The core role of the nurse practitioner: practice, professionalism and clinical leadership

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Abstract
Aim. To draw on empirical evidence to illustrate the core role of nurse practitioners in Australia and New Zealand.

Background. Enacted legislation provides for mutual recognition of qualifications, including nursing, between New Zealand and Australia. As the nurse practitioner role is relatively new in both countries, there is no consistency in role expectation and hence mutual recognition has not yet been applied to nurse practitioners. A study jointly commissioned by both countries’ Regulatory Boards developed information on the core role of the nurse practitioner, to develop shared competency and educational standards. Reporting on this study’s process and outcomes provides insights that are relevant both locally and internationally.

Method. This interpretive study used multiple data sources, including published and grey literature, policy documents, nurse practitioner program curricula and interviews with 15 nurse practitioners from the two countries. Data were analysed according to the appropriate standard for each data type and included both deductive and inductive methods. The data were aggregated thematically according to patterns within and across the interview and material data.

Findings. The core role of the nurse practitioner was identified as having three components: dynamic practice, professional efficacy and clinical leadership. Nurse practitioner practice is dynamic and involves the application of high level clinical knowledge and skills in a wide range of contexts. The nurse practitioner demonstrates professional efficacy, enhanced by an extended range of autonomy that
includes legislated privileges. The nurse practitioner is a clinical leader with a readiness and an obligation to advocate for their client base and their profession at the systems level of health care.

**Conclusion.** A clearly articulated and research informed description of the core role of the nurse practitioner provides the basis for development of educational and practice competency standards. These research findings provide new perspectives to inform the international debate about this extended level of nursing practice.

**Relevance to clinical practice.** The findings from this research have the potential to achieve a standardised approach and internationally consistent nomenclature for the nurse practitioner role.

**Key words:** advanced practice nursing, core role, nurse practitioner, nurses, nursing, scope of practice

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**Background**

The nurse practitioner (NP) role originated in the US during the 1960s, to improve quality and access to primary health care within under-serviced communities. The NP role was quickly adopted throughout the United States, with university-based educational programs developing rapidly (Walsh 2001). Similar factors to those evident in the US and Canada paved the way for the implementation of NPs in the UK in the 1980s (Harris & Redshaw 1998), including cost containment in health service provision, the development of a more skilled nursing workforce and the need to provide improved access to health care services (Horricks et al. 2002). Despite the longevity of the NP role and the common impetus for its inception internationally, there is a lack of consensus on the definition of the NP role (Reveley et al. 2001). Although the role of NP is well established in countries with very different healthcare systems, there are international similarities in the controversial issues surrounding NP education and role definition.

The experience of other countries reported in previous research, has already demonstrated particular features of the NP role. Nurse practitioners have developed a new level of health service that builds upon extensive clinical experience (Offredy 1998), is characterized by specialization (Walsh 2000), provides health service to populations that previously had poor access (MacLellan et al. 2002, O’Keefe & Gardner 2004) and works autonomously and in collaboration with other health care providers (Gardner & Gardner 2005). Development of the role in New Zealand and Australia has undoubtedly drawn from the experience of other countries, but also represents a unique interpretation of the role congruent with the nature of the two countries and their respective health services. While there is some research into the specialist areas, no previous research has identified the core role of the NP and the numerous standards and competencies in current existence internationally are not directly derived from research.

Hence, there is scant research that has attempted to define the essential and generic nature of NP practice. To date most research has focused on comparing the NP role with medicine on cost, quality, patient satisfaction and safety issues and some evaluation of the role from a health outcome perspective (Brown & Grimes 1995, Jenkins & Torrisi 1995, Kinnerley et al. 2000, Mundinger et al. 2000, Venning et al. 2000, Horricks et al. 2002). The current research makes a significant contribution to understanding the role itself and the actual and potential contribution of the NP to health service models.

This research into the core role of the NP was commissioned as a joint project between the respective nursing councils for Australia and New Zealand (Gardner et al. 2004). The findings were intended to provide a platform for development of standardized authorization processes and agreed competencies for practice and education for this relatively new role.

**Method**

The aim of the study was to describe the core role of NPs in Australia and New Zealand and to develop national/Trans Tasman standards for the recognition and education of NPs. In order to direct the data collection and analysis for the study, this aim was formulated into the following research objectives:

1. To draw on empirical evidence to illustrate the core role of NPs in Australia and New Zealand;
2. To investigate the current standards of education and program accreditation for NPs in Australia and New Zealand;
3. To describe the current authorisation requirements and processes for NPs in Australia and New Zealand.
This paper reports on the outcome of the first objective, namely research into the core role of NPs.

The study used multiple data sources and was primarily interpretive. The data collected related to current NP practice, established processes across a range of jurisdictions, documentary evidence, unpublished literature and the experiential aspects of the NP level of service in different geographical and clinical contexts of practice. Hence, the data sources used included research of policies and curricula, as well as interviews with clinicians.

Recruitment and participant sample

The number of authorized and practicing NPs in both countries at the time of this research was less than 100, hence purposeful sampling was used for an interpretive research approach. The inclusion criteria were authorized NPs currently practicing in a NP role. Nurse practitioners in New Zealand and three states in Australia where NPs were both legitimized and practicing were invited to participate in the study. Recruitment occurred through the nursing regulatory authority in each jurisdiction with a letter of invitation to participate, contact details of researchers in the jurisdiction and information and consent documents. Sampling concluded after 15 interviews, at which time data saturation through identification and strengthening of themes had occurred. Almost one in every three of the NPs interviewed practiced in New Zealand.

Data collection

The primary source of data for this component of the study was interviews with participating NPs. The interview contained two components: a semi-structured format was used to collect data relating to the NPs’ employment, education and authorization experiences; in addition, the participants were asked to describe a de-identified case that represented for that participant an exemplar of NP service. In-depth interview technique was used around this description to collect data on the experiential dimensions of NP work. This resulted in data of an in-depth examination of NP practice and reflections on that practice. These interviews were audio recorded and transcribed to produce text data.

Data analysis

Data were analysed to gain insight into the core role of the NP as described, experienced and reported by these clinicians. The analytical techniques used were those recommended by Boyatzis (1998), Denzin (2001) and Seale (2000) and involved an inductive approach. An iterative reading of the texts identified patterns within and across the interview data. The data were then aggregated thematically according to these patterns. Inductive analysis was used to order these themes into conceptual categories. Through this process, we have identified three major conceptual categories that are identified as the practice domains that describe the core role of the NP, namely:

- Dynamic practice
- Professional efficacy
- Clinical leadership

A final read cross-checked all interviews for the identified themes and highlighted textual samples which best captured these three conceptual categories.

Rigour

Research rigour was established according to the standard for interpretive research. All four investigators were involved in the collection and analysis of the data from NP interviews. Participant recruitment and data collection processes are fully reported to establish a clear audit trail. In addition, the reporting of the findings has included thick descriptions from the textual data to enable the reader to assess the interpretations and follow the investigators’ reasoning processes. The initial findings from analysis of the interviews were returned to the participants for member checking of fidelity of the findings with their own experience. The participants were invited to comment on these findings. All responses validated our findings according to the participants’ own experiences working as a NP.

Ethical considerations

Relevant university ethical approval for the study was secured. Informed consent was obtained from all participants. Robust efforts have been employed to protect the identity of individuals who participated in the study. Pseudonyms have been used throughout the report. None-the-less, the number of NPs in Australia and New Zealand is small and for that reason we have not reported a breakdown of demographic information relating to NPs, their service profiles, or the employing institutions.

Findings

The 15 NPs who were interviewed included eleven women and four men, aged between 29–56 years. The NP models included a range of health service specialties and contexts of practice, including rural and remote community centers and
Dynamic practice

Dynamic practice is structured through the themes that identify those features of NP practice that describe clinical work (knowledge and skills), the contexts of that work and the measures taken by the NP to maintain their clinical expertise. Analysis in this category indicated that at the core of the practice of the NP was extensive and systematic clinical knowledge and skill. Further to this was the ability to apply systematic empirical processes in both conventional and unconventional ways, according to the social and clinical contexts.

Comprehensive skills in patient assessment, as described by the participants, were central to all NP practice. The NPs showed that they extend the scope and depth of patient assessment and readily determine when collaboration or referral is needed. Joanne described how her knowledge of pathophysiology underpins her assessment process:

She had venous ulcers of long standing but now there is an arterial element as well, although I actually picked up a good Doppler signal from both the dorsalis pedis and the posterior tibial arteries. But I was unable to do a good brachial pressure index because of the way the ulcers were and the amount of pain. She had reasonable pain control, but not as good as I would have liked. She had persistent infections. She had a prominent allergic rash when I saw her, due to antibiotics which she had actually told them she was allergic to; and she was also passing frequent small amounts of urine and the antibiotics she had been given for the urinary tract infection had given her the rash.

There is an additional expectation that the NP will respond to the findings of the assessment in a particular way. All nurses are expected to carry out assessments and respond to their findings within a nursing scope of practice. The NP extends the scope and depth of that assessment and responds therapeutically to the results of their assessment or determines that referral is needed. Fran demonstrated that level of decision making:

So, I decided he didn’t need to go to hospital and I commenced emergency treatment for him, which was oxygen at 40 to 50 per cent, per British guidelines; and gave Salbutamol via nebuliser, which started to help him; and administered Prednisone and that would’ve been done intravenously if I’d needed to.

Our study showed that for these clinicians, assessment included the direct physical and psycho-social assessment of the person. Whilst the biophysical aspect of assessment was frequently described, many of the participants also reported assessment of communities and the context as well as the patient, in terms of who they are and what circumstances were affecting their health issue. As one participant noted:

A 72-year-old woman lives alone, pensioner; has one daughter, but she lives in Sydney; doesn’t drive. There’s no public transport out here and she relies on friends for her fortnightly visit to the nearest major town for groceries and to do business. Her abode or her living conditions are poor. Meds. – nil. This lady is an ex-nurse actually, tough as nails. History - none significant; nil allergies.

In reporting this assessment, the NP does not differentiate the physical from the social aspects of assessment, but easily provides a holistic evaluation of this patient through building a picture that will inform the approach to management.

The nature of a NP position requires first line response to a wide range of situations, depending on the sphere of practice of the nurse and the context in which practice is located. NPs need an extensive knowledge base from which to provide this service. Maree related a situation where application of scientific knowledge, rapid decision making and technical skill in the emergency treatment of a patient resulted in positive outcomes:

This guy was in the pit in a mechanics place and he was burnt by fire. His wife rang me and I was there within two minutes. I had said to them put him in the shower, so they had put him in the shower. I wrapped him in a sheet, put him in my car and took him to the clinic. I had him in the shower while I was getting all the bandages and everything ready and then his wife and I put SSD cream over every part of his burns and bandaging; and I was on to (the named emergency service) of course and I had him on morphine. Now I got a drip into a pretty shocked man, which I think is quite a thing to do; and he was in awful pain so he sort of shut down and I got morphine and loads of fluid into him. The bandages were all done and we had him in the plane 20 kilometres away within three hours and in hospital in four hours, under good pain control. He didn’t suffer any
infection, he didn’t even have to have skin grafting or go to (named) hospital and he was home within about five days.

Dynamic practice, as defined in this interpretive study, has several core components. These include highly developed clinical practice skills, focused on a particular population group or area of specialty practice. Key elements of dynamic practice are comprehensive assessment based on skills in advanced physical assessment, analysis of the person in context and advanced knowledge in human sciences. Dynamic practice incorporates the ability to initiate therapy, prescribe medication and to initiate investigative procedures. Finally dynamic practice includes the need to address currency of practice as a continuous process.

Professional efficacy
Professional efficacy describes nursing at a level of practice that is supported by significant autonomy and accountability. Whilst collaboration is important, the very nature of the NP role allows that the nurse is responsible for the complete episode of care. This means accepting the need to act autonomously in decision making and follow through in patient care. The NP crafts a new and different health service relevant to the consumer population and unmet access needs, grounded in a nursing model of care. The notion of professional efficacy also aptly describes the facility to participate as a senior member of the multidisciplinary team in effective processes of collaboration.

The participants described their role as characterized by the combination of an increased range of technical skills delivered within a nursing framework. The centrality of nursing to the extended level of practice was a repeated theme in the narratives across all interviews. For example, one participant concluded her description of highly technical practice with sick neonates including intubation, respiratory support, blood gas management, insertion of lines and titration of medications with the following statement:

So it’s kind of busy when you have a patient like that in the unit because there is a lot of emotional work to be done.

In the following narrative, Sam described her view of the distinction:

Well, the main difference is that I’m a nurse and they are doctors and our philosophies are very different; and nursing is more focused, I think, towards the health and wellness model and looking at maximising a person’s well-being. Even if we can’t fix their problem, then we help them to be as well as they can and to cope with living with [their diagnosis].

In the following narrative, Rita described the way that a patient/client responded to her as a nurse:

I saw a young woman, a 35 year old, yesterday, with one of our doctors; that was our first visit to her and it was almost like we touched on things that she didn’t really want to talk about and it was a bit of an uncomfortable visit. I went back today because there were a few things that I need to follow up on and we had a connectedness – she just poured all this stuff out that didn’t come out yesterday. Do you know what I mean? I just think it’s a different way – people with nursing training just give off a different aura that people connect to. They don’t see you as the busy doctor whose only got a limited amount of time, (with no) time to talk.

This illustrates the therapeutic link between patient and NP. Through that therapeutic link, the NP incorporates the complex social context of each client and aims for lengthy and meaningful encounters. Explicit in the data was the NPs’ highly developed personal autonomy and accountability, but also the inclination of these clinicians to stay with a patient’s problem until both they and the patient were satisfied with the outcome.

The participants were also clear that their role had some overlap with activities previously considered to be within the domain of medicine. The addition of diagnostic ability, the ability to request pathology tests and X-rays and prescribing were viewed as a convenience for patients to improve timely health service previously compromised by remoteness or workforce shortages. However, more importantly, they demonstrated that the ability to provide care that is more comprehensive assisted with reducing fragmentation, thus benefiting patients.

Autonomy and accountability were identified as inherent in the NP role. What perhaps focuses the notion of autonomy is the context of extended practice, in that NPs in New Zealand and most states of Australia are now legally sanctioned to carry out functions which they may have previously done in the grey area of standing orders, customary practice in some areas and relationships of trust between particular individual health professionals. The following narrative from Carmel illustrated this:

[We were autonomous before, but I actually, I am actually working more autonomously because I feel I have got the Nursing Council’s approval to do it. Before I would just say to one of the medical staff ‘Is this ok?’ Now I will just do it and I will say to them this is what I have done.

Professional efficacy captures the professional identity and authority that supports the NPs’ extended practice. This domain also defines the NP as a senior member of the
multidisciplinary team, recognizing autonomy and collaboration as central to this extended practice role.

Clinical leadership
Our third practice domain in the core role of the NP is defined as clinical leadership. Our findings indicate that the NP role is derived from a strong base of clinical experience and education, which develops both extensive and extended clinical skills and a critical awareness of the place of nursing in health service delivery. Consequently the NP role is a leadership role in clinical practice. In addition NP participants noted their need to draw from that knowledge base and to conform to consistent evidence review, to inform and guide local and national health policy and to participate as a senior member of the discipline especially in relation to their sphere or scope of practice.

Nurse practitioners expect to and do lead, both in the immediate clinical environment and in the wider context of health service delivery. Leadership here involves several components, including leading and developing practice and leading in the sense of responsibility for service. One NP demonstrated how her leadership involves responsibility for the practice of others:

Well, he, himself wasn't a challenge at all. He was quite agreeable to everything, but it was probably his situation; where I was needing to work with a lot of different people and everything was happening to him really, without having a lot of control. It was working with the nurse and making sure that all the other variables were taken care of, such as proper techniques of blood glucose monitoring and testing.

For many of the participants this aspect of their practice was still developing and this is reinforced by the lack of specific literature in this area. The leadership aspect of the role is tacitly recognized by all, managed effectively by some and is embryonic in others. There was recognition by participants that they have still to develop and achieve their full potential in this area.

The final aspect of leadership is the need for NPs to have in-depth knowledge of the legal and ethical dimensions of practice, policy directives and best practice guidelines that influence their own practice and the practice of the people they lead:

The bit that I don’t do a lot of is policy, influencing policy … because we haven’t had really good education surrounding policy development.

Key elements of clinical leadership were articulated as the need to guide and influence care delivery systems through engagement in policy development, either directly at local organisation or local Government level, or through active engagement in the policy work of their professional organisation. Kim’s comments illustrate this aspect of leadership:

I look at the model of NP that I’m trying to hold onto or develop to show people that this can be; this can be a model for a NP working in a community area.

The data on clinical practice leadership, whilst convincing, was tentative. This may well be related to the newness of the role in Australasia and the developing maturity of the clinicians as they scope out their role in health services.

Discussion
This research demonstrates that the core role of the NP is characterized by three practice domains: dynamic practice, professional efficacy and clinical leadership. The practice is dynamic in that it involves the application of high-level clinical knowledge and skills in a wide range of contexts. The NP demonstrates professional efficacy, enhanced by an extended range of autonomy and including legislated privileges. The NP is a clinical leader with a readiness and an obligation to advocate for their client base and their profession at the systems level of health care.

Aspects of Daly and Carnwell’s (2003) work on role development supports the findings from this study, in that they describe role development as resulting from new demands and perceived shortcomings in the quality of patient care and health care resources. This study has clearly shown that NPs are delivering a new level of service in which they extend nursing by the incorporation of a range of tasks and procedures and by increasing the range of service contexts in which they practice. However, because of the lack of international standardization in nomenclature, legislation and role definition relating to advanced practice nursing roles (Lyon 2004), Daly and Carnwell’s analysis does not sit easily with NP role development and definition in Australia. Indeed, this research provides a sound basis from which to build international consistency related the role of the NP.

The findings from this study related to the requirement for the NP to apply extended practice skills in both conventional and unconventional ways, supports previous research (Offredy 1998). Offredy studied NP decision making and found that NPs have an understanding of the patient in terms of their social circumstances as well as their presenting problem. Additionally, in approaches to decision making, NPs used a combination of pattern matching and intuition in arriving at decisions about patient care. This approach, according to her research, enables the NP to engage in reasoning processes in non-problematic or stable as well as uncertain situations.

Our research indicates that, as well as a comprehensive
that is characterized by the data in this study. At the time of
to date been focused on the wider systems level of leadership
example Mick & Ackerman 2000), research attention has not
leadership role of the advanced practice nurse in general (for
literature in this area. Whilst there is literature related to the
still developing and this is reinforced by the paucity of
For many of the participants this aspect of their practice was
of clinical leadership is emerging as a central role for the NP.
participants. Nonetheless, our research indicates that the area
indicate a pressing need for further research in this area. The
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