

**Solutions for enhanced access to healthcare in the  
Corner Brook-Rocky Harbour and Stephenville-  
Port aux Basques regions: An examination of  
Nurse Practitioner Models of Care**

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## **EXECUTIVE SUMMARY**

In Newfoundland and Labrador (NL) there are currently 127 licensed Nurse Practitioners (NP). There are more NPs per population in NL than any other province in Canada. Yet it is generally acknowledged that many of our rural and remote populations do not have adequate access to primary health care.

The literature and key informant interviews strongly suggest that with adequate preparation and support, NPs can be a viable solution to improving access to health services, particularly in rural and remote areas.

Key informant interviews and the literature suggest that many of the barriers that NPs face in the initial implementation can be overcome with adequate commitment and support. Successful implementation of NPs in other jurisdictions has promoted the NP model of care as a viable option to improve access to health services.

Appropriate enabling legislation, support from the provincial NP and/or nursing association, the community, the local RHA, and local physicians are required to make the implementation of a NP model of care successful and sustainable in the long term.

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## **PROJECT BACKGROUND**

The Rural Secretariat Councils for the Stephenville-Port aux Basques and Corner Brook-Rocky Harbour area have a strong interest in issues relating to improving access to healthcare in their regions. In 2012-13 the Health Research Unit conducted a joint research project for the Councils to identify issues and barriers to accessing healthcare in western Newfoundland. In this initial study they explored potential solutions to improving access to health services. The 2012-2013 research identified five potential solutions to improving access to health services in western Newfoundland, including:

- The recruitment of more rural and remote physicians;
- The adoption of a nurse practitioner (NP) model;
- Improved assistance with medical related travel cost and the development of specialist outreach services;
- Increased use of telehealth services; and,
- The initiation of additional rural and remote health services research.

Building on these findings and as a second phase to this initial project, this current research examines the potential role of NPs as a means to improving access to health services. This review is comprised of a jurisdictional scan (including a limited number of key stakeholder interviews) and literature review. This research explores the different ways NP models have been applied in other jurisdictions, the challenges they faced when implementing NPs, and ways NPs might be applied in the Newfoundland context.

### **History of Nurse Practitioners in NL**

NPs have been a part of healthcare in Newfoundland for over 15 years. The education program for NPs who are working under the current legislation and regulations started in 1997 and the first graduates of the NP program were in 1998. Thus, the actual licensure of NPs in Newfoundland and Labrador began in 1998. These first graduates were from various regions of the province but mainly from rural and remote areas. This was because when the program was established it was intended to provide access to healthcare services by using NPs in rural and remote locations. In the first year of the education program there were seven Registered Nurses from Western Newfoundland, four from Central Newfoundland and two from Labrador. At this time primary healthcare pilot projects were being initiated and there were primary healthcare sites established in rural areas; Port-aux-Basques, Twillingate and Port Saunders. The original focus of the NP program was to staff those three primary health care sites.

Initially the program was a certificate program offered through the Centre for Nursing Studies. In 2006 this certificate program transitioned into a Baccalaureate Program. In 2012 it transitioned further into a Master's program at Memorial University. Prior to the Master's program being available at Memorial University, a Master's program was available at the University of Toronto and the Newfoundland Government supported nurses financially to complete that program. The intention of this Master's program was primarily to recruit educators for the program here at Memorial University. To be eligible for support an individual had to have a Master's degree in Nursing, be an educator, and be prepared to teach in the NP program. As of March 2014, there

are 127 registered NP's in the province. An additional 11 have finished the program but have pursued other roles.

NPs start their careers as nurses and must complete a minimum of a Master's degree program and pass a national certification exam before they can practice. The role of NP's vary and depends on the geography, population and employer. Generally, the scope of practice for an NP is very broad. The Canadian Nurses Association (CNA) define NPs as "registered nurses with additional educational preparation and experience who process and demonstrate competencies to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform specific procedures within the legislated scope of practice" (CNA, 2009). NPs diagnosis, monitor, and treat an array of injuries and illnesses. They are permitted to order and interpret laboratory tests, prescribe drugs, perform procedures and interventions and provide orders to other health care providers. NPs possess the competency to provide comprehensive health assessments, identify health risks and health needs, and diagnose diseases, disorders, injuries, and conditions. The NP discusses health assessment findings, diagnoses, prognosis, and outcomes with clients and/or the health care team.

The role of the NP is more advanced than that of Registered Nurses and Licensed Practical Nurses (LPN). LPNs complete a one to two year training program and perform simple medical procedures under the supervision of a RN or physician. The role of an LPN includes: collecting patient history, taking vital signs from the patient, delivering medication to the patient, collecting samples for the lab, and assisting patients with feeding and basic personal hygiene. A Registered Nurse (RN) has a diploma or a Bachelor's degree in Nursing, and must perform a requisite number of hours of practice in a given time period to maintain licensure. RN's supervise LPNs, orderly's, and assistants. The role of an RN includes performing comprehensive health assessments to diagnose and treat health problems, to order and interpret the results of diagnostic and screening tests and to prescribe drugs and medication.

## **RESEARCH OBJECTIVES**

The principal objective of this research was to explore the use of NPs as a way to enhance access to health services for rural communities in the Stephenville-Port aux Basques and Corner Brook-Rocky Harbour regions. More specifically, key areas of interest for this project included:

1. Exploring various NP models in use at a regional, provincial, national and international level;
2. Examining barriers and enablers to implementing NPs within different regions (e.g. rural or remote areas vs. urban areas);
3. Examining the principal benefits and drawbacks associated with NPs;
4. Exploring the key components of NP practice that are critical for the successful delivery and integration of this practice with existing health services; and
5. Exploring issues associated with recruitment and retainment of NPs.

## **METHODS**

### **Literature Review**

A scan of the seminal literature available (both academic and grey) was completed to examine the potential use of NPs as a possible solution to increasing access to health care in the region. This literature review was completed using key words submitted by the principal investigators and the Rural Secretariat.

### **Key Informant Interviews**

The interview guide was developed by the Rural Secretariat, Office of Public Engagement (OPE) and the Principal Investigators at Memorial University based on the findings of the literature review and the research objectives. Five interviews (all by telephone) were conducted with professionals working in healthcare familiar with the issues related to NPs and who the researchers believed would be helpful in identifying key issues related to implementing NPs within the region.

Prior to each interview a consent form was emailed to the participant for their signature. The interviews were all audio recorded and transcribed verbatim. The data from the transcripts were analyzed and organized according to the questions asked, issues uncovered, and suggestions for resolutions to the issues. De-identified quotations are used in the final report to highlight areas of interest.

## **KEY FINDINGS**

### **Literature Review**

The specific purpose of the literature review was to: examine the current scope of NPs in this province, to explore the different ways NP models have been applied in other jurisdictions and the challenges they faced during implementation.

### **Research Questions**

The following research questions guided the review:

- 1) What is the current NP model that is used in the province and in the Western Health region? For example; numbers employed, roles, scope of practice, challenges they face?
- 2) How have NP models been used in other jurisdictions to lessen the implications of health barriers and/or to enhance healthcare access?

### **Literature Search Terms**

Nurse practitioner  
Primary Health Care  
Rural

### **Research question 1**

**What is the current NP model that is used in the province and in the Western Health region? For example; numbers employed, roles, scope of practice, challenges they face?**

As noted above, the Canadian Nurses Association (CNA) define NPs as “registered nurses with additional educational preparation and experience who process and demonstrate competencies to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform specific procedures within the legislated scope of practice” (CNA, 2009). It is believed that the NP role contributes significantly to improve timely access to individualized, high quality, cost effective care through a broad range of health care services.

Within Newfoundland and Labrador (NL), NPs fall into two main categories: 1) those who are employed by one of the four Regional Health Authorities (RHAs, i.e. Eastern, Central, Western or Labrador Grenfell Health), and 2) those who are independently employed, i.e. outside of the RHAs, for example within the offshore oil industry. If a NP is employed by either one of the four RHAs in NL, the framework under which they practice is similar.

As an employee of one of the RHAs a NP is required to declare to the Association of Registered Nurses of Newfoundland and Labrador (ARNNL) that they are affiliated with a physician for the purposes of consultation and collaboration. That is, the NPs work autonomously within the NP scope of practice and consult with physicians, and other team members as required. The majority

of NPs in NL work within this category. There are a small number of NPs who are employed independently in industry such as offshore oil. As with the NPs working within the RHAs, an independently employed NP is also required to declare to the ARNNL that they are affiliated with a physician for the purposes of consultation and collaboration (i.e. the name and address of the physician must be stated) (<http://www.arnnl.ca>).

The distribution of NPs across the province and within each RHA is dependent upon funding availability and the identified need within each region. Funding is allotted for particular positions and roles, and hiring is in accordance with RHA policies. Currently, the distribution of NPs varies with the higher percentage employed in the Central and Eastern RHAs. In NL there are a total of 127 NPs, 55 in Eastern Health, 26 in Central Health, 14 in Labrador/Grenfell Health, and 10 in Western Health.

NPs in NL previously worked under one of two categories; 1) Primary Care or 2) Specialty NP. Primary care would encompass general family practice whereas specialty NPs would have an area of specialty such as vascular, cardiology or radiology. Currently, to be in line with the streams of practice within the rest of Canada, NPs now work under one of three categories: 1) Family, 2) Pediatric or 3) Adult. (ARRNL, 2013).

NPs in NL independently assess, diagnose and manage patients in community clinics, emergency departments, acute care programs, long term care, mental health and other settings. They are not, however, able to admit or discharge patients to hospitals despite having the knowledge and skill. This is due to a RHAs Act and Bylaws that designate physicians as the sole authority to admit or discharge a patient. The role of admitting and discharging patients by NPs could potentially enhance patient's access to health services and reduce wait times (ARRNL, 2013).

### **Research question 2**

#### **How have NP models been used in other jurisdictions to lessen the implications of health barriers and/or to enhance healthcare access?**

Patient access to primary healthcare is a significant issue in Canada. In a 2007 International Health Policy Survey in seven countries, Canadian adults were least likely to report same day access and most likely to report long wait times to see a doctor when they were sick and to report difficulty getting after hours care (Schoen et al., 2007). Canadian adults were also least likely to report having a nurse or NP regularly involved in managing their care.

According to Dumont, Zurn, Church & Le Thi (2008) the low utilization of nurses and NPs in disease management in Canada is of concern particularly because physician density in Canada has remained unchanged between 1990 and 2005. In the past decade, all Canadian provinces and territories have launched team based, primary healthcare initiatives designed to improve access and continuity of care (Beaulieu et al., 2008). NPs are increasingly seen as integral members of primary healthcare teams across the country. NPs were introduced in Canada in the 1970's (Haines, 1993) but were not sustained because of funding and other challenges. According to the Canadian NP Initiative (2006) efforts are now being made to successfully integrate NPs into the Canadian Health Care System.

In countries around the world the potential of NPs to enhance health care is being examined. Chang et al., (1999) evaluated the role of NPs in a major rural emergency department to investigate whether NPs were able to provide a level of primary health care service applicable to remote and isolated settings in Australia. In the study, the role the NPs fulfilled was consistent with an autonomous role that could have been undertaken in a remote health care setting. This study found that there was strong support for the role of NP in the rural emergency setting. NPs were accepted by medical staff and patients and were satisfied with the treatment provided. There was a strong acceptance and support for a NP role and it showed a benefit of decreased waiting time. However training and accreditation, defining the scope of the NP role, and development of standardized protocols are issues that remain.

In Australia collaborative practice underpins NP models. The NP practices as a senior member of an interdisciplinary health care team with the common goal of achieving optimal patient outcomes. The scope of practice includes but is not limited to: developing a collaborative approach to healthcare, ordering diagnostic tests and therapeutic regimes, prescribing medication, educating registered nurses, engaging in health promotion, admission and discharge of patients, developing partnerships and promoting service delivery.

Scotland is currently examining the potential role that NPs can play in their health system. They recognize the key role these clinicians add to the healthcare system. Currently the NP model in Scotland is on par with the Australian model.

According to Sullivan-Bentz et al. (2010) a number of researchers from the United States have examined the transition of NPs from graduate students to the work place but no Canadian research exists about the support requirements of NP graduates in Canada. In Ontario enrolment of nurses into NP programs has now doubled to fill the need in primary health care. Using narrative analysis Sullivan Bentz et al. (2010) made the recommendations that when employing new NPs it is important to ensure that they receive formal mentorship and support from physicians as well as written resources for consultation. It was also recommended that employers familiarize themselves with the scope of practice, meet regularly with team members and collaborate with NPs. It was emphasized that strategies for mentorship and the integration of NPs are available and need to be implemented by health care professionals and administrators.

Lindeke, Jukkala, & Tanner (2001) conducted a statewide survey of NPs that examined NP perceptions to barriers in practice in rural areas in Minnesota. They reported a lack of peer network, limited space and facilities, lack of understanding of the NP role by other professionals and lower salary as barriers to practice.

Ryan (1998) reports on a policy conference during an annual meeting of the Society of Rural Physicians of Canada where a group of doctors and NPs discussed how they can work together to provide quality healthcare in rural and remote areas of Canada. The status of NPs varies from province to province, with some provinces having legislation governing their practice while others do not have supporting legislation. The roles and responsibilities and the scope of practice differs but the demand for NPs is being driven by the public, particularly people in rural communities that experience challenges recruiting and retaining doctors.

DiCenso et al., 2010 described two approaches to NP integration; 1) the introduction of NPs into traditional fee for services practices in British Columbia and 2) the creation of NP led clinics in Ontario. In the Fee for Service (FFS) model NPs are hired under the Regional Health Authority in collaboration with the FFS physicians. They function under the terms and conditions of the RHA, which pays their salary and benefits. Physicians complete a proposal providing the rationale for incorporating a NP into their practice. When patients request appointments, the medical office assistant who is knowledgeable about the NPs scope of practice, offers suitable patients an appointment with the NP. Patients are assigned to the NP but may be seen by either the physician or NP depending on their presenting problem at the time of the visit. The NP facilitates changes in the delivery of care, addresses patient self-management goals, links with other health resources in the community, provides comprehensive primary healthcare focusing on health promotion and illness prevention and refers to specialists as required. Healthcare professionals involved in this model of care reported increased job satisfaction, mutual trust and respect between and among practitioners, open positive communication between the NP and physician and a heavier focus on patient centered care. Patients felt they had improved access to healthcare services, more time with a practitioner during their appointment and more comprehensive healthcare. NPs felt they were part of a healthcare team (Hogue et al., 2008).

In their evaluation Hogue et al. (2008) identified the need for more formal information and education for healthcare professionals and the public about the NP role. A shared physician role and involvement of all members of the clinic in enhancing the NP role was required. Strengths of this model include the addition of government salaried NPs into a FFS practice that promotes inter-professional teams, increased patient access care, team members offering complementary skills to patients and increased patient and provider satisfaction. The primary limitations of this model were concerns over physicians' loss of income if the NP instead of the physician is seeing the patients or if the physician is spending time with the NP consulting rather than seeing patients. There is also concern about the additional cost to the funder if both the NP and physician see the patient during the same visit.

Sangster-Gromley et al. (2013) explain the process of NP role implementation as it was occurring in British Columbia, and identifies factors that could enhance the implementation process. They reported that planning for the role beforehand and long-term planning after the NP was hired were important to help team members better understand the reason the NP role was implemented. Once a NP is hired, team members needed to clarify the intentions of the role primarily because they were not involved earlier in the process and did not have a clear understanding of it. In the early stages of implementation, team members should receive support and guidance from senior management within the health authority to clarify the intentions for the role.

NP led clinics are being described as a new model of care in which NPs work in collaboration with physicians and other members of an inter-professional team to provide comprehensive, accessible, coordinated family healthcare services in populations where many patients do not have a regular primary healthcare provider. This model provides comprehensive family health care services through an inter-professional team, coordination of care, emphasis on health promotion, illness prevention, early detection and diagnosis, and patient centered care. The

limitation of this model relate to clinic and physician funding. Its strength lies in the increase to patient care access, efficient utilization of sacred physician resources, and an inter-professional team approach and patient and provider satisfaction.

The role of NPs was first implemented in Nova Scotia in 1995 and an evaluation found that patients were satisfied with the quality of NP services and that NPs increased health promotion and illness prevention and improved chronic disease management. Martin-Misener and colleagues (2004) examined the role of NPs in rural Nova Scotia by examining the perceptions of rural health chairpersons and healthcare providers. Participant perspectives on the health needs of rural communities, the gaps in the current models of primary health care services, the envisaged role of NPs in rural communities and the facilitators of and barriers to NP role implementation were gathered. Martin Misener et al. (2004) reported that in order to implement NPs role in rural communities, NPs need to work collaboratively with family physicians to provide coordinated care and avoid duplication of services. They stressed it would be essential to have physician support. They noted that some physicians were reluctant to “giving up their turf” while others were more open to collaborating with NPs. Health board chairpersons also stated that it was important to identify the right health care provider for each type of service. It was concluded that NPs provide individual and family focused clinical care with an emphasis on health promotion, illness prevention and the diagnostic and the management of chronic and episodic disease. They concluded that the NP role presents a significant opportunity to improve the accessibility to rural communities to a full range of health care services.

According to Sceren, Hurloch-Chorostecki, Goodwin & Baker (2009) Canada lags behind commonwealth countries in providing timely access to high quality primary healthcare. NP models are trying to address this problem. There is little research about NP models of care but the preliminary research suggests that NPs improve patient access to quality health care. There is still a need for further research to identify the impact on patient access, whether patient needs are being met, how much and how well professionals are collaborating, and the costs and benefits of team based care.

One of the distinctions of the NL model and the rest of Canada and other countries is the authority to admit and discharge patients. Many of the NP models in other provinces in Canada have an expanded scope of practice which includes the admission and discharge of patients managed by NPs, in collaboration with physicians, in tertiary centers, long term care facilities and health care centers where physician access may be limited. In Ontario for example, legislation was amended in 2011 granting NPs the authority to discharge hospital inpatients. As of July 2012 the Public Hospital Act was amended to permit NPs in Ontario to admit patients to a hospital/health care facility. British Columbia, Alberta, Manitoba, Saskatchewan and Nova Scotia are in the process of amending the required acts to Allow NPs to admit and discharge clients in their respective jurisdictions. Enabling NPs to admit and discharge patients will further enhance client access to health services, enhance continuity of care and reduce fragmentation of the client experience while improving patient flow through the system thereby reducing wait times.

Pogue (2007) acknowledges that much work has been done to promote the role of NP across Canada as provinces and territories learn from one another and overcome barriers furthering this

advanced practice nursing role. The context within which the NP role is being implemented across Canada is important. If we are to sustain our publically funded healthcare, change has to take place. Effective NP role implementation can bridge the gap associated with shortages in primary healthcare.

## **Interviews**

Five telephone interviews were conducted with professionals working in healthcare. Participants were familiar with the topic of Nurse Practitioners and were helpful in defining the key issues related to implementing NPs within the region. All participants were asked 12 questions (see Appendix One: Key Informant Interview Guide).

### ***1. History***

In Newfoundland and Labrador (NL) the education program for NPs started in 1997 with the first graduates entering the field in 1998. The graduates were from various regions of the province but mainly from rural and remote areas. The original intent of the program when it started was to provide access to health services by using NPs in rural and remote locations. At this time Primary Health Care projects were being implemented with sites in rural and remote areas in NL. The focus was to have the NPs provide service at these sites. The NP education program evolved to meet this growing need.

The initial educational program was a certificate program at the Centre for Nurses Studies in St. John's. In 2006-2007 that program transferred into a bachelors program and in 2012 it evolved into a Master's program. Prior to the Master's program being available in NL, the University of Toronto offered a NP Master's program. The province of NL supported nurses to study in Toronto to complete the program. The goal of this was to get educators to enroll in the program since it was required that you hold a Master's degree to be able to teach in the NL NP program.

The Province also supported a selection of nurses to study a specific specialty where there were identified gaps in the province such as Urology and Cardiology. Newfoundland and Labrador has 138 licensed NPs. New Brunswick and Manitoba have in excess of 100 licensed NPs while Prince Edward Island has 10-12 and Ontario has nearly 2500. The actual licensure of NPs has been in place since the late 1900's. In one province, poor implementation led to an unsuccessful attempt initially but did achieve success in the early 2000's.

NPs are working across all programs, external to regional health authorities as well as within the regional health authorities and within industry and private companies. Within the regional health authorities, NPs work across all programs such as cardiology, rheumatology, radiation, gerontology, addition centers and emergency rooms.

NP scope of practice is very broad. They work in one of three streams of practice; Adult, Pediatric and Family All Ages. The scope of the practice depends on the population they are working with and the setting in which they are practicing. It also is dependent on the knowledge, skill and ability of the NP. Restrictions or limitations are based on the practice setting you are in and one's own knowledge, skill and ability.

## **2. Barriers**

When asked about the barriers to implementing NPs, all informants indicated that there has been a number of barriers to effective implementation. However, they all noted that these barriers have been overcome with time. Some of these barriers included:

### Legislation

NPs were stepping into new areas of practice, therefore, relevant provincial health acts had to be created or amended to permit NPs to practice within a legislative structure.

### Role clarity and role confusion

There were several issues related to defining the specific roles and responsibilities of NPs:

- In the beginning it was not clearly identified what the NPs would do, and employers did not have a specific implementation plan.
- Provincial governments provide money to employ NPs through specific Primary Health Care funding. The money was used to employ them but no implementation plan was put into place to delineate how this would happen. Because the employer did not have an implementation plan it caused confusion not only with physicians, but with NPs and other health providers as well. It took several years to establish and define the specific role of NP.

### Restrictions on Scope of Practice and Roles

While this is reportedly steadily improving, there were challenges associated with NPs prescribing any of the control substances. The admitting and discharging of patient continues to be a barrier for some provinces. This is restricted by the Regional Health Authority bylaws and significant changes would be required to permit NPs to admit and discharge patients.

### Funding Restrictions

Government funds NPs through the RHAs. NPs have to be hired through the RHA otherwise they cannot be paid by government funds.

### Leadership Changes

All informants noted that changes in leadership were a barrier, i.e. leadership of RHAs and physicians was required for successful implementation of NPs in their region. Leadership support for NPs was essential to successful implementation.

### Licensure requirements

In Newfoundland and Labrador, New Brunswick, and Prince Edward Island the requirements needed to obtain and maintain an NP license was considered a barrier.

### Physician resistance

All informants stated that initially there was considerable resistance from physicians, often resulting from lack of a clear understanding of the potential benefit of NPs. While there is now much more support, some issues still exist around salaries and from other professionals such as specialists who won't take referrals from NPs.

*"...it was a little bit of a turf concern thinking of what you know was going to be the scope of the nurse practitioner and would that impact the scope of the physician."*

### Human Resources

Some concern has been expressed about the lack of human resource planning for the future, for example succession planning when the current NPs retire.

*"...Close to 50% of our NPs, if they're not at age 50, they're pretty close... so what's going to happen in five years when all those NPs exit from the health authority..."*

### **3. Enablers**

In response to whether there were factors that enabled the implementation of NPs practicing, informants noted the amending and expansion of the relevant Acts, the support of a variety of key players including the government, provincial leadership, the Minister of health, Nurses' Associations, nursing leaders, stakeholder groups and education leaders as being key enablers. Basically, it was the people behind the movement that made implementation successful.

### **4. Legislation**

When asked what legislation regulates their practice all provinces reported their provincial Nursing Act and the Expanded Nursing Act provided for the regulation of NPs.

### **5. Key Components for success**

The key components of practice considered critical for successful delivery and integration with existing health services were:

- Personal contact with key stakeholders, including meeting with every group that could possibly be affiliated with NPs, as well as making contact with all government departments;
- Collaboration, consultation and relationship building with other disciplines;
- Collaboration, not just with physicians but with all team players;

- Communication and clarity about responsibilities, positions, roles, and the value added by the NPs.

## ***6. Key Benefits of NPs***

All key informants report that the key benefit of utilizing NPs is the increased access to quality care for the population.

*“... they’ve seen nurse practitioners and they’re very happy with the time they take to ensure that all their needs are met”*

NPs are also reported to be beneficial to the provincial budgets as the appropriate use of NPs is cost effective.

## ***7. Drawbacks***

Drawbacks to the utilization of NPs by key informants were not directed toward NPs themselves but rather drawbacks associated with the restrictions placed on NPs practice. These included:

- Restrictions on independent practice
- Restrictions with the funding model
- Restrictions on scope of practice

## ***8. Regional Variation in Scope of Practice***

When asked about the scope of practice varying from region to region within provinces it was noted that the scope of practice is always the same as it is regulated by the Nurses Act but the enactment of the scope, or practical implementation may vary depending on where an NP is working and the area in which they specialize as determined by the regional health authority.

## ***9. Considerations for rural and remote practice***

When asked about certain considerations unique to implementing the NPs in rural or remote locations the importance of creating an infrastructure of support was emphasized, as well as minimizing isolation. It was also noted that there should be community awareness surrounding NPs and the importance of giving community members a “heads up” of what to expect with an NP.

## ***10. Recruiting and Retaining***

With regard to issues associated with recruiting and retaining NPs, several informants mentioned a “Grow your Own” initiative. Basically this is referring to training nurses who are already working in or who are from a particular rural and remote area to become NPs. The idea is that persons are more likely to stay in an area where they are employed and have family or community “roots”.

## **11. Job Satisfaction**

It was noted by all informants that they feel that NPs are generally very satisfied with their jobs. Also mentioned was the importance of maintaining this job satisfaction by enabling NPs to fully enact their scope of practice by providing them support from administration and from colleagues. The ability to have competitive compensation including salary and other conditions like professional education, benefits, vacation, etc. was also considered important.

## **CONCLUSIONS**

The literature and key informant interviews strongly suggest that with adequate preparation and support NPs can be a viable solution to improving access to health services. In Newfoundland and Labrador there are currently 138 licensed NPs. There are more NPs per population than any other province in Canada. Yet it is generally acknowledged that many of our rural and remote populations do not have adequate access to primary health care. The key informant interviews and the literature suggest that many of the barriers that NPs face in the initial implementation can be overcome with adequate commitment and support. With time and the successful implementation of NPs in other jurisdictions the role of the NP is now more widely understood and accepted.

Successfully recruiting a NP to practice in a rural community requires the presence of several supporting and enabling factors and conditions. First and foremost, there must be a process to identify a genuine need for a NP in a community. There is extensive literature on how to identify community needs from the perspective of health service delivery.

Appropriate enabling legislation, support from the provincial NP or nursing association are essential requirements. Most important, the community, the local RHA, and the local physicians need to agree on the need and supports required to make a NP successful. Recruiting the right person and retaining them in the long term requires a concerted effort on the part of all interested parties (government, RHA, physicians, community, etc.).

Assuming all the right conditions are in place to recruit a NP, there are some recruitment strategies that merit further exploration. The 'grow your own' initiative has been successful in some jurisdictions. This approach builds on the notion that if you can identify and encourage a local nurse from a particular region to complete an NP program, there is a greater likelihood they will return and work in their own community. Recruiting and retaining a NP from an urban area to practice in a remote location can be more challenging.

The effectiveness of implementing a NP will be influenced by a number of factors including:

- a. adequate salary and compensation; including benefits, professional development, travel support, etc.
- b. adequate support for consultation with other health care professionals including physicians, specialists and other NPs and,
- c. strong leadership and support from the local RHA to support the NP in practice.

## **RECOMMENDATIONS**

Successfully recruiting a NP to practice in a rural community requires the presence of several supporting and enabling factors and conditions:

1. Appropriate legislation, support from the provincial NP or nursing association, and funding from government are essential requirements to ensure NPs are able to practice within a region;
2. Initiate a collaborative, consensus building process (among relevant government officials, the leadership of the RHA, local communities and physicians) to identify a genuine and realistic need for a NP in a community.
3. Determine highest priority areas for NPs among various communities in a region based on need.
4. The community, the local RHA, and local physicians need to agree on the supports necessary to enable a NP to practice effectively including: the presence of appropriate physical facilities, adequate salary and compensation (including benefits, professional development, travel support), appropriate processes for consultation with other health care professionals including physicians, specialists and other NPs;
5. Recruiting the right person and retaining them in the long term requires a concerted effort on the part of all interested parties (government, RHA, physicians, community, etc.).

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## **APPENDICES**

### **Appendix 1** **Key Informant Interview Guide**

1. Tell me how NPs practice in your province.
  - a. Tell a brief history of how NPs started practicing in your province?
  - b. How long have they been practicing in your province?
  - c. How many NPs are employed?
  - d. In what areas are they employed?
  - e. What is the scope of their practice?
2. Were there barriers in the implementation of NPs practicing in your province?
  - a. If so, what were they?
3. Were there enablers in the implementation of NPs practicing in your province?
  - a. If so, what were they?
4. What legislation regulates their practice?
5. What are the key components of their practice that are critical for successful delivery and integration with existing health services?
6. What do you see as the principal benefits associated with NPs?
7. What are some of the drawbacks associated with NPs?
8. Does the scope of practice vary for region to region within your province?
  - a. If so, in what way?
9. Are there certain considerations which are unique to implementing the NPs in rural or remote locations?
10. Are there issues associated with recruiting and retaining NPs?
  - a. If so, what are they and how have they been addressed?
11. Are there issues surrounding the job satisfaction of NPs?
  - a. If so, what are these issues?
  - b. How are these issues being addressed?
12. Is there anything that I have not asked you that you would like to share with me regarding NPs?