The use of a customized training needs analysis tool for nurse practitioner development

Carolyn Hicks BA MA PhD CPsychol
Senior Lecturer in Psychology, School of Continuing Studies, University of Birmingham,

and Deborah Hennessy BA PhD RN RM RHV
Senior Lecturer in Health Service Management, Health Services Management Centre,
University of Birmingham, Birmingham, England

Accepted for publication 8 July 1996

INTRODUCTION

Over the past decade, changes in health policy and resourcing have increasingly emphasized the contribution primary and community services make to the delivery of care. More particularly, modifications of general practitioner (GP) contracts, together with the introduction of the internal market and GP fundholding, have engendered a dramatic shift both in primary care culture and in the way in which care is delivered within the primary forum. One consequence of these changes has been an exponential...
increase in the workload of all primary health care personnel, and GPs in particular, despite a growth in the number of staff employed within this sector. Inevitably, there has been a concomitant rise in reported occupational stress, with all the attendant problems of low morale and reduced job satisfaction (Ford & Walsh 1994).

Although many solutions to these problems have been put forward, of particular relevance to the present study is the introduction of nurse practitioners (NP) to primary and community care, on the assumption that a significant proportion of the GP’s work can be devolved to this professional group. Indeed, early exploratory studies attest to the value of the nurse practitioner in this domain (Salisbury & Tetersell 1988, Stilwell et al. 1987), suggesting that they provide both a function distinct from that of the doctor and extend the range of care choices for the patient.

Other evidence serves to support the NP initiative in primary care. American research findings, provided by Ventura (1988), indicate that there are benefits for both patient and NP, with a high degree of satisfaction being reported by both parties. In an era of consumerism and mounting occupational stress within the public sector, these findings should not be dismissed as trivial, providing they translate to the British National Health Service (NHS). Moreover, despite conflicting evidence, there remains an unshakable belief in some quarters that NP care is a cheaper option than GP provision, thus strengthening the potential stronghold of the NP in this arena. Although this assumption has been shown to be spurious, largely because consultation times with the NP tend to be significantly longer than those with the GP (Salisbury & Tetersell 1988), it is conceivable that the position could be retrieved, as long as the NP’s functions are properly managed.

Role definition

Despite these preliminary findings and the increasing interest expressed in the potential contribution the nurse practitioner might make both to the primary sector specifically and the UK health service generally, the momentum for expansion has been constricted to a considerable degree by continuing confusion over both the role definition of NPs and their occupational function (Salvege 1991, Ford & Walsh 1994, Lenehan & Watts 1994). Although the NP concept has been in existence for around three decades, it has not been fully or unequivocally endorsed in the UK as a discrete branch of nursing practice. This position contrasts starkly with that of the United States, where the nurse practitioner has been firmly established as a complementary contributor to health care delivery, especially within a community context (Ventura 1988).

Although numerous attempts have been made to try to clarify the occupational definition of the NP, both titular and functional, it is conceivable that these efforts may have served only to add to the quandary. Recently, the UKCC Report (1993) Post Registration Education and Practice rejected the term NP as being misleading and ambiguous (Casey 1993), a perspective obfuscated by the publication of a report by the NHSME in the same week, which presented a diametrically opposed viewpoint.

This impasse is further buttressed by other recent policy recommendations, such as the UKCC (1992) Scope of Professional Practice document. While this paper has undoubtedly paved the way for development of the NP role beyond a simple role extension, its recommendations, however, are simply that and do not constitute formal guidelines for implementing NP role boundaries, training and education. Consequently, this report can be creatively interpreted and variously implemented. Moreover, other statutory body initiatives, such as the ENB Higher Award, do little to clarify the position. This means that there remains the possibility that the quality and level of NP educational programmes and scope of their clinical practice may remain predicated on random, rather than systematic, foundations. Furthermore, such a situation is likely to persist until such point as some agreement can be reached about the salient issues surrounding the NP role.

In the absence of unity on the core issues, it is conceivable that the NP will be devalued, used and abused in a variety of ways, operating as a cheap medical alternative or practising beyond the competence limits defined by inappropriate and inadequate training.

Clearly, if the NP is to have a function which is not merely that of substitute or second order doctor, but one of providing complementary and qualitatively distinct care of a nationally agreed standard, then it is imperative that efforts to resolve the existing ambiguities are doubled. The continuing debate and disagreement regarding an acceptable definition and interpretation of the NP role and their essential practice responsibilities, have undoubtedly compromised the position of the NP as an essential component of the health care team. As long as their existence, nature and function are determined by political, organisational and economic pressures operating at both the local and national levels, then there will be no cohesive development of the NP in any stratum of the health service.

Recent studies

Recognition of the problems that fuzzy boundaries continue to create for NP development has prompted a number of recent studies, whose aim has been to investigate the problems and potentially feasible solutions to the current predicament. For example, in 1994, Touche Ross Management Consultants evaluated 20 NP pilot projects in South Thames, England, and recommended that particular attention was given to the development of NPs in
primary health care, especially as their role within this context appeared to have more clarity of definition than that of nurse practitioners in other clinical areas. Their conclusions are largely corroborated by those emerging from a similar study conducted by Atkins et al. (1994), which together undoubtedly re-fuel the argument in favour of the widescale introduction of the NP to primary care. This corpus of supportive evidence, together with the emphasis on a primary care led NHS, the continuing shift of the locus of care to the community and the need for more cost-effective solutions to the growing crisis of service delivery in the NHS, have nurtured the imperative to evolve more systematically the role of the NP in this health care domain.

Despite this welcome intention to enhance the profile and potential of the NP, there remain unresolved questions about appropriate education and general professional development. It is self-evident that these more complex and advanced nursing roles demand a high degree of knowledge, skill and competence to ensure safe and effective functioning, although the actual level of education is still being openly debated. Concern to avoid an elitist group of supernurses has prompted many writers to recommend that a first degree is an appropriate compromise position between educational necessity and professional supremacy (Ford & Walsh 1994), although the need for professional credibility and clinical autonomy both with medical colleagues and patients may mean that higher degree status would be more advantageous (Barker 1988). While this may have the effect of limiting numbers, it is undoubtedly the case that the strong position and powerful professional status that the NP holds within the American health care system has been due in large part to their academic accreditation at higher degree level.

Training

Educational level notwithstanding, there is also little consensus regarding the content of NP training. The growing demand for professional updating within primary health care has led to a proliferation of courses, typically developed in an haphazard way and without reference to the specific needs of either the potential participants or the educational commissioners. Not only will this lead to cohorts of NPs ill matched to the role they are required to perform, but may also lead to unwise and unfocused investment of resources. To offset this problem, it is essential that NP training must be systematically informed if it is to meet the needs of all those involved. Clearly such courses must offer more than the training of new technical nursing skills, incorporating instead a range of topics designed to equip the NP with the competencies necessary for dealing with constantly changing national and local care delivery systems. These premises lead to the inevitable conclusion suggested by many writers that whatever education is commissioned, it must be responsive to local needs and constraints (Ford & Walsh 1994). While such an argument makes undoubted sense, the practical reality of such a recommendation means that information about training and educational requirements must be constantly collected and updated from local and regional surveys.

In summary, then, if the NP is to establish and maintain credibility as an independent and complementary professional within the primary care team, then a degree of unity must be achieved over role definition and occupational boundaries. Out of this should emerge educational and training protocols, designed to meet nationally accepted standards of quality. If, however, there is to be an acknowledgement of the importance of indigenous, regional requirements in NP development, then these educational courses must incorporate and reflect the local dimension. To do this means that training-needs surveys must be conducted as a means by which educational commissioning can be fully and appropriately informed and potential participants specifically targeted for professional development. To be of value, however, the data should go beyond eliciting unprioritized wish lists from the respondents, and provide instead, a valid and reliable data set which reflects the dual perspectives of the organization and the potential course participants.

Insofar as training needs surveys have been conducted before (Atkins et al. 1994, Touche Ross Management Consultants 1994), they have taken little account of these issues and in consequence have generated an information base fundamentally flawed by the nature of the instrument used to collect it. Conversely, a training-needs analysis tool which has demonstrable psychometric qualities should elicit data capable of informing the precise commissioning of NP education by extent, type, content and level. By so doing, a more systematic and cost effective training strategy can be implemented, with optimal benefit both to the members of the primary health care team as well as to the patient.

With this remit, the present study was conducted throughout a regional health authority. The principal aim was to identify, through the use of a scientifically constructed needs analysis instrument, the training requirements of those nurses employed in general practice who wished to upgrade their role to that of NP (Hicks et al. 1995, Hennessy & Hicks 1996). By obtaining a current occupational profile and comparing it with an assumed NP role profile, a working definition of the nurse practitioner could also be derived. In this way, the survey results could be used to inform the educational commissioning of NP training throughout the region, in a way which would meet locally determined needs as well as ensuring that national standards were maintained. This approach now has an added urgency, because of the growing demand for general professional updating and training
within primary health care generally that has created a proliferation of training courses, many of which are ill-founded and untargeted.

Aims

1. To survey a total regional population of practice nurses, using a semi-opaque questionnaire specifically designed for use with practice nurses and with demonstrable formal psychometric qualities.
2. To compare practice nurses’ perceptions of their own occupational profile with that of the nurse practitioner.
3. To identify the number and location of practice nurses wishing to upgrade their qualifications to nurse practitioner level.
4. To identify the level and content of training required by those respondents desiring professional updating to NP level.

METHOD

Design

A postal survey was undertaken in a large regional health authority in an attempt to meet the aims outlined above. From this information, it was anticipated that detailed planning provision could be made for appropriate continuing education courses.

Sample

The total population of nurses employed directly by general practitioners was selected for study. Of the 1940 nurses targeted, 420 responded, representing nine FHSAs. Of the respondents, 418 were female and their average age was 40·34 (range 24–66 years). The average length of time the respondents had been in their current post was 5·1 years, 96% were qualified nurses and the majority had additional nursing or midwifery qualifications.

Materials

A specially devised training needs analysis questionnaire was administered to the target population. This questionnaire had been developed along formal psychometric guidelines and had high validity and reliability scores (for further details of the instrument, see Hicks et al. 1996). Moreover, the information is elicited in a semi-opaque way, in order to avoid response distortion and the creation of demand characteristics by the participants. In this way, the resulting data base is relatively unbiased and reliably informative. Consisting of two main sections, the questionnaire is preceded by a page requesting relevant occupational and biographical details.

The first section comprised 31 core occupational tasks, arranged in five superordinate categories (research/audit, administrative/technical, communication/teamwork, management/supervisory and clinical activities). Each task had to be rated in each of five different ways, along a seven-point ordinal scale. The first rating involved the respondents in assessing the criticality of each task to the successful performance of their job; the second involved the respondents’ assessment of their current performance level on the tasks; the third required them to assess the criticality of the task to the successful performance of the nurse practitioner’s role; the fourth rating required them to evaluate the degree to which changes in the GP practice would facilitate the work of the nurse practitioner with regard to each task; and the fifth rating asked the respondents to evaluate the extent to which appropriate training would enhance the work of the nurse practitioner on each task.

By making various comparisons of the ratings awarded, the following information could be obtained:

- a comparison of the perceived roles of practice nurses and nurse practitioners, which could be used to formulate a definition of the nurse practitioner; and
- an assessment of the type and level of training required for upgrading to nurse practitioner level.

The second section of the questionnaire comprised a free response section to allow respondents to specify their perceived training needs and the nature of the optimal organizational changes required for nurse practitioner development. This section afforded an unstructured and unconstrained response category which could be used in conjunction with information provided by the closed format first section.

The data provided by the biographical section on the cover page, whilst anonymous, identified the respondents’ FHSAs and preferred educational venue for training. It also asked the respondents to state on a four-point scale the degree to which they wished to upgrade their training to nurse practitioner level. This information could be used to estimate potential numbers for training by FHSA and location, thereby enabling the more precise commissioning of relevant education.

Procedure

The sample of 1940 practice nurses was targeted by name from lists supplied by the Family Health Service Authorities (FHSAs), and each participant was sent a copy of the questionnaire, a covering explanatory letter and a pre-paid reply envelope. Prompting letters were distributed to the whole sample, in order to encourage any non-returners to complete the questionnaire. The data were coded and entered onto a database for analysis.
RESULTS

Biographical data

The total response rate was 420, constituting 21% of the population studied. Of these, around one-third expressed great desire to upgrade their qualifications to nurse practitioner level (137 respondents). These figures can also be broken down by FHSA to identify the degree of interest at a local level, for the purposes of future educational commissioning. On the basis of this information, it can be estimated that around 7–10% of the practice nurse population in the region require this form of professional training.

Nine educational institutions were identified as preferred venues, both overall and by FHSA, thus allowing courses to be mounted in organizations that were deemed convenient by potential participants.

Younger participants and those who had been in post for a short time expressed most desire to upgrade. Of the respondents most interested in upgrading, 67% already possessed degrees or post-basic diplomas.

The questionnaire findings

The following key findings emerged from the rest of the questionnaire and are presented graphically both overall and selectively below.

Figure 1 shows the responses of the sample to the closed section of the questionnaire. (Because of copyright restrictions, the precise items cannot be included. Instead, the superordinate categories will be represented.)

Closer analysis of the data that constitute this graph (using a range of inferential techniques) demonstrates the following key findings.

1 Communication and teamwork activities were generally perceived to be the most important aspect of the practice nurse’s job, with research/audit being least important (means = 6.55 and 4.38 respectively).

2 There was general agreement on the way in which the practice nurse’s role is perceived across the sample. This conclusion is drawn from the results of 31 one-way analyses of variance (unrelated samples), conducted for each occupational task across the nine FHISAs, of which only five demonstrated significant differences (P < 0.05) in the way the practice nurse’s role is construed. These included writing clinical audit and research reports, making do with limited resources, collecting and collating relevant audit/research information and undertaking administrative/business activities.

3 Current performance levels on 27 out of the 30 tasks appertaining to the practice nurse were similar across the sample. Using 31 one-way analyses of variance for unrelated samples, the only areas of discrepancy included writing audit/research reports, making do with limited resources, and collecting and collating relevant research information (P < 0.05).

4 Comparisons of the roles of the practice nurse and nurse practitioner suggested that the major differences are seen to lie in all research/audit tasks identified in this part of the questionnaire, together with undertaking diagnostic and clinical examinations of patients, staff management/supervision, management of change and administrative and business activities. The relevant statistical details are presented in Table 1.

5 Combined responses from both the closed- and open-ended parts of the questionnaire suggested that the following topics should be considered priorities for nurse practitioner training: research, audit and information handling skills, to include a range of systematic...
Table 1  Comparison of practice nurse and nurse practitioner roles

*** Writing clinical audit and research reports  
*** Statistically analysing own patient or research data  
*** Collecting and collating relevant audit/research information  
*** Designing a research/audit investigation  
*** Undertaking clinical examinations of patients  
** Identifying areas worthy of audit or research investigation  
** Introducing new ideas at work  
** Accessing relevant literature for clinical work  
** Managing other staff  
**showing colleagues and/or students how to do things  
** Developing systems for patient recall  
** Diagnosing patients' clinical needs  
** Personally coping with change in the NHS  
* Paperwork and routine data inputting  
* Critically evaluating published research  
* Developing protocols in practice  
* Appraising own and others’ performance  
* Interpreting practice data  
* Making appropriate patient referrals  
* Planning/organizing an individual patient’s treatment  
* Assessing patients’ psychological/social needs  
* Using technical equipment including computers  
* Giving advice to patients and their carers

*** $P<0.001$,  
** $P<0.01$,  
* $P<0.05$.

methodologies and data analysis techniques; advanced technical nursing and clinical skills to include techniques of patient examination and specific diagnostic skills; chronic disease management and sexual health; and management expertise which would involve patient, administrative and business management skills. This information is presented graphically in Figures 2 and 3.

6 Preferred strategies for intervention as identified by the closed section of the questionnaire suggest that overall, organizational development within the context of the practice is considered to be less useful in skill enhancement than are relevant training courses (see Figure 1).

7 The preferred organizational strategies reported in the open-ended section of the questionnaire as being of most value to enhancing the work of the nurse practitioner included: a clearly defined role in the practice; a more accepting attitude by the GPs; a greater commitment to nurse practitioner training; and more infrastructure support. This information is represented in Figure 4.

DISCUSSION

The return rate of 21% is lower than the average of around 40% for postal questionnaire surveys, but can be explained by the fact that the covering letter indicated that the questionnaire was primarily intended for those practice nurses interested in updating their skills to nurse practitioner level, thereby implicitly excluding those nurses for whom this did not apply. In this regard the sample may be considered to be self-selected. Of the 420 returns, 137 respondents expressed great desire to upgrade their qualifications.
When these figures are broken down by FHSA and preferred educational venue, it is possible to make predictions about numbers of potential participants enrolling on courses provided in any given area and designated institution (Hennessy & Hicks 1995). The biographical information obtained from the sample showed that the practice nurses most wanting to update their qualifications tended to be younger and so have been in post for a shorter period of time than the rest of the sample. This is consistent with findings derived from other occupational groups which suggest that younger members of the workforce typically have greater career aspirations and are therefore more likely to undertake further training to maximize these prospects.

Of the 137 respondents expressing considerable interest in NP training, 37% already possessed first degrees and 25% had diplomas. This would indicate that the most appropriate level for NP education would be at higher degree (master’s) level. While it is possible that this could have the effect of generating an elitist breed of advanced nurse, this disadvantage might be offset by the fact that higher degree level education may be necessary to establish the professional credibility of the NP in the eyes of the medical community. Although this might, at face value, appear to be genuflecting to the prejudices and power of the doctors, the reality remains that if NPs are to deliver care in a complementary, autonomous and accountable way, then the GPs’ acceptance of their capacity to do so is essential. Without this, the NP role is likely to be impossibly constrained and the medical stranglehold on the primary care sector will continue unabated. The status enjoyed by the American NP is largely attributable to the fact that training takes place at master’s level. If the cognate professional bodies are serious about securing the discrete and unique role of the NP in a range of clinical areas, then it is imperative that this message is reinforced by the proper educational commitment to NP development.

Taken together, this biographical database would provide prospective educational commissioners with sufficient information to determine the level at which NP courses should be mounted. These would be based on the existing reported qualifications of the interested respondents, together with a clear estimate of the numbers of potential participants on the courses, overall, by institution and by FHSA. In this way, training and education
could be rationalized, targeted and customized, thereby maximizing uptake at preferred venues and presumably minimizing attrition and consequent resource wastage.

Comparisons between the occupational profiles of the practice nurse and the nurse practitioner derived from the closed section of the questionnaire, revealed discrepancies in role perceptions, which could be interpreted as an indicator of the way in which the NP role should be defined and discharged. The principal area of perceived difference between the two roles related to the heightened research activities expected of the nurse practitioner. These activities embraced the whole gamut of research tasks from reflective practice, through research awareness to the active involvement in research design, data analysis and interpretation. This finding is consistent with recommendations made by Hancock (1996) and Ford and Walsh (1994) who emphasized the essential research role of the NP and suggested this should be a mandatory topic in their training. Moreover, these recommendations are in line with general government and professional body policy regarding the shift towards evidence-based care.

Clearly, if nursing is required to participate in the new scientific culture, it is imperative that there is a critical mass of sound nursing research available to inform practice. The available information, however, would suggest that a considerable proportion of nursing practice remains heavily founded on ritual rather than on empirically derived data (see Walsh & Ford 1992 for a review of the area). One explanation put forward to account for this chasm relates to the assumptions that many nurses and their managers hold about the core functions of the nurse, which do not necessarily include research (Hicks 1995). It is conceivable, then, that in the absence of a massive attitude change programme aimed at altering the occupational stereotypes of nurses, it may be more effective and productive to focus detailed and extensive research training on a specified group of nurses, for whom research could be made an essential component of their work contract. In this way, immediate gains could be made in developing a valuable, relevant and significant corpus of nursing research, which would facilitate the more rapid progress of nursing from hunch-based to evidence-based care.

If, at the same time, a consistent propaganda and education programme was directed at all nurses, the intention of which was to ensure that the significant majority of the workforce had the basic skills to evaluate and implement research findings, then it might be realistic to expect a perceptible shift in the care culture and the assumptions on which it is based. As long as advanced research training and activities were not the exclusive property of the NP, using this group of nurses as a spearhead may be a practical expedient to a continuing problem, particularly as it has been generally acknowledged that it would be wholly undesirable and pragmatically impossible to convert all nurses into active researchers.

Two other core areas were considered by the respondents to be critical and more central to the nurse practitioner’s job, namely advanced clinical activities, such as patient examination, diagnosis and prescribing, and management/business/administrative activities. The former task area is consistent with the philosophy underpinning the nurse practitioner initiative, which conceived the role as one which would relieve doctors of some of their more routine tasks and in this way is an almost predictable finding (Hancock 1996). The second task category reflects the growing need for health carers to develop a range of management skills in order to process the various business activities inherent in general practice, especially those which are of fund-holding status. Ford and Walsh (1994) confirm the need for management skills as an essential feature of NP training, perhaps as an aid to empowerment.

The key differences emerging from these comparisons may be used to construct a tentative definition of the role responsibilities and practice boundaries of the NP. It is suggested that the NP role should include three main priority areas: research/audit, advanced clinical and technical skills, and business/administrative/management activities. With respect to the first domain, it is recommended that research and audit cover the entire range of skills, including research literature awareness and critical evaluation, data collection and analysis, a range of methodological approaches, and the identification of topics meriting research and report-writing skills, especially for publication.

Regarding advanced clinical activities, it is suggested that the primary locus of attention should be directed at patient examination and diagnostic skills, together with health promotion and advice giving. This latter accords with Ford and Walsh’s contention that primary care NPs are in an ideal position to conduct health promotion activities, which besides its implicit health care function would simultaneously have the added benefit of empowering the patient. Lastly, the business/administrative and management role of the NP will become of increasing importance in the evolution of the NP as an autonomous health care professional, capable of directing, supervising and managing colleagues and patients.

These emerging functions partially corroborate the analysis and synthesis of American NP training programmes conducted by Huch (1992) which noted six common areas of focus: patient assessment, communication skills, health promotion, disease prevention, management of chronic illness and the medical management of patients. With the exception of communication skills, the remaining issues are broadly consistent with this study. What is of interest, however, is the absence of research in the American agenda. While this could be subsumed implicitly within all the main topic areas, it is also conceivable that the major emphasis given to the role of research by respondents in the current study may be a direct reflection of the comparatively
neophytic stage of the emergence of the evidence-based care culture in this country.

The above definition is largely supported by the free responses provided in Part B of the questionnaire, which indicated that among those respondents expressing interest in updating, the most salient self-reported training requirements related to research, audit and information handling skills, a range of patient examination, diagnostic and disease management skills, general business management and health promotion activities. These similarities notwithstanding, however, the most frequently requested topic for training was pharmacology and prescribing, an area which remains unresolved among the cognate authorities, largely because of the political and legal implications. Until this issue has been negotiated to a satisfactory conclusion, it would be wholly inappropriate to recommend it as a central part of the core curriculum on NP courses.

The findings from the first part of the questionnaire which relate to preferred intervention strategies (represented in Figure 1 above) suggest that specific training courses were generally considered to be of more value in the development of relevant skills, with organizational changes being consistently lower rated for their potential benefit. This implies that prospective NPs require specially constructed training courses, designed to enhance performance on those skills deemed salient to the delivery of care at NP level. The answers provided in the open ended section of the questionnaire, however, do make a number of valuable suggestions for organizational reform within the GP practice which would facilitate the NP’s role in this context (see Figure 4 above). Of most importance was attitudinal acceptance of the NP role by the general practitioner, which clearly accords with observations made by a number of writers regarding the inhibitory impact that adverse medical attitudes have on the way in which the NP is permitted to deliver care (Ford & Walsh 1994, Bowling & Stilwell 1988).

Without the widespread recognition by the entire primary care team of the qualitatively distinct responsibilities and status of the NP, then it is unlikely that this role will evolve in a useful and productive way, to the benefit of all concerned. This position is supported by some of the other responses identified in Figure 4.

The second most frequently cited organizational change was the request for a clearly defined role for the NP. Although this research may have gone some way towards an operational definition, its adoption by the relevant care personnel is not necessarily assured and may require proactive measures to ensure that an unequivocal, collective understanding is reached on the role responsibilities and boundaries of the NP. The professional bodies have clear policy and propaganda obligations in this regard.

What may be concluded from this section of the questionnaire is that the role of the nurse practitioner will not be fully realized without the support both of the GP and of infrastructure mechanisms. Without any formal role prescription, laid down as a contractual statement of the nurse practitioner’s scope and remit, it is obvious that the extent of this function will of necessity be controlled by local forces. In other words, it is likely that the NP will only be able to perform those duties permitted by the GP and this in turn will be driven by attitudinal factors to some degree. Indeed, the full support of practice colleagues may be so fundamental that without it, the role of the advanced nurse practitioner may be functionless. Clearly, training alone will not be sufficient to ensure that the scope of the NP is either realized or fully optimized. What is needed, in addition, is a level of organizational commitment which embraces the ideology and its translation into practice. If NPs are to act as autonomous professionals, working in a complementary and collaborative way, then empowerment is crucial and this must of necessity entail the recognition of their unique and qualitatively distinct functions by both managers and GPs.

Conclusion

In conclusion, the use of a psychometrically valid and reliable training needs analysis instrument may be an essential tool in the establishment of the parameters surrounding the definition and education of nurse practitioners. With the potential to identify both common assumptions as well as local requirements, educational courses can be designed in response to fairly precise potential recruitment figures, their location, level and content. In this way, it may be seen as a valuable aid to rationalizing resources and informing regional NP development strategies.

References


Huch M. (1992) Nurse practitioners and physician’s assistant, are they the same? Nursing Science Quarterly 5, 52–53.


