Nurses' understanding of a developing nurse practitioner role in the Norwegian emergency care context: A qualitative study

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Published in:
Nordic Journal of Nursing Research

DOI:
10.1177/2057158518783166

Publicerad: 01/01/2019

Document Version
(Referentgranskad version om publikationen är vetenskaplig)

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Boman, E., Ösp Egilsdottir, H., Levy-Malmberg, R., & Fagerström, L. (2019). Nurses' understanding of a developing nurse practitioner role in the Norwegian emergency care context: A qualitative study. ***Nordic Journal of Nursing Research, 39*****(1), 47–54. https://doi.org/10.1177/2057158518783166**

Abstract

In Norway the nurse practitioner (NP) role is still in its infancy. To succeed with implementation of this new role stakeholder involvement is important, and there should be an explicit need for change. The aim of this study was to explore registered nurses understanding of how the NP role could contribute to meeting the patients' needs of care in the emergency care context, and nurse's perceptions about the implementation process. The study is a qualitative interview study. The interviews were analysed by means of qualitative content analysis. Two themes occurred: the NP role being an autonomous role suitable for non-urgent patients, and the NP role being diffuse as well as threat to colleagues and organizational structures. The results indicate that the NP role can make a valuable contribution to meet current challenges in the emergency care context. However, for successful implementation, the management team plays an important role in leading change and engaging co-workers to be part of the process. In further research, it is recommended to evaluate the forthcoming implementation process, and later on, to evaluate the outcomes of NP practice in the emergency care context in Norway.

Keywords: advanced practice nursing, hospital emergency service, nurse practitioner, nursing roles, implementation

Introduction

Emergency department (ED) crowding and long wait times are associated with an increased risk of in-hospital mortality,[1–4] a higher probability of leaving the ED against medical advice or without being seen[1,4] and decreased overall patient satisfaction.[4,5] Several factors contributing to ED crowding are not amenable to interventions (e.g. it is unlikely that new hospitals will be built, inpatient beds will be added to hospitals, or that acuity suddenly will decrease[6]). Therefore, effective strategies for the optimization of patient outcomes regardless of crowding status are emphasized, and nurses are seen to have a unique and valuable perspective in identifying safe and effective care.[6] It is suggested that advanced practice nursing can positively impact ED throughput, decreasing ED wait times and/or length of stay,[7–10] and have a positive impact on delivering effective and high quality care,[8,11] as well as increasing patient satisfaction.[8,9,11]

Nursing on advanced level is included in the nurse practitioner (NP) role. According to the International Council of Nurses (ICN) NP/APN Network,[12] an NP is 'a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A master's degree is recommended for entry level.'[12] The ICN further specifies the nature of NP practice to include advanced skills in health assessment, decision-making and diagnostic reasoning. Further, the NP role includes research and practice integration, a high degree of professional autonomy and independent practice, a case management role/own caseload, provision of consultant services to health providers and the ability to plan, implement and evaluate programmes.[12]

In the Nordic countries, the NP role has already been implemented in some countries since the beginning of this century.[13,14] However, research from the emergency care context is scarce.

This study is being performed at an ED in Norway, where the NP role is in its infancy. There are in total five Master programs in advanced practice nursing in Norway today, with different areas of focus, i.e. geriatric-, acute-, emergency- and family-care. However, all programs are more or less recently implemented, and thus studies within the field being very limited (see also Henni et al.[15]). Even though there are studies on implementation of NP role in emergency care in other parts of the world, it is important to study the role in this new context. This especially as Norway, compared with many other countries, has a somewhat different healthcare system for patients to gain access to emergency care. Patients have to pass a 'gatekeeper', meaning that the first contact with the healthcare system is usually through the patient's regular general practitioner (GP) or an emergency outpatient clinic. Thus, the vast majority of patients entering the ED have been seen by a doctor or the ambulance services, and consequently have had a first pre-hospital assessment.[16] Further, in Norway the doctor–patient ratio is estimated to be better than that of registered nurses (RNs) to patients, a situation that differs from many other countries being afflicted by doctor shortages.[17] However, there is an ongoing national discussion about medical resources not meeting the needs of the population. Further, the management team of the ED in this study have been struggling with problems similar to those initially mentioned as occurring in EDs (i.e. long wait times and shortcomings in achieving patient satisfaction). Consequently, the management team has made a decision to invest in development and implementation of the NP role; this through taking part in the participatory action research (PAR) project 'Providing person-centred healthcare – Development of new models of advanced nursing practice in cooperation with patients, clinical field and higher education'.

The project incorporates implementation of the NP role into emergency care in Norway. The project is founded in a participatory, evidence-based, patient-focused process for advanced practice nursing role development, implementation and evaluation, the so-called PEPPA

framework.[18] The PEPPA framework recommends, in the beginning of the process, that sufficient data is to be provided to support the need of new models of care and identify priority problems and goals.[18] This is in line with recognized theories and models of leading change (e.g. Lewin[19] and Kotter[20]). The PEPPA framework further embraces a participatory action research (PAR) approach. PAR can contribute to closing the gap between theory and practice as practitioners become directly involved in nursing research.[21] PAR aims at enabling action, and action is achieved through a reflective processes and participation of all included co-partners. PAR further emphasizes careful attention to power relationships, meaning that power is to be shared between the researcher and the researched.[22]

Accordingly, stakeholder involvement is emphasized in the PEPPA framework.[18] Stakeholders may include patients, families, management, advocacy groups or government agencies, and also members of the healthcare team, as stakeholder participation at the outset is reported to be critical for ensuring commitment to and providing support for planned change.[18,23] Previous literature reviews show that nurses can be critical of and feel threatened by implementation of the NP role,[24,25] and NPs themselves can initially find the role having unclear role expectations.[25] To succeed with implementation of new NP models of care, it is thus important to explore the perceptions – both of nurses and of NPs in training – of the need, goals and clarity of the NP role. The aim of this initiatory study was therefore to explore RNs understanding of how the NP role could contribute to meeting the patients' needs of care in the emergency care context, and RNs perceptions about the implementation process.

Method

The study is a qualitative interview study based on interviews with RNs working in the ED.

Participants

The participants comprised seven RNs (women, n = 6; men, n = 1), of whom three had attended NP training in September 2015 (interviews were performed in December 2015 and March 2016). The inclusion criterion was RNs working in the studied ED, of which some should have initiated NP training. The participants were selected through convenience sampling.[26] The management team assisted with recruiting of participants. As there is such a limited amount of NPs in Norway and the role in emergency care is new, we have chosen to revile limited information about the participants and the setting to protect the anonymity of our participants.

Data collection

The plan was to perform focus group interviews. That proofed to be difficult due to high workload and sick leaves in the ED during the recruitment period. Therefore, of the five interviews, three were performed individually (interview no. 1-3), and in two interviews the RNs were interviewed in pairs (interview no. 4-5). The semi-structured interviews covered topics on current problems and unmet needs in the care of patients in the ED, comprehension of NP competences, the RNs' comprehension of a feasible NP role, and facilitators and hinders in implementing the NP role. The interviews were performed by one of the co-authors (HÖE) having experience of qualitative data collection in previous studies. The interviews were performed at the worksite of the RNs and lasted between 28 and 85 minutes (mean length 52 minutes). The interviews were recorded and transcribed verbatim.

Analysis

The transcribed interviews were analysed by means of manifest qualitative content analysis;[27] the interviews were read several times; meaning units were highlighted; and the content was condensed, coded and organized into categories and two overarching themes, exemplified in

Table 1. One of the authors (EB) made a preliminary coding. Secondly, the analyses were read and reflected on by the interviewer (HÖE), to later be confirmed by the research group as a whole.

Please, place table 1 about here.

Ethical consideration

The study has been approved by the Norwegian Centre for Research Data (NSD; Ref. nr. 44387/3). In line with the Declaration of Helsinki[28], information about the study was given (orally), together with information about voluntary participation and the opportunity to withdraw from the study. Written informed consent was collected from all participants.

Results

The results are presented in six categories and summarized in two themes: *NP role being an autonomous role suitable for non-urgent patients*, and *NP role being diffuse as well as menacing to other professions and to organizational structures* (Table 2).

Please, place table 2 about here.

NP role being an autonomous role suitable for non-urgent patients

The theme consists of three categories. The first present *incentives for new models of care*, i.e. long wait times, patients having to tell their story repeatedly and recurrent loss of competence. The second category refers to *dimensions of competence*, being a mix of deepened but broad competence as a foundation for an autonomous nursing role and offering holistic care. The third category builds on the previous two categories and represents *areas of responsibilities*, i.e. NP role being suitable for non-urgent patients, and a role that should contribute to professional development and should include supervision of co-workers.

Incentives for new models of care

The RNs said that one challenge in the ED is that the number of patients increases, and so do the wait times. One general obstacle identified by the RNs is the accomplishment of a comprehensive assessment and confirmation of a care plan. In general, a RN admits the patient, assesses vital signs and orders/takes eligible tests (e.g. blood sample, ECG). Next, the patient is being seen by a junior doctor who makes a medical assessment. The junior doctor may in turn need a second opinion from a senior doctor. All these steps, presupposed to be done in the order mentioned, may contribute to prolonged wait times. In the interviews it was made clear that this procedure also obstructs admission of further patients, adding to wait times for those waiting for assessment.

One group of patients mentioned to be especially afflicted by long wait times were patients with non-urgent care needs, who are triaged as low priority. One RN exemplified:

> For patients with DVT (deep venous thrombosis) it can take years and days, become winter and spring before they are looked at. (Interview no. 4)

These non-urgent patients were also seen as occupying staff resources and spatial area. One RN said:

> …the non-urgent patients occupy an incredible amount of resources and time and space without necessarily needing it… also withholding doctors from doing work where they are most needed. (Interview no. 4)

Another concern among the RNs was patients having to tell their story repeatedly. The patients may answer similar questions from the RNs, the junior doctors and one or several senior doctors, and the efficiency in such a practice was questioned. This situation also posed a moral dilemma for the RNs wanting to ease the situation for the patient; should one ask as little as

possible to spare the patient, or should one take a more thorough medical history and make a more thorough assessment to be sure of not missing something of relevance, however, still risking the patient having to go through the same questions and assessments by a doctor later on.

Nonetheless, the RNs had a, in general, sympathetic attitude toward nurse and doctor cooperation. However, it was questioned whether it is optimal to have the initial assessment of the patients in the ED being done by junior doctors, who have limited experience in emergency care medicine. In addition, the placement of the junior doctors ranges over a six-month period, after which they are substituted with a new group of junior doctors. This was put forth as a recurrent loss of competence and was remarked to not be in the best interest of the patients and also stressful for co-workers. One RN said:

> It is strenuous for everyone having a new group of junior doctors every sixth month, as it at least takes three to four weeks before they get into it. (Interview no. 3)

Another variable mentioned as contributing to loss of competence was from time to time is high nurse turnover rates. New employees, often newly graduated RNs, not having gained adequate competence to meet all patient cases presented in the ED, slow down the patient flow and increase the stress and workload on the more experienced RNs. However, the situation was also considered to be stressful for the new graduated RNs. It was declared the ED can be a harsh environment for inexperienced RNs as there is not always time for supervision or giving adequate support.

Dimensions of competence

Among the RNs it was understood that becoming an NP means gaining a deeper understanding; it is about learning more about human physiology, achieving improved competence in observing and assessing patients, as well as in pathophysiology and medical treatment. One of

the RNs expected that with the new education and previous experience, one would become able to put into words what was previously just sensed, and thus be able to identify and designate the problem, including knowing when the situation exceeds one's own competence. It is about making the decision on what should be done, when, why and how – or not. It was declared that previous work experience is of great importance; to be able to be an excellent NP one has to have developed intuition. Competence was further related to quantity of training, and this was emphasized, this as '… (the NPs) must be good because it is patients, it is not… this is not a playground' one RN said (Interview no. 2). NP competence was further said to be about having broad competence, not being specialized in a specific area, but being 'a general nurse specialist'. One of the RNs said:

> The traditional nurse specialist is specialist in one specific area. A nurse with NP education will hopefully have a broader competence… a broader (foundation of knowledge). (Interview no. 1)

The NP role was also expected to bring about more holistic care in the ED; not only emphasizing holistic nursing, but also adding a medical perspective. With enhanced competence, the NP role is expected to include working more independently, making autonomous decisions and having competence to take on tasks traditionally performed by junior doctors. However, NPs are not to replace junior doctor. One RN said:

> After all, they (junior doctors) have another and much longer and more thorough education. (Interview no. 3)

Further, the NP role should not only be about performing single advanced procedures; it is also about adding value for the patients. The NPs were presumed to have competence to offer something other than doctors traditionally offer. One RN said:

> (NPs) should add value for the patient… if there is something that concerns the patient… many patients experience a more intimate connection with the nurse… than with other professions that focus more on the problem, the actual problem, but perhaps oversee other issues. (Interview no. 1)

Areas of responsibilities

In the interviews the RNs said that NPs could have an important role in caring for patients diagnosed with chronic medical conditions, attributed with a poor general condition and complex and extensive care needs, for example, patients with cancer or COPD. These patients are seldom being triaged as critically ill and are thus being struck by long ED wait times. Some of the patients with extensive care needs are also reoccurring in the ED, and the NP could have an important role to go more in to depth in the patient's problems and hopefully preventing unnecessary readmissions.

It was also suggested that patients with less complicated fractures, minor traumas and minor medical conditions, such as DVT, could be suitable for NP care models. One RN said:

> As long as one is aware of one's limitations I think a NPs can do quite a lot… especially for 'outpatients'… waiting and waiting for a minor measure and eventually perhaps being worse taken care of by a junior doctor than by an experienced nurse, for example in need of replacement of a catheter or some stiches in a fingertip. (Interview no. 1)

NPs were also said to be able to take on a greater responsibility than RNs traditionally do, however not work autonomously, in caring for patients with patients with more acute concerns such as abdominal and heart conditions and sepsis. It was nonetheless disclosed that it would be beneficial to have doctors handle patients who really are critically ill, and NPs could handle less complicated patient cases.

With this new competence, the NP role was expected to contribute with new knowledge and supervision of co-workers to improve the professional competence level at the unit. One RN said:

> I think they should be used as a resource to teach what they have learnt… and I think it would be useful if there were days were… for example I could follow one of them while they teach… there is one thing to be told that should do this and that, and another thing to learn while you are doing… (Interview no. 4)

The NP role being diffuse as well as menacing to colleagues and to organizational structures

The theme consists of three categories. Firstly, there is *an unclear role and scope of practice* whereas nurses describe that they are struggling to comprehend the role and scope of practice for NPs in emergency care. Secondly, the NP role is seen as *a threat to colleagues*. The RNs visualize that implementation of NP models will include task-shifting between doctors and NPs, which in turn will deprive junior doctors from learning situations. The RNs also anticipate that there is a risk for downgrading of other nurses, affecting motivation to work and develop in the ED. Thirdly, the nurses foresee implementation of NP models as *a challenge to the organizational structure*; a structure that is understood as rigid and hard to change.

An unclear role and scope of practice

The RNs declared that even having an idea about NP models of care, the NP role and scope of practice were seen as unclear. One RN said:

> I have a hard time visualizing what they shall do and what authority they will have… and I don't think anyone has tried to explain that for me either. (Interview no. 5)

It was recognized that different actors were included in the implementation process of the NP role, and that the process was not straightforward. It was said that the University College, training the becoming NPs, seems to have one agenda, and the employer seems to have another, more or less hidden agenda, resulting in a feeling of being left out. The RNs expressed that it would be important to get more information and to discuss the NP role and potential NP models, both pros and cons. One RN said:

> …one has to dear to take the discussion, to get a pragmatic debate, and discussions… also those who are uncomfortable… we cannot expect that NPs will save the world… we also have to reconsider if this is the right path to take… (Interview no. 1)

In addition, it was questioned whether the NP generalist competence has a place in the ED or whether the competence could be more suited to primary healthcare. Further, the healthcare system in Norway includes the gatekeeper function. The question was put forth, if NPs in EDs in other countries have a role similar to that of the gatekeepers in Norway, whether the NP role has a place in emergency care in Norway?

The level of NP educational degree was also discussed. A master's degree brings about competence in research and development work; however, it requires quite a lot of effort to develop and retain such competences in praxis. There was also comments on limited need of nurses with research competence; the majority of nurses should focus on practical patient care. It was anticipated that too many nurses with high academic degrees might lead to no one doing the basic nursing tasks. One RN said:

> There is a limitation for how many we need, because it is a matter of fact that we need to get the patients through the system… We need people who are not afraid to wash, move beds, and I see… I can already now see that it gets like, 'No, I'm too good for that, and I

won’t do that’… That is what happens… it can even be newly graduated nurses saying, ‘No, that is not one of my tasks’… No, but whose tasks are they, then? (Interview no. 4)

Further, having nursing staff attending different types of higher education on a regular basis means that replacements have to be found to carry out the work in the ED. The replacements are often newly graduated nurses, leaving the burden on more experienced RNs working in the ED to take on greater responsibility and to supervise the newcomers.

A threat to colleagues

The RNs said that the NP role was understood to include task-shifting between doctors and nurses as well as between RNs and NPs. Task-shifting was seen as a threat to other professions. The RNs referred to the current ED organization, having the junior doctors rotating for six months in a structured learning programme. Implementation of the NP role, including task-shifting, was by the RNs understood to deprive junior doctors of learning situations, and this was anticipated to create trouble.

> If you are going to move yourself into another area of expertise there will be harshness. (Interview no. 1)

The RNs also expressed concerns about implementation of the NP role in the ED could mean downgrading of other nurses. It was questioned whether the RNs would have to leave aside tasks that they find interesting. One RN said:

> If I am to work together with an NP and receive an acute abdomen, I'll undress the patient and take vital signs but I should not touch the stomach because NP should do that… I wouldn’t like that. I don’t have a problem working with others, and I do want to learn, but I want to do things myself also, otherwise you lose… Then it gets totally uninteresting

> for me… Then I would rather be somewhere else where I can do more things on my own. (Interview no. 4)

It was said that the RNs in the ED have chosen to work there because they want to care for patients who are critically ill. One RN asked:

> Will NPs take the most exciting tasks away from RNs? Is that morbid to say? (Interview no. 4)

Further, based on previous reading of the NP curricula, the RNs asked how NP competence differs from the competence of RNs with long work experience, especially RNs who, in addition, have taken a moral standpoint to learn and to improve competence on their own, but are not awarded with a certificate, a new work title or a raise in salary. It was brought to the table that such concerns may lead to discussions about injustice and what is worth more: being a competent RN or having an NP certificate.

Consequently, there was scepticism regarding the new role, but in the end, one respondent said that general opposition and criticism towards changes does not need to be negative. It means that people care about their work.

A challenge to the organizational structure

Implementation of the NP role was further understood to challenge not just other professions, but also the organizational structures. The RNs questioned whether it is possible at all to implement an entirely new role within existing – what were said to be rigid – hierarchical structures. One RN said:

> I'm a bit sceptical if it is possible to find a place for the (NP) role as the health care system is built on such hierarchical structures. I compare with the midwives, when they got the

> right to prescribe contraceptives, it took many years before that was accepted… (Interview no. 4)

To be able to implement the NP role in the ED the RNs anticipated that it would be necessary to make an exposition of the current organizational structure and models of care; it is not possible to just add a new role without an overview of the current situation. Also, it was said that the overall nurse manning must be reconsidered; NPs should be seen as a profession of their own, and not administratively be part of the regular nursing schedule. This would mean that new, probably unexperienced RNs must be recruited. Another mentioned scenario was not being able to make any new recruitments due to economic restrictions, leading to a diminished RN work force. Also, it was made known that the ED has gone through some other organizational changes in the last couples of years, and a general exhaustion in the reverberations of those was expressed. The RNs expressed that there is not a general keenness with respect to changes, especially since some previous innovations have not been that successful and have even led to nurse turnover. The impending change was understood to include hard work and persistence. One RN said:

> It is pioneer work, and pioneer work is hard… You first have to lift the stones, then you have to turn the soil… There is a lot to do before you can sow and plant. (Interview no. 4)

The RNs further expressed worries about that implementation of the NP role does not only concern the organisational structures in the ED; NPs need to be able to cooperate with other clinics and professionals, for example cooperate with consultants from other clinics. ‘There are many that needs to be convinced’, one RN said (Interview no. 5). Another RN said that ‘It is a canvas that is hard to bleach,’ (Interview no. 4) about selling the NP concept to others and revising organizational structures between units.

Discussion

This study is part of a larger PAR project developing, implementing and evaluating NP models in Norway; a country where the NP role is still in its infancy. This initiatory interview study in the emergency care context aimed at exploring RNs understanding of how the NP role could contribute to meet the patients' needs of care and RNs perceptions about the implementation process. The results are understood to contribute with significant information for the project as a whole, as well as for others being in the beginning of the process of implementing NP models in similar contexts.

It is acknowledged that to succeed with implementation there has to be need for change (cf. 'driving force for change'[19] or 'a sense of urgency'[20]). The results showed that there is a need for change, i.e. incentives for new models of care emerged. Further, the RNs anticipated that the NP role could meet some of those needs. A patient group that was brought special attention and that was assumed to be suitable for the deepened but broad NP competence, was non-urgent patients with extensive care needs, often reoccurring in the ED. It is known from previous research that non-urgent patients in the emergency care context feel that they are being given little attention and 'being a nuisance', bringing about a feeling of being exposed and powerless.[29] NP practice, including being responsive to patients' needs and offering holistic and attentive care, could increase patient satisfaction and might reduce the risk of readmission, as well as reduce omitted basic care needs in the dominant medical–technical culture in the ED (see also Dahlen, Westin and Adolfsson[29] and Kihlgren et al.[30]). Having NPs take on a case management role[12] could address the in the results mentioned problems, as gaining comprehensive assessments and finalizing care plans, as well as avoiding patients having to tell their story repeatedly.

Nonetheless, the results reviled that the NP role and scope of practice was found unclear, in line with previous research.[24,31,32] Thus, this result was not unexpected, especially as the NP role only recently has been implemented in the Norwegian health care system. One main mission for this ongoing project is to develop new models of care, and in the spirit of PAR, to co-generate meaning and knowledge with the stakeholders. [18, 22] Hence, the RNs and the forthcoming NPs have an important saying in the development and implementation process of the new role. However, it did not seem that the interviewed nurses were fully aware of their part in the process, but had an expectation that the management team should present an outright plan. Thus, in addition to get important information on the aim of this study, we have understood that the stakeholders at the point of the study did not feel included. Therefore, it is recommended to in a greater extent involve the RNs in the process. This, as stakeholder participation at the outset is reported to be critical for ensuring commitment to and providing support for planned change.[18,23,33,34]

Further, the RNs in our study expressed a sense of being threatened by the new role. Implementation of the NP role was according to the results expected to menace the current organizational structure, including deprive co-workers of control over and familiarity with their work. This phenomenon can be viewed in the light of the theory of organizational ownership. From a psychological perspective work can be understood as being a possession (similar to, e.g., a house or car). Work plays an important role in the owner's identity, and offers 'having a place' in the greater whole. This ownership can emerge through controlling the target (i.e. workplace), being familiar with it and investing oneself in it.[35] The results of this study give the notion of a threat depriving workers of their psychological ownership of work, as nurses expressed concerns about how the new NP role would affect their own role (and the roles of others). Previous research shows that more experienced nurses initially may feel that NPs take over their roles as mentors and experts,[24,25] and this may be an important

topic to discuss in the team, to not end up with lack of trust and respect within the team (see Andregard and Jangland[24]). Here management team, and especially the nurse leaders have an important role in leading change. If wanting a sustainable change, leaders have to invest in not only leading the process, but also the relationships and the culture. By doing so leaders create prerequisites not only for change, but also for good patient care.[23,34,36] Lastly, it understood that implementing a new role in the hierarchical health care system is ever so challenging. It is not just about planning and starting a Master program; implementing a new role effects both the organisation and the people working in it.

Methodological considerations

The number of participants was relatively small (n = 7). However, there are no fixed rules for sample size in qualitative studies, and similar information was reported in the different interviews, indicating data saturation (see Polit and Beck[26]). Nonetheless, it would have been interesting to have a greater number of participants to contrast NP students and other RNs. NP students, not unexpectedly, had a broader view of the NP role and scope of practice in emergency care; however, NP students also expressed uncertainty about the coming role.

In two interview sessions the RNs were interviewed in pairs. Paired interviewing builds on the interaction between participants and leads to the pairs filling in gaps in the narrative,[37] which can be seen as fruitful. On the other hand, a particular concern when conducting joint interviews is that one of the pair will dominate the talk.[38] To avoid this, there were sometimes specific requests for one of the pair to expand on particular responses. It was experienced that all RNs spoke and answered questions freely.

It can further be seen as a weakness that the management team assisted with the recruiting of participants. There could be a risk that RNs were chosen based on having a similar stance to that of the management team concerning the current questions. This criticism can, however,

be met with the fact that the RNs had broad points of views covering a spectrum that included both pros and cons regarding the current model of care and the potential NP role and scope of practice. It can also be seen as a weakness that the description of setting and participants is rather vague; this to protect the anonymity of the participants.

In line with the qualitative design, the results are not expected to be generalizable. However, it is expected that the results could be similar if the study had been performed in similar contexts elsewhere in EDs in other parts of Norway and even in other western countries.

Conclusion

The results revile that there is a need for change in meeting patients' needs of care in the emergency care context. The results further indicate that the NP role is assumed to make a valuable contribution to meet current challenges, particularly among non-urgent patient with extensive care needs. Nonetheless, the NP role is understood to be diffuse and a threat to other professions and to organizational structures. We encourage the management team to act on this sense of uncertainty and get directly involved in the essence of change; the management team plays an important role in leading change and involving co-workers to be part of the process. In further research, it is recommended to evaluate the coming implementation process, and later on, to evaluate the outcomes of NP practice in the emergency care context in Norway.

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