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Nurse Practitioner Role Acceptance In The Emergency Department : A Case Study

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NURSE PRACTITIONER ROLE ACCEPTANCE IN THE EMERGENCY DEPARTMENT:

A CASE STUDY

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ABSTRACT

Nurse Practitioner Role Acceptance in the Emergency Department: A Case Study

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The Ministry of Health and Long-Term Care (MoHLTC) invested in a pilot project that introduced nurse practitioners (NPs) into emergency departments (EDs) in order to improve patient care. Since the launch of the project, there have been no documented studies exploring how the NP role has been accepted by others. Role acceptance is critical to NP integration and thus effectiveness of the role in achieving its desired outcomes. This study explored NP role acceptance in the ED as perceived by NPs, physicians and nurses. Case study approach was employed using semi-structured interviews, the researcher's field notes and publicly accessible documents. NP role acceptance was found to be influenced by participants' understanding of the initial impetus for the role, the role itself, their appreciation of value-added components of the role, NP-specific characteristics and professional relationships among NPs, physicians and nurses. Implications for policy, practice, education and research are explored.

ACKNOWLEDGEMENTS

"Writing is an adventure. To begin with, it is a toy and an amusement. Then it becomes a mistress, then it becomes a master, then it becomes a tyrant. The last phase is that just as you are about to be reconciled to your servitude, you kill the monster and fling him to the public."

Winston Churchill

No one writes alone.

Although my thesis often felt like a journey of endless solitude, I could not have been able to start nor finish it without the unconditional support from my committee, my family and my friends.

I would like to firstly thank my thesis committee for their constant guidance throughout this process. Dr. Mary McAllister's ability to challenge my thinking and provide me with insightful feedback has been invaluable in making me a better writer. She was not only a supervisor but a research mentor who pushed me to dig deeper and get to the root of every issue. Dr. Souraya Sidani's brilliance has been an ongoing inspiration over the past years and has helped me to strive to become a better researcher. Dr. Nancy Walton has been an immense source of methodological knowledge and expertise, but also has always kept me in check and reminded me of what is truly important.

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DEDICATION

I would like to dedicate this thesis to my mother, Roza Jurczak, who has put up with me for the past 26 years and has endured my 22 continuous years of education. Mom, there are not enough words to express my endless gratitude. I know it may not have felt this way, but believe me, your constant and unconditional love and support have helped me to pick myself up when I have fallen. Promise me you will continue to be here for me when I start my PhD.

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CHAPTER ONE: INTRODUCTION

The nurse practitioner (NP) role has existed in Ontario for many years, and is found across a variety of practice settings, including the emergency department (ED). In 2007, as a result of a Ministry of Health and Long-Term Care (MoHLTC) initiative, NPs were strategically deployed in select EDs to decrease ED patient wait times and to improve patient access to emergency care. Additionally, there was an ongoing challenge with physician coverage in many community EDs. The role of the NP was seen as a viable option to address all of these needs (HealthForceOntario [HFO], 2008; Ministry of Health and Long-Term Care [MoHLTC], 2006a). In order for the NP role to be effective in achieving the intended goals and purpose, it was important that the role be well integrated into the ED. In order for integration to occur, the NP role must be accepted by the members of the interprofessional and intraprofessesional teams with whom NPs work. The focus of this study was to explore how the NP role in the ED is accepted by physicians and nurses with whom the NPs work.

Background

Since 1998, the MoHLTC has funded over 780 NP positions in underserviced areas, the community, long-term care facilities, primary care/public health units and in Aboriginal health centers throughout Ontario (MoHLTC, 2005). The MoHLTC commissioned the Primary Health Care (PHC) NP Integration Study in order to "determine how best to integrate PHC NPs into Ontario's health care system and, specifically, into various practice settings" (MoHLTC, 2005, pg. 2). The purpose of the study was twofold: (1) to determine what barriers must be overcome and what facilitators need to be developed in order to best implement and integrate NPs in Ontario health care settings and, (2) which practice models are the most conducive for NP integration (MoHLTC, 2005). Physicians and NPs across various practice settings were

surveyed to explore the barriers and facilitators to NP integration, as well as evaluate their

satisfaction with the NP role (MoHLTC, 2005). Patients were surveyed regarding their overall

satisfaction and experiences with NPs as care providers. It is of note that nurses and other

members of the care team were not surveyed.

NPs and physicians identified several major barriers to integration of NPs into various

practice settings. These included impact of NP practice on physician salary, professional

liability, and the potential for impeding physician retention and recruitment (MoHLTC, 2005).

Facilitators included having NP title protection, patient awareness of NP role, financial resources

to support the role, and role acceptance by team members. The results of the patient survey

indicated that patients who had previously been cared for by a NP were highly satisfied with the

role. Patients who had never seen a NP had the role explained to them and two-thirds reported

that they would be willing to be cared for by a NP (MoHLTC, 2005).

One of the major facilitators to NP role integration identified by both physicians and NPs

in the study was role acceptance. While integration and acceptance may appear to be similar

concepts it is important to recognize that a role needs to first be accepted in order for it to be

successfully integrated (MoHLTC, 2005). Role acceptance refers to having a favourable

response to role and being willing to work with the individual in the role, whereas role

integration refers to the incorporation of a role and recognition as an equal member in the team

("Acceptance", 2010; "Integration", n.d.). According to the PHC NP Integration Study

(MoHLTC, 2005), the concept of role acceptance entailed being recognized by fellow team

members as having strong clinical skills and knowledge, receiving positive patient feedback, and

establishing NP role clarity among team members. Physicians who reported high levels of NP

role acceptance identified having a good understanding of the NP's role and responsibilities, had

'professional trust' in the NP's knowledge, skills and expertise, and had previous experience working with a NP. It was reported that NP job satisfaction and integration were positively related to NP role acceptance (MoHLTC, 2005).

Since 2007, and subsequent to the PHC NP Integration Study, NPs have been strategically introduced into several Ontario EDs to reduce wait times and improve patient care, while specifically attending to patients with low-acuity needs (Thrasher & Purc-Stephenson, 2007).   The introduction of the NP role in any setting has an effect on physicians, nurses and other health care professionals with whom the NP will be working because the NP role influences the roles and responsibilities of these professionals (Wilson-Barnett, 1998). Several studies have indicated that having collegial support and acceptance is of paramount importance for the successful integration of the NP role. Concurrently, there have been documented barriers and facilitators to NP role integration across health care settings. If the NP role in the ED is to be effective in reducing wait times, and improving patient care, it is important that NPs be accepted by their colleagues which in turn may facilitate role integration.

While the PHC NP Integration Study included a small number of NP participants who practiced in the ED (2.6%), the survey results were aggregated across various practice settings, and did not report specific results relating to the ED. The study also took place prior to the MoHLTC's initiative to deploy NPs in the ED, and now NPs are far more prevalent in EDs than they were in 2005 when the study was initially conducted. In addition, the study did not survey nurses; key members of the team who may have significant interaction with the NP. Finally, while the notion of role acceptance was identified as a facilitator to NP integration, the concept was not explored in significant detail from the perspectives of participants (MoHLTC, 2005).

The concept of NP role acceptance is multifaceted and complex and therefore requires thorough exploration to understand the factors that influence it.

There has been no published study that focused on the acceptance of the NP role in the ED. Attention to NP role acceptance may contribute significantly to effective role integration in the ED. By understanding NP role acceptance in the ED, practice settings can be influenced in order to better integrate the role. Improved integration in the ED will help NPs to better fulfill their intended purpose by decreasing patient wait times and improving patient satisfaction. Due to the lack of existing research, there was a clear need to investigate how the role of the NP in the ED was accepted by the nurses and physicians with whom the NP worked.

Statement of Study Purpose

The purpose of the study was to explore NP role acceptance in EDs from the perspectives of NPs, nurses and physicians working together in Ontario EDs.

Researcher as Insider

It is important that researchers reveal what they believe about their phenomenon of interest prior to starting their inquiry. Explicitly identifying their suppositions, ideas, thoughts, and personal biases regarding the phenomenon is important in order for researchers to approach their research openly and honestly (Speziale, 2007c). Once these thoughts and perceptions are explicated, the researcher can attempt to minimize the influence of these thoughts and perceptions through the process of reflexivity (Ahern, 1999). Reflexivity entails realizing, through an examination of the researcher's own values and interests, that the researcher's experiences and beliefs may impinge on the credibility of the data. Researchers must therefore "put aside personal feelings and preconceptions" (Ahern, 1999, p.407) in a reflexive journal and refer back to this journal if they are challenged in understanding the source of their findings.

As the researcher's clinical expertise is in the area of emergency nursing, there exists a deep and thorough understanding of the inner workings and the politics associated with the ED and it was important that the researcher maintain a journal to which she could refer to ensure the credibility of the research findings. While the researcher has never practiced with a NP in the ED, the researcher has engaged in discussions with her colleagues in relation to potentially introducing the role within the ED where she practices. Many discussions with ED physicians reflected a negative connotation regarding the NP role in the ED, specifically around scope of practice, knowledge and skills. With respect to ED nurses, conversations often had a hint of hostility whereby nurses felt threatened by the notion that the NP may be used to replace both nurses and physicians. What the researcher did not understand was the complex rationale for this lack of acceptance by her ED colleagues. It is this that has provided the motivation to engage in this research.

It is the researcher's belief that NPs have tremendous potential in the ED to reduce wait times, improve patient flow and ultimately improve patient satisfaction. It is known that the majority of patients present to the ED with minor injuries or illnesses and often end up waiting the longest to be seen and treated by an ED physician (Cole & Ramirez, 2002; Cole, Ramirez, & Luna-Gonzales, 1999). This has an effect on patients' overall satisfaction and many patients leave without being seen by a physician. Additionally, the academic and clinical preparation of NPs with a PHC specialty enables them to manage the care of patients who present to the ED with minor injuries or illnesses (CNO, 2008b). Furthermore, it is the belief of the researcher that NP role clarity and the understanding by nurses and physicians in the ED play a major role in NP role acceptance. With the lack of role clarity, nurses and physicians may have a difficult time appreciating the value added by the role to the ED and its overall purpose in the department. So,

if nurses and physicians do not have a clear understanding of the purpose and scope of the NP role in the ED, and are unable to recognize its value, there may be challenges in integration and subsequent acceptance of the role.

These thoughts and perspectives were what initially stimulated the researcher's interest in NP role acceptance. It was impossible to engage in the research process with a completely objective perspective and therefore it was necessary to take measures to acknowledge that the researcher was not a 'blank canvas'. Beliefs and perspectives on NP role acceptance in the ED were documented in the researcher's journal prior to starting any in depth literature reviews or any data collection (Ahern, 1999). This journal was referred to throughout the research process in order to ensure that data analysis was not a result of the researcher projecting her own thoughts and perspectives on NP role acceptance.

CHAPTER TWO: REVIEW OF THE LITERATURE

The purpose of this literature review was to discover what is known about the NP role in the ED and to identify the gaps in knowledge to be addressed in this study. Scholarly articles pertaining to role acceptance of NPs in the ED in Canada and globally were sought. Only a few articles that were of limited relevance to the study were found, so the search was broadened to include articles discussing the 'use of NPs in the ED', 'role acceptance', 'NP role integration and NPs in Canada', all as separate searches. Articles were found using scholarly search engines including Academic Search Premier, Proquest Research Library and the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and all were reviewed. This literature review includes articles on 'EDs and wait times', 'NP scope of practice and regulation', 'the NP role in the ED', and 'NP role integration' as these were the themes that surfaced in the PHC NP Integration Study. This chapter concludes with summary of the literature identified through this literature review, which serves as a basis for this study.

Emergency Departments and Wait Times

Literature on ED wait times, specifically those addressing the Ontario jurisdiction, was reviewed. As identified in Chapter One, the NP role was implemented in several Ontario EDs in order to help decrease patient wait times and improve access to emergency care (MoHLTC, 2005). It is important to understand the issue of wait times in Ontario EDs in order to appreciate the rationale and need for the NP role in the ED.

The Canadian Institute for Health Information (CIHI) published a report on wait times in Ontario EDs which demonstrated that the average wait time for patients to be seen by a physician was three and a half hours, with patients spending approximately seven hours in total from the time they were registered until they were discharged from the ED (CIHI, 2005a). Long wait

times in the ED have potentially dangerous implications for patients who are acutely ill and need to be seen within a very short period of time (Canadian Association of Emergency Physicians [CAEP], 2005a). Long wait times also increase the length of time paramedics must wait in the ED to offload patients, which results in fewer ambulances available to the community (CAEP, 2005b). Nurses working in the ED are also affected by long wait times and are challenged to provide quality care in overcrowded environments such as hallways and waiting rooms, which in turn poses an ongoing challenge for recruitment and retention in the ED due to stress and burnout of nursing staff (CAEP and National Emergency Nurses Affiliation [NENA], 2001).

Given the high percentage of patients with low acuity presenting to the ED and increased patient wait times, Ontario hospitals are faced with the ongoing challenge to accommodate and treat all patients in a timely manner. Since a high proportion of patients in the ED are seeking services for minor problems or injuries that are considered primary care, several hospitals have introduced the NP role in order to provide care for this group of patients because the NP role is seen as a possible solution to this problem (CIHI, 2005a; MoHLTC, 2005).

Scope of Practice and Regulation

Literature on NP scope of practice and regulation was reviewed, with a particular emphasis on understanding the NP role in Ontario. The purpose of this review was to understand the authority that NPs have and the acuity of patients that fall within the realm of the NP scope of practice. It was vital for the researcher to gain clarity on the NP role in order to be able to embark on the research process. This was important so that when the researcher was interviewing participants regarding their understanding of the NP role, the researcher herself had a good understanding of the NP scope of practice. In Ontario, NPs are registered nurses (RNs) who have successfully met the College of Nurses of Ontario (CNO) requirements for extended

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class registration. The requirements are: (1) completing an approved NP program; (2) completing an approved NP exam; and (3) demonstrated evidence of safe and competent practice (College of Nurses of Ontario [CNO], 2009b). Until recently, NPs did not have title protection in Ontario, as RNs do, and therefore were subject to extensive criticism regarding their scope of practice and competency (CNO, 2009b; Worster, Sarco, Thrasher, Fernandes & Chemeris, 2005). Title protection is important because it protects the public from unqualified individuals who inappropriately call themselves NPs despite not having met the CNO requirements for the NP role. By legally protecting the title of the NP, the public can be assured that only those professionals who have met the entry to practice requirements can refer to themselves as NPs and be granted the rights to use the title (CNO, 2003). As of August 2007, new government regulations were passed to legally protect the NP title within Ontario with the following specialties: paediatrics, adult, anaesthesia and PHC (CNO, 2009b). Whereas RNs are authorized to perform three controlled acts, according to the Regulated Health Professionals Act, NPs have the authority to perform six (Worster et al., 2005). The three additional controlled acts include: communicating diagnoses, ordering selected diagnostic tests (x-rays, ultrasounds, laboratory tests), and prescribing certain medications (CNO, 2009a; CNO, 2009b; Sidani, Irvine & DiCenso, 2000; Worster et al., 2005). Understanding the controlled acts that NPs can perform is essential if members of the health care team are to understand the regulatory parameters that define the NP role. Distinguishing the regulatory difference between nurses, physicians and NPs is vital to establishing role clarity.

NPs in Canada have been working in settings such as community health centres, long-term care facilities, inpatient units and public health units, but rarely in EDs (MoHLTC, 2005; CIHI, 2005b). From a historical standpoint, the role of the NP was deployed in areas of Canada

where it was difficult to attract physicians, such as rural and northern communities. This

engendered the notion that the implementation of an NP role should only be considered when a

physician is inaccessible (Office of Nursing Policy, 2006). According to the CIHI (2005b)

approximately 45% of licensed NPs work in community health, whereas others work in various

direct care settings such as medicine/surgery, ambulatory care, geriatrics, and administration. At

the time of the CIHI survey only 4.4% of NPs in Canada identified themselves as working in

emergency care (CIHI, 2005b). What is evident is that the NP role has a clearly defined scope of

practice that applies to NPs working in any practice setting. While the scope of practice is

helpful in understanding some of the professional responsibilities NPs have, it does not provide

clarity on the specific responsibilities of the NP role in the ED, as every ED operates in a unique

fashion and may utilize the NP role differently (Institute for Clinical Evaluative Sciences, 2001).

Knowledge of ED-specific responsibilities influences overall NP role clarity in the ED and may

have an influence on how well the role is accepted by nurses and physicians.

<div align="center">NP Role in the ED</div>

There was limited Canadian literature exploring NP roles in the ED and therefore the

search was expanded to include international literature. It was necessary to understand the

reasons contributing to NP role integration in the ED, how the NP role functions in the ED and

the outcomes of implementing the role. In the United States (US), the role of the NP in the ED

has been in existence since the early 1980s and resulted from a growing number of less-urgent

patients seeking PHC in the ED (Cole & Ramirez, 2002; Cole et al., 1999). EDs in the United

Kingdom (UK) and Australia began employing NPs in some of their EDs due to increasing

numbers of patients seeking PHC (Chang et al., 1999; Cole & Ramirez, 2002; Cole et al., 1999).

A randomized controlled trial in Australia investigated whether NPs and physicians working in

the same ED provided a similar level of PHC. The findings of this study demonstrated that the

NPs provided the same quality of care as measured by patient satisfaction, and patients also had

decreased wait times with the integration of this role in the ED (Chang et al., 1999). Similarly, a

randomized controlled trial by Sakr and colleagues (1999) compared minor injury care delivered

by NPs and junior doctors (who can be considered the Canadian equivalent of residents), and

found that outcomes from care provided by NPs in the ED were equal to, and were sometimes

better than, the outcomes of care provided by junior doctors. There was no difference in the

specific clinical outcome of patients who had ankle injuries between both groups. Additionally,

patients reported higher levels of satisfaction after being treated by the NP as compared to those

treated by junior doctors. Lastly, patients who were treated by the NP had shorter wait times;

this was attributed to the fact that junior doctors had to attend to acute patients as well and were

not assigned solely to the less-urgent patient group, as was the case with the NPs (Sakr et al.,

1999). Finally, Horrocks and colleagues (2002) reviewed 11 randomized controlled trials and 23

observational studies from the UK and the US in an attempt to determine whether NPs and

physicians provided equivalent care in primary care settings. The results of this meta-analysis

showed that there were no differences in patients' health outcomes; patients were more satisfied

with the care they received from the NP; and they waited shorter periods of time to be seen

(Horrocks, Anderson & Salisbury, 2002).

A study in Vancouver, British Columbia examined patients with non-urgent medical

conditions and their attitudes towards being treated by an NP in the ED (Moser, Abu-Laban, &

van Beek, 2004). Patients were asked whether they would be willing to be treated by an NP

versus an emergency physician. Of the 213 patients enrolled in the study, 72.5% indicated that

they would be willing to be treated by an NP in the ED, 15.5% were uncertain, and 12.1% were

not willing. While the findings of Moser and colleagues' study are interesting, they only

evaluated the hypothetical scenario of receiving care from an NP in the ED, not actual care being

provided.

In summary, the literature review demonstrates that the implementation of the NP role in

the ED has helped to decrease wait times for patients presenting with non-urgent needs while

also maintaining similar clinical outcomes when compared to ED physicians (Chang et al., 1999;

Cole & Ramirez, 2002; Cole et al., 1999; Horrocks, Anderson & Salisbury, 2002; Sakr et al.,

1999). Because health care systems differ between the UK, Australia, the US, and Canada, the

transferability of research from international literature to Canadian practice is questionable.

Even within Canada, scope of practice for NPs, health care funding models, and government

sponsored initiatives vary across provincial jurisdictions (Canadian Nurses Association [CNA],

2009). Therefore, it is important that research on the NP role in the ED be conducted in Ontario,

where the MoHLTC initiative took place. Considering there is a lack of not only Canadian

literature but Ontario research, this study is particularly important.

NP Role Integration

It was evident through the PHC NP Integration study (MoHLTC, 2005) that there were

issues surrounding NP integration in various practice settings. It was necessary to explore how

NP role integration is achieved and identify some of the barriers and facilitators related to

successful integration.

Sullivan and colleagues (1978) identified that one of the key barriers to the successful

integration of the NP role in the US health care system was the attitude of other health care

providers and patients toward the NP. Described as the product of professional ego, collegial

opinions, and feelings about delegation and interprofessional hierarchies, attitudes have the

power to shape how well the NP role fits within the department and how well they are accepted

by other health care providers. Reed and Roghmann (1971) investigated the acceptability of an

'expanded nurse role' as perceived by nurses and physicians. The expanded nurse role is similar

to the NP role such that both have the authority to perform additional interventions that were

traditionally authorized only to physicians. As success of new roles depends on the degree of

acceptance by the interprofessional healthcare team members, Reed and Roghmann (1971)

surveyed nurses and physicians at a US hospital about their attitudes towards the expanded nurse

role. Results indicated that nurses were the most accepting of the expanded nurse role, as

compared to physicians and medical students; however, only 56% of nurses, 32% of medical

students, and 16% of physicians surveyed reported a high level of role acceptance (Reed &

Roghmann, 1971). Clearly the studies on role acceptance are rather dated and more current

research has not been published. Additionally, research found was not contextually applicable

seeing as though it was not conducted in a Canadian setting.

More recently, a descriptive, quantitative study in Illinois investigating nurses' attitudes

towards NPs revealed that nurses generally had positive attitudes toward the NP role. Nurses

understood the NP role, were confident in the NPs' knowledge and abilities, and thought the NPs

provided high quality patient care. At the same time, however, nurses felt that NPs did not show

respect to the nurses through their interactions in various practice settings (Gooden & Jackson,

2004).

Marsden and Street (2004) explored health care team members' views of the NP role

within the primary care setting in the UK, using semi-structured interviews. They found that

nurses were very accepting of the NP role. Nurses reported that the NP role "embodied the best

of both professions, able to consider patients' needs from both a medical and nursing

perspective" (Marsden & Street, 2004, p.23). Additionally, nurses identified patients as the

primary beneficiaries of the NP role within the PHC context because they had shorter wait times

and had longer, more detailed consultations. In this particular study, nurses did not identify that

the NP role affected them in any negative way and they were accepting of the role within the

interprofessional PHC team. While nurses viewed NPs in a mostly positive light, they did

express some concerns regarding the NP role before its implementation, including the NP's

scope of practice, NP role boundaries and how the NP would collaborate with the existing

members of the team (i.e., nurses and physicians). Lastly, nurses identified the importance of

communication from management to staff about the new role in reducing anxieties and barriers

in the implementation phase. Physicians, on the other hand, identified that a lack of clarity

regarding the NP role resulted in role ambiguity; they were unsure about what to expect. Other

physicians identified the need to "get used to it before they could make any firm judgment about

what the NP had to offer compared with a GP" (Marsden & Street, 2004, p.21).

 Reveley (2001) examined the perceptions of physicians and nurses regarding the NP role

in a general practice setting in the UK. Nurses reported an overall acceptance of the NP role and

identified minimal overlap between nurse and NP work; NPs often provided holistic care to

patients on their own without eliciting help from nurses. However, nurses expressed a blurring

of roles between NPs and physicians; specifically a lack of clarity as to where the NP role and

scope of practice ended and where the physician role started. Physicians agreed that this was an

issue but felt that this was an acceptable and inevitable result of the introduction of advanced

nursing practice roles (Reveley, 2001).

 Allen and Fabri (2005) interviewed nurses, physicians and patients to explore their

perceptions of and experiences when working with a NP within an interdisciplinary health care

team in Australia. Nurses and physicians were accepting of the NP role; they viewed it as a great source of support and education to nurses and a great advocate for patients. Additionally, the results showed that the NP worked well in collaboration with other members of the interprofessional team and was seen as an effective member of the team (Allen & Fabri, 2005).

Baldwin and colleagues (1998) explored the acceptance of the NP and physician assistant (PA) role within a rural community health centre in the United States using focus group methodology. Community members, health care professionals, and patients were asked for their opinions on and perceptions of potentially working with a NP or PA. The findings showed that there was a need for the NP role provided the NP worked in collaboration with physicians, had an understanding of the community and was readily accessible to patients. Additionally, this study identified the need to educate members of the community and the health care team further about the NP and PA roles, specifically about the services offered and how they differ or complement physicians' and nurses' services (Baldwin et al., 1998). Similarly, Bergeson and colleagues (1997) surveyed family physicians in rural Minnesota to examine their attitudes and perceptions regarding working with a NP in a PHC setting. Physicians generally expressed a positive attitude towards NPs and a strong degree of confidence in working with them. Physicians did, however, express a concern regarding having to function in a supervisory role to NPs but thought that the role would still free up physicians' time and allow them to see more complex cases (Bergeson, Cash, Boulger, & Bergeron, 1997).

Jarman (2007) investigated ED staff attitudes toward the newly implemented emergency care nurse role (ECN) within a UK resuscitation room. The ECN was responsible for taking care of a specific population of patients, the critically ill, and worked within an expanded scope of practice, similar to the NP role. Staff members (nurses, medical assistants and physicians) were

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surveyed regarding their perceptions of the ECN's role, practice, skills and knowledge, and collaboration. Staff responses reflected an overall favorable attitude towards the ECN role. Most participants felt that the ECN had a beneficial impact on patient care in the resuscitation room and worked well in the collaborative team. They expressed an overall good understanding of the ECN role, though they identified some issues of role clarity and role threat. The author described role threat as the feeling of intraprofessional hierarchy, which is commonplace in the nursing profession and was often associated with resistance to newly implemented nursing roles (Jarman, 2007).

Martin and Considine (2005) examined the attitudes and knowledge of nursing and medical staff regarding the NP role in the ED before and after the implementations of the NP role in their ED in Australia. Survey methodology was used to assess staff attitude and knowledge of the NP role, scope of practice, collaboration and overall satisfaction with the NP role. Before implementation, physicians and nurses were generally supportive of and positive about the NP role in the ED but participants did not have a good understanding of how the role would function and thrive within the environment. Post-implementation, there were statistically significant improvements in participants' knowledge of and attitudes toward the NP role. Participants identified that they received education on this role prior to implementation, including just before the role was officially introduced as part of the interprofessional ED team. The authors suggested that the educational sessions may have had a significant influence on participants' perspectives. The results of this study suggest that staff education is important when implementing a new role within a clinical setting (Martin & Considine, 2005). Interestingly, staff attitudes improved from pre- to post- implementation despite the fact that implementation created a major change in the ED with respect to patient care and flow. The

introduction of the NP role had the potential to elicit negative attitudes from participants due to

NPs "encroach[ing] on conventional professional boundaries and potentially threaten[ing] the

traditional domains of other members in the health care team" (Martin & Considine, 2005, p.77).

The results of this study suggest that a collaborative and interprofessional approach to role

education prior to implementation is beneficial with respect to role acceptance (Martin &

Considine, 2005).

Thrasher and Purc-Stephenson (2007) conducted semi-structured interviews with NPs,

nurses, physicians and ED managers at six Ontario EDs to identify barriers and facilitators to

role integration. What was found was that integration of the NP role in these EDs was affected

by the ED environment in which NPs practiced, understanding of the NP role and by the process

and criteria used to recruit NPs (Thrasher & Purc-Stephanson, 2007). What was revealed by the

PHC NP Integration study (MoHLTC, 2005) was that "acceptance of the NP role facilitated

effective integration of NPs" (p. 19). While Thrasher and Purch-Stephenson (2007) examined

NP role integration, they did not focus specifically on role acceptance and therefore there is a

need to explore the element of NP role acceptance specifically. .

Review of the literature has identified that the introduction of the NP role, while

generally positively received by colleagues and patients, raises a multitude of issues related to its

implementation and integration. NP role implementation has an influence on the

interprofessional relationships among physicians, nurses, and other health care professionals

working within the department. Questioning of preparation, scope of practice, and role clarity

are common issues that NPs face when working in a new environment. What is also known is

that NP role acceptance is positively related to NP job satisfaction and successful integration.

With the recent implementation of NPs in Ontario EDs, it is important that the NP role be

accepted by inter and intraprofessional colleagues in order to enhance integration, therefore

enhancing effectiveness (Allen & Fabri, 2005; Baldwin, Sisk, Watts, McCubbin, Brockschmidt,

& Marion, 1998; Bergeson et al., 1997; Gooden & Jackson, 2004; Jarman, 2007; Marsden &

Street, 2004; Martin & Considine, 2005; MoHLTC, 2005; Reed & Roghmann, 1971; Reveley,

2001; Sullivan, Dachelet, Sultz, Henry, & Carrol, 1978; Thrasher & Purc-Stephenson, 2007). To

date, there has been no published follow-up on NP role acceptance in Ontario EDs since the

MoHLTC initiative, even though attention to NP role acceptance may contribute significantly to

effective role integration in the ED. Additionally, there have been no Canadian studies that have

examined NP role acceptance in the ED. Thus, it is important to explore the concept of role

acceptance in relation to NPs in Ontario ED.

CHAPTER THREE: METHODS

Introduction

A qualitative, case study methodology was used to understand the participants'

experiences and views related to NP role acceptance in Ontario EDs (Pope & Mays, 1995).

Qualitative research methods are underpinned by the belief that multiple realities exist,

that the researcher is intimately involved in the research process and that participants' views

need to be captured with the use of rich descriptions (Speziale, 2007b). It was the belief of the

researcher that the most meaningful way to describe NP role acceptance was through the

exploration of multiple perspectives. The views of NPs, physicians and nurses were integral in

understanding acceptance of the NP role in the ED. The use of multiple perspectives allowed the

researcher to understand what barriers and facilitators existed for role acceptance of the NP.

Additionally, the researcher acknowledged her own beliefs and perspectives regarding the

phenomenon of interest and the notion that these views had the potential to influence the

research process (Ahern, 1999). Thus, she engaged in reflexivity in order to mitigate the

influence of her own thoughts. Lastly, the researcher took meticulous field notes in order to

gather rich descriptions throughout the data collection process, which were triangulated with

publicly accessible documents.

Design

NP role acceptance is contextual and complex and the need for in-depth exploration was

necessary in order to comprehensively understand the phenomenon. It was not only important to

gain an understanding of NP role acceptance from the NPs themselves, but from the key

professionals who worked closely with NPs and from other relevant sources (i.e., researcher,

field notes, publicly available documents). Physicians and nurses were specifically chosen as

participants because they are the professionals with whom NPs work closest in EDs (Gooden &

Jackson, 2004; Marsden & Street, 2004; Revely, 2001).

Case study methodology was chosen to explore this complex and contemporary

phenomenon (Hancock & Algozzine, 2006), because it encompasses an approach to research

design and data analysis that allows the exploration of the phenomena within a "real-life context,

especially when the boundaries between phenomena and context are not clearly defined" (Yin,

1994, p.13). Case study methodology is used when the researcher intentionally wants to

incorporate the contextual conditions in which their phenomenon of interest is housed with the

presumption that contextual conditions have a high influence on the case (Yin, 1994). Case

study methodology incorporates multiple sources of data in order to synthesize information to

help understand the phenomenon (Yin, 1994). Although case studies have often been regarded

as a "weak sibling among social science methods" (Yin, 2003, p.xii), this methodology is

increasingly being used in professional research (social work, nursing, education), and traditional

fields (sociology, psychology, history, anthropology) (Yin, 2003). In addition, Yin (2003)

identifies that "case study in not either a data collection tactic or merely a design feature alone,

but a comprehensive research strategy" (p.14). The acceptance of the NP role in the ED is a

multifaceted and complex phenomenon and therefore case study methodology is an appropriate

methodological choice.

Data triangulation is a key feature of case study methodology. In case study

methodology, it is commonplace to have a small sample of participants, so it is important to

ascertain that the phenomenon being explored is, in fact, being accurately represented. Using

multiple sources of evidence allows the findings of the case study to be more convincing as the

conclusions drawn will be based on multiple realities and multiple documents (Yin, 2003). Data

triangulation is more than merging two or more techniques for data collection; rather, it allows

the researcher to explore a phenomenon at different levels (Pope & Mays, 1995). Data were

triangulated through the analysis of semi-structured interviews, field notes and the review of

publicly accessible documents and literature. In this study, in order to fully understand the

acceptance of this relatively new role in Ontario EDs, it was important to gain an understanding

of the perspective of the individuals in that role and those who work closely with them.

Additionally, it was important to understand under what context this role was implemented (i.e.,

the rationale and the need for the role) (Yin, 1994). This was accomplished by reviewing the

scope and practice documents from the CNO and relevant publicly accessible documents that

were the basis for establishing the NP roles in EDs (Hancock & Algozzine, 2006).

<center>Sample and Setting</center>

Data Collection

Data were collected through the use of semi-structured interviews with NPs, physicians,

and nurses and by reviewing publicly accessible documents, field notes from site visits and site

specific job descriptions of the NP (Hancock & Algozzine, 2006; Stake, 1995; Yin, 1994).

Publicly accessible documents included, but were not limited to, reports, position statements and

press releases from the Ontario MoHLTC, the Canadian Nurse Practitioner Initiative, and the

Nurse Practitioner Association of Ontario (NPAO), which are available on-line. Therefore the

researcher did not require any special permission to access these documents.

Semi-structured interviews

Interviews provide the researcher with insight into the case that is critical to

understanding the phenomenon and have been recognized as one of the most important sources

of information in case study methodology (Yin, 2003). Interviews have the potential to provide

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the researcher with "shortcuts to the prior history of the situation, helping [the researcher] to identify other relevant sources of evidence" (Yin, 1994, p.85). It is imperative that the interviews are not rigid, but rather fluid, and that the line of inquiry is supported by guided queries and not structured conversations (Britten, 1995). It is essential that the researcher ask questions in an unbiased manner but still follows the path of inquiry as related to the phenomenon of interest (Yin, 2003).

Semi-structured interviews were conducted with NPs, physicians and nurses from each site using an interview guide (Appendices A, B, and C). There were three different interview guides (one for NPs, one for nurses and one for physicians). Questions pertained to NP role implementation, role clarity, relationships, and challenges/benefits to the NP role, and were based on the literature review. While the questions asked of NPs, physicians, and nurses related to the same concepts, there was a need to frame questions in a manner that took into consideration the professional role of the participant. For example, the interview guide for NPs explored the relationships with both nurses and physicians, whereas physicians were only asked about their relationships with NPs. Twenty interviews were conducted with seven NPs, five physicians, and eight nurses across three sites. One of the NPs had recently left one of the sites but still agreed to be interviewed regarding her experiences at her former site. Data were collected between January 2010 and February 2010.

Interviews were conducted in locations that were convenient for the participants and that were private, distraction-free and neutral (Creswell, 2007; Stake, 1995). The interviews were audio recorded with the participant's consent and supplemented with notes taken by the researcher during the interview. Field notes documented after the interview allowed the researcher to be engaged and immersed during the interview instead of focusing on writing down

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the minute particulars during the interview (Britten, 1995). Interviews were subsequently transcribed verbatim and any identifying information was removed (Carpenter, 2007; Creswell, 2007). Audio-files of the interviews were erased once they were transcribed.

Publicly accessible documents

As Yin (2003) identified, publicly accessible documents, in addition to interviews, are excellent sources of evidence because they allow the researcher to understand the phenomenon from different perspectives and are widely used in the case study approach. Publicly accessible documents for this study included scope of practice documents, government reports, position statements and press releases. While there were no site specific documents available to the researcher that were used for this research, participants often referred to the CNO scope of practice for NPs as a guide for their practice, which was also used as a data source. Relevant documents were located through various means. Firstly, the MoHLTC (2005) report on the integration of NPs and its reference list was retrieved from an online government website. This report offered insight into other publicly available on-line documents. Secondly, online NP and nursing organization websites, such as the CNA, NPAO, CNO, were also examined and policy statements, reports or other documents relevant to the study were retrieved. Lastly, while at individual data collection sites, the researcher had informal conversations with NPs, physicians, nurses and administrators. Notes about these conversations were added to the site specific field notes. In addition, some participants referred to a specific report during or after the interview which prompted the researcher to seek it out. All these documents were crucial in helping the researcher understand the rationale for the implementation of the NP role and the context in which it was initially implemented. Position statements from various medical associations and nursing associations were invaluable, providing descriptions of how such organizations can

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promote or hinder the integration and acceptance of the NP role in the ED. These documents also allowed the researcher to gain a historical background, which is important to understanding the context in which the role was created, and provide rationale for why certain processes exist (Yin, 2003).

Setting

This case study is a single-case, with multiple units of analysis. The case is the phenomenon of ED NP role acceptance, and each professional group is a unit of analysis, such that NPs are one unit of analysis, physicians are another unit of analysis and nurses are a third unit of analysis (Yin, 1994). The selection of the sites for the study is an integral component in case study research. Sites are meant to house the phenomenon of interest and must meet the inclusion and exclusion criteria outlined by the researcher (Keen & Packwood, 1995). In this study, each site had a 24-hour, 7-day-a-week functioning ED with an NP who was introduced as part of the MoHLTC pilot project. A convenience sample of three community ED sites was chosen based on the functions/responsibilities of the NP, and the proximity to the researcher. Initially, the researcher received NP contact information from many ED sites across Ontario. Not all NPs who responded functioned within the NP-PHC role. Some of the NPs that expressed interest in the study were responsible for only geriatric ED patients and others were only assigned to patients who presented to the ED with stroke-like symptoms. It was important that the NPs chosen were assigned to less-urgent or fast-track patients because these NPs were part of the MoHLTC ED initiative.

Data were collected at three sites in Ontario. It was decided that more than one site was necessary to effectively explore the phenomenon. Since this was a small descriptive case study, more than three sites would have been beyond the time and budget constraints of this study.

Additionally, more than three sites would have been cumbersome for data analysis purposes two sites might have provided stark differences in data had the experiences of the participants varied. Therefore, it was decided that three sites would be appropriate and would allow the researcher to explore the concept in a rich and minimally time intensive fashion. In addition, collecting data from three to six participants from each site allowed the researcher to obtain rich data regarding the phenomenon of interest. The researcher had initially anticipated recruiting one to two NPs, one to two physicians, and one to two nurses per site in order to have equal representation from each professional group. However, when participants were recruited, not every site had equal representation of NP, physician and nurse participants. It was subsequently decided that the unit of analysis would be the professional group, rather than ED site (Yin, 1994). This meant that all physician interviews, regardless of their site, were considered a unit of analysis. Between units of analysis, there was a fairly equal number of participants (7 NPs, 8 nurses and 5 physicians). All three sites were community based acute care hospitals, located in different geographic areas of Ontario and had at least one NP that was introduced as part of the MoHLTC pilot project. Whereas the hospitals varied in number of yearly ED visits, they all had proportionally similar numbers of patients presenting with less urgent or non-urgent chief complaints (Table 1).

Table 1

Sites used for data collection

	Site A	Site B	Site C
Number of Beds	165	300	33
Annual ED visits	45, 000	49, 000	33,000
Number of NPs in ED	2	3	1

Inclusion Criteria

NPs were selected if they had been hired as part of the MoHLTC pilot project and had been functioning in the role of the NP for at least one year at the time of data collection. Emergency physicians and nurses were included in the study if they had worked with the NP(s) for at least six months. The rationale for these inclusion criteria was to ensure that participants had a chance to practice with one another long enough to be able to have an opinion and speak to NP role acceptance.

Selection and Recruitment

Participants were recruited using a two-step process. Initially the researcher contacted the Nurse Practitioner Association of Ontario (NPAO). The NPAO is a professional organization for NPs in Ontario and an interest group of the Registered Nurses' Association of Ontario (RNAO). Membership with the NPAO is voluntary. The NPAO's mission is to be the professional voice for NPs in Ontario through promoting public awareness and visibility of the NP role, by providing opportunities for networking, and through lobbying government groups and associations on behalf of NPs in Ontario. The researcher contacted the executive director of the NPAO to explain the purpose of the study. The executive director agreed to send an email (Appendix D) to the NPs who work in EDs across Ontario on behalf of the researcher. The researcher received responses from several NPs expressing their interest in participating in the study.

The researcher contacted individual NPs via telephone to further understand their specific roles in the ED in which they were employed. As some NPs were employed as NPs but functioned as educators or coordinators, it was important that the researcher assessed the roles and responsibilities of all NPs to ensure that they met the inclusion criteria.

The NPs served as the contact person and liaison between the researcher and other

participants (physicians and nurses) at each site. The NPs were also integral in connecting the

researcher with the directors/managers of each ED and facilitated the researcher's site-specific

Research Ethics Board (REB) applications. Once the NP and the site ED manager/director

agreed to have the researcher conduct her research at the site, the researcher began the site-

specific REB process. The researcher maintained regular communication with the NPs to ensure

that they were kept updated on the REB process. Once REB approval was granted at individual

sites, the researcher re-connected with the site manager/director to commence the recruitment of

participants.

Since the NPs were pre-determined contact persons, the researcher contacted the NPs to

set up a date and time for an interview that was mutually convenient. The researcher then

contacted the site manager/director to inform them what day she would be at the site to interview

the NP. The manager/director then informed ED physicians and nurses that were scheduled to

work on that particular day and provided them with information about the study. Interested

participants informed the manager/director, who in turn passed the information along to the

researcher. This approach was used in order to decrease any perception of coercion. All

physician and nurse participants that expressed interest in participating in the study did so.

Analytical Procedures

This study used several sources of data: semi-structured interviews, publicly accessible

documents and the researcher's field notes during data collection. The researcher employed

Strauss & Corbin's (1998) methods for data analysis which include: open coding, axial coding

and selective coding. While this particular method is more often used with grounded theory

research it was seen as the most appropriate given the richness of the data and the need for the

researcher to be well immersed in the data. Strauss & Corbin's (1998) technique is highly

inductive and systematic which helps to minimize the influence of the researcher's own biases

and beliefs about the phenomenon.

The first stage in the analysis is open coding (Strauss & Corbin, 1998). Strauss and

Corbin (1998) describe this stage as the "process through which concepts are identified and their

properties and dimensions are discovered in data" (pg. 101). In order to uncover concepts, the

researcher must "open up the text and expose the thoughts, ideas, and meanings contained

therein" (Strauss & Corbin, 1998, pg. 102). After transcribing the interview audio-files

verbatim, the researcher read through each transcript without writing any codes or formulating

any ideas, but rather gained a general sense of what participants were discussing. This process

was repeated for the researcher's field notes and the publicly accessible documents. After

reading through the transcripts, publicly accessible documents and field notes, the researcher

then began to code individual documents and pieces of data. Transcripts were set up in such a

way that the margins were adjusted in order to allow for writing of codes. Additionally, lines

were numbered to allow for easy retrieval of codes and quotes. A code referred to an idea or

concept that the piece of data was illustrating. The researcher read through the transcript or

document line by line and underlined data that related to an idea or concept and, subsequently,

wrote out the code label in the margin. Once completed, the researcher generated a coding list.

The goal of the second step in data analysis, axial coding, is to consolidate the number of

codes by grouping them together around central categories. The researcher looks for connections

between codes and tries to group them into smaller, but more abstract, categories (Strauss &

Corbin, 1998).   For this study, the researcher printed off the coding list and began to cut out

individual codes and put them into meaningful categories. As an example, codes such as 'fee-

for-service', 'salary', and 'fees', were grouped together under the category of 'remuneration'. Several codes did not fit in the early coding framework. These codes were reviewed with the thesis supervisor who assisted in providing clarity in determining the appropriate category.

The final stage of coding, selective coding, takes place when the researcher integrates and refines the categories to formulate an in depth understanding of the phenomenon reflected in major themes (Strauss & Corbin, 1998). In grounded theory method, this is traditionally done by generating theories around the phenomenon and the research questions. However this study employed a modified thematic analysis as the choice for data analysis. While the procedural steps in the analysis were consistent with Strauss and Corbin's (1998) methods for data analysis, the end result is not a theory but an understanding of the major influences for NP role acceptance in the ED. Additionally, while the researcher used case study methodology for data collection, it was not the intention of the researcher to theorize about the phenomenon as suggested by Yin (1994). Because little was known about the concept of NP role acceptance in the ED, the researcher aimed to explore this phenomenon rather than generate a theory. What this study did achieve during the selective coding phase was an illumination of possible influences and connectivity among the themes. As an example, the researcher initially grouped together 'physician-NP trust', 'power', 'physician remuneration', and 'referrals to specialists' under the theme of 'physician-NP relations'. After examination and comparison with other themes, the theme of 'physician-NP relations' was further refined and became a subtheme of an overarching theme, 'professional relationships'.

A unique feature of qualitative research is the notion that data collection and analysis are performed concurrently. While Strauss and Corbin (1998) outline how data analysis is a systematic and step-wise process, it is important to note that data analysis is also a dynamic and

reflective process. As new data are being collected they are constantly being compared and contrasted with patterns that emerged from previously collected data. Data analysis can then inform data collection whereby the researcher identifies aspects of their phenomenon of interest that they wish to clarify or further explore. For this study, data collection became an iterative process whereby the researcher began to uncover patterns and develop themes as she collected data. The researcher wrote reflective notes in her journal about emerging patterns and themes, and noted differences between units of analyses (nurses, physicians and NPs). The researcher then compared and contrasted subsequent data collected with her journal notes. As an example, after a few participants identified the issues that NPs faced when referring patients to specialists, the researcher decided to further explore the relationships between NPs and specialists in subsequent data collection. This process allowed the researcher to be simultaneously engaged in data analysis whilst collecting data.

Rigour

Qualitative research has often been criticized for its lack of scientific rigour; that is, data are subject to researcher bias and hence are not reproducible (Mays & Pope, 1995). This criticism can be overcome if researchers give adequate description of the methodology and data so that another researcher could analyze the raw data in the same fashion and arrive at similar conclusions (Mays & Pope, 2000). Additionally, qualitative researchers need to produce lucid and coherent explanations of their phenomenon of interest (Mays & Pope, 1995). For this study, rigour was ensured by addressing credibility, dependability and confirmability, specifically through the use of data triangulation, peer review, and "clarifying researcher bias" (Creswell, 2007, p.208; Speziale, 2007a).

Credibility

To address credibility, the researcher must demonstrate that the results are a valid account of the phenomenon of interest (Mays & Pope, 1995). This can be achieved through data triangulation. As previously mentioned, triangulation, through the use of semi-structured interviews, publicly accessible documents and the researcher's field notes, was used to corroborate data and shed light on this phenomenon (Creswell, 2007). Data triangulation refers to having two or more data sources (Mays & Pope, 2000). For this research, data were obtained from NPs, nurses and physicians as well as relevant documents. This allowed the researcher to analyze and ultimately converge the different views in order to paint an overall picture of NP role acceptance in the ED

Dependability

To address dependability, the researcher kept an audit trail of the decisions made throughout the study and the rationale for methodology, data collection strategies, site/participant selection and data analysis choices (Koch, 2006). Dependability "seeks means for taking into account both factors of instability and factors of phenomenal or design induced changes" (Graneheim & Lundman, 2004, pg. 110). This specifically refers to the changes that the researcher makes over time in data collection and analytical procedures made by the researcher during data collection and analysis. During the data collection process, the researcher "acquires new insights into the phenomenon of study that can subsequently influence follow-up questions or narrow the focus for observations" (Graneheim & Lundman, 2004, pg. 110). This study used an interview guide to assist the researcher in asking questions that were meaningful to the purpose of the study and to ensure that the researcher touched on all the important topics related to role acceptance. Participants commonly addressed a topic that would trigger the researcher to

explore deeper by asking additional questions. Those moments in the interview whereby a

participant would bring forth interesting information pertaining to the phenomenon were

documented in the researcher's journal and often addressed with future participants in

subsequent interviews. To account for these inevitable iterations in the data collection process,

the researcher kept field notes and a journal to document thoughts and ideas about the interview

process.   Field notes also included information about the layout of the ED, the interactions

observed among health professionals, non-verbal communication during interviews, and

perceived participant comfort during interviews. Field notes were a rich source of data when the

researcher was reading through the interviews. As an example, interviews from one site alluded

to the idea that the NP was not seen as an integral member of the ED team. When looking

through the field notes, it was noted that the NP worked in a separate part of the ED and it

became apparent that the physical separation might influence the ED team's perceptions of the

NP as a member of the team.

Lastly, the researcher's own biases about the phenomenon of interest can have an

influence on the dependability of the data. As discussed in Chapter One, the researcher's clinical

expertise as an ED nurse introduced a set of beliefs and biases in the research process. It is

important to identify beliefs and biases in order to ensure that the interpretations of data through

analysis are not influenced by the researcher's professional nursing experience. The researcher's

experiences, however, may have influenced some aspects of the research process as they may

have allowed her to have a deeper understanding of the inner functioning of an ED and be

familiar with the processes involved in working within the department (Creswell, 2007; Mays &

Pope, 2000). While insider information may have been beneficial it may also have introduced a

bias regarding the NP role and its value to the ED. Also, having insider knowledge may have

influenced data collection, such that the researcher may not have probed further into some of the participants' responses, assuming that she knew to what they were referring. The researcher made efforts to engage in reflexivity in order to minimize the influence of her own biases on the research process. Reflexivity acknowledges the intimate relationship that the researcher has with the research process and encourages the researcher to be aware of the biases that she holds. Researchers are also encouraged to document their biases prior to engaging in the research process (Ahern, 1999; Dowling, 2006). For this study, the researcher started by writing her beliefs and perceptions about NP role acceptance in the ED in a journal. These beliefs were based on previous experiences in the ED, literature read about the NP role, and discussions with colleagues. This was an iterative process during data collection and the researcher would often refer back to her journal to ensure that she was not projecting any of her own biases onto the data collection or analysis process. The researcher would make notes in her journal after every interview to describe her own emotions and thoughts about the interview (Ahern, 1999). For the first few interviews, the researcher recognized that she was feeling intimidated by some of the physician participants and as a result was refraining from probing further into some of their responses. Recognizing this, the researcher realized that this feeling of intimidation needed to be set aside and that asking physicians more thought-provoking questions would help to uncover some of the rich, contextual data. She acknowledged her feelings and proceeded with the following interviews in a more assured manner that, upon review of transcripts, provided the researcher with richer data.

During the analysis stage, the researcher employed reflexivity to ensure that she was not favouring any particular interviews nor using more quotes from one transcript versus another. Ahern (1999) explains that researchers need to be aware of being biased towards any one

particular interview and if so, need to step back from the process and ask themselves why this is occurring. For this research, the researcher found herself being more intrigued by a select number of NP interviews because of how much information they provided the researcher. The researcher realized that she was using more quotes from a couple of NPs when compared with other participants' interviews. In recognizing this she made a conscious effort to explore the other transcripts and to use other quotes to illustrate the thematic analyses (Ahern, 1999). It was important that the researcher engage in reflexivity to ensure that the researcher's biases and beliefs did not impinge upon the data collection and analysis (Ahern, 1999; Dowling, 2006).

Confirmability

Researchers have argued against the use of confirmability as a method to ensure rigour, asserting that people have multiple realities and thus it is expected that two researchers will have multiple interpretations of the same data (Poses & Isen, 1998). Despite this argument, the researcher employed several methods to enhance the study's confirmability. Meticulous field notes and records of meetings, interviews, and observations were maintained; interview data were audio recorded and interviews were transcribed from the audiotapes verbatim; and attention was paid to detail such as pauses and body language (Creswell, 2007; Mays & Pope, 1995). A log of the analysis process was maintained, keeping the process explicit and clear (Armstrong, Gosling, Weinman & Marteau, 1997; Rowan & Huston, 1997). Additionally, having a second reader of the transcripts enhanced confirmability. This entailed having a member of the thesis committee read through several randomly selected transcripts and code the data and then examine intercoder agreement (Creswell, 2007). Agreement between the coders demonstrated that the highly interpretive data were, in fact, coded similarly, which contributes to confirmability (Creswell, 2007; Mays & Pope, 1995).

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Ethical Considerations

The researcher received ethics approval from Ryerson University REB (Appendix E), and the REBs at each site. Issues that often arise in qualitative research pertain to confidentiality, anonymity, informed consent, coercion, participant selection and risk/benefits (Canadian Institutes of Health Research [CIHR], Natural Sciences and Engineering Research Council of Canada [NSERC], & Social Sciences and Humanities Research Council of Canada [SSHRC], 1998; Carpenter, 2007; Creswell, 2007). Each of these is discussed.

Confidentiality and Anonymity

As anonymity cannot be guaranteed by virtue of the research design, the information obtained from the interviews was kept confidential. Audio files were transcribed and coded by the researcher. Coding lists, hard copies of the transcripts and consent forms were securely stored in a locked filing cabinet in the researcher's office at the University. Any electronic data (transcripts) were kept password protected, without identifiers attached to the data. Audio files were destroyed once transcribed, and transcripts will be kept for a period of 5 years, at which point they will also be destroyed. Information regarding data storage and security was included on the consent form. Only the researcher and the second reader (thesis supervisor) had access to the transcripts (Carpenter, 2007; CIHR, NSERC, & SSHRC, 1998).

While the number of participants and sites may be considered to be problematic in maintaining confidentiality of the participants, the researcher has presented data in an aggregate fashion and has not associated any direct quotes with specific study sites. For example, any direct quotes or paraphrasing identified participants as NP1, physician2, nurse3, without providing any information about which site they are from. Additionally, the researcher avoided

using any direct quotations that contained any site-specific information that would allow identification.

Informed Consent

Each participant was asked to sign a consent form (Appendix F) that provided a clear description of the study and described how ethical issues have been addressed. The consent form also explained that the researcher's second reader (thesis committee member) will read the transcribed data and codes/themes will be compared. The second reader did not, however, have access to the raw audio files, nor have access to participant-coding lists. The consent form also indicated that participation was voluntary and that participants had the right to withdraw from the study at any point and that their relationship with the University or with the researcher would not be affected. In addition, the researcher reviewed the consent form with each participant prior to the interview to ensure their understanding (Carpenter, 2007; Creswell, 2007). Raw data have been kept in the researcher's office at the University and are only accessible to the researcher.

Coercion and Participant Selection

In order to decrease coercion the researcher did not approach any NPs, but rather sought assistance from the executive director at the NPAO to disseminate the recruitment e-mail. As well, physician and nurse participants were not approached by the researcher for participation in the study. It was the role of the ED manager/director to inform potential participants about the study and to provide them with the information so they could make a decision regarding participation or non-participation (Appendix G). Participants were given the contact information of the researcher and it was their decision to connect with the researcher. The researcher was not present when the manager/director informed the potential participants of the study.

Risks and Benefits

Risks associated with participating in this study included other ED colleagues being cognizant of individual participation or non-participation. As an example, one site had only one NP in the department and therefore it was quite apparent that she was participating in the study. The researcher explained the risks of being the only NP in the ED to the NP participant and the potential for identification by her colleagues. Whereas there were no direct benefits to participating in the research, participants had the opportunity to add to a growing body of knowledge of the NP role in the ED. Risks and benefits were explained in the consent form and the researcher reiterated these points prior to participation.

CHAPTER FOUR: RESULTS

Introduction

This chapter presents the study's findings and identifies the factors influencing acceptance of the NP role in the ED. Results have been organized according to the five major themes that emerged from analysis of the semi-structured interviews with NPs, physicians and nurses, the researcher's field notes and the publicly accessible data. The five themes are: stimulus for NP role implementation, role clarity, value-added components of the NP role, NP-specific characteristics, and professional relationships.

Stimulus for NP Role Implementation

Data analysis revealed the influence of understanding the stimulus for NP role integration on overall role acceptance. Participants were asked to identify why the NP role was implemented initially in the ED. Across all three sites, participants had a difficult time in articulating their responses to the question. Nurses and physicians were often unsure of the reasons for the implementation but assumed that it was a government funded initiative that allowed them to have a NP in their ED. They also noted that NP role implementation was part of a pilot project:

> "Well, that's a good question. I'd say one was that there was a pilot program so we were willing to take part in the pilot program. At the time when the pilot program was offered we were having some struggles with personnel in terms of nursing staffing and physician staffing too and we were getting really busy and we thought it would be good to have an extra hand on deck to help in seeing these extra people... Those two factors combined with the pilot program came around I think at a fairly opportune time for us to jump on the bandwagon."(Physician5)

NP responses varied; some of the NPs who were interviewed were the first NPs at their site, while others had been hired into an NP role that was already established in that ED. This was significant because not all NPs recognized that they were hired as part of a pilot project. All NPs reported that the main purpose of their role was to help facilitate flow of patients in the ED and to decrease wait times and the number of patients who left without being seen by a physician:

> "Wait times, and 'left without being seen'. People were waiting far too long. We'd get that backlog when the physician was busy with a crisis. Either, you know, a [motor vehicle collision], or a trauma of some kind, or… a [cardiac] arrest… he would be busy, tied up with that particular patient for some time, and everything came to a standstill. So they really needed another level of provider that could keep the flow of emerg[ency] going." (NP4)

The review of publicly accessible documents revealed that the stimulus for NP implementation in the ED was a $2 million pilot project that was launched in six communities across Ontario and was part of the HealthForceOntario strategy to employ NPs and PAs to work in EDs (HFO, 2008). This was a one-year pilot project aimed at decreasing patient wait times in the ED, decreasing the number of patients that leave without being seen, and shortening patients' length of stay in the ED. Additionally, the stimulus for implementing NPs in the ED was to assist with ED coverage, especially in communities where physician recruitment was an ongoing challenge (HFO, 2008). Because of the ongoing effectiveness of the NP role in meeting its intended goals, the three sites used for this study reported receiving ongoing funding each year since the pilot project finished in order to retain the NP role in the ED.

Understanding the stimulus for role implementation emerged as an important influence in overall NP role acceptance. This is important because, if the nurses, NPs and physicians do not understand why the NP role is implemented in the first place then it may be difficult to understand its purpose and to accept it. Additionally, if nurses and physicians do not feel that there is a need to implement the NP role in the ED then there may be challenges associated with accepting it. Many participants had an understanding that the impetus was part of a MoHLTC initiative to reduce patient wait times and to improve patient access to emergency care. So the findings suggest that, while understanding of the purpose for NP role implementation was identified as an important factor in NP role acceptance, nurse and physician participants were not entirely aware of the impetus for implementation which may have hindered acceptance.

Role Clarity

NP participants were asked to describe their own role in the ED, whereas nurse and physician participants were asked to describe their understanding of the NP role in the ED. These questions were asked to establish how clear the NP role was to participants. Role clarity emerged as an important factor related to NP role acceptance because the individuals with whom the NP works expressed a need to have a clear understanding of the NP role and how their own role fit within this model of care. Without role clarity, boundaries between health professionals may be blurred and role ambiguity may occur. Role clarity involves a definition of parameters of the role, outlines responsibilities, and specifies accountabilities and deliverables. In essence, role clarity helps nurses and physicians understand the NP role, and thereby begin to accept it. Role clarity was discussed by participants in terms of their knowledge of the NP's scope of practice, the NP's responsibilities in consulting with ED physicians when uncertain about patient care management, and the expectations of working with ED nurses.

Many nurse and physician participants reported not understanding the NP role when it was initially implemented in the ED. Participants identified that they were unsure of how the role would fit within their ED, what the difference was between a NP and an ED physician, and they were hesitant to accept this change. On the other hand, several nurses and physicians reported knowing about the role of the NP when it was implemented, but they were unclear of how the role would function with other nurses and physicians as part of their ED team. Many participants also reported that they did not receive a proper orientation to the NP role in the ED and hence had ongoing hesitation and resistance thereby hindering role acceptance.

NPs also expressed their concerns with staff not having clear knowledge about the NP role. NPs reported that a major barrier to role acceptance was staff not understanding their role and being reluctant to work with the NP. Many reported a sense of ignorance from the staff with regards to role functions and responsibilities and reported that they had to educate staff about the role and communicate the purpose and responsibilities of the NP role in the ED. A NP reported taking the initiative and conducted information sessions with staff to help them understand the NP role and its expectations in order to clarify their concerns and facilitate her own integration and acceptance by colleagues:

"Even though there have been NPs working there for a while I don't think that they actually understood what it meant to be an NP and what the entire scope was. I don't think there was any kind of formal education around it so when I came into this new role here I talked to the manager and I talked to the Emerge[ncy] director and I said "we need to have information sessions where I can talk to people and say 'this is my role, this is what I do' and let them fire questions at me" because I think that's one of the best ways to alleviate some of the anxiety from the physicians because I think they're worried about

the legality of my scope and my practice and how it impacts them. Nurses don't always

understand what the scope is. I think that having the information sessions and having the

ability to talk really helps alleviate some of the resistance and barriers to those concerns".

(NP6)

Another NP reported that she did not conduct any formal education sessions, but rather

role knowledge acquisition was attained when she worked alongside new staff:

"Well they don't get any orientation to my role. They're told: 'Oh, and a nurse

practitioner works here.' And then the first shift I work with them, like we had a new

physician start, oh, maybe four, five months ago…brand new emerg[ency] doc, he'd

never worked with a nurse practitioner before, he was told he would work with one.

When I first started, he said, 'I've never worked with a nurse practitioner, so you'll just

have to… fill me in.' And the chief of the staff, chief of emerg[ency] at the time, told me

later he went home and emailed him that night, and said: 'That was a very positive

experience, the nurse practitioner is very helpful in emerg[ency].'" (NP4)

NP participants added that if a NP had previously worked at their site there was much more

understanding from staff about the NP scope of practice, and responsibilities, and the role was

generally more easily accepted.

NP, physician and nurse participants reported that the NP worked within his/her own

scope of practice, seeing less-urgent and non-urgent patients, and consulting with ED physicians

when patients fell outside the NP scope of practice. Many participants also identified that the

NPs were responsible for follow-up of abnormal results for patients who were discharged home

and often worked under medical directives:

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"We have a scope of practice. Through the College of Nurses. And we have a drug list

that we're allowed to prescribe off of. We have, in our scope of practice, certain x-rays

that we're allowed to order independently. If there's anything that we want to do that's

outside of that scope, then it's just a matter of consulting with a physician." (NP2)

Participant responses were consistent with the College of Nurses' scope of practice

guidelines (CNO, 2009b) and the Health Professions Regulatory Advisory Council (HPRAC)

report (Health Professionals Regulatory Advisory Council [HPRAC], 2009). What was also

revealed was that the CNO, the NPAO and the RNAO had requested that NPs have 'open

prescribing' authority from HPRAC. Open prescribing means that NPs would no longer have to

seek consultation with ED physicians in order to prescribe medications that are not on their list

of approved drugs. As an example, intravenous antibiotics are not on the NPs drug list and

therefore NPs must consult with an ED physician for this medication to be prescribed for their

patients. According to an NPAO position statement, the purpose of this proposition was to

enable NPs to provide total care management of patients and to be consistent with the depth and

breadth of their knowledge. Additionally, the rationale was that NPs provide care for patients

who have complex co-morbidities and the limitations in prescribing make total patient care an

ongoing challenge (HPRAC, 2009). These documents shed light on role clarity by identifying

reasons for NPs to consult with ED physicians when prescribing certain medications. Several

participants added that the NP role should have a broader scope where the NP does not have to

seek consultation with the ED physician but rather they be allowed to manage the care of the

patient on their own.

Participants also discussed aspects of the NP role that were not defined by the NP scope

of practice, but were rather the contextual responsibilities of the role in their specific ED.

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Participants at two of the three sites reported that the NPs at those sites worked independently without the help of staff nurses to carry out their orders. NP and nurse participants identified that it was not considered common practice that nurses took orders from NPs to do things such as medication administration, phlebotomy, or wound care. One site had medical directives in place for registered practical nurses (RPNs) to carry out NP orders, but these did not apply to RNs. Another site did not have medical directives at all for nurses to carry out NP orders but some nurses would do so in order to help the NP. This was, however, not common practice:

> "It's a bit of a problem in that the NP—I think she feels isolated some of the times, because the nurse and the physician are doing their thing and she's got really nobody to help, and we're so used to…working together. And at this point in time she's not allowed to say: 'you do this, I'll do this, you do this, I'll do this.' You know? You can't take orders from her. So she's really an entity unto herself. We haven't got it… meshed just right". (Nurse6)

Many participants described the NP role as independent and isolated, with NPs providing total care and carrying out all their own orders. NPs suggested that nurses should help carry out their orders just as they do for ED physicians, to maintain ED flow, decrease patient wait times and total length of stay in the ED. Nurses expressed that they should not be carrying out the NPs orders because the NPs have professional preparation in nursing and thus have the skills to do it themselves. Many NPs acknowledged that this perception of independent capacity as a barrier to NP role integration. Nurses reported that carrying out orders for the NPs is not common practice at their institutions.

Many NPs reported feelings of isolation in their role. This was mostly in relation to physical isolation in the actual set up of their work environment. NPs felt that the location in

which they physically practiced in the ED affected the integration and acceptance by their colleagues. Several NPs worked in a separate and distinct area of the ED where they were not visible to staff who worked in the main section of the ED:

"I think a lot of it is that they don't see what we do. Because we're not visible to them. We're off in our own little corner, and so they don't see us. They're busy doing their stuff, we're busy doing our stuff…They know what our scope is, they know what we do. But as far as, you know, 'are we actually over there working, and doing stuff, while they're working over here'…Are they sittin' chattin', while I'm workin' [here]'? I think that's where the disadvantage in this setup is. It kind of impedes that relationship".

(NP2)

This also reportedly led to an under appreciation by nurses of the work the NPs did. One NP commented that because they are not visible to the other staff, the role is not fully understood and appreciated:

"I think it's a barrier. We were put in a separate area by ourselves instead of a mix… within the emerg[ency]. There's not, I don't feel that – within the whole nursing staff, there's a really clear understanding what we do, other than, you see a bunch of sore throats, and, you know, those are 'easy'. But they don't see the whole role in what we do, and I think that has affected the integration in the department….Because they're not with us. We're separated, we're in the fast track area. They're in another area, they never work with us". (NP1)

Overall, while NP, physician and nurse participants emphasized the importance of NP role clarity in influencing role acceptance, many reported having an unclear understanding of the NP role when it was initially implemented. Examination of the data revealed that participants

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mainly learned about the role through working alongside the NPs and that NP role clarity developed over time. So what was revealed from data analysis was the importance of having a clear understanding of the NP role in order to be accepting of it. While the importance was stressed by participants, especially NPs, data revealed that many nurses and physicians did not, in fact, have a clear understanding of the NP role, or how the role would fit in their ED when the role was being implemented. Nurses and physicians need to have an understanding of what the NP role entails so as to be able to accept it. The need for NP role clarity is evident in order for NP role acceptance to be facilitated.

<div align="center">Value-Added Components of the NP Role</div>

Value-added components of the NP role referred to the participants' perceived benefits of the NP role in the ED and what participants felt were the advantages of having an NP in the ED. Physician and nurse participants were asked to explain what their perceptions of the role were and what they thought was the benefit to having an NP in the ED. Participants explained to the researcher that new roles and new staff have the potential to be a burden on the department and on those who work there. If a new role is seen as a burden as opposed to a value-added position, staff will have a difficult time accepting the role as it will be perceived as creating more problems than it will solve. As one NP reports:

> "If it's not helpful to them, they're not going to accept you…. I did want it to be helpful to the nurses. Mostly, I wanted it to be helpful to the patient. I wanted to decrease wait times and I wanted to decrease 'left without being seens': because that was the objective of the project. So I wanted it to be successful. But I also wanted it to help the nurses, because if they don't see you as successful, they're going to be a barrier. If you are a problem to them, they will…become a barrier to you, as well". (NP4)

<div align="center">47</div>

All participants were able to identify some benefit of having an NP in the ED. Two of the major benefits of the NP role, as identified by participants, were the decrease in patient wait times and the increased flow in the department. Participants acknowledged that, while these were, in fact, some of the reasons why the NP role was initially implemented in the ED, they had noticed that patient wait times, specifically for Canadian Triage and Acuity Scale (CTAS) level 4s and 5s, had decreased and that there was not as much of a back log of patients in the waiting room. CTAS 4s and 5s are patients who are considered less-urgent or non-urgent. Some of these conditions include limb sprains/strains, sore throats, minor lacerations, and urinary tract infections. What would occur, before the implementation of the NP role, was that an ED physician would attend to a patient who was triaged as non-urgent and then, while waiting for test results, would see an acutely ill patient. The results of the non-urgent patient would return, and often the physician would still be seeing the acutely ill patient. The non-urgent patient would have to wait for an extended period of time to receive his/her results and thus occupy a stretcher in the ED and block ED flow. Because the NP was often assigned to a specific area of the ED or restricted to care for only non-urgent patients the NP was able to ensure timely follow-up with results and thus improve patient flow. All participants also added that the number of patients that 'leave without being seen' had decreased and that patient satisfaction had increased since the implementation of the NP role in the ED; two areas that have been identified as ongoing challenges for Canadian EDs:

> "When I work on the weekend, it's just the doctor here. So depending on what time that doctor comes in, you can just see the difference. People who have waited seven hours versus somebody an hour or two—there's a big difference. There's a lot less yelling at you when you don't have to wait that long. And people don't want to wait that long.

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And even if it is just a sore throat. If there was no fast track, if there [were] no NPs, if

somebody else ahead of them was sick, they're not getting called in just because they've

been here seven hours. The person who is sick is going in before them. Frustration goes

through the roof; complaints come in. So… it matters." (Nurse1)

 All participants also identified that the NPs were often a valued resource to other health

care team members. NPs who were recognized as 'experts' or senior nurses prior to their

transition into the NP role carried 'expert' status into their roles as NPs. These NPs were

respected for their expert knowledge and skills in the ED and were often approached for medical

advice by nurses regarding their own personal health matters because the NP was often seen as

more approachable and just as knowledgeable as an ED physician:

"[The staff] come to [you for] quite a bit for medical care. I find that you're like the

family doctor for the nurse department. You know, you fill the birth control

prescriptions, you treat all the [urinary tract infections] of all the nurses, and renew

prescriptions if they haven't gone to their doctor for it. Maybe some stuff that really

should be done at their family doctor they're coming to you for." (NP7)

Because the NP scope of practice is often limited to patients who present to the ED with

less-urgent, non-life threatening illness, NPs were primarily assigned to care of this particular

patient population. This allowed the ED physicians to see more complex emergent patients:

"Because they take a huge load off the emergency department. It leaves the doctors to see

the urgent and the emergent patients, and actually the nurse practitioners, when they're

sort of caught up, they will go and look at the urgent patients and see if there's any of

them that they can see. And sometimes they'll start them, knowing that they will need to

consult with the doctor. And so that way, that patients at least feel like someone is taking

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care of them. And so, even though they know that they will have to consult, and that there will be further things they will have to ask the doctor about, at least someone is caring for them and they're not sitting in the waiting room waiting. Some of them are very proactive and will go ahead and do that." (Nurse3)

One NP informed the researcher that if she noticed that there was a long wait for patients who were potentially beyond the scope of her practice, she would perform a patient history and order diagnostic tests that were within her scope of practice and then pass them on to the ED physician in order to save time for both the patient and the physician:

"I will get them started, knowing full well that I'm going to have to consult with a physician at some time. Like those fingers that I saw this morning: I knew I was going to have to have the physician order [intravenous] antibiotics if they were broken. But I don't just not see something… I will go ahead and do what I can. And it really expedites it for the physician. I think it took me an hour to stitch that person up? If the physician is tied up for an hour, you can imagine what the waiting room would look like when he was done." (NP4)

Some participants also identified that the NP was sometimes seen as an 'extra pair of hands' when critically ill patients presented to the ED. The NP was accommodating and would help the team when there was an abundance of acutely ill patients:

"Another set of hands, another set of confident hands for trauma, cardiac arrest, anything that's very severe they're more than happy to help us out. We have lengthy suturing jobs that need to be done, lengthy casting jobs that need to be done where our physician could be in there 45 minutes…if that nurse practitioner can go in there and do that, that's super; it takes all the burden off the physician to see other patients". (Nurse8)

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The researcher also noted during a site visit that a patient presented to the ED with a major medical emergency. The NP, who was discussing a case with another colleague, readily shifted her attention to the critically ill patient and assisted in the resuscitative measures until the physician was able to attend to the patient. It was evident that, while she had some patients still waiting to be seen, she recognized this patient's need for immediate medical attention. Afterwards, colleagues, who were also present during this resuscitation, thanked her for her help.

Another perceived value of having the NP role in the ED was that NPs reportedly provided more holistic care, spent more time with patients and engaged in health teaching. One NP gave an example of how she was able to uncover some social issues that the patient was having while suturing his arm. While this patient initially presented with a laceration, the NP discovered that the patient had ongoing depression and alcohol dependency issues that potentially led to the laceration. The NP reported that this was a very important discovery because she was able to help the patient not only with the immediate laceration issue but also with community resources that would help him and his family deal with the social issues:

> "I know the patients I see, I make a difference. May not be on every sore throat, but that elderly person that I sorted out some issues. Like a man who's come in with just a laceration and we've sorted out that he had a drinking problem and had gotten family involved, and I spent three hours with them sorting out the drinking issue and trying to get some supports at home, and talking with the patient and finding out he's actually depressed, and picking up on those things can take a long time." (NP1)

The NP saw this as a huge benefit to the ED because it potentially decreased return visits of this patient to the ED and helped the family to connect with the appropriate resources. Similarly

another NP reported how she takes the extra time with patients to ensure that they comprehend their treatment plan in order to decrease return visits to the ED for the same issue:

> "It's not just 'put a band-aid on it and get your stitches out'. I talk to them about wound care, I talk to them about preventative health measures if they have some kind of lung infection, I talk to them about smoking cessation and what it means or I describe to them what my findings are and I don't think that that often is the case in health care so maybe I'm a little more open and I get that feedback from my patients." (NP5)

Lastly, nurse, physician and NP participants identified how integral the NPs were in facilitating care for ED patients. This entailed the NP coordinating community resources, ensuring that a patient had proper follow-up care and making arrangements for specialist referrals. This was particularly important for patients who did not have a family physician.

It is important that physicians and nurses understand the value of the NP role in the ED and what it offers for both patients and health care team members. This is significant because if the NP role is not perceived to be helpful then team members may not be willing to accept the role in the ED. The analysis indicated that all participants saw the value that the NP role brought into the ED. Although many nurse and physician participants did not work alongside the NP, they were still able to see how the NP role impacted their daily practice. This was important in terms of role acceptance because participants saw the NP role as a favourable addition to the ED as opposed to being burdensome.

<center>NP-Specific Characteristics</center>

Individual attributes and traits of NPs also influence the overall acceptance of the role by physicians and nurses. Whereas there was no specific question that was asked to participants with respect to individual characteristics, participants were asked to discuss some of the

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challenges and benefits of the role (for nurse and physician participants) and highs and lows of the role (for NP participants). Nurse, physician, and NP participants discussed the importance of personality traits, being knowledgeable with strong clinical skills, having previous experience as an ED nurse before transitioning into the NP role and being a good overall fit in the department. Of the three sites that were examined in this study, two sites had more than one NP. Participants often would compare and contrast the NPs at their site when articulating the benefits and challenges of working with an NP.

A common response from all participants pertained to the notion of previous experience in the ED as a nurse prior to transitioning into the NP role. Of the seven NPs who were interviewed for this study, six NPs had previous work experience in an ED setting. Participants identified that not having experience in their particular ED could be a challenge for role acceptance. Most participants reported that having prior experience in the ED, and often in that particular site's ED, meant nurses and physicians were familiar with that particular NP's knowledge and skills. Participants also emphasized the importance of prior experience in terms of understanding how that ED functions: "I think it was very beneficial, just to understand the flow, and the process, and how things are done, and who orders what, and that sort of stuff" (NP2). Several participants also discussed the importance of strong ED knowledge and skills in addition to understanding the importance of patient flow and volume management:

> "I think there has to be a real push towards making sure that an emergency room NP has good emergency room skills and understands the concept of emergency medicine so that you can improve efficiency and see more people; not that quantity is all we want, we certainly want quality, but I think there has to be both." (Physician5)

Some physicians reported that having NPs who were once RNs in the department helped to make the transition smoother and allowed for a better fit in the department: "We've raised most of our NPs. Most of them were staff nurses before, and they were good ones. And we've watched them grow" (Physician1). What was interesting was that while NPs agreed that having prior experience in their particular ED was helpful in terms of familiarity of processes and workflow, they identified that the relationships they had with nurses prior to their transition did not make their segue easier. NP participants reported that role acceptance may have been better, with respect to relationships, if they had not worked in the same ED prior to moving into the NP role:

"[Personal name] had come from another hospital in another emergency department. So she was like a stranger to the people here. No history, no conflict, no friendships and alliances and stuff. Just nothing. Coming in fresh, I think, is easier than transitioning from the RN staff nurse role into a different advanced practice role" (NP3).

Nurse and physician participants also identified that individual personalities of NPs played a factor in overall NP role acceptance as the personalities of NPs, nurses and physicians did not always fit well:

"We don't have any challenges in this department but I suppose that with whoever you work with there could be personality differences. Type A personalities, those are usually the ER nurses as well as somebody who is probably taking on the NP role. You could bump heads a little bit that way but we don't here, we're all a really good team and it doesn't happen but I could see how that would be a problem in other departments." (Nurse8)

Participants did not, however, identify what types of personalities help in overall ED NP role acceptance but did discuss that the NP's personality must be a good fit within the department.

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What is understood is that NP-specific characteristics, such as knowledge and skill, and having previous experience influenced how well the NP fit within the department. NPs that were perceived to fit within the ED were more accepted by nurses and physicians; therefore it is important that NPs fit well within their ED in order to help facilitate NP role acceptance.

<center>Professional Relationships</center>

All participants were asked to describe the professional relationships that exist among NPs, physicians and nurses in the ED. Analysis of the findings revealed that relationships are an important aspect to both nursing and physician practice. Relationships among NPs, nurses and physicians were observed by the researcher and were discussed by participants during the interviews. What emerged was that in order for the NP role to be accepted by other colleagues, it was imperative that the NP have a good relationship with nurses, physicians, and specialists, and collaborate with all of them. In discussion and observing professional relationships, three subthemes surfaced: NP-physician relationships, NP-nurse relationships, and collaboration.

NP-Physician Relationships

Physician and NP participants discussed their professional relationships in the ED. Nurses were also asked to describe the relationships that they observed between physicians and NPs. All participants revealed that some physicians were more NP-friendly than others, which was influenced by factors such as remuneration, trust, and power. Additionally, participants discussed the relationships that existed between specialists and NPs.

Physicians suggested that relationships with NPs existed on a spectrum and that some physicians were more NP-friendly whereas others were not. NP-friendliness referred to a positive relationship that existed between the NP and the physician whereby the NP's knowledge

and skills were trusted, the NP's work was seen as valuable and physicians worked collaboratively with the NP when consulted regarding patient care management:

"Willing to delegate some of the decision-making ability and to accept the history and physical. And that's a personal comfort level. And that's something that's by and large earned. I'm willing to accept, I may want to clarify a few salient points, but I'm willing to accept by and large the bulk of it, and I'm willing to accept the role and not try and micromanage and start from scratch. That's what I'd consider NP-friendly".

(Physician1)

Individual physician's friendliness towards NPs was also related to how NP-friendly the hospital was and whether the physician worked with NPs in the past:

"So there's some physicians that are very NP-friendly and there's some that aren't. I think the whole acceptance of nurse practitioners, now, is a lot better than it was five years ago, even. When the role first came about, there was a lot of struggling with that. It's getting better and better, and depending on the area you are. In the [geographical name] area here, we have a huge number of nurse practitioners compared to elsewhere in Ontario. So even just in this hospital itself, we have fourteen nurse practitioners. It's a huge number. And so it is an environment, here in this hospital, that is, for the most part, very nurse practitioner-friendly." (NP2)

Several factors that influenced NP-friendliness: finances/remuneration, power, and trust. Additionally, the relationships between specialists and NPs will be discussed.

Remuneration

Many participants discussed remuneration and its role in the relationships that exist between physicians and NPs. Physician participants identified that fee-for-service (FFS)

remuneration is not an NP-friendly reimbursement schedule because physicians end up competing for patients with NPs because less-urgent and non-urgent patients are often regarded as the 'easy work'. Participants identified that the best remuneration schedule is one that has both NPs and physicians on a salary. Physician participants were all paid a salary, though one physician discussed the potential issues that could occur had he worked on a FFS schedule of remuneration:

> "If it was fee for service, and I got paid solely based on the number of patients I saw, then it may be an issue…If it was a significant factor, like, you know fifty per cent of the pay-cheque was gone because I wasn't seeing the patients, then, perhaps it would be an issue, for sure…Again, not being on a fee for service, thank God, it doesn't really affect us….Difference is, if I see ten people or I see fifty people, I get paid roughly the same amount. It's a slow day or a busy day, it's the same. But if I was on fee for service, and, what should be a busy day (i.e. I'd make a lot of money) was a slow day, then because the nurse practitioner was seeing people, then yeah, probably would affect my thinking. So I guess you would almost need a system …where everyone's kind of a balanced playing field (i.e. AFP [alternate funding plan] or salary based) therefore it takes some of the territorial aspects out of it. I think that would probably be the best. There's only about eight or ten [EDs] left in the province that are on true fee for service. I don't know if they have nurse practitioners or not. Doubt it." (Physician3)

Clearly the model of remuneration has an influence on physicians' perceptions of the NPs' financial threat and is a precursor for how willing physicians are to work with NPs. If the remuneration model is such that physicians are reimbursed for each patient they see then they are less willing to work with an NP since the number of patients that the physicians see will be

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decreased. If physicians are unwilling to work with an NP it will have negative influence on how they accept the role.

Power

All participants discussed the concept of power between physicians and NPs. Physicians, nurses and NPs discussed how many physicians feel as though medical management of ED patients should only be performed by physicians and not NPs. This attitude served as a hindrance to NP role acceptance because it created a reluctance to relinquish power over patient care and work collaboratively with the NP. This was reportedly more prevalent with older physicians who were used to being the only health care professional that attended to the patient's medical needs. Some of the recent graduate and younger physicians reported that power was not a major issue and they were more accepting of the NP role:

> "I'm young, so I'm probably an outlier in my acceptance. I think some of the older
> physicians, do feel threatened, and… feel it's a territorial battle, et cetera. …If they're not
> used to something, change is always hard. And some people are loners, and some people
> like just having the department to themselves as a doc and working and not having
> medical students, not having another doc, not having a nurse practitioner. So that might
> be an issue for some." (Physician3)

Physician participants reported that some of their physician colleagues have a difficult time with accepting the NP role because they feel that NPs are trying to perform the work of a physician: "The old school thinking that a doctor's work is doctor's work and a nurse's work is nursing work and you can't mix the two up, kind of thing" (Physician 5). This participant added that many physicians would have a difficult time accepting the NP role because they felt they were relinquishing power and control over patient care management, which traditionally remained

within the medical profession. This view was consistent with the HPRAC report (2009);

physicians were opposed to allowing 'open-prescribing' for NPs because they were concerned

about NPs "bypassing the traditional gate-keeping role of MDs" (p. 291)

Trust

The notion of professional trust was discussed by all participants. Trust was discussed in

terms of physicians' confidence in the NPs' clinical skills and judgment. Physicians reported

that fear of medical liability had a strong influence on their ability to trust NPs' patient care

management skills. Concerns about trust and liability decreased over time after working with the

NP:

> "I think there was a little apprehension…Concerns over liability…before we knew about
>
> what they were going to be seeing, and … whether patients who might get misdiagnosed
>
> or not managed probably. But I think that was sort of prior to the role starting, but I think
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> we've been doing this for a while now; we're all fairly comfortable with the
>
> management, and the patients they're seeing, and it's a good relationship, and we have
>
> trust in them" (Physician4).

Many participants added that trust was more readily earned by NPs who had previous

experience as nurses in the department whereby the physicians knew them as expert nurses and

were comfortable with their knowledge, skills and judgment:

> "I don't know how eagerly the person would have been to transition into the role and I
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> don't know how quickly they would have been accepted by the physicians. I think
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> having somebody that they know and trusted as an emerge[ncy] nurse, I think that helped
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> a lot." (NP6)

Lastly, several NPs discussed the challenges in working with HFO physicians. HFO

physicians are physicians who are not full-time employees of the hospital but rather fill in for

absent physicians on a temporary basis. Participants reported that these HFO physicians had a

very difficult time accepting the NP role, primarily because they had not worked with the NP. It

created challenges for NPs to function effectively in their role because the HFO physicians often

felt the need to reassess patients that had been seen by an NP:

> "You know they have to get Health Force physicians who are physicians that just sort of
>
> come in and out; they're not regular here in our community...They're not familiar with
>
> the NP role. They're not familiar with us as practitioners, they don't know what we've
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> done in the past, what our experience is, if they can trust us. There has to be sort of a
>
> trusting relationship between the nurse practitioner and the physician. So that, you find
>
> that a little bit more difficult to consult with them, because they don't know, they want to
>
> do things over again." (NP1)

This was a significant finding because HFO physicians are placed in smaller EDs where

physician coverage is a challenge and so have an influence on the overall role acceptance of the

NP and the subsequent efficacy of the role.

Specialist relationships

In the ED, there is often the need to refer patients to specialty services such as surgery,

paediatrics or internal medicine. While it may be the case that most patients that NPs attend to

are discharged home the same day, some patients that may have presented with minor medical

issues require specialist assessment due to complex health needs. Prior to the implementation of

the NP role, ED physicians referred directly to the specialist. Since the implementation of the

NP role in the ED, NPs have had to initiate consults with specialists in order to access

appropriate care referrals for patients. All NPs expressed some challenges in referring patients to specialists. Specialists were reportedly hesitant to take referrals from NPs and wanted to speak to the ED physician first:

"The biggest barrier to my practice are specialists. And not all specialists, but some specialists. They don't want to talk to me on the phone, they don't want to give me advice. I will phone…an orthopedic [surgeon]…And I'll say: 'I have this fellow here, I'd just like you to take a quick look at the x-ray. My question is, do you need to see this patient today? They've got a fractured distal radius. Or is this something that you can see in your clinic next week.' 'Well what did the doctor say?' I say: 'Well, the doctor told me to call you. I also told him to look at the X-ray, and he told me to call you.' 'Have him call me.' And then [the orthopedic surgeon] will give that same person the advice I just asked for. But he won't give it to me. That's frustrating, but I can't help that. They don't want nurse practitioners in the system." (NP4)

What was also revealed was that specialists received a higher remuneration for referrals and consults from ED physicians when compared with those of NPs. They are more reluctant to receive a referral from an NP and often requested that the attending ED physician call the specialist, even if the ED physician had minimal or no involvement with that particular patient:

"It's a payment issue. If I consult, say, an obstetrician, whether it's from emerg[ency] or from the community, they don't get paid the same as if a physician consults with them, even though it's the same case, it's the same client? So I have to get a physician to co-sign a referral if it's from the community, or I get the physicians in emerg[ency] to do the referral so that they get paid properly. And that's just a political thing. And it's really sad that they have not made that change to the way things are paid because it actually

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creates a sense of 'untrust'. Because it is my patient, and I'm doing the referral, and the

doc really had nothing to do with the case". (NP7)

In exploring the data with respect to physician-NP relationships, it was revealed that

remuneration, power and trust were factors that influenced how NP-friendly some physicians

were. Additionally, the relationships between NPs and specialists can hinder overall NP role

acceptance.

NP-Nurse Relationships

Nurse and NP participants were asked to discuss their professional relationships in the

ED. All nurse and NP participants reported that the relationships between nurses and NPs had an

influence on overall NP role acceptance. Nurses and NPs reported a shift in their professional

relationships when NPs started in their new roles. All NPs except one were staff nurses in their

respective EDs. They worked side by side with the ED nurses, during night shifts, and during

holidays. Once these nurses transitioned into their new roles as ED NPs, the relationships and

dynamics between them and their nurse colleagues changed. The transition from nurse to NP

brought many changes to the relationship which often was seen as hierarchal conflict. Many

nurses discussed the NP-nurse relationship as having a power differential whereby the NP was in

a higher status with more clinical power than a nurse. One nurse in particular expressed her

concerns about being told what to do by the NPs:

"Well, I think we always had the fear that, [the NPs] would be 'bossing us around' kind

of thing. You know? Because they are up a level from us, or whatever, and saying they

can do more and so on." (Nurse6)

A few of the physician participants also acknowledged that the transition from nurse to

NP was particularly challenging for the nurses with whom the NPs worked:

"It may have been a bit harder for that nurse in transition; I think it may have been a bit harder for them. And I think maybe not so much with physicians, but with other nursing colleagues. Just that they now have a different role than their colleague, they worked side-by-side with them and now they're in a different role. And that may have been more of a problem… for them". (Physician4)

Participants acknowledged the fact that, because the NP no longer worked night-shifts and only worked with the less-urgent and non-urgent patients, this created an impediment to their working relationship. NPs believed that nurses felt threatened by the NP role and were not comfortable with the change in professional dynamics: "And there was some nurses [who were] threatened by change, and were concerned with the whole 'well, she thinks she's going to order me around,' notion…" (NP7). Several NPs also reported that nurses at their site refused to carry out their orders because they felt they are to only carry out the physician's orders. One NP reported how she was treated by the nurse when she asked a nurse to initiate intravenous (IV) therapy:

"Some of them were completely like 'no, we're not helping you' because I had a comment where it was like 'I'm here for the physician, not for you'. That was a little hurtful, but okay...[or] I'll get the occasional comment like 'you have two hands, why can't you just do the IV?'" (NP6)

Analysis of the data revealed that the relationships between nurses and NPs took on a shift in dynamics when NPs, who were once ED nurses, transitioned into their new roles. This change often placed tensions on the relationship because some nurses felt threatened by the power differential, hindering role acceptance.

Collaboration

While collaboration affected NP role acceptance, it was interesting to note how collaboration differed across the study sites. At one site, the NPs worked in a separate and distinct area of the ED; the 'fast-track'. This fast-track area had a separate entrance from the waiting room and shared minimal resources with the main ED. There were often two NPs working on the same shift and they would work together and consult with the ED physicians as needed. These NPs reported that consultation and collaboration with ED physicians and specialists were challenging at times and NPs knew which physicians were more approachable and NP-friendly. The NPs worked with nurses who were RPNs and were specifically assigned to the fast-track area. RPNs would carry out the orders for the NPs, while NPs would continue to assess new patients.

The second site had one NP who worked within the ED without a separate area for a fast-track. The NP worked independently most of the time, carrying out her own orders with help at times from nurses, but not on a consistent basis. This NP reported that she would request help from nurses if they were available rather than expect that the nurses would carry out the orders. The NP described her consultations with physicians as easy and, despite some challenges with specialists, she reported that the collaborative relationship with physicians had improved and that the relationship was good.

At the third site, the NPs worked in a separate fast track area of the ED, though this area was still part of the ED, unlike the first site. Each shift there was one NP who would work in this fast-track area along side an ED physician and nurse. Physicians and nurses did not cover the fast track area during their entire shift but had designated times that they would be assigned specifically to this area of the ED. The NP, on the other hand, would be left to work on her own

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during her entire shift. The NP would carry out her own orders such as phlebotomy, electrocardiography, or medication administration. NPs would consult with ED physicians but they reported challenges in collaborating with specialists.

The location in which the NPs worked had a strong influence on the collaborative relationships. In the sites where the NPs worked in a separate part of the ED they reported some challenges in collaborating with the ED physicians and nurses. Several NPs noted the feeling of isolation which resulted in a lack of collaboration:

> "Each setup has… I think, advantages and disadvantages. The disadvantage with it being set up this way is you're very isolated from the rest of the people. And so you don't develop a relationship as quickly as you might if you were right in the midst of them. So I personally find, I don't have a problem with any of the nurses here, but I find that it's taken me a lot longer to get to know people and to develop and to build that rapport and that relationship here than it did when I worked elsewhere because… you were right there, and you were talking to them all the time." (NP2)

Another NP added that the isolated nature of the fast-track was not conducive to building collaborative relationships:

> "Separate and isolated from the rest of the emergency department, it's not the best or most healthy… integration relationship. So, the emergency department can't operate well with any kind of efficiency without the nurse practitioner. So they're absolutely essential, and everybody knows it. But they're this sort of isolated entity that just sort of operates in their own little world out there. And every once in a while, their world collides with the world in the main part of emerg[ency], but not very often". (NP3)

Other participants reported that the collaborative relationship was hindered by the fact that the NPs do not provide the ED with 24 hour coverage, nor coverage on all weekends or holidays. This was a reported frustration among many team members who felt that NPs should also work 'shift-work' as they do:

> "Forget emergency medicine, if you just think about having a team, you would expect any new members of the team to function as all the other members of the team do and to me that's a big gap in terms of the working hours and the commitment and those sorts of things… not having to work the tough days and the midnight wee-hours and things like that then you create resentment on the team and things like that and there is just this underlying feeling of 'you're sort of part of the team but not really committed to being on the team'". (Physician5)

NPs attributed some challenges in NP-nurse-physician collaboration to the fact that nurses felt that it was not part of their role to help the NPs with patient care. They felt that this attitude may be due to the fact that some nurses still perceived the NPs to be ED nurses and thus did not require any help in patient care:

> "In their eyes, I'm still, [Personal name] the nurse who works in emerg[ency] and I have some advanced skills. But, if I started bossing them around, it would definitely be not accepted, whereas a physician could boss them around and they would just take that, because they see them as sort of their superior…there are [nurses] that aren't team players and they would be… 'well, why am I doing that for you? You're a nurse and you can do that too,' so. And I would just say: 'well, I can go see another patient? What would you like me to do? See another patient, or do this?'"(NP7)

One NP, who was not in a separate nor distinct part of the ED reported that she did not

expect nurses to consistently collaborate with her, especially if they are busy with caring for

acutely ill patients:

> "And there'll be nurses that aren't too busy, and they'll be reading the paper or chatting
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> to each other. Doesn't happen very often, but, you know, we have our lulls. In which
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> case, if there's other patients to see, I'll say 'would you put a dressing on that? I'm going
>
> to go and see this next patient.'…I recognized, when I came here, they didn't have any
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> more nurses; but I'm another healthcare provider that can order things for nurses to do.
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> You can't overwhelm your staff, and it's important that… a nurse practitioner recognizes
>
> right away: 'I can create more work for nurses, but they're not hiring another nurse.' So I
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> don't create more work for nurses. I make sure that I don't do that. If it's really busy, I
>
> draw my own blood, I do my own dressings, [an] I put on my own splints. I put on my
>
> own splints all the time. I don't ask nurses to do that." (NP4)

So, the NP role needs to be accepted if it is to be integrated as part of the team. It is

evident from the data collected that there are variances in collaboration depending on the

physical location of the NP and the degree of interdependence of the role with nurses and

physicians.

NPs are accepted in the ED if there are collaborative relationships established with ED

colleagues. NPs must have a good relationship with ED physicians, ED nurses and other

specialists in order to be accepted. Participants in this study revealed that ongoing inter and

intraprofessional relationship struggles exist which may hinder professional collaboration and

overall NP role acceptance.

In summary, data revealed five major themes that influence NP role acceptance in the ED: stimulus for NP role implementation, role clarity, value-added components of the NP role, NP-specific characteristics, and professional relationships (Table 2). The themes reflected participants' responses and they were corroborated with publicly accessible documents and the researcher's field notes. Differences were noted in NP role acceptance between physicians and nurses. Whereas physicians' acceptance of the NP role was influenced by power, trust and remuneration, nurses reported that power and changes in the NP-nurse relationship influenced how the NP role was accepted. These factors helped illustrate the multifaceted and highly contextual nature of role acceptance in the ED.

Table 2

Themes revealed from data analysis

1. Stimulus for NP role implementation

2. Role Clarity

3. Value-Added Components of NP role

4. NP-Specific Characteristics

5. Professional Relationships
    5.1. NP-Physician Relationships
        5.1.1.Remuneration
        5.1.2.Power
        5.1.3.Trust
        5.1.4.Specialist Relationships
    5.2. NP-Nurse Relationships
    5.3. Collaboration

CHAPTER FIVE: DISCUSSION AND LIMITATIONS

In Chapter Four, results pertaining to NP role acceptance in the ED were presented and arranged into five major themes: stimulus for the NP role, role clarity, value-added components of the NP role, NP-specific characteristics, and professional relationships. Through triangulation of interviews, the researcher's field notes and publicly accessible documents, the interconnected and interrelated nature of these themes became apparent.

This discussion aims to link themes found in this case study to existing research and literature, and concludes with an exploration of the limitations of this study.

Stimulus for NP role

Participants identified that the main stimuli for NP role implementation were to decrease patient wait times and to improve flow in the ED. They identified long patient wait times as a problem that their sites faced prior to the implementation of the NP role. Most participants were not, however, aware that the implementation was part of a larger MoHLTC strategy and that their hospital was one of the chosen sites where the pilot project would be conducted (MoHLTC, 2006a).

Analysis of the findings led the researcher to believe that understanding the stimulus for NP role implementation is the first step in role acceptance. If the NP role were to be implemented in an ED where physicians and nurses felt that wait times and patient care were not concerns, it may be difficult for them to understand the rationale for implementing an NP in their department. Acceptance of the NP role may have then been hindered because participants may not have understood why the role was initially implemented and may not have valued its contribution within the ED. There are few studies that support this belief, however, it appears as

though understanding the stimulus is an antecedent to accepting the NP role when it is implemented.

The PHC NP Integration Study (MoHLTC, 2005) reported the importance of members of the team understanding why the NP role is being implemented in their setting in the first place. Understanding the rationale serves as a foundation for NP role clarity, and having both role clarity and understanding the stimulus for NP role implementation have an influence on the overall acceptance of the NP role. As part of the PHC NP Integration Study, site visits were conducted. Participants, who had a recently implemented NP role in their setting without understanding the impetus for the role, reported challenges in understanding how the role would fit within their present care model and had hesitations in accepting the NP role. It is important that staff understand the rationale behind NP role implementation because it provides an initial purpose for implementation.

Additional evidence assisted in gaining insight into how participants in this case study may perceive the stimulus for NP role integration. In Ducharme and colleagues' study (2009), the purposes of integrating NPs in the ED were to improve patient flow, decrease patient wait times in the ED and to decrease the number of patients that leave without being seen. Prolonged patient wait times can affect patient satisfaction, patient suffering, and have a negative impact on patient outcomes in the ED. This can lead to an ED environment where recruitment and retention of ED staff becomes an issue and there can be a high risk for violence directed at ED staff from patients due to significant delays (Ducharme, Alder, Pelletier, Murray & Tepper, 2009). Additionally, Thrasher and Purc-Stephenson (2007) interviewed NPs, physicians, registered nurses and managers, and explored the barriers and facilitators to NP role integration in the ED. One of the questions posed to participants was why they thought the NP role was

initially introduced into their ED. What participants revealed was that, with the lack of family physicians, there had been an increase in non-urgent patients in the ED who mainly sought primary care, as opposed to care for urgent or emergent health care needs. As a result there is a proportionately higher number of patients that present with less acute problems, and this has an impact upon the departmental wait times and patient flow. Participants also revealed that non-urgent patients were waiting too long to be seen by a physician and the physician would often get pulled away in order to attend to patients that were more acutely ill. They identified that this was a gap in ED care and that the NP was an ideal candidate to fill this gap (Thrasher & Purc-Stephenson, 2007).

Ducharme and colleagues' study (2009) and Thrasher and Purc-Stephenson's research (2007) support this study's findings by emphasizing the importance of clarifying the rationale for the NP role in the ED. So what is evident is that when there is a place, in terms of patient care needs and departmental gaps, for the NP role in the ED, physicians and nurses need to understand the reasons behind the implementation in order to begin accepting the role. The literature supports the need and rationale behind NP role implementation. What is lacking, however, is literature that validates that understanding the stimulus for NP role implementation is an essential precursor to role acceptance.

<center>Role Clarity</center>

The findings of this study suggest that role clarity is influential in ED NP role acceptance. While many participants were able to identify that NPs function within their own scope of practice, nurses and physicians were unclear as to how their own roles fit with the NP role, and identified not having a clear understanding of what the NP role would entail. The significance of this is that if others do not know what the NP role entails they will have a difficult time accepting

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it. Similar to understanding the stimulus for NP role implementation, participants needed to have clarity about the new role that was being implemented. They wanted to know how the department would function with the NP as part of the team, and how all professionals in the interdisciplinary team would work together. Implementation entailed change in professional dynamics, professional responsibilities and departmental flow, and it was important that those affected by the implementation of the NP role were cognizant of the forthcoming change. It was evident from the data that there was a lack of role clarity prior to the implementation and hence physicians and nurses were hesitant to accept it.

Extensive literature exists that discusses NP role clarity as being a very important factor in new role integration and acceptance. What was emphasized was that team members need to know what to expect from one another in order to begin to accept the NP role and collaborate effectively (Cummings, Fraser, & Tarlier, 2003; Glover, Newkirk, Cole, Walker, & Nader, 2006; Griffin & Melby, 2006; Martin & Considine, 2005; Makowsky et al., 2009; MoHLTC, 2005; Tye & Ross, 2000). According to the PHC NP Integration study, it was important that team members be educated on the NP's role. "The degree and ease of acceptance of the NP appeared related to a clear understanding of the NP scope and methods of practice" (MoHLTC, 2005, p.224-225). This is particularly important in sites and settings where a new NP role was an addition to the patient care team (MoHLTC, 2005). Team members needed to have a clear understanding of the NP role as well as any particular changes to the model of care that came as a result of implementing the NP role.   The PHC NP Integration Study reported that education addressing the NP role also included community partners such as outpatient clinics, with whom the NP may collaborate with to provide patient care (MoHLTC, 2005). As one NP in the PHC NP Integration Study discussed, "it's very important to establish a rapport at the beginning, be

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very clear about what the roles and responsibilities are. That's probably where problems can

arise" (MoHLTC, 2005, pg. 226).

With the implementation of new roles, there is a chance that professional responsibilities

begin to overlap and that boundaries between professional groups (nurses, physicians and NPs)

are not well delineated. Additionally, while nurses and physicians may be aware of the NP's

scope of practice, there often exists a lack of clarity about the actual responsibilities of the role

(Baldwin et al., 1998; Cummings et al., 2003; Kaasalainen, Martin-Misener, Carter, DiCenso, &

Donald, 2010; McKenna et al., 2008). Results of these studies revealed that not all members of

the health care team had an understanding of the NP role, despite feeling positive about the

potential influence of the NP role on patient care. Participants in the aforementioned studies

discussed how boundaries were blurred between nurses, NPs, residents, and staff physicians,

resulting in an uncertainty regarding their own duties (Baldwin et al., 1998; Cummings et al.,

2003). This lack of clarity was "associated with perceptions of role overlap and subsequent lack

of receptivity to the NP role by other healthcare team members" (Kaasalainen et al., 2010, pg.

549). Having clear boundaries through protocols or detailed job descriptions provided

professionals in new roles boundaries within which they would be practicing. Because of the

development of new roles, blurring of boundaries and misunderstandings of who is responsible

for certain tasks sometimes occurs (McKenna et al, 2008). McKenna et al. (2008) stated that

role "ineffectiveness was also because of the role not being accepted generally by nursing

staff…unclear role definition and high and unrealistic expectations of the role" (p. 232).

This study's results revealed that, while an understanding existed that the NP practiced

within their CNO Scope of Practice guidelines, there was ongoing ambiguity as to whose

responsibility it was to carry out the NP's orders. Nurses reported not readily carrying out orders

for NPs because they felt it was not part of their role, despite the fact at some sites it was indeed part of the nurses' role responsibilities to take orders from the NP. This was consistent with findings from Tye and Ross (2000) who identified that nurses were unwilling to carry out treatments and orders on patients that were seen by the NP. Nurses were unclear on their responsibilities in terms of carrying out orders for the NP and felt that they should only be working for the physicians (Tye & Ross, 2000). In this case study, a NP discussed how she clarified her role to the other health professionals with whom she worked. This NP reported that it was necessary that she explain her role in order to avoid any inter or intraprofessional role conflict. What this means is that if the NP role is to be accepted, the ED staff need to be educated on the responsibilities of the NP and on how the ED team should function. It was evident that strategies to enhance role clarity, such as education of team members, were necessary to help nurses and physicians understand the NP role and thereby accept it more easily.

An interesting finding was the influence of physical location and visibility of the NP within the ED on role clarity. During her site visits, the researcher observed that the difference in professional relationships was influenced by where the NP practiced; this observation was supported by participants' responses. One site had a separate area in the ED where the NPs practiced. In this case, there were very few nurses who worked with the NPs. At this site, participants reported more challenges with professional collaboration and analysis of the findings revealed that NPs were not as well accepted as compared to other sites. At another site, the NP role was integrated into the ED without having a separate and distinct area to practice. At this site, NPs, physicians and nurses worked together and collaborated frequently. Analysis of interviews from this site revealed that the NP was well accepted and seen as an integral member of the ED team. The third site also had a separate area for the NPs to practice. However this

particular site had physicians and nurses working alongside the NP at various times in the day. Findings from this site revealed that role acceptance was not consistently reported by nurses, physicians and NPs. Some participants reported that the NP role was accepted while others did not. Interestingly, some NPs practiced only in the fast track area while others would work in the fast-track area and help also out in the other parts of the ED when the fast-track area was not busy. These findings suggest that the lack of visibility of the NP can influence the understanding of the NP role and may hinder NP role acceptance. It can be difficult at times to understand the role of the NP without seeing them within the department and seeing first-hand what they actually do. What became evident through analysis of participant interviews was how lack of contact between nurses and physicians, and NPs had a negative impact on role acceptance. There is no literature that addresses the visibility of the NP (by virtue of physical space and location) as it related to role clarity and role acceptance. Further exploration is required in order to illuminate this relationship.

What is known is that role clarity is an important influence in NP role acceptance. It is important because it gives nurses and physicians an understanding of their own responsibilities and those of the NP. Having a clear understanding of how each person's role fits within the department can help to ensure that boundaries remain clear in order to facilitate NP role acceptance. The findings from this study indicate that despite understanding that NPs practice according the CNO scope of practice, most nurses and physicians were not clear about the NP's actual clinical responsibilities and how all the roles would work together in the ED. This was not a new finding, as many studies revealed that the integration of NPs into various practice settings raised questions of role clarity. The issue of lack of role clarity is therefore not unique to the ED but still requires attention in order to help facilitate NP role acceptance. What was particularly

unique to the ED was the notion of NP visibility within the practice setting, which was not addressed by any literature. It is important to further investigate how the NP's physical location influences role clarity, and subsequently role acceptance in the ED.

<div align="center">Value-Added Components of NP Role</div>

Participants in this study revealed many benefits of having an NP in the ED. Appreciating the value-added components of the role, as opposed to perceiving the NP role as being a burden in the department, was important in overall role acceptance. Understanding value-added components included having an awareness of whether NPs were fulfilling their intended purpose and what other departmental benefits arose from having the NP role in the department. Many nurse and physician participants were able to see the value-added components of the NP role despite not having a clear understanding of the NP role, not working alongside the NP and many nurses not being willing to carry out the NP's orders. While there was no literature addressing this phenomenon, it is speculated by the researcher that despite the above mentioned factors, physicians and nurses were able to see how the NP role had an positive impact upon their own day-to-day activities. As an example, some sites had a separate fast track area where the NPs worked. The nurses did not work with NPs in the fast-track, nor did they see first-hand the work that NPs performed, yet the nurses were able to recognize that the volume of patients in their own area of the ED had decreased. Patients were also reportedly more satisfied with their ED experience because they did not have to wait as long. This example demonstrates how, despite not fully understanding the NP role and not visibly seeing the role in action, participants were still able to have an appreciation of the impact and value of the NP role.

Participants identified that implementation of the NP role had decreased wait times, helped to improve patient flow in the ED and decreased the number of patients that leave without

being seen. Review of site specific data did not provide the researcher with any specific statistics about the impact of the NP role on its intended purposes. Other researchers did, however, assess the impact of the NP and PA roles on ED patient wait times, patient flow and the number of patients that leave without being seen in six Ontario EDs (Ducharme et al., 2009). Their study revealed that the integration of both NP and PA roles had a positive impact on the ED, such that patient wait times, lengths of stays in the ED and the number of patients that left without being seen were all decreased. It was also found that, in comparing NPs and PAs in relation to ED patient lengths of stay, the patients who were seen by a NP had a shorter length of stay than those seen by a PA (Ducharme et al., 2009). This may be attributed to the fact that PAs are non-regulated health care providers and thus have to work under the supervision of a physician. According to Ducharme and colleagues (2009) delays may arise because PAs may not be able to independently order tests or medications, nor can they discharge a patient home without the ED physician's approval. While PAs were not the focus of this research, some participants in this case study did mention that there were differences in working with a NP versus a PA. Nurses mentioned that the PA had to constantly discuss patient cases with the ED physician, which took additional time, whereas the NP was able to attend to a patient, treat and discharge them without having to involve the ED physician. Nurses reported this to be a valuable aspect of the NP role because it helped to decrease wait times and improve patient flow, which is what the implementation of the NP role was meant to do and that the NP role was better accepted by nursing staff than the PA. Findings from this case study are aligned with those obtained in research conducted by Ducharme and colleagues' (2009).

Several studies have identified that understanding the value-added components of a role influences overall implementation and acceptance (Cummings et al., 2003, Griffin & Melby,

2006; Kaasalaninen et al., 2010; Marsden & Street, 2004). Awareness of the benefits that the NP role brings to the department influences role acceptance through an appreciation of the NP role's value by the NP's professional colleagues. This also has a positive influence on their overall receptivity to the NP role. Receptivity means that participants were open to the notion of having the role as part of the health care team.

Findings from this study were also consistent with Marsden & Street's (2004) study which identified that the NP helped to reduce patient wait times and provided more holistic care and detailed examinations. Some literature, however, suggested that the benefits of reduced wait times, and fewer patients leaving without being seen were not unique benefits of NP role implementation and could be a result of the NP simply being an extra pair of hands (Drummond, 2007, Marsden & Street, 2004). Marsden & Street (2004) identified that the addition of any clinician, whether a NP or a physician, would help decrease wait times because it would be an additional professional seeing and treating patients. Other authors have claimed that the NP role is unique and that it brings other valued benefits that contribute to a holistic approach to patient care, such as engaging in patient teaching and ensuring proper follow-up care, which can, in turn, reduce return patient visits to the ED (Carter & Chochinov, 2007).

Another unique feature of the NP role, when compared to others is the notion of cost-effectiveness. While no participant in this study discussed the cost of NPs as compared to physicians, review of publicly accessible documents and scholarly literature revealed that one of the benefits to the NP role is the overall cost-effectiveness in care delivery. When compared to an ED physician, NPs have been presented as a more cost-effective health human resource, especially in community EDs where there is a high volume of patients who present with low-

acuity medical problems (CNA, 2002; Carter & Chochinov, 2007; McGee & Kaplan, 2007; Office of Nursing Policy, 2006).

The findings from this study indicate that nurses and physicians were able to articulate several of the value-added components of the NP role, and the literature supports that NPs can be perceived as adding value. The NP role has been reported to decrease wait times, decrease length of stay for patients in the ED, provide more holistic care to patients, and improve patient satisfaction. While participants articulated many benefits of having the NP in the ED cost effectiveness of the role was not identified in as beneficial this study. Recognizing the value-added components of the NP role in the ED is a factor that influences role acceptance.

NP-Specific Characteristics

Participants in this study discussed how NP-specific characteristics were important in terms of the overall fit within the ED in facilitating NP role acceptance. This meant that the individual NP's knowledge and skill, personality, and professional experience must be well-suited and congruent with other physicians' and nurses' expectations in order for the role to be accepted.

According to the PHC NP Integration Study, the fit between NP knowledge, skills and experience and those required in the ED is important to establishing an environment conducive to NP role acceptance (MoHLTC, 2005). Thrasher and Purc-Stephenson (2007) and Tye and Ross (2000) also emphasized the importance of fit in reducing barriers in NP role integration in the ED. Participants in these studies revealed that the NP's clinical skills and previous experience as an ED nurse are of utmost importance in helping to accelerate the NP role integration process. Additionally, NPs who were successfully integrated into the ED were described as "team players" (Thrasher and Purc-Stephenson, 2007, p. 278) and were embraced

by physicians and nursing staff. Participants in this study also discussed how departmental fit is influenced by the personality of the NP. Similarly, role acceptance has been shown to be dependent on the person in the role (Baldwin et al., 1998) and according to participants, individuals in the NP role should posses a number of essential characteristics in order to facilitate role acceptance. These include clinical competence, nursing roots in that particular specialty and a personality that works well with other staff. In order to ensure a good fit, Steiner and colleagues (2008) suggest that the recruitment and selection process of the NP in the ED be rigorous. Most participants in this study had previously practiced as nurses in the individual ED sites. NP participants, however, did not report any rigorous interview process. Five NP participants instead transitioned from a being an ED nurse to an ED NP at the same site without a thorough rigorous process. The two NPs who had not practiced as clinical nurses in those particular ED sites (but had previously practiced at other facilities), also did not report a thorough hiring process. Ensuring good fit is important in facilitating NP role acceptance, as identified in the literature, and thus it is important that nurses are carefully selected for the NP role to establish a good fit.

Though many participants identified previous experience as a nurse as helpful in facilitating NP role acceptance, there was minimal empirical evidence that correlated clinical experience as an RN with NP competence. Rich (2005) explored the relationship between years of experience as a nurse and the clinical skills competence of NPs, specifically whether the years of experience as an RN had an impact on the NP's clinical competence. Interestingly, the researcher found that there was no correlation between years of experience and clinical competence. Rather, it was reported that more experience as a nurse was associated with less competence as a NP (Rich, 2005). While the author did not provide a rationale for this finding, it

is speculated that nurses who have extensive experience may have a difficult time in transitioning from practicing as a nurse to practicing as a NP. Several other studies indicated that previous experience as a nurse was seen as a favourable NP-characteristic; however, those studies failed to identify if a relationship exists between experience as a nurse and clinical competence as a NP (Griffin & Melby, 2006; Martin & Considine, 2005; McKenna et al., 2008; Steiner et al., 2008; Thrasher & Purc-Stephenson, 2007). Though Rich's (2005) study showed no correlation between previous experience as a nurse and clinical competence as a NP, this was not supported by this case study. So while NPs with previous experience as nurses may not be more clinically competent, the perception of nurses and physicians in this study is that this experience is helpful in facilitating role acceptance.

While the findings from this study indicate that personality of the NP, previous experience as a nurse, and knowledge and skill were important in overall NP role acceptance, there is inconsistent support regarding contributions of these characteristics to role acceptance. The concept of fit is well supported by the literature, and it is evident that the individuals in the NP roles need to be a good match in the department in order to be accepted by the nurses and physicians. However, it is unclear as to how fit is defined. It is evident that knowledge and skills of the NP are important to overall NP role acceptance, but evidence supporting the contribution of NP personality is inconclusive. Evidence suggests that previous experience as a nurse may not ensure the NP is more clinically competent, however its perception did facilitate role acceptance in this study.

<div align="center">Professional Relationships</div>

Professional relationships among NPs, nurses and physicians had an effect on role acceptance. All participants identified that relationships between NPs and nurses, NPs and

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physicians, and professional collaboration among all three groups of professionals were important influences on overall role acceptance of the NP in the ED. In particular, NPs and nurses reported some challenges in their relationship due to the role transition of the NP from staff nurse to NP. This was often stimulated by feelings of hierarchy from the perspectives of the nurses and resulted in an unwillingness to help NPs with patient care. This appeared to be related to nurses' perceptions of NP power because of the NP's elevated position in the hierarchy. Analysis of data from interviews revealed that a common source of barriers in the NP-physician relationship was in relation to power, trust, finances and the specialist referral process. Lastly, many NP participants reported difficulties in collaborating with both nurses and physicians.

From a historical viewpoint, NPs have been given the authority to practice in underserviced areas, where physicians were scarce (Hamric, Spross & Hanson, 2009). The role of the NP was implemented despite some resistance from both nursing and medicine. Tensions with medicine revolved around autonomy, control and financial competition. Nursing has had significant professional issues with the NP role as well, particularly within the context of change. The NP role has represented professional advancement, professional innovation and challenged the nursing profession's view of what it meant to be a nurse (Hamric, Spross & Hanson, 2009). While these tensions have decreased over the years due to stronger presence and global proliferation of the NP role, it would not be surprising that some of these views of NPs may still exist within the nursing and medical communities (Hamric, Spross & Hanson, 2009).

Many challenges have been reported in the professional relationship between nurses and NPs, such as those related to role boundaries and delineation of tasks which had a reported impact on NP role acceptance. While many nurse participants did not discuss this issue in detail,

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they did mention it as a professional tension. Relationships between nurses and NPs have historically been conflictual, specifically around delineation of responsibilities. Hamric, Spross and Hanson (2009) reported that conflict was more prevalent between NPs and nurses in the 1980s and 1990s when there was more confusion regarding role responsibilities. Nurses' resistance in performing certain tasks and skills, such as performing phlebotomy or obtaining vital signs, for patients under the care of NPs have been reported in previous studies. Referred to as a form of horizontal violence, authors have identified that, while it has been decreasing over the years between nurses and NPs, it is still quite prevalent with NPs transitioning into new roles (Hamric, Spross & Hanson, 2009). It is suspected that a large influence in the professional relationship between nurses and NPs is the perceived hierarchy. NPs began their professional careers as nurses before pursuing additional education to become NPs and thus have their educational and professional roots in nursing. Nurses, however, are in a position where they can have an influence on NP role effectiveness by not carrying out NP orders. If NPs must carry out their own orders, this can impede patient flow and the role can be seen as ineffective (Kelly & Mathews, 2001; Tye & Ross, 2000). If the role of the NP is seen as ineffective, the value of the role is less evident and can reduce acceptance by physicians and nurses.

In reviewing the literature related specifically to physician-NP relationships there also appears to be a well documented history of tension between physicians and NPs. In fact, the tensions encompassed advanced practice nurses as an aggregate, including nurse midwives, clinical nurse specialists, nurse anaesthetists as well as NPs. Hamric, Spross and Hanson (2009) identified that the complementary nature of advanced practice nurses was neither well understood nor appreciated by physicians and a common misconception by physicians is that nurses are trying to practice medicine without a license. While there are some controlled acts

that overlap between NP and physician practice, it is important to note that the nature of the NP role is described as complementary rather than a physician replacement (Griffin & Melby, 2006).

In this case study, physicians revealed that trust in NP's practice influenced their acceptance of the role. In particular, physicians identified that having previous experience working with a NP played a major role in their trust in the NP's practice. Physicians who had previous experience working with a NP were more accepting of the role as compared to physicians who had no previous experience. Trust in the NP was reported to influence how NP-friendly physicians were. Therefore, physician trust and comfort with the NP role were largely influenced by the physician's familiarity and previous experience with the NP role. There is no literature that explores the relationship between physician trust in the NP role and NP role acceptance and there is a need for further exploration of this relationship.

Participants in this study also identified that remuneration had the potential to influence physicians' overall NP-physician relationships and ultimately role acceptance. They also reflected that Fee-For-Service (FFS) remuneration in the ED is not conducive to NP's practice because the NP role creates a financial threat for ED physicians. The sites used for this study had physicians and NPs on a salary remuneration structure and therefore the competition for patients and money was not an issue. What NP and physician participants did identify, however, was the potential for financial threat had the physician remuneration model been FFS. The issue of physician remuneration is important in relation to NP role acceptance in the ED because the willingness to work with NPs, or lack thereof, is influenced by the financial incentive as opposed to the goal of quality patient care in the ED. Consistent with this finding, the PHC NP Integration Study revealed that the "propensity to be willing to work with a NP is substantially reduced for fee-for-service physicians" (MoHLTC, 2005, pg. 138). FFS physicians did, in fact,

express interest in working with NPs; however they were considerably less accepting of

implementing the NP role in their practice setting than physicians on other remuneration

schedules (MoHLTC, 2005). Similarly, the results of Thrasher and Purc-Stephenson's research

(2007) revealed that compensating ED physicians using a FFS model creates a barrier to NP role

implementation in the ED whereas physicians who are compensated using a salary remuneration

model are more likely to embrace the NP role, which helps to facilitate its acceptance. The

reason for this difference is that physicians on a FFS model are paid for every patient they see

and treat. Physicians identified that the patients that NPs treat in the ED are referred to as the

"bread and butter" (Thrasher & Purc-Stephenson, 2007, pg. 278) because these patients can be

seen and treated quickly and are normally a huge financial incentive for physicians. In this study

a FFS remuneration plan was seen as having a potentially negative effect on the relationship

because it perpetuates competition for billable patients and may create animosity and competitive

behavior between physicians and NPs.

In Ontario, two remuneration models exist for physicians working in ED: a FFS model

and an alternate-funding-arrangement (AFA) model (Schull & Vermullen, 2005). Traditionally,

ED physicians have been remunerated through a FFS model whereby ED physicians bill the

Ontario Health Insurance Plan (OHIP) for every patient they see and treat and for every service

that is rendered. In an AFA, "emergency physician groups contract with the MoHLTC to

provide around-the-clock physician ED coverage in return for a negotiated lump sum" (Schull &

Vermullen, 2005, p.101). This lump sum is based on the volume of patient visits in the ED and

patient acuity as defined by the CTAS. Between 1999 and 2003, about 75% of Ontario EDs

switched from a FFS model to an AFA model. This change was greatest in teaching hospitals

and small/rural hospitals and lowest for community hospitals. The reason for this variation is

that community hospital ED physicians tend to earn more on a FFS model than ED physicians in small, rural or teaching hospitals. This is mostly attributed to the fact that many community hospitals have a high volume of lower-acuity patients where the ED physicians have the highest earnings. Presently, the AFA is the dominant remuneration model for ED physicians in Ontario but community hospitals have adopted it the least (Schull & Vermullen, 2005). Coincidentally, the hospitals used for this site were small hospitals that were situated in small communities.

Whereas many NP participants identified that for the most part, specialists were not accepting of the NP role, a few NPs explained the reason for the specialists' resistance to receive referrals from NPs. They indicated that specialists do not like receiving referrals directly from NPs even though patient referrals are within their scope of practice. This was because specialists receive less remuneration if the referral is signed by a NP rather than if it is signed or co-signed by an ED physician. Review of documents confirmed that specialists received less remuneration when receiving a referral from a NP versus a physician. According to the MoHLTC (2010) specialists claim a consultation fee and an assessment fee when receiving a referral from a physician. When receiving a referral from a NP, specialists can only claim an assessment fee, which amounts to 24-39% lower remuneration (NPAO, 2008b). According to the PHC NP Integration Study, over 90% of NPs surveyed reported referring their patients to specialists. Of those NPs who do refer, 88% reported that they write the consult note to the specialist and the physician who is working with them signs the consult note (MoHLTC, 2005). In fact, the typical referral process to a specialist (i.e., undergoing an additional step and having the referral co-signed by a physician) was ranked by the NPs as the top barrier to practice, (MoHLTC, 2005). While this does not indicate that specialists have reservations in acceptance of individual NPs per se, it does demonstrate that the disparity in remuneration to specialists is a hindrance in their

willingness to work with NPs and their overall acceptance of the role. The Report of the Nurse

Practitioner Integration Task Team (2007) suggested that the Minister of Health "amend the

Schedule of Benefits for Physician Services to recognize the NP as a direct referral source for

which specialists can claim a consultation fee from the Ministry" (pg. 4). This report also

revealed that the Ontario Medical Association does not support the notion of NPs referring

directly to specialists, despite the PHC NP integration study demonstrating that physicians

signing referrals to specialists was unnecessary, as reported by physicians and NPs.

Lastly the collaborative relationships among nurses, physicians and NPs were determined

to be an influencing factor. One of the contentious issues that participants identified was that

physical location of the NP when practicing may hinder collaborative relationships. As

previously mentioned, all three sites had differing layouts of the ED and NPs worked in different

places. While one site had a separate and distinct area of the ED where NPs worked, another site

had the NP physically integrated in the ED. Participants at sites where NPs worked in a separate

fast-track area of the ED reported that their physical location hindered effective collaboration

and acceptance by their colleagues. Physical location could influence role clarity and

collaboration among NPs, nurses and physicians. If the NP role is to be accepted by members of

the team there needs to be a good working relationship amongst team members. For that

relationship to flourish, members of the team need to work together and constantly and

consistently interact in order to foster the relationship. The relationship between physical

location and collaboration has not been examined in previous research but its nature and its

contribution to NP role acceptance should be further explored.

What has been revealed is that relationships among ED nurses, ED physicians, specialists

and NPs influence overall NP role acceptance. Analysis of the results and review of the

literature reveal that there is opportunity for the professional relationships to be improved, which

can impact how well the NP role will be accepted in the ED. Literature supports that

remuneration for both ED physicians and specialists can influence how willing a physician or

specialist is to work collaboratively with a NP. In situations where the physician or specialist

receives little or no remuneration, they may be less willing to engage in a professional

relationship with a NP and role acceptance is reduced. Literature also supported the notion that

tensions exist between nurses and NPs due to the intraprofessional hierarchy. What was lacking,

however, was literature to support how physical space influences collaboration and ultimately

role acceptance of the NP. It is speculated that the issue of physical space is unique to the ED.

Since EDs are often set up in a fashion that separates patients based on their acuity, there is a

potential that NPs remain physically separated due to the patient population to which they attend.

There is still, however, a need to explore this dimension in further detail.

Limitations

All research studies have limitations and a finite scope. While some limitations were

imposed by time and budget constraints, others involved limitations inherent in the case study

methodology, and participants' social desirability.

This case study was conducted using a small number of participants from three different

EDs in Ontario. This was a convenience sample of staff working during the day of the

interviews as facilitated by site administrators. Because the interviews were conducted in-

person, the researcher spent one to two days performing site visits and data collection. Data

collection visits were based predominantly on the availability and schedule of the NP at each

site. There may have been more staff that did not have the opportunity to participate because

they were not working on the day of data collection. Additionally, volunteer bias may have

affected the results because those who feel very strongly about the subject are more likely to volunteer to be part of the research. That being said, other potential participants who do not carry strong feelings about the topic of NP role acceptance may have been able to provide the researcher with valuable data. It is recommended that future studies provide opportunities for all staff to participate, and not limit participation to the staff working on that particular day.

A potential limitation inherent in case study methodology is the notion of transferability. Flyvbjerg (2006) suggests that a common criticism and misunderstanding of case study methodology is its lack of transferability which would mean that the findings of such studies do not add significantly to scientific knowledge. This stems from the notion that data collected from case studies are often too context-specific that they cannot be generalized to other similar cases. The counter argument to this is that context-dependant knowledge is much more valuable when exploring human phenomena (Flyvbjerg, 2006). The findings of this study were not meant to be transferable to all EDs, but to provide a rich exploration of the phenomenon of NP role acceptance. Additionally, all three sites were community hospital EDs and findings may differ if the study were to be conducted using urban and rural EDs. Thus, the findings are applicable to community hospital EDs only.

The final limitation for this study relates to social desirability, whereby participants may respond to interview questions in a fashion that they perceive to be more favourable or acceptable despite their actual perceptions and feelings on the subject matter. Social desirability may have provided the researcher with inaccurate reflections on the concept of role acceptance (Polit, Beck & Hungler, 2001). While the researcher informed the participants that their interviews were to remain confidential and that only the researcher would have access to the raw data, there was a potential that participants provided the researcher with responses that may have

painted them in a more favourable light. In order to counter this limitation, the researcher

ensured convergence of data from interviews with data obtained from the researcher's field notes

and with results of previously published studies. While any differences between what

participants reported and what was observed by the researcher were noted, it was still important

to ensure that there was consistency in the findings. Another tactic that mitigated social

desirability was the fact that participants did not have any contact with the researcher until the

day of the interview. Other than NP participants, the researcher had no knowledge of who the

nurse and physician participants would be and therefore there was no opportunity for the

participants to interact with the researcher prior to or after the interviews. This lessened

participants' desire to respond in such a way that would please the researcher.

CHAPTER SIX: IMPLICATIONS AND CONCLUSION

In this chapter the major findings are reviewed and implications are explored. Future

steps for policy, practice, education and research are presented.

Implications

The findings of this study suggest there are several factors that need to be addressed prior

to the implementation of a NP role in the ED and several factors that should be considered after

the implementation of a NP role in order to stimulate and sustain role acceptance. Factors that

must be addressed prior to the implementation of the NP role in the ED include: identifying and

articulating the impetus for the NP role to all ED staff, establishing NP role clarity, ensuring the

physical space fosters collaboration, ensuring physician remuneration is NP-friendly, and

ensuring that key stakeholders are informed of the value the NP can add in the ED. Several

issues need to be addressed in order for NP role acceptance to be sustained in the ED. These

include: ensuring ongoing professional staff education about the NP role, demonstrating the

value-added components of the NP role, and fostering collaborative practice among professional

staff and the NP. All of these pre- and post- implementation factors can be enabled and

supported through several system improvements. All these findings provide the impetus for

policy, practice, education and research recommendations.

Policy

It is evident that the NP role fulfills its intended purpose of decreasing ED patient wait

times and improving patient flow in the ED. It is recommended that NP salary be added to

hospital global (base) funding as opposed to being funded through pilot projects or other one-

time funding. Adding the NP salary to global hospital funding budgets from the MoHLTC

would ensure the continuity of the role in hospital EDs while concurrently ensuring job stability

for the individual NPs.

By securing funding for NPs in the ED, the MoHLTC will clearly signal the value it places on the role. This could increase NP role acceptance by physicians and nurses, not only in EDs where the NP role has already been implemented, but also in EDs where the role is about to be introduced. A decision by the MoHLTC to sustain the NP role in the ED over the long term would be supported by the evidence-based benefits of the NP role and this action could be expected to improve role acceptance. Hospitals would also benefit by avoiding the burden of reapplying for MoHLTC funding, and needing to justify the benefits of the role. Despite no definitive guarantee of usage towards funding NP positions in the ED, global funding can ensure continuity and allow hospitals to better plan and optimize their resources.

The individual NP benefits greatly as their employment will no longer be deemed to be temporary. Rolling NP salaries into the hospital base funding will provide NPs with job security and a sense of being a permanent part of the ED team. A NP working on a short-term contract, with no guarantee of job security, could be less committed to and engaged in their role as the end of the contract comes near. The role's effectiveness could possibly be affected if the NP is less engaged, and therefore may not have the same positive impact on patient wait times and departmental flow.

Furthermore it is recommended that the Ministry of Health take action to amend the Schedule of Benefits for Physician Services in order to recognize the NP as a direct referral to specialists. If specialists are able to claim a consultation fee for referrals from NPs then there would be no financial disparity for specialists in receiving a referral from an NP versus a physician. This could help to foster collaborative relationships between NPs and specialists and help to facilitate NP role acceptance. Recruiting support from the Ontario Medical Association could strengthen this action to amend the Schedule of Benefits for Physicians services and would

require a change in the perception that physicians are the only gatekeepers for patient access to health care. Amendment to the Schedule of Benefits for Physician Services may facilitate role acceptance by specialists that consult for the ED by giving them the proper remuneration which would give them the opportunity to work directly with the NP. In addition, this could help improve NP-physician relationships, as the NP would no longer have to request a co-signature from an ED physician to co-sign a referral. This will not only save time, but will allow the NP to be more autonomous and practice to their full scope of practice.

Practice

There are several implications for the practice setting that can facilitate NP role acceptance in the ED. First of all, it is imperative that staff understand the rationale behind implementation of the NP role and be provided with education around the scope and purpose of the role prior to the role being implemented. Physicians and nurses need to understand the reasons why the NP role is being implemented (i.e., long ED wait times, ED overcrowding of non-urgent patients, etc.) and they need to be clear about the role boundaries in order to understand how their own role is to work with the NP. It is also recommended that hospitals that are piloting a new NP role in their ED relay to staff the success stories from other ED sites in Ontario in order to give staff an example of how the NP role can impact their department. This can demonstrate to staff that, while there may be a change in their ED environment and work flow, the NP role has been shown to be effective in helping solve ongoing issues with wait times and ED patient flow. This education session should be conducted by the ED's administrative team after funding has been approved, and when a date for implementation has been set. The administrative team, as the decision makers to bring the NP role to the ED, would be best suited to explain the stimulus for the role and make the announcement to the department. The session

should take place prior to the start of the NP in order to give staff ample time to appreciate the forthcoming change and address concerns they may have.

An important second recommendation is that staff (including physicians) receives orientation to the NP role prior to it being integrated in the ED, but preferably after the NP has been hired. While some staff may be familiar with the NP scope of practice through previous experiences, it is important that all staff be informed on how the role will function within their ED site. Staff needs to be aware of how patient flow in the ED will take place, where the NP will practice, who is responsible for helping the NP carrying out orders (if anyone) and what the roles and responsibilities are of each team member, including those of the NP. It is recommended that a resource manual with all team members' role and responsibilities be available within the department in order to ensure that staff has a resource to access if there are any questions regarding roles and responsibilities and scopes of practice. Multiple orientation sessions are recommended to reach all ED staff. Orientation sessions should include the NP as well, which will give staff an opportunity to ask any questions and raise any concerns prior to the NP role being integrated. This will also give staff a chance to have input into the new processes of the ED and reduce the chance of any misunderstandings. Furthermore, it is recommended that newly hired staff (post-implementation of the NP role) receive the same orientation to the NP role. This is important because newly hired staff may not be familiar with the NP role in the ED and they require proper orientation to the NP role to help them understand the role clearly which will positively impact on their acceptance of the role.

Thirdly, it is recommended that the NP practice in an area of the ED where they are visible to staff. It is understood that NPs attend to patients who are triaged as less-urgent or non-urgent and these patients are often seen and treated in a 'fast-track' area of the ED. If possible,

the fast-track area should be physically integrated within the rest of the department so that the NP is visible to other staff where they can see the NP practice and be able to appreciate first-hand the work they perform. Having the visual presence of the NP can help staff see that the NP is helping to improve flow and decrease wait times, and thus help staff in accepting the NP role.

Fourthly, it is important that when ED teams are considering implementing the NP role in the ED, they take into account how physicians are remunerated. The findings of this study lend support to previously published literature that suggests that EDs where physicians are paid through a FFS model are not ideal settings to introduce the NP role (Drummond & Bingley, 2003; Schull & Vermullen, 2005). As such, ED sites should only consider implementing a NP role if physicians are reimbursed on an AFA plan. This would alleviate any physician concern that the implementation of a NP could potentially negatively affect physician remuneration. If physicians feel a financial threat from NPs then they will likely have a challenging time embracing and accepting the NP role in the ED. In order to mollify this potential issue, both ED physicians and NPs should be remunerated on a salary basis as was the case in all three sites included in this study.

The study findings showed that familiarity with the NP role has an influence on overall NP role acceptance. It is important that nurses and physicians have an understanding of the value-added components of the NP role. All participants identified that staff and physicians need to see a benefit for their practice and the department when implementing a NP role in order for them to be able to accept it. The Report of the Nurse Practitioner Integration Task Team (2007) revealed that there is a need for the development of mechanisms to track information regarding the NP's individual contributions to patient care in order to demonstrate the benefit in having the NP role. Information that reflects the NP's contribution to the ED, including reports on site-

specific patient wait times, letters from patients and family, or statistics on ED lengths of stays should be shared with all ED staff. This information can be presented in staff lounges or distributed in ED newsletters or via electronic mail and discussed in regularly scheduled staff meetings.

Education

Several implications for education are presented to facilitate NP role acceptance in the ED. It is recommended that intra and interprofessional education be employed in order to help facilitate understanding of scope and boundaries within and between professionals and lay the foundation for role acceptance of the NP. Interprofessional education can "begin the process of mutual understanding and respect between professionals that can continue throughout their practice careers" (Aquilno et al., 1999, pg. 227). Intraprofessional education can take many forms. One recommendation is that schools of nursing that have both baccalaureate and NP programs create opportunities for NP students and nursing students to have classes together. By attending certain classes together NP students and nursing students will learn each other's scopes of practice, begin to establish role clarity and build the foundation for NP role acceptance. Because of the increase in the number of NPs in Ontario, nursing students will potentially have their practica at sites where NPs are employed. For schools of nursing that do not have an NP program, discussion of the NP role could be integrated into the undergraduate and graduate curriculum. Baccalaureate nursing students should be educated regarding all members of the intra and interprofessional team but there should be an emphasis on elucidating the NP role since the role is relatively new as compared to other professions, such as medicine. Lastly, in universities that offer both NP and medical education, an interprofessional education opportunity for NP and medical students could be offered. While not all universities that have NP programs

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also have a school of medicine, information about health professional roles could be included in the both curricula.

Research

This study represents the first of its kind in Canada to explore NP role acceptance in depth. Whereas its results add to a growing body of knowledge of NPs in the ED, future research should aim at exploring role acceptance of NPs in the ED, incorporating the views of other health care professionals that work with NPs in the ED. It is important to take into account the views of other individuals (e.g., administrators, support staff and other health disciplines such as social workers and respiratory therapists) that work within the ED team, not just those who work most closely with the NP. This is important in order to better understand role acceptance through the eyes of all members of the ED team.

It would be worthwhile to explore the similarities and differences in role acceptance in urban, community and rural ED NPs and in departments that use different physician remuneration models. It is recommended that this study be replicated with a larger sample size and include as many, if not all, Ontario EDs that employ NPs in order to confirm or refute the findings of this study and generate general jurisdictional recommendations to facilitate NP role acceptance in the ED.

Additionally, it is recommended that future research be conducted using other methodologies. As an example, an intervention study could be conducted whereby the ED setting is prepared in accordance to the recommendations set out in the 'practice' section of this chapter, and NP role acceptance is evaluated. It may be also of benefit to develop a questionnaire that participants can complete to and then anonymously mail back to the researcher to supplement the data collected during the interviews. This mixed method approach may

minimize the risk that participants alter their responses in order to provide those that are socially desirable.

Conclusion

What has been revealed through this inquiry is that acceptance of the NP role in the ED is a complex and contextual phenomenon. The purpose of the study was to explore NP role acceptance in EDs from the perspectives of NPs, nurses and physicians working together in Ontario EDs. To date, there have been no studies exploring NP role acceptance in a Canadian ED and none that addressed the views of nurses, physicians and NPs. This is the first study of its kind to be conducted in Canada and it contributes to a growing body of research on NPs and on role acceptance.

Many of the findings of this study have been substantiated by the literature including the influences that affect NP role acceptance in the ED. Not all findings, however, have been substantiated. For example, there is no literature on the issue of physical locations' effect on role clarity and subsequent role acceptance.

It is clear that ED team members need to have an understanding of the purpose of the NP role and why the role is being introduced into the ED in order to be able to accept it. In addition, it is important that nurses and physicians have an appreciation for the value that the NP role adds; including decreasing wait times, improving patient flow in the ED, and providing care with which patients are satisfied. Additionally, there is a clear need for ED nurses and physicians to have an understanding of the NP role in the ED and how the role will influence their daily ED practice. Furthermore, there needs to be a fit between the individual NP and the ED in which they are deployed. Lastly, the relationships between nurses, physicians and NPs are an important

influence in the overall acceptance since these are the individuals with whom the NPs practices on a daily basis.

NP role acceptance in the ED has been shown to influence role integration. In order for the NP role to fulfill its intended purpose, there needs to be acceptance by the staff with whom the NP works. This is because role acceptance has an effect on daily practice of all ED health professionals and without role acceptance the intended purposes for the NP role may not be fulfilled.

In conclusion, this study of NP role acceptance at three ED sites has revealed that physicians and nurses can accept the NP role over time. By understanding the factors that influence NP role acceptance it has become evident that organizations can influence the acceptance of the NP role in the ED by physicians and nurses. In addition, several recommendations have been proposed to improve NP role acceptance, allowing NPs to function more effectively to their full capacity with the support from ED team members. These findings can be used to better understand NP role acceptance in the ED, and enhance NP role acceptance when more NPs are being implemented in the ED setting.

Appendix A

Interview Guide - NPs

1. Tell me about your role in the ED (What is your role?)
    a. *how long have you been working as an NP*
    b. *Do you have any previous ED experience as an RN*
    c. *How many patients do you see each day?*
    d. *What types of patients do you see?*
    e. *How are you paid? (wage, salary?)*
2. How did you obtain this position/role?
3. What is your understanding about why this role was introduced in the ED?
4. Are there written "protocols" for your role? (Long, McCann, McKnight & Bradley, 2004)
5. Who decides what patients you see and when? (Long, McCann, McKnight & Bradley, 2004\
6. Are there any barriers that you face in your role that affect your day-to-day practice? (Sullivan, Dachelet, Sultz, Henry, Carrol, 1978)
    a. Legal restrictions
    b. Resistance from other health care providers
    c. Resistance from patients
    d. Too few patients
    e. Too many patients
    f. Limitations of space
7. Tell me about your relationships with the nurses in the ED?
8. Tell me about your relationships with the physicians in the ED?
9. Tell me about your relationship with patients in the ED?
10. Do you feel respected by your colleagues? (Copnell et al., 2004)
11. How well do you think your colleagues in the ED understand your role? (Long, McCann, McKnight & Bradley, 2004)
12. Do you think your colleagues are accepting of your role? (Long, McCann, McKnight & Bradley, 2004)
13. What have been some of the highs of your role thus far? (What has gone well?)
14. What have been the lows of your role thus far? (What has been challenging, discouraging)

Appendix B

Interview Guide - Nurses

1. What do you understand the NPs role to be?
   a. *Responsibilities*
   b. *Function*
   c. *activities*
2. What is your understanding of the reasons/rationale for introducing the NP role in this ED?
   a. *Purposes for implementation*
   b. *Reasons behind this implementation*
3. How did you feel and what did you think about this role when it was being introduced into your ED?
4. What input did you or your nursing colleagues have into the implementation of the NP role in the ED?
5. What are the benefits of working with an NP in the ED?
   a. *Who has the NP helped?*
6. What are some challenges of working with an NP?
   a. *Who has the NP hindered?*
7. Do you think that the NP role in the ED is appropriate and effective?
   a. *In providing care to patients in the ED?*

Demographic questions
   1. How long have you been working in the ED?
   2. How long have you worked with an NP in the ED?
      a. Is this the first time you've worked with an NP? [if No, then]
   3. What other experiences have you had working with NPs?

Appendix C

Interview Guide - Physicians

1. What do you understand the NPs role to be?
   a. *Responsibilities*
   b. *Function*
   c. *activities*
2. What is your understanding of the reasons/rationale for introducing the NP role in this ED?
   a. *Purposes for implementation*
   b. *Reasons behind this implementation*
3. How did you feel and what did you think about this role when it was being introduced into your ED?
4. What input did you or your physician colleagues have into the implementation of the NP role in the ED?
5. What are the benefits of working with an NP in the ED?
   a. *Who has the NP helped?*
6. What are some challenges of working with an NP?
   a. *Who has the NP hindered?*
7. Do you think that the NP role in the ED is appropriate and effective?
   a. *In providing care to patients in the ED?*

Demographic questions
   1. How long have you been working in the ED?
   2. How long have you worked with an NP in the ED?
      b. Is this the first time you've worked with an NP? [if No, then]
      c. What other experiences have you had working with NPs?

Appendix D

THE NURSE PRACTITIONER ROLE IN THE EMERGENCY DEPARTMENT
Recruitment Email

Seeking Emergency Department NP Volunteers to Participate in a Research Study

I am currently conducting a pilot study for my Master's thesis entitled "Nurse Practitioner Role Acceptance in the ED: A Case Study".

This study aims to examine the acceptability of the NP role in Ontario EDs, as perceived by NPs, nurses and physicians.

A short one-on-one interview (30-60 minutes) will be conducted with each participant (NPs, nurses and physicians). You will be asked questions related to the NP role and its acceptance by your fellow ED colleagues (nurses and physicians).

Your choice to participate or not will be kept completely confidential. Participation is entirely voluntary and will have no impact on your current or future relations with Ryerson University.

Lastly, if you know of any other nurses, physicians or NPs, who you think may be interested in the study, please feel free to forward this email to them.

I would like to assure you that this study has received ethical approval by Ryerson's Ethics Review Board.

If you are interested in learning more about this study and how you might participate please contact Alexandra Jurczak, RN, BScN, MN(c) at ajurczak@ryerson.ca

Appendix E

RYERSON UNIVERSITY
RESEARCH ETHICS BOARD

To: Alexandra Jurczak
        Nursing

Re: REB 2009-148: Nurse practitioner role acceptance in the emergency department: A case study
Date: July 21, 2009

Dear Alexandra Jurczak,

The review of your protocol REB File REB 2009-148 is now complete. The project has been approved for a one year period. Please note that before proceeding with your project, compliance with other required University approvals/certifications, institutional requirements, or governmental authorizations may be required.

This approval may be extended after one year upon request. Please be advised that if the project is not renewed, approval will expire and no more research involving humans may take place. If this is a funded project, access to research funds may also be affected.

Please note that REB approval policies require that you adhere strictly to the protocol as last reviewed by the REB and that any modifications must be approved by the Board before they can be implemented. Adverse or unexpected events must be reported to the REB as soon as possible with an indication from the Principal Investigator as to how, in the view of the Principal Investigator, these events affect the continuation of the protocol.

Finally, if research subjects are in the care of a health facility, at a school, or other institution or community organization, it is the responsibility of the Principal Investigator to ensure that the ethical guidelines and approvals of those facilities or institutions are obtained and filed with the REB prior to the initiation of any research.

Please quote your REB file number (REB 2009-148) on future correspondence.
Congratulations and best of luck in conducting your research.

Nancy Walton, Ph.D.
Chair, Research Ethics Board

Appendix F

Ryerson University
Consent Agreement

<u>**Nurse practitioner role acceptance in the emergency department: A case study**</u>
You are being asked to participate in a research study for a Master's of Nursing thesis. Before you give your consent to be a volunteer, it is important that you read the following information and ask as many questions as necessary to be sure you understand what you will be asked to do.

<u>**Investigator:**</u>
Alexandra A. Jurczak, RN, BScN, MN (candidate)

<u>**Thesis Committee**</u>:
Dr. Mary McAllister, RN, PhD (thesis supervisor)
Dr. Souraya Sidani, RN, PhD
Dr. Nancy Walton, RN, PhD

<u>**Purpose of the Study**</u>:
The purpose of the study is to explore acceptance of the nurse practitioner (NP) role by nursing and medical colleagues in Ontario emergency departments.

<u>**Description of the Study**</u>:
In order to fully understand the acceptance of this relatively new role in Ontario EDs, the researcher will explore the perspective of the NP and those who work intimately with them, such as physicians and nurses who work closely with them. You will be asked to provide your personal insights and opinions. Your comments and opinions will not be depicted as representative of your hospital or your profession.

Approximately nine (9) participants will be asked to participate in this study (3 nurse practitioners, 3 physicians and 3 nurses):
If you are an **NP**, you must have been working in your present ED in an NP role for at least **one (1) year.**
If you are a **physician,** you must have been working with an NP in the ED for at least **six (6) months.**
If you are a **nurse,** you must have been working with an NP in the ED for at least **six (6) months.**

If you consent to be part of this study, you will be asked to participate in a face-to-face interview with the researcher. This interview will last 30-60 minutes and will take place at a time and location that is mutually convenient for you and the researcher. The interview will be audio-taped using a digital recorder so that it can be transcribed verbatim later.
You will be asked questions about the NP role in your ED. Your perspective is important in gaining an understanding how different health care professionals see the NP role fitting within the department.

Study Location
Interviews will take place at a time and location that is mutually convenient for you and the researcher. This can be in a private meeting room at Ryerson University or at your hospital.

Risks or Discomforts:
One of the risks associated with participation is the potential of being identified. To reduce this risk, the researcher will use codes to identify study participants (e.g., NP1, physician1, nurse1. If you are NP and you are the only NP in your hospital's ED, there is a chance that your colleagues may be aware of your participation. The researcher will remove all identifiable information from the final report to protect your privacy. The researcher will not use any identifying information in any direct quotes. Any of your direct quotes will be sent to you to verify accuracy.

You will be asked to answer questions about the NP role in your ED. There is a chance that some of the questions may make you feel uncomfortable. If you do not want to answer a question, you may tell the researcher to skip to the next question. If you wish to stop the interview at any time and/or withdraw from the study, you are free to do so. There will be no consequences for skipping questions, stopping the interview, or withdrawing from the study. Your participation, partial-participation or withdrawal from the study will not affect your relationship with the researcher, the university, or your hospital.

Benefits of the Study:
There is no direct benefit to being a participant in this study. The only potential benefit is the opportunity to share your opinions and insight about the acceptance of the NP role in your ED.

Confidentiality:
All data from the interviews will be coded to ensure confidentiality. Only the researcher will have access to the original consent forms and interview audio-tapes. The researcher will transcribe all of the audio-tapes and destroy them once they are transcribed. Only members of the thesis committee will be see the un-coded transcripts, however, your name, hospital, and any other identifiable characteristics will be removed to maintain confidentiality. Additionally, your name, hospital, and any other identifiable characteristics will be removed to maintain confidentiality in any publications. Transcripts and coding lists will be password protected and will be kept in a locked cabinet, separate from the consents which will also be locked in the researcher's locked office at Ryerson University. All documents will be kept for five (5) years and will then be destroyed.

Incentives to Participate:
No incentive is offered and participants will not be paid to participate in this study. Participation is completely voluntary.

Costs and/or Compensation for Participation:
There are no costs associated with participation. Additionally, you will not be expected to take time off from work to participate in this study.

<u>Voluntary Nature of Participation:</u>
Participation in this study is voluntary. The choice you make about whether or not to participate will not influence your future relations with Ryerson University or the hospital(s)/institution(s) for which you work. If you decide to participate, you are free to withdraw your consent and to stop your participation at any time without penalty or loss of benefits to which you are entitled. At any particular point in the study, you may refuse to answer any particular question or stop participation altogether.

<u>Questions about the Study</u>: If you have any questions about the research now, please ask. If you have questions later about the research, you may contact.

<div align="center">

Alexandra Jurczak (researcher/MN student)
ajurczak@ryerson.ca
905-598-2206

Or

Dr. Mary McAllister (Thesis Supervisor)
mmcallis@ryerson.ca

</div>

If you have questions regarding your rights as a human subject and participant in this study, you may contact the Ryerson University Research Ethics Board for information.
<div align="center">
Research Ethics Board
c/o Office of the Vice President, Research and Innovation
Ryerson University
350 Victoria Street
Toronto, ON M5B 2K3
416-979-5042
</div>

<u>Agreement</u>:
Your signature below indicates that you have read the information in this agreement and have had a chance to ask any questions you have about the study. Your signature also indicates that you agree to be in the study and have been told that you can change your mind and withdraw your consent to participate at any time. You have been given a copy of this agreement.

You have been told that by signing this consent agreement that you agree to have the interviews recorded through the use of audio-tape.

You have been told that by signing this consent agreement you are not giving up any of your legal rights.

_____
Name of Participant (please print)

_____   _____
Signature of Participant   Date

_____   _____
Signature of Researcher   Date

Appendix G

THE NURSE PRACTITIONER ROLE IN THE EMERGENCY DEPARTMENT
Recruitment Email

Seeking Emergency Department Nurses and Physicians to Participate in a Research Study

I am currently conducting a pilot study for my Master's thesis entitled "Nurse Practitioner Role Acceptance in the ED: A Case Study".

This study aims to examine the acceptance of the NP role in Ontario EDs, as perceived by NPs, nurses and physicians.

A short one-on-one interview (30-60 minutes) will be conducted with each participant (NPs, nurses and physicians). You will be asked questions related to your role in the ED and the acceptance of the NP role by nurses and physicians.

Your choice to participate or not will be kept completely confidential. Participation is entirely voluntary and will have no impact on your current or future relations with Ryerson University.

Lastly, if you know of any other NPs, or any nurses/physicians, who you think may be interested in the study, please feel free to forward this email to them.

I would like to assure you that this study has received ethical approval by Ryerson's Ethics Review Board and your institutional ethics review board.

If you are interested in learning more about this study and how you might participate please contact Alexandra Jurczak, RN, BScN, MN(c) at ajurczak@ryerson.ca

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      Publications Inc.

LIST OF ABBREVIATIONS

Acronym	Phrase
AFA	Alternate Funding Arrangement
CNA	Canadian Nurses Association
CIHI	The Canadian Institute for Health Information
CNO	College of Nurses of Ontario
CTAS	Canadian Triage and Acuity Scale
ED	Emergency Department
ER	Emergency Room
FFS	Fee-for-service
HFO	Health Force Ontario
HPRAC	Health Professions Regulatory Advisory Council
MoHLTC	The Ministry of Health and Long-Term Care
NP	Nurse Practitioner
NPAO	Nurse Practitioner Association of Ontario
PA	Physician Assistant
PHC	Primary Health Care
REB	Research Ethics Board
RN	Registered Nurse
RPN	Registered Practical Nurse