day practice, it is not always easily documented. Rural nursing was described as 'unpredictable and you must hold a large basket of skills and be adaptable to any presenting situation'.

Competency number three concerns nursing leadership and consultancy and the nurses were divided on whether or not there were opportunities in rural practice to meet these requirements. More found it problematic than not, one noting that it was 'difficult to do with distances involved. Opportunities are limited'. The fourth competency expects NP candidates to be able to develop and influence health/socioeconomic policy and practice at local and national levels. This was reported as being easier to achieve at a local than national level and dependent on the role. One nurse summed the situation up by saying: 'I believe this is the most difficult for rural, remote nurses to demonstrate. To take part in policy making even at a local level can be demanding

due to distance and inability to get a reliever. To influence policy at a national level is even more difficult and demanding and only possible with a flexible and understanding employer'.

In the responses to competency number five, the requirement to show scholarly research inquiry into nursing practice, the challenges of rural location and isolation were again prominent. Many respondents acknowledged the problems saying 'shaping nursing practice is difficult when working in isolation'.

Discussion

The findings capture the experience of 21 nurses who have considered an NP position as a new role in the health system selected on the basis of international evidence that it makes a major contribution to health service delivery. They had contemplated the possibility of serving a rural community as an NP but many had not taken the first step because they felt daunted by the requirements. The 21 respondents who were on the journey expressed consistent claims about the inherent challenges.

In the rural context of high need there appears to be no formalised or universal process for ensuring the transition of willing nurses to NP status. One aspect that serves to define rural nursing is the level of commitment these nurses have to community life and welfare. This social connectedness is described as leading to rural nursing providing valuable social capital.[4] 'Rural nurses may directly and indirectly contribute to the growth, development and cohesion of a rural health care system through multiple professional and social interactions'.[4] But in as much as the rural environment shapes the nature of practice required, it places particular obstacles in the way of development and these appear not to have been accommodated in workforce development for nurses.

There is still resistance to the NP role despite evidence supporting its effectiveness, safe practice and acceptance by patients.[5,6] In remote regions where medical staff are either reluctant to practise or stretched beyond acceptable levels, NPs make even more sense. Bourgois-Law concludes that 'The time has come for both family physicians and NPs to focus on what they have in common, that is, a concern for patients' well-being and a desire for respect and acknowledgement of their unique and often difficult roles.'[7]

Many GPs, who are often these nurses' employers, appear to have concerns about the role, perhaps due in part to perceived financial implications for them personally,[8,9] as rural GPs have elsewhere acknowledged their low income rate compared to their urban counterparts.[10] However, there also appeared to be a lack of appreciation of how the GP and NP roles can coexist and even have symbiotic potential. Not all GPs are concerned about the NP career pathway, since many of the nurses in this study reported receiving support and mentorship from GP employers and colleagues. It may be that many GPs need experience with working alongside NPs, or an even more serious workforce shortage, to appreciate NP abilities and contributions.

Despite national policy frameworks directed towards NP development, the sector itself seems strangely wedded to a less formalised process for utilising advanced nursing skills and knowledge. A letter to professional leaders from the NZ Institute of Rural Health in December 2009,[11] stated that 'If rural New Zealanders are going to continue to have available to them in their communities, an ongoing high standard of primary health care, then there needs to be better utilisation of the skills of the workforce'. The letter went on to note that 'rural primary care nurses are the ideal resource to challenge current work norms and indeed many already have'. However, without formalised support and guaranteed employment and remuneration once the journey is completed, it is perhaps remarkable that any nurses have been prepared to embark on the journey.

We note the continued existence of nearly 60 legislative barriers which create daily obstacles to NP practice, waste time and money and reduce the quality of care and access for patients.[12,13] Barriers include restrictions to the right to examine, treat, or refer clients, assess clients as fit or unfit for a particular job, and assess clients for eligibility for ACC (Accident

Compensation Commission) and social welfare benefits. Even where legislative barriers do not exist, there are custom and practice issues and regional variation in the extent to which funders, planners and managers are aware of the legislative rights of NPs.[14]

There is uncertainty about the actual potential for becoming an NP and additional uncertainty is associated with process issues which have obstructed rather than supported nurses on the pathway. Process issues are made especially challenging for rural nurses as they are compounded by relative isolation.

Nurses generally—and especially those interested in becoming NPs—are not interested in doctor substitution, and are far more interested in being afforded the opportunities to fully use their nursing skills and knowledge.[7] Some rural nurses, however, by virtue of location and circumstance, need to provide substitute doctor care due to the absence of rurally-based doctors—particularly after hours. There is a general theme of role ambiguity in the NP literature,[15] which may be compounded for rural nurses.

Meeting NP competencies clearly has specific challenges for rural nurses. Essentially the rural NP needs to be an expert primary health care nurse with well-honed skills in emergency and first contact care. But it is also clear that the NP competencies related to leadership and scholarship place additional and perhaps unacceptable demands on the nature and needs of rural practice. All aspects of the journey to NP status are much easier for those nurses who are on a recognised and supported pathway to NP employment within their organisation. It is salient that an apparently much needed form of workforce development is frequently left to chance and circumstance.

Conclusion

A number of key messages arise from this project. One, at the systems level of workforce design, is a call for strengthening linkages between policy development, scholarship investment, employment creation, funding streams, regulation and overall communication within the sector. For nurses themselves the study results emphasise the importance of establishing a planned NP 'registrar programme' so that both candidate and employer 'own' the process. There is value in increased dialogue with the regulatory body, the Nursing Council of New Zealand, to address the specific problems expressed by rural NP candidates in meeting the competencies not directly related to clinical knowledge and skill.

As numerous reports attest to the current and worsening workforce challenges in New Zealand it seems surprising that the implementation of a role such as NP has been left largely to chance and goodwill.

COMPETING INTERESTS
None declared.

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Appendix A

Questions

1. If you have completed a master's degree but not applied for nurse practitioner status, please tell us why you have not applied.

2. Please tell us about any mentorship you have received during your nurse practitioner journey. This may have included specific individuals or professional organisation membership or connection to a nurse leader (note: there is no need to name individuals).

3. Please describe any events or experiences that have assisted you during your nurse practitioner journey.

4. Tell us about the factor that has assisted you the most so far.

5. Please tell us about any people who have obstructed your progress towards becoming a nurse practitioner (note: there is no need to name individuals; we are interested to know the role titles and nature of any obstruction).

6. Please tell us about any barriers you have experienced during your journey to becoming a nurse practitioner (e.g. events or experiences).

7. Tell us about the most significant barrier so far.

8. Has the possibility of a lack of available employment as a nurse practitioner influenced your decision to become a nurse practitioner in any way?

9. Please describe your own opportunity or lack of opportunity in relation to the following competencies:

    - **Competency 1:** Articulates scope of nursing practice and its advancement.
    - **Competency 2:** Shows expert practice working collaboratively across settings and within interdisciplinary environments.
    - **Competency 3:** Shows effective nursing leadership and consultancy.
    - **Competency 4:** Develops and influences health/socioeconomic policies and practice at a local and national level.
    - **Competency 5:** Shows scholarly research inquiry into nursing practice.