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## A Conceptual Model for Nurse Practitioner Practice

Prepared for the Canadian Nurse Practitioner Initiative (CNPI)

Rob Calnan, Manager, Practice and Evaluation

By

ROBINSON VOLLMAN INC.

Ardene Robinson Vollman, RN, PhD

Ruth Martin-Misener, RN, NP, PhD(c)

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In this document, we propose a model for nurse practitioner (NP) practice within the context of advanced practice nursing<sup>1</sup>. The model depicts practice as a registered nurse (a nurse practitioner) providing care and service (advanced practice nursing) to a client (individual, family, aggregate, or community), in a network of social and cultural contexts, over time.

The CNA has a framework for advanced nursing practice. "It describes an advanced level of nursing practice that maximizes the use of in depth nursing knowledge and skill in meeting the health needs of clients" (1, p.1).

Advanced nursing practice is an umbrella term used to describe the roles of NPs (2) and clinical nurse specialists (CNS) (3). Advanced practice nursing is used to describe the whole field of advanced nursing practice (4).

Advanced practice nurses exhibit

several characteristics and are able to demonstrate competencies in five key areas (clinical competence, leadership, collaboration, research, and change agency) (1).

In March, 2005 several experts met in a two-day colloquium to debate key questions leading to NP practice model development (5). In preparation for the colloquium, we asked "Is a new model for NP practice needed; is there nothing available in the current literature we can use to describe NP practice for the CNPI?" In response, we reviewed a number of models of advanced practice nursing and nurse practitioner practice models and found each wanting, in different ways (6). Few models were Canadian and, as a consequence, did not respect our unique healthcare system, context, identity, strengths and challenges. Therefore, we opted to create a model of NP practice based on the literature commissioned for the CNPI.

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<sup>1</sup> The March 2005 Colloquium report advised the term "advanced practice nursing" not be capitalized or abbreviated because it is not a title protected by regulation.

In colloquium discussions, the NP was affirmed as an advanced practice nursing role, and a recommendation was put forward that urged CNA to revise its framework to reflect the broader conceptualizations of advanced practice nursing. Further, the colloquium identified key differences in NP and CNS roles and recommended discussions continue in conjunction with key stakeholders to achieve clarity. The colloquium began the task of describing unique qualities and characteristics of NP practice:

1. The primary focus of NPs and what makes them different from other nursing roles is the legislated authority for autonomous diagnosis of disease, prescribing, and treatment;
2. The focus of the NP role is direct clinical care with clients that emphasizes health promotion and prevention, early detection and treatment of episodic, acute, and chronic health problems; and
3. What is unique about the services offered by NPs derives from blending highly developed clinical diagnostic and therapeutic knowledge, skills, and abilities within a nursing framework that emphasizes holism, health promotion and partnerships with individuals and families, as well as communities.

Over the remaining months of the CNPI, exemplars and stories of NP practice were collected and analysed to further develop understanding of the NP role.

Practical deliberation (7) forms the foundation for our conceptualization of NP practice. To deliberate means “to think carefully and attentively; reflect”(8). Deliberation is purposeful and intentional. By the term ‘practical’ we mean that the concepts and descriptions we use are derived from and are applicable to actual real-life events and descriptions of NP practice, the decisions that need to be made, and the outcomes of those choices. In contrast, theoretical problems are more abstract and further way from real experiences. The model we propose is consistent with the metaparadigm of nursing<sup>2</sup>, but has been derived by a different process – deliberation.

In deliberating about practice, we find Schwab’s four “commonplaces” to be instructive: the nurse practitioner (NP), the client, the discipline; and context (7). Further we add Ben Peretz’ fifth commonplace (time) to connote the novice to expert conceptualization inherent in the evolution of practice of the discipline of nursing (9).

What is a commonplace? A commonplace is an ordinary, natural, everyday element that serves to organise thinking about topics. Using the commonplaces in deliberations allows full assessment of situations and helps to uncover and seriously consider enough alternatives. To ignore any of the commonplaces, or privilege some over others, would bring an inadequate assessment to the deliberations. A

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<sup>2</sup> Person, health, environment, nurse.

systematic consideration of all five commonplaces is essential.

In this sense, to think about NP practice, one needs to examine the NP, his/her unique subject matter or discipline (advanced practice nursing), people and or communities served by the NP (client), and the places, and nature of those places, where NP practice occurs. Since we appreciate the notion that upon graduation, nurses are not expert at nursing, we include the commonplace of time to allow deliberation of the process by which, over time, the NP moves from novice NP practice to expert NP practice. Time is included in each of the commonplaces to indicate how, over time, knowledge levels expand with respect to clients and the complexity of their needs; the body of knowledge of the discipline; and complex systems and contexts that affect the practice environment.

In the first section of this document, we will present the approach we used for model design. Then, we will detail the elements of the NP Practice Model in light of the vision of the healthy client and the five commonplaces. We show how the model is situated within scholarly inquiry and evidence-based practice, the Canadian healthcare system, and the norms and values of the broader Canadian society.

### **Approach to model design**

Using the key concepts discussed above, a draft model was proposed by the facilitators (Robinson Vollman &

Martin-Misener) at a colloquium held in March 2005 comprising key experts in NP practice that had been brought together to provide advice and direction to the Manager, Practice and Evaluation, CNPI. We incorporated feedback provided by these experts into a second draft model that received feedback on a teleconference. This report captures the input and reflections on the model (Figure 1) through the colloquium and feedback process. In a practice workshop held in June 2005 with a group of NPs, administrators, regulators and health care providers from other disciplines, we obtained further input on practice configurations and facilitators and barriers to NP practice that further informed the model.

In the next sections, we discuss each component of the model separately. The order of presentation begins with the discipline because this is where the subject matter content knowledge is held and where regulatory and educational institutions address standards and licensure issues. The client commonplace follows because the *client* base determines the focus of NP practice while the *context* determines the practice pattern arrangement within which the NP works. Next we present the *NP* commonplace, illustrating its dependence on each of the other commonplaces that create its foundation. The *time* commonplace completes the discussion and illustrates how the NP moves from novice to expert, the context from micro- to multi-system, the client from individuals to families and communities, and the

discipline from a narrow focus to breadth of focus.

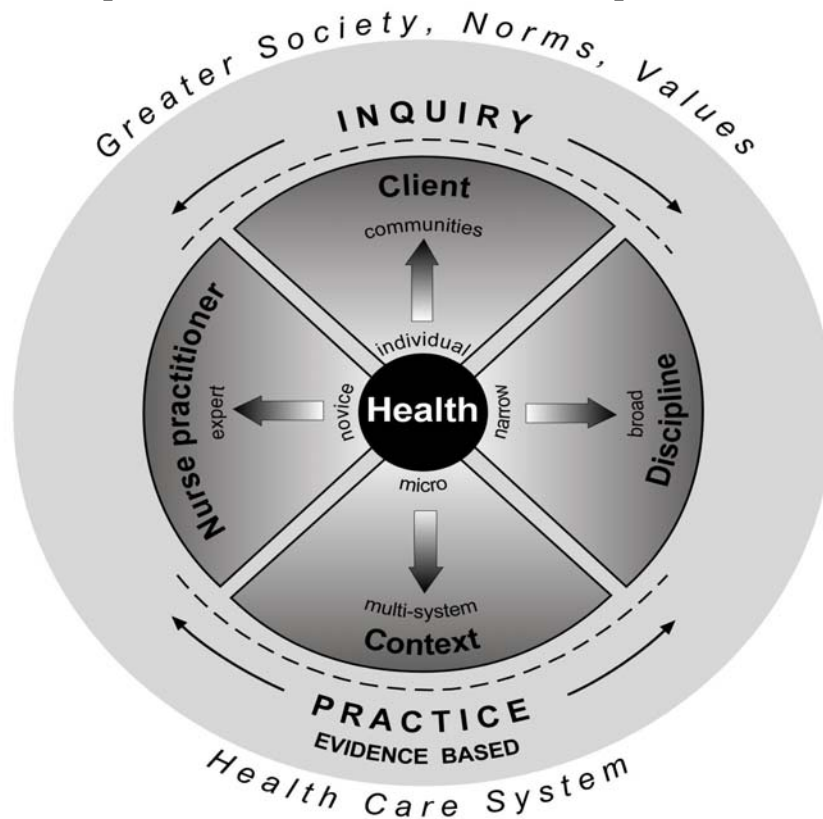
*Vision of health*

First, we see health at the centre of the model. The vision of the healthy client (individual, family, group or aggregate, community, and/or population) or, in other words, the “outcome” of nurse practitioner practice is defined here. What is health? According to the Ottawa Charter for Health Promotion (10) health is defined as: “a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment.

Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities.”

In order to achieve this vision of health, and therefore a healthy client, the five commonplaces need to act separately but in concert towards health as the central goal of NP practice. In the next section, we will describe each commonplace. Each commonplace is viewed as a separate entity, not as intersecting or interacting with others or the external environments in which practice is situated. Later, if evidence warrants,

**Figure 1: A conceptual model for Nurse Practitioner practice in Canada**



researchers can speculate on or demonstrate the interactions among the commonplaces.

### *The Discipline commonplace*

This commonplace contains the body of knowledge of the discipline of nursing and self-regulatory aspects for the profession of nursing. What does the discipline of nursing offer in terms of understanding the content (body of knowledge) associated with NP practice? As a result of the efforts of the Canadian Nurse Practitioner Initiative (CNPI) Practice Component, the definition of the NP has been recommended to read as follows:

“Nurse practitioners are experienced registered nurses with additional education that have achieved the competencies required for nurse practitioner registration or licensure in a province or territory. Using an evidence-based, holistic approach that emphasizes health promotion and partnership development, nurse practitioners complement, rather than replace other health care providers. Nurse practitioners, as advanced practice nurses, blend their in-depth knowledge of nursing theory and practice with their legal authority and autonomy to order and interpret diagnostic tests, prescribe pharmaceuticals, medical devices and other therapies, and perform procedures. They carry out these actions for the purposes of:

1. diagnosing and/or treating acute and chronic disease;

2. promoting, protecting, maintaining, rehabilitating or supporting health;
3. preventing illness or injury; and
4. supporting end of life care.”

Advanced practice nursing “is an umbrella term that describes an advanced level of nursing practice that maximizes the use of in-depth nursing knowledge and skill in meeting the health needs of clients (individuals, families, groups, populations, or entire communities)”(1). In this way, advanced practice nursing extends the boundaries of nursing knowledge and contributes to the development and advancement of the profession.

Advanced practice nursing is not a title and therefore should not be capitalized or abbreviated. It occurs within the full scope of registered nursing practice, and a nurse working at an advanced practice level exemplifies certain characteristics listed in the CNA Framework (1). In addition, advanced practice nursing comprises a set of core competencies.

As we deliberate the discipline commonplace, it is important to note that this is where the specific subject matter knowledge is held, skills are articulated, and where competencies that are “licensed” are located. Standards also fit in this commonplace as specific targets and ethics of NP work.

Acts governing NP practice need to be examined in light of their impacts or effects on other relevant professional Acts that either facilitate or impede NP

practice. If, for instance, pharmacists, diagnostic imaging technicians, laboratory technicians, and/or others are prohibited by their Acts from acting on prescriptions or requisitions from NPs, the nursing profession needs to step in and advocate for NPs. In this case, the Federal, provincial and territorial (FPT) Nursing Associations and/or Colleges represent the discipline commonplace. Standards of NP performance are set by the discipline (profession), even though the employer may enact them.

Outcomes or performance standards (11) of NP practice include improved access to quality cost-effective care; timely access; addressing service gaps (p. 28); and patients' satisfaction with NPs ability to care for them in primary care practices, including time spent and quality of information provided (p. 29).

The discipline is where NPs go to learn more about the situations that they face, current knowledge and research, the emerging skills needed, and the politics, economics, and values that impact practice. Often the discipline partners are involved in creating and disseminating new knowledge through educational institutions, professional journals, researchers, and continuing education sessions and conferences, offering CE credits and/or certificates for achievement.

### *The Client commonplace*

The description of the specific client base and the characteristics, needs, desires, and capacities to which a NP must respond is part of the deliberation

process for this commonplace. The nature of the client, health status, health literacy and knowledge of self-care, aspirations for health outcomes, anxieties, capacities, and barriers in place to healthy outcomes – these are key topics for deliberation. It is important that this deliberation be undertaken by direct involvement with the client group, or with the participation of the client group in the deliberations.

Who is the “client”? What are the client characteristics? The CNA Framework (1) depicts clients as individuals, families, groups, aggregates, populations, and communities. We can further suggest that clients are recipients of care, come from diverse backgrounds, span a large age range, have a variety of health needs and coping skills, and live within social contexts. Additional detail will be added to this conceptualization based on the narratives we will obtain from practising NPs.

### *The Context commonplace*

The context refers to the immediate milieu in which NP practice occurs. In what sorts of settings do NPs carry out their work? How do these and other contexts influence the NP? Consider these influences not just from the NP perspective but also from client and co-worker points of view.

Deliberations regarding this commonplace must include the various milieus in which practice takes place and which the outcomes of care are

brought to bear. The relevant contexts are manifold, nested one within the other, and include the setting and organizational structure in which NPs interact with clients and other professional colleagues. What are their relations to each other? What is the structure of authority? What is the relationship of this practice grouping with other practice groupings or healthcare professionals and/or systems?

Literature reviews prepared for the CNPI reveal a number of contextual descriptions. First, the client/public lacks understanding of the role of the NP and the benefits to the public of that role.

Second, there is lack of understanding of the role by physicians who have not practised with an NP; those that have, are more clear about the role and its contributions to the healthcare system. Physicians underscore this lack of understanding by claiming to be unhappy with NP role preparation (i.e., knowledge base). Further, they view collaborative practice as time-consuming, disruptive and potentially deskilling for themselves. Physicians fear they are being asked to change their practice behaviours to accommodate NP practice, creating tension and slowing the pace of change to collaborative practice models. These factors are affecting physician-NP relations at the front lines, relations at the Association levels, and creating tensions around professional legislation and regulation in many provinces. The economic and

financial barriers are significant barriers to NP implementation.

In the third place, there is concern around remuneration and medico-legal liability as they relate to inter-professional practice. Physicians are anxious about their liability for care provided to patients in the context of collaboration with an NP. Some NPs have concerns about their liability for delays in patient care that occur as a result of system-related barriers to NP practice, for example, when lab results are sent to the physician instead of the NP.

Other contextual factors are played out at the employer agency level with respect to practice pattern arrangements. At the organizational level, who should manage NPs and how is unclear in many settings; job descriptions may not be clear; and performance benchmarks for quality care have not been determined. Setting-specific policies (11) regarding coverage of week-end shifts, statutory holidays, sick time need to be developed, and continuing education, remuneration, and other employment issues need to be more standardized (p. 54).

There are many practice pattern arrangements in which NPs provide health services. The literature, including Canadian research (12-16), suggests that some of the key concepts in these arrangements or models are:

- The nature, needs and priorities of the client;
- The focus and scope of services provided by the NP;

- The context, including geography, availability of resources, roles of other health care team members, employer policies and supports;
- Legal and regulatory requirements;
- How collaboration, consultation and referrals occur internally in the setting among team members and externally to other health care providers, organizations or levels of care;
- The availability of information systems such as electronic health records, telehealth, internet, etc.; and
- Models for funding and remuneration.

The following are some of the models of care now being used in Canada; it is evident that the variety and scope of the settings and the nature of the populations served are diverse:

- Geographical settings – remote; rural; urban
- Institutional settings – community health centres; long term care centres; community hospitals; ambulance transport; nursing stations; family practice offices; home care services; student health services; mental health settings; correctional facilities; academic practices; emergency rooms; among others.
- Populations – all ages primary care; lower socioeconomic groups; aboriginal populations; people with chronic diseases; students; employees; among others.
- Practice configurations – solo (independent) practice; interdisciplinary teams; legislated

collaborative agreements; consultative models; inter-professional practice; among others.

The future may offer fewer health human resources to meet the increasing demands for care from elders who are living longer with chronic conditions, aging in place, and have need for technology and support in the community. In addressing the context commonplace, NP practice pattern arrangements need to be assessed to ensure the NP role is optimized without unnecessary barriers/restriction placed on it.

### *The NP commonplace*

For the deliberations of this commonplace, we must understand the expectations of nurse practitioners as a population – what they know, what they have experience in doing, what skills they hold, how flexible they are in terms of learning new ways of carrying out their nurse practitioner skills, their values, attitudes, and capacities. We need to understand how they are likely to interact with colleagues, with clients, with one another. We need to understand what they have learned in their NP programs and what they bring with them in terms of nursing theoretical approaches, biases, and what issues they champion.

The role of NP has suffered from a lack of clarity so that the various federal, provincial and territorial jurisdictions have had to write their own definitions, determine respective scopes of practice,



and set educational requirements for role preparation and performance standards that differentiate NPs from other advanced practice nursing roles. This makes stipulating national-level characteristics for NP a difficult task.

The basic preparation for the NP is founded upon a set of agreed-upon pan-Canadian core competencies that all NPs will demonstrate (17). These 78 core competency statements describe the minimum requirements with respect to the integrated knowledge, skills, judgment and attributes required of an entry-level nurse practitioner to practise safely and ethically in a designated role and setting, regardless of client populations or practice environments. There are four categories of NP core competencies that build upon the foundation of RN competence: health assessment and diagnosis; health care management and therapeutic intervention; health promotion and prevention of illness, injury and complications; and professional role and responsibility.

According to the literature provided by the CNPI (11, 19-21) and our own experience and reflections, NPs have the ability to practice in a variety of settings; with multi-faceted clinical role skills; often in ambiguous and/or complex situations where they need to use complex reasoning, critical thinking and analysis to inform practice, judgement, and decision-making. Hence, the NP must be an independent learner who is continually seeking new understandings through a variety of means to reflect

critically on practice. He/she also has well-developed communication, negotiation and conflict resolution skills that fosters the ability to demonstrate leadership in planning, implementing and evaluating interventions; provide care to a variety of clients (individuals, families, aggregates, populations, and communities) by engaging clients in care. It is important for NPs to work at multiple systems levels to get to the root of the problems that surface.

### *The Time commonplace*

Ben Peretz (9) suggested a fifth commonplace that offers a means of incorporating the novice to expert practice component we acknowledged previously. A newly graduated NP will not be expert in the competencies, but over time (and with experience, mentorship, and continuous learning) to fully appreciate the NP role, he/she will develop expertise in all areas (22).

Similarly, over time and with appropriate inquiry we increase the body of knowledge of the discipline; improve our understanding and ability to work within and influence multiple system contexts; and gain a breadth of understanding of our client population (from individuals, families, groups, aggregates, populations and communities) as we interact with it over time and history.

### *Evidence-based practice and the external environment*

Nurse practitioners practice within a professional context that demands that practice be based on research and evidence. Hence, the core model is encircled by permeable lines that comprise “society” and “evidence-based professional practice and inquiry”. This means that greater societal norms impact on practice and that there is impact of society on each of the commonplaces. Further, inquiry and evaluation are necessary conditions to ensure quality and coordination among deliberations and action.

### *The Canadian healthcare system*

There have been several initiatives, commissions, and reports in place that have and are affecting the role of professionals practising in the health system across the country. Each of these professions is regulated in different ways, from different perspectives, and for different purposes. This larger environment (and perhaps others, such as the education and social welfare systems) has an impact on how NPs are situated in the practice arena. Any discussion of practice therefore must consider these elements since this larger system will govern the emphases of funding and practice for the next decades in terms of primary health care, long term care, acute diagnostic and tertiary critical care service, response to crises, and the like.

CNPI literature reviewed revealed the following healthcare system and environmental factors:

- Having no national legislative regulatory framework has allowed inconsistencies to develop across jurisdictions. Legitimacy of the role and public safety are the key reasons why a national approach is imperative.
- Without sustainable funding, appropriate reimbursement models, and quality assurance/improvement models, health human resource planners cannot successfully interpret or respond to supply demand issues in current times of scarce resources.
- Cultural and historical bases for healthcare funding and delivery in Canada, attitudes about and by the professions, and lack of understanding by the public are hampering healthcare reform and the emergence of an appropriate place for NP practice.

### **What does this model offer?**

There are authors (6, 19) that have done good critical overviews of existing conceptual models/frameworks related to advanced practice nursing, three of which are specific to the NP role. The Schuler (23) framework, for instance, is very complex and focused on what NPs do in clinical encounters. As such it is very focused on individual encounters, has a lifestyle emphasis, and does not acknowledge the NP role with communities or groups. The circle of caring model by Dunphy & Winland-

Brown (24) tries to demonstrate how the knowledge and skills from nursing and medicine might come together in the NP role. A third model that is of specific interest to the NP role is the domains of NP practice identified by Fenton & Bryczynski (25). Hamric's model of advance practice nursing (26) has some merit for consideration as we develop the NP Practice Framework for the CNPI. Notwithstanding this scholarly work contributed by the above authors, none represents the Canadian context. Therefore development of a Canadian model will offer a significant contribution to the discipline in our country.

### Summary

This promising model is in early stages of conceptualization. With the vision of the healthy client in a central role, the four commonplaces can be separately deliberated, time can be considered as a fifth commonplace. Evidence-based NP practice can be situated in the broader social context within the Canadian health care system, with the overarching goal being achieving the vision of health.

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