A triangulation approach to the identification of acute sector nurses’ training needs for formal nurse practitioner status

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The current confusion surrounding the definition and role function of the nurse practitioner (NP) has created a situation in which advanced clinical practice is delivered in a variety of ways and at many levels. Not surprisingly, this has led to difficulties in regulating educational provision for NPs. This study reports a survey of the perceptions of the role definitions and training needs of all nurses working at advanced clinical levels within an acute sector Trust. Although this concept is not a novel one in advanced nursing practice, the procedure adopted differed from previous studies in two fundamental ways: firstly, a unique training needs assessment instrument was used, which because of its validity and opacity, was capable of yielding a highly reliable data-base, comprising a prioritized profile of real training needs as opposed to the standard wish-list typically elicited. Secondly, it did not rely simply on the self-reported needs of the nurse sample, but also included the perceptions of the sample’s immediate medical and managerial colleagues. In this way, a triangulation paradigm was adopted. The results indicated that overall, there was high agreement between the nurses and their managers, regarding both the definition of the NP role and the essential training requirements, with somewhat different opinions being offered by the medical staff. When the raw scores were standardized to correct for response bias, the data provided an operational definition of the role of the NP and a prioritized profile of training needs for nurses who wished to train to this level.

*Keywords*: nurse practitioner, training needs, triangulation, validity, reliability, needs prioritization

INTRODUCTION

Over the last decade, changes in health policy and provision have created a range of new service developments, with consequent training and updating requirements. Of particular relevance to the present study is the relatively recent reduction in junior doctors’ hours (NHSME 1991) which, together with a general increase in knowledge and technology, have led to the emergence of many new nursing roles nationally. Studies of these new occupational functions suggest that many of these nurses are working...
at an advanced practice level, undertaking tasks which were previously the domain of the doctors (e.g. Hennessy & Hicks 1996). This position has created an imperative to define the role boundaries and essential educational provision for these post-holders, as a means by which standards can be regulated and maintained. Thus far, within the United Kingdom, no firm agreement has yet been reached as to what constitutes an advanced nurse practitioner, either by title, occupational function or prerequisite skill levels (Ford & Walsh 1994).

The titles clinical nurse specialist, advanced nurse practitioner, nurse practitioner and others have a history of about 15 years in the United Kingdom, having originated in the late 1960s and early 1970s in the United States in response to the shortage of primary physicians required to meet North America’s health care needs (Guido 1995). Within the United States the hallmark of the advanced nurse practitioner combines the caring role of the nurse with the traditional clinical role of the physician. Advanced nursing practice in this context provides basic health care to all people, involving health promotion and maintenance, increasing the quality of care and ensuring the development of better informed consumers.

The emergence of the nurse practitioner in the United Kingdom closely parallels that in the United States with the earliest advanced nursing practice roles being in community and primary care. Exploratory studies attest to the value of the nurse practitioner in this domain (e.g. Stilwell et al. 1987, Salisbury & Tetersell 1988), suggesting that they provide both a function distinct from that of the doctor and also extend the range of care choices for the patient.

Despite these preliminary findings and the increasing interest expressed in the potential contribution that advanced nursing roles might make to the health service in the UK, the momentum for expansion has been restricted by confusion over role definition and occupational function (e.g. Salvage 1991, Lenehan & Watts 1994, Ford & Walsh 1994). Although the title and concept of the nurse practitioner have been in existence for nearly two decades, it has not yet been fully or unequivocally endorsed in the UK as a discrete branch of nursing practice. Recently the UKCC report ‘Post Registration & Practice’ (1992a) rejected the term nurse practitioner as being misleading and ambiguous (Casey 1993), a perspective obfuscated by the publication of a report by the NHSME Nursing in Primary Health Care: New World, New Opportunities in the same week, which presented a diametrically opposite viewpoint within the community sector, at least. The UKCC report The Future of Professional Practice (1994) stated that advanced practice is ‘not an additional layer to be superimposed on specialist nursing practice. It is rather, an important sphere of nursing practice...’.

This confusion has delayed progress in nurse practitioner development and furthermore, has been exacerbated by other recent policy recommendations, such as the UKCC’s guidelines in ‘Scope of Professional Practice’ (1992b). Although this document paved the way for the development of advanced nursing practice that goes beyond a simple role extension, the recommendations do not constitute formal guidelines for defining the cognate roles, training and education. Consequently, this document, as well as other statutory body initiatives such as the ENB Higher Award, can be variously and creatively implemented. This means that the quality and level of advanced nursing practice courses may remain fluid, until such time as agreement can be reached about the nature and boundaries of the relevant clinical functions.

In the meantime the titles and roles of advanced nursing practice may be used in a variety of ways, which may not be advantageous for patient care, since they carry with them an implicit failure to standardize and agree clinical role responsibilities. For example, where the NP is used as a more economical alternative to the medical practitioner or where nursing practice is conducted beyond the competence limits defined by inappropriate, or inadequate training then patients may conceivably be at risk. If advanced nurse practitioners are to provide quality care to a nationally agreed standard which is complementary to medicine, then the current controversy must be resolved. As long as the existence and functions of the advanced nurse practitioner are determined by professional, political, organizational and economic pressures, both locally and nationally, then there will be no cohesive development of this role in the National Health Service. Furthermore, it will be extremely difficult to develop the appropriate training and education.

Recognition of the persisting nature of these problems has prompted a number of recent studies, whose aim has been to investigate both the problems and potential feasible solutions. For example, four issues have been identified by Glen (1996) as crucial to the debate about advanced nursing practice, and include: accountability and responsibility; development of clinical expertise within the scope of professional practice boundaries; defining the educational preparation which all specialist and advanced practitioners should achieve; and the resulting outcomes of care.

Of particular relevance to the present study is the issue of prerequisite education and training requirements for NP status, which like all other aspects of the NP debate, remains shrouded in controversy. While the debate is indicative of the growing interest in nurse practitioner development and of the concern regarding its current, unregulated state, it also clearly illustrates the weaknesses in the present position, namely the lack of a strategic plan for development, the variable levels and standards of both practice and training, the wide-ranging role functions and a lack of corporate identity.

One outcome of this turmoil which is of particular relevance to the present study has been the need for individ-
ual Trusts and health authorities to define the NP role at the local level, thus adding further potential diversity in professional roles and responsibilities. It would seem that in many Trusts, some of the advanced nursing roles have developed in response to the need to devolve selected activities previously undertaken by doctors, or to fill a gap in care. Alternatively, the belief that the development of specialist nursing skills, knowledge and expertise in a particular clinical area would offer continuity and an enhanced quality of care to patients has been responsible for the evolution of the NP.

Because of the miscellaneous origins of the advanced nursing roles there is inevitable variability in the way the roles are currently defined and discharged within and between different Trusts. Consequently, there is a continuing need not only for clarification of occupational functions and responsibilities, but also for educational opportunities to develop these new nursing roles within the framework of the United Kingdom’s Central Council for Nursing, Midwifery and Health Visitors’ guidelines, introduced in ‘The Scope of Professional Practice’ (1992b).

The present study focused on the training needs of those nurses working at advanced level within an acute Trust, but without the formal status or qualification of nurse practitioner. Within this population, numerous titles had been conferred upon this particular occupational function, namely: technician; expanded staff nurse; focus specialist; mini doctor, ‘house nurse’; advanced nurse practitioner and nurse managed care. Preliminary investigations revealed that the way in which advanced clinical nursing was being delivered within the Trust was inevitably divergent, depending on a range of factors, such as the clinical speciality involved and the qualifications and experience of the incumbents. Cognisant of the potential problems this situation would create for establishing defined standards of training and clinical practice, the Trust conducted a training needs analysis survey of all its nurses working at advanced levels. It was intended that the resulting data could be used to inform precisely, their educational and training requirements, thus meeting not only the needs of the nurses themselves, but also the clinical and policy requirements of the Trust.

While this initiative is not novel in itself, the means by which it was carried out differed radically from previous surveys of this kind. Standard training needs analyses focus on self-reported wish-lists, which typically reflect the subjective views of the respondent. In consequence, an unverifiable data-base is obtained, which usually reports the respondents’ own interests rather than actual skill deficits. This study adopted an alternative approach to these problems. Firstly, it used an indirect means of accessing the participants’ training needs, using a highly reliable and valid instrument which had been developed in accordance with stringent psychometric principles (Hicks et al. 1995). This tool, because of its semi-opacity, yields a reliable data base, uncontaminated by personal interests or response biases. Secondly, the questionnaire was administered not only to the target sample of nurses themselves, for self-completion, but also to each nurse’s immediate line manager and medical director. These other two participants were requested to fill in the questionnaire according to what they believed the identified nurse’s training requirements were. In this way, three sets of data for each nurse were obtained, which, when compared, could provide a more complete picture of training requirements. In this way, the separate, as well as the collective, perspectives of the three professional groups could be considered during the educational commissioning process.

More specifically the objectives of the study were as follows:

- to provide an agreed operational definition of the nurse practitioner role
- to establish accord regarding the knowledge and skills needed to fulfil the NP role and in this way, to identify the prerequisite education and experience.

**METHOD**

**Design**

A questionnaire survey was undertaken, using a validated training needs analysis questionnaire (see Materials). The information collected was confidential, although the respondents’ positions and names were known to a single co-ordinator. This part of the procedure was made clear to the sample in advance of the survey and the option to withdraw was offered, should it be considered unacceptable to anyone.

A triangulation approach to the data collection was undertaken, in order to elicit three perspectives of the training needs of the nurses targeted in the study. These perspectives were as follows:

- the self-reported training needs of the nurse practitioners at the focus of the study
- the relevant manager’s perspectives of the nurse’s training needs
- the relevant medical director’s perceptions of the nurse’s training needs.

In this way, then, data were collected in triadic format.

**Sample**

The total population of nurses working at advanced clinical level in various capacities in the Trust were selected for study (50 in total). Of these only one was formally classified as a qualified nurse practitioner. The others were grouped under the following models of advanced practice:
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- technician
- mini doctor or house nurse
- expanded staff nurse
- advanced nurse practitioner
- managed care nurse

The respective manager and medical director for each NP were also asked to participate, in order that a completely triangulated data set could be obtained for each nurse participant. The triads came from the full spectrum of clinical specialities offered in the Trust, including general and specialist surgery (e.g. transplants, haematology, dermatology, gynaecology, oncology, paediatrics, cardiac, pathology and accident and emergency. This produced a total sample of 150 (50 nurses, 50 managers and 50 doctors). Each member of the sample was approached individually, advised of the purpose, nature and implications of the study and invited to participate.

**Materials**

A highly valid and reliable training needs analysis questionnaire, which had been developed along formal scientific principles was used for the survey. The full details of the questionnaire’s construction and relevant psychometric properties are reported elsewhere, together with its application to other nurse practitioner populations (see Hicks et al. 1995, Hennessy & Hicks 1995).

Two versions of the questionnaire were produced, one for the NPs and the second for the manager and medical director. Although the wording differed slightly to take account of the first and third person perspectives on the topic, the questionnaire content was in all other ways identical. In essence, the questionnaire comprised two sections, the first of which consisted of 38 occupational tasks central to the roles of advanced nursing practice. These tasks fell into six superordinate categories viz: clinical tasks, research/audit, business/administration, management/supervisory, communication/teamwork and advanced professional issues. The first five categories derived from the original questionnaire and the last from focus groups of nurse practitioners. In this way, it had demonstrable construct and content validity. Each task had to be rated along a 7-point scale, according to four rating criteria (see Hicks et al. 1995 for further details).

By making various comparisons of the ratings for each criterion, an enormous corpus of information could be amassed, of which the following is relevant to the present study:

- an occupational profile of the qualified nurse practitioner. This would provide an operational definition of the NP role.
- a prioritized index of the training requirements necessary for qualified nurse practitioner status.

It should be noted that the areas on which the three subsamples (nurses, doctors and managers) agreed would constitute both the above data bases.

This first section, because of its construction, is semi-opaque, and therefore has the potential to elicit information uncontaminated by response bias.

The second part of the questionnaire consisted of an open-ended response section concerning the training needs perceived to be necessary for development to nurse practitioner status. The information derived from this section could be used to confirm or embellish that from section A of the questionnaire.

The questionnaire was prefaced by a set of instructions about the method of completion and occupational/biographical questions.

**Procedure**

All the nurses working at advanced clinical levels within the Trust were targeted for inclusion in the study. These nurses had a range of occupational titles and role functions, with only one operating officially as a qualified nurse practitioner (see sample details above). The purpose of the study was explained to each nurse and agreement to participate sought. When this had been obtained, each individual nurse’s medical director and line manager were approached and invited to participate, with the remit that they would be completing the questionnaire in terms of their perceptions of the identified nurse’s training needs. In this way a fully triangulated picture of each nurse’s requirements for NP training could be obtained.

The questionnaires were administered through the co-ordinator, who coded the questionnaires, so that prompts could be sent out to non-returners. This would have the effect of maximizing the number of completed triadic data sets. The completed questionnaires were then coded and analysed.

**RESULTS**

Of the 150 questionnaires which were distributed, 139 were returned, which constituted an exceptionally high response rate of 93%. These returns comprised 49 questionnaires from the nursing staff, 47 from the managers and 43 from the consultants, and included 39 completed triadic data sets.

The analyses of the results will be presented with reference to the study’s objectives, as outlined at the end of the introduction above.

**Operational definition of the nurse practitioner**

Results from the closed section of the questionnaire

The key rating scale to ascertain an operational definition of the NP derived from the third rating criterion of section
A of the questionnaire. When the ratings for each subgroup were compared for similarities and differences, it was found that the tasks shown in Figure 1 were assumed by all groups to be crucial to the work of the NP.

Closer analysis of this graph indicates that the areas considered by all three groups to be of most importance to the NP role are:

- establishing a relationship with patients;
- giving advice to patients and their carers;
- getting on with colleagues;
- working as a member of a team;
- doing routine paperwork and/or routine data inputting;
- using technical equipment;
- recognizing and managing risk in clinical care;
- making appropriate patient referrals;
- making decisions about the clinical problems of patients;
- prioritizing work according to patient need;
- introducing new ideas at work; and
- interpreting own practice data.

When these skills are categorized generically they indicate that advanced clinical/technical skills are considered by all groups to be most important to the NP role, with communication and teamwork activities also considered to be essential. There were, however, some notable differences between the sub-samples, with the medical staff differing from the nurses and the managers regarding the extent to which the following tasks were considered to be important: an extended range of research skills; greater autonomy in the management of patient care; and innovative work which crosses the traditional role boundaries between medical and nursing staff.

**Results from the open response section**

When the results from the open response section of the questionnaire were analysed for the whole group, the following training needs, presented in Figure 2, were obtained:

- recognizing and managing risk;
- interpreting own clinical and patient data; and
- identifying areas worthy of research/audit investigation.

These results, while self-explanatory, suggest a different set of priorities to those emerging from the closed section of the questionnaire, with advanced clinical/technical activities, research, business/management, counselling and communication, and professional role development being viewed to be most relevant. The ratings given by each group to these training needs are presented in Table 1.

**Identification of the knowledge and skills necessary to fulfill the NP role**

**Results from the closed section of the questionnaire**

By comparing the mean scores for all respondents on the second and third rating scales, it was possible to establish the following training priorities for NP development for this group of nurses (in order of priority):

- designing a research/audit investigation;
- critically evaluating published research;
- appraising own and other’s performance;
- statistically analysing own patient/research data;
- applying pharmacology to practice;
- writing clinical, research and audit reports;
- planning/conducting health promotion and other clinics;
- undertaking clinical examinations of patients;
- recognizing and managing risk in clinical care;
- interpreting own practice data;
- undertaking patient consultations; and
- identifying areas worthy of research/audit investigation.

These data are represented in Figure 3.

It can be seen from the above information that advanced clinical practice and a range of research methodologies are considered to be the most essential training requirements for NP development. Closer scrutiny of Figure 3, however, suggests that the mean ratings given by all respondents are skewed towards the top end of the scale, and indeed, the component scores for each sub-sample are similarly skewed. This bias is indicative of a positive response set. When this is corrected by converting the raw data to z scores (with a mean of 0 and a standard deviation of 1-0), relative positionings can be obtained and these are presented in Figures 4, 5 and 6.

These figures demonstrate the relative criticality of each task to the NP role compared with relative scope for improvement through training, for each sub-sample. Those areas considered to be most critical for NP training are represented in the top right hand quadrant. More detailed inspection of these graphs suggests that all groups perceive the following tasks to have greatest relevance for NP development:

- appraising own and other’s performance;
- recognizing and managing risk;
- interpreting own clinical and patient data; and
- undertaking patient consultations.

Items on which two of the three subgroups agreed were:

- critically evaluating published research;
- making appropriate patient referrals;
- making decisions about the clinical problems of identified patients;
- assessing patients’ psychological and social needs;
- interpreting and using the results from the clinical investigations of identified patients; and
- giving advice to patients and their carers about their illness and treatment.
Figure 1 Criticality of activities to successful performance of qualified NP’s job.
Figure 2 Frequencies of suggested training needs for qualified nurse practitioner status (all staff, n = 139).
Table 1 Ranked frequencies of suggested training needs for qualified nurse practitioner status

<table>
<thead>
<tr>
<th>Training Need</th>
<th>All staff Rank*</th>
<th>Nurse (A) Rank*</th>
<th>Manager (B) Rank*</th>
<th>Medical (C) Rank*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific clinical awareness/education programmes</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>General research/audit skills</td>
<td>2</td>
<td>4·5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Technical skills/clinical procedures</td>
<td>3</td>
<td>2·5</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Patient assessment skills (physical &amp; interpersonal)</td>
<td>4</td>
<td>2·5</td>
<td>10·5</td>
<td>2</td>
</tr>
<tr>
<td>Nurse prescribing</td>
<td>5</td>
<td>4·5</td>
<td>17</td>
<td>9</td>
</tr>
<tr>
<td>IT and database skills</td>
<td>6</td>
<td>8</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Interpreting clinical results</td>
<td>7</td>
<td>6·5</td>
<td>20·5</td>
<td>6</td>
</tr>
<tr>
<td>Business management and contracts</td>
<td>8·5</td>
<td>9·5</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>Inter-professional communication and teamwork</td>
<td>8·5</td>
<td>19</td>
<td>14</td>
<td>3·5</td>
</tr>
<tr>
<td>Role enhancement and development</td>
<td>10·5</td>
<td>6·5</td>
<td>14</td>
<td>29·5</td>
</tr>
<tr>
<td>Teaching/training skills</td>
<td>10·5</td>
<td>11·5</td>
<td>10·5</td>
<td>16</td>
</tr>
<tr>
<td>Accountability, ethical and legal issues</td>
<td>12</td>
<td>11·5</td>
<td>8</td>
<td>38</td>
</tr>
<tr>
<td>Counselling skills training</td>
<td>13·5</td>
<td>9·5</td>
<td>23·5</td>
<td>16</td>
</tr>
<tr>
<td>General education leading to qualifications</td>
<td>13·5</td>
<td>19</td>
<td>6</td>
<td>29·5</td>
</tr>
<tr>
<td>Continuing clinical updating and education</td>
<td>16</td>
<td>35</td>
<td>6</td>
<td>29·5</td>
</tr>
<tr>
<td>Data entry and statistical analysis</td>
<td>16</td>
<td>13</td>
<td>28·5</td>
<td>12</td>
</tr>
<tr>
<td>Patient interpersonal and communication skills</td>
<td>16</td>
<td>19</td>
<td>10·5</td>
<td>29·5</td>
</tr>
<tr>
<td>Implementing service changes</td>
<td>20</td>
<td>19</td>
<td>17</td>
<td>22</td>
</tr>
<tr>
<td>Other training needs</td>
<td>20</td>
<td>14</td>
<td>23·5</td>
<td>16</td>
</tr>
<tr>
<td>Planning and organizing patient care</td>
<td>20</td>
<td>19</td>
<td>34·5</td>
<td>9</td>
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<tr>
<td>Professional role clarifications and referral process</td>
<td>20</td>
<td>40·5</td>
<td>34·5</td>
<td>3·5</td>
</tr>
<tr>
<td>Time management/organization/prioritizing work skills</td>
<td>20</td>
<td>19</td>
<td>10·5</td>
<td>38</td>
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<td>Conceptual skills</td>
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<td>35</td>
<td>14</td>
<td>29·5</td>
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<tr>
<td>Interpreting research data and results</td>
<td>23·5</td>
<td>27·5</td>
<td>20·5</td>
<td>22</td>
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<tr>
<td>Empathetically dealing with ‘sensitive issues’</td>
<td>26·5</td>
<td>35</td>
<td>39·5</td>
<td>9</td>
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<tr>
<td>Informing patients and informed consent</td>
<td>26·5</td>
<td>19</td>
<td>34·5</td>
<td>16</td>
</tr>
<tr>
<td>Personal coping skills</td>
<td>26·5</td>
<td>27·5</td>
<td>20·5</td>
<td>29·5</td>
</tr>
<tr>
<td>Test selection and request procedures</td>
<td>26·5</td>
<td>27·5</td>
<td>28·5</td>
<td>16</td>
</tr>
<tr>
<td>Patient diagnostic skills</td>
<td>30·5</td>
<td>27·5</td>
<td>39·5</td>
<td>12</td>
</tr>
<tr>
<td>Research/evidence-based practice</td>
<td>30·5</td>
<td>27·5</td>
<td>20·5</td>
<td>38</td>
</tr>
<tr>
<td>Self-assessment skills/performance appraisal</td>
<td>30·5</td>
<td>35</td>
<td>17</td>
<td>38</td>
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<tr>
<td>Understanding organizational change in the NHS</td>
<td>30·5</td>
<td>27·5</td>
<td>28·5</td>
<td>22</td>
</tr>
<tr>
<td>Standards and protocols</td>
<td>33·5</td>
<td>19</td>
<td>28·5</td>
<td>38</td>
</tr>
<tr>
<td>Writing reports and papers</td>
<td>33·5</td>
<td>19</td>
<td>28·5</td>
<td>38</td>
</tr>
<tr>
<td>Evaluating and reviewing clinical evidence</td>
<td>36</td>
<td>35</td>
<td>28·5</td>
<td>29·5</td>
</tr>
<tr>
<td>Monitoring and evaluating patient skills</td>
<td>36</td>
<td>40·5</td>
<td>28·5</td>
<td>22</td>
</tr>
<tr>
<td>Techniques for collecting and collating data</td>
<td>36</td>
<td>27·5</td>
<td>28·5</td>
<td>38</td>
</tr>
<tr>
<td>Application of research to practice/evaluating clinical outcomes</td>
<td>38</td>
<td>35</td>
<td>39·5</td>
<td>22</td>
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<tr>
<td>Development of nurse-led activity</td>
<td>40</td>
<td>35</td>
<td>39·5</td>
<td>29·5</td>
</tr>
<tr>
<td>Setting up and running clinics</td>
<td>40</td>
<td>27·5</td>
<td>39·5</td>
<td>38</td>
</tr>
<tr>
<td>Specific nurse practitioner courses</td>
<td>40</td>
<td>40·5</td>
<td>39·5</td>
<td>22</td>
</tr>
<tr>
<td>How to apply for research funding</td>
<td>42</td>
<td>40·5</td>
<td>34·5</td>
<td>38</td>
</tr>
<tr>
<td>Number of professionals</td>
<td>139</td>
<td>49</td>
<td>47</td>
<td>43</td>
</tr>
<tr>
<td>Percentage of staff who made at least one training suggestion</td>
<td>89·20%</td>
<td>95·92%</td>
<td>85·11%</td>
<td>86·05%</td>
</tr>
</tbody>
</table>

*1 = most frequently suggested training need; 42 = least frequently suggested training need.

DISCUSSION

The aims of this study were to attain agreement from the three key occupational groups under investigation regarding an operational definition of the NP role, and the identification of training priorities. The results presented above go some way towards establishing a consensus position on each aim within this particular Trust, and in this way, should facilitate the evolution of the NP role and educational preparation without excessive conflict. It should be emphasized that a salient feature of this study was its triadic approach to data collection, using a psycho-
Figure 3 Comparison of current performance levels with critical tasks for the NP role, to identify training priorities. □ = current performance levels; ■ = criticality of task to NP role.

metrically sound assessment instrument. These attributes distinguish the study from other similar ones, which typically use subjective, self-reporting procedures, unverified by other personnel.

With respect to the first aim, the definition of the NP within the context of the Trust was determined by the clinical functions all three groups attributed to the position. Considered to be of most importance were a range of advanced clinical/technical skills and communication/teamwork activities. These issues were corroborated to some degree by the findings from the free response section of the questionnaire, which noted the salience of specific clinical competencies, such as patient assessment skills, nurse prescribing and the interpretation of clinical results. In addition, the free response section confirmed the significance of a number of communication abilities, ranging from a teaching function, to counselling and inter-professional teamwork.

Definition of the nurse practitioner

From this information, a first-stage definition of the NP can be attempted. Couched within an operational framework, it is suggested that the role of the NP should include advanced clinical and psychosocial responsibilities for the patient, to cover patient assessment, care planning, referral and clinical decision making. In addition, a high level of communication skill is essential in order for the NP to function effectively within the multidisciplinary team as well as in the enhanced clinical role outlined above.

The accord achieved between the three participant groups in these domains is welcome, since, derived as it is from both the closed and open sections of the questionnaire, it reflects the both conscious and uncensored views of the respondents. Nonetheless, there remain some different opinions. It would appear from a comparison of the closed and open data sets that there is little consent regarding the role of research/audit, IT skills, and risk management in its broadest sense, this latter incorporating referral systems, clinical decision making and priority setting. If to this conflict is added the research and clinical autonomy task domains which the medical staff construed as being less salient than did the other two sub-samples on the closed section of the questionnaire, a rather less integrated picture emerges. The emergence of autonomy and research as key points of divergence mirrors much of the existing
literature on the clinical boundaries of advanced nursing practice.

**Autonomy and research**

Taking the issue of autonomy first, a number of researchers have identified this as a critical distinguishing feature of advanced nursing practice. Huch (1992), for example, notes that the main distinction between the traditional role of the nurse and that of the NP relates to the autonomous and independent functioning of the NP. Moreover, it is this attribute of the job that has also made a significant contribution to the high level of job satisfaction reported in this group (Ventura 1988). Shuttleworth’s (1991) view confirms this perspective, suggesting that NPs should be an elite cohort of practitioners, operating at ever more responsible levels. It is, however, fair to say that the extent to which this vision can be realized must, of necessity be constrained by legal reality, since many of the medical functions implicit within an autonomous role must be sanctioned by medical staff, thereby referring accountability back to its historical location. This, though, is not to suggest that the NP role should be one of constrained reactivity as the responses of the medical staff within this study might imply.

**The need for negotiation**

What is clearly necessary within the context of the Trust under investigation, is that a negotiated position should be attempted. This should take account of the need to facilitate the functioning of this group of nurses at an appropriately advanced level, as well as the imperative to be mindful of legally permissible guidelines. What might be important to avoid is the reflex protection of historically determined professional boundaries. In short, the progress of an agreed occupational profile for the NP should not be governed by the medical staff’s need to defend their
The position of clinical supremacy, but rather by a more practical assessment of the ways in which advanced nursing practice can offer an improved level of patient care, in a way that is cost and health effective.

This argument also applies to the different perceptions among the respondent groups regarding the role of research in the NP role. Although the nurse and manager sub-samples were in notable agreement with respect to the assumed importance of research for the core functioning of the NP, the medical staff revealed very different views, relegating this skill domain to an insignificant position relative to other activities. Such a stance is indicative of a collective need to protect an area of activity hitherto exclusively the domain of doctors. Research carries with it connotations of intellectual kudos, and is an area of activity that medical staff have traditionally undertaken. Many researchers have identified both the overt and covert means by which doctors have negated the research activities of other groups of health care professionals, for reasons no more valid than a desire to retain the most prestigious activities for themselves (e.g. Hunt 1987).

This position, while well documented, nevertheless conflicts not only with the ideology underpinning the creation of an evidence-based care culture generally, but also with the advances in the basic nursing role itself. The advent of Project 2000 (UKCC 1986), with its emphasis on reflective practice, evaluation and basic research competencies means that even at the basic grade level, rudimentary research should be an integral part of routine nursing care. This position is, of necessity, more pronounced for the NP. Markham (1988), for example, has suggested that advanced nursing practice can only be defined by reference to independent research activity, although in reality she found that many nurses working at this level were involved only in supporting medical research, rather than developing their own. This finding is buttressed by the argument presented by Ford & Walsh (1994) who state that the accountability inherent within
the NP role necessitates a high level of research awareness and skill, without which clinical practice can neither be advanced nor evaluated.

It would seem axiomatic that a health service founded on evidence-based care practices requires that all the professionals working within it should be delivering care founded on empirical findings rather than intuition and historical precedent. To confine research activities to the medical stratum would be to condemn all non-medical health care to unchallenged ritual. That clearly (and rightly) would be unacceptable both to the professions allied to medicine as well as to the recipients of the service.

If, however, the Trust in question is to develop both its clinical practices according to top-down fiats regarding evidence-based care and the advanced nursing role, then it may be necessary to consider an attitude-change programme to modify the views of the medical staff. Without such an expedient, it is conceivable that research activities will be limited and limiting. To the extent that the medical staff in the sample are representative of the profession as a whole, it may be important to contemplate a wide-scale, national propaganda initiative, the aim of which would be to raise the profile and status of research emerging from other professions. As Ford & Walsh (1994 p. 161) note:

A great deal of work is necessary with the medical profession to overcome a century or more of traditional beliefs about the roles of nurses if doctors are to stop treating nurses as inferiors.

Only when this issue is addressed will the entire spectrum of service delivery be improved.

Taking these arguments, then, together with the majority (as opposed to the consensus) verdict, of the participants in the study, it would seem pertinent to include clinical autonomy and research in the operational definition of the NP role offered above. Therefore, the NP:

should have autonomy and independence to the extent of her professional competencies, whilst being aware and informed of
risk and accountability. In addition, the NP should possess sound basic research skills, which are routinely used to inform and evaluate practice and to identify areas worthy of proper empirical investigation. The functions outlined in these frameworks should not be seen simply as a good performance of the traditional nursing role, but rather as a greatly extended development of it, into conceptual, flexible, reflective and innovative domains.

The definition suggested above inevitably carries with it educational implications, which are reflected in the training needs identified in this study.

**Training requirements for NP development**

Comparisons of two of the ratings scales used in the first part of the questionnaire provided an index of the prerequisite training perceived by all three participant groups to be necessary for NP status. By looking at current performance levels on those task domains maximally critical for the NP role, areas for training can be prioritized from most to least important, in order that any consequent educational provision can be rationalised (Figure 3). This analysis suggested that prospective NP training was dominated by a range of research activities from critically evaluating published research data to designing a research/audit investigation and writing the consequent report. In addition, several areas of advanced clinical practice were identified, such as applying pharmacology, undertaking patient examinations and consultations, risk management and planning and conducting health clinics of various types. The only skill identified for development which did not fall into the superordinate categories of research and advanced clinical practice, was self and other appraisal.

The starred items have been imported from the operational definition of the NP, outlined above. Their inclusion can be justified on the grounds that they are critical skills, the performance of which should be maintained at the highest standard. Updating and consolidation of these competencies must therefore be considered essential.

The content of the educational curriculum outlined above is consistent with much of the literature on advanced nursing practice. Markham (1988) for example, stressed the relevance of management skills in the NP repertoire and Shuttleworth (1991) noted the imperative for NPs to be pushing back the boundaries of clinical practice.

**Research/audit**

- Critical evaluation of published research identifying areas worthy of research/audit.
- Designing a research/audit investigation
- Statistically analysing data writing clinical, research and audit reports

**Advanced clinical practice.**

- Application of pharmacology.
- Planning/conducting health promotion and other clinics.
- Clinical examination of patients.
- Interpretation of clinical data.
- Risk management.
- Undertaking patient consultations.
- Clinical decision making.
- Patient assessment.

**Communication/teamwork**

- Critical performance appraisal.
- Advice giving to patients and carers.
- Interpersonal skill development for patient and colleague communication.*
- Team building and team working.*

**Business**

- Using technical equipment, including computers.*

**Management**

- IT skills.*
- Priority setting.*
- Routine data inputting/paperwork.*
- Innovation.*

The starred items have been imported from the operational definition of the NP, outlined above. Their inclusion can be justified on the grounds that they are critical skills, the performance of which should be maintained at the highest standard. Updating and consolidation of these competencies must therefore be considered essential.

The content of the educational curriculum outlined above is consistent with much of the literature on advanced nursing practice. Markham (1988) for example, stressed the relevance of management skills in the NP repertoire and Shuttleworth (1991) noted the imperative for NPs to be pushing back the boundaries of clinical practice.
Ford & Walsh (1994) also highlight the importance of innovation, creativity, the introduction of change and interpersonal and communication skills as core features of the NP's role.

While the present study did not investigate the level at which NP education should be offered, the curriculum content suggested above provides a set of useful, if implicit, guidelines. The emphasis on reflective practice, research and advanced level skills of all types would seem to exclude in-service training courses. While this is a position diametrically opposed to that espoused by Potter (1990), it would nevertheless be one which received support from the growing cohort that believes in-service training for NP development serves only to undermine the role and function, leaving the incumbent ill-prepared for the challenges inherent in the position (e.g. Ford & Walsh 1994). Furthermore, since all new nurses will achieve at least a diploma under the Project 2000 scheme, it is self-evident that the advanced practitioner will need to pursue an educational course at a post-diploma level. This would suggest that NP training must operate at least at first degree standard, although the salience of the research element identified in the above tentative curriculum, together with the focus on reflective practice, would argue for a course at Master's level. While this could conceivably have the undesirable effect of creating an elite stratum within the nursing profession, the credibility and status it would bring in its wake might be highly effective in establishing the necessary credibility for independence and autonomy.

CONCLUSION

This study, with its focus on a multi-perspective approach to identifying the essential training requirements for NP development has revealed important areas of consensus between and within the nursing, management and medical participants. Introduction of NP training and education which targets these areas of agreement should facilitate the passage of the NP's training and occupational function within the Trust, and in this way, may go some way towards offsetting inter-professional conflicts. Notwithstanding, there were significant differences between the doctors and the other two groups regarding research activities and autonomy.

While these areas have been highlighted in the literature as being central to the NP role, they nonetheless are skill domains which hitherto have been the exclusive province of medical practitioners. Defending the professional boundaries as a means of preserving supremacy is a predictable response when a group perceives itself to be under threat. A failure to resolve this conflict before the formal introduction and development of the NP role within the Trust will serve only constrain and inhibit its progress. The areas of discord, now that they have been identified, can at least be addressed constructively in a pre-emptive move to facilitate the NP initiative.

References


