Nurse practitioners in the emergency department

To the editor: The recent article entitled "Introducing a nurse practitioner into an urban Canadian emergency department" by Steiner and colleagues[1] compares the care provided by a nurse practitioner (NP) with that of an emergency physician working in an urban emergency department (ED). Steiner and coworkers provide timely insight regarding the potential role of a nurse practitioner in emergency care in Canada. However, the impact of developing an NP evaluation framework that is inconsistent with the existing nursing model for implementing the role of the NP in the Canadian health care system requires further clarification.

In Alberta, schedule 24 of the Health Professions Act (2005)[2] identifies the College and Association of Registered Nurses of Alberta (CARNA) as the sole professional body responsible for licensing and regulating professional nursing practice. In the CARNA (2005) document "Nurse practitioner competencies," the core competencies for NP entry to practice are identified.[3] Additionally, the role of the NP is defined as a provider and manager of health care services that is grounded in professional nursing values, knowledge, theories and practice. CARNA also defines the scope of practice for NPs as both autonomous and collaborative and indicates that NPs should not be considered role replacements for any other health care providers.[3]

The framework for graduate NP education in Alberta is built on the Health Professions Act (2000),[2] CARNA's core competencies for NP practice,[3] and Brenner's model of novice to expert[4] master's education programs in Alberta support the assumption that graduate NPs are prepared as novice and progress to expert through continued exposure to the clinical practice environment. CARNA's continuing competency program for NPs also indicates the necessity for NPs to progress from novice to expert and requires that NPs evaluate and develop interventions to expand their professional practice annually. Additionally, validation of the NP's involvement in continuing education is required by CARNA.

The approach by Steiner and coworkers of developing, implementing and evaluating the role of the NP in the ED is in stark contrast with existing nursing theories and is inconsistent with CARNA's mandate for implementing the role of the nurse practitioners. The Steiner and colleagues' program development methodology compares the clinical competencies of an NP with those of an emergency physician. Moreover, this methodology prevents the NP from collaborating with the health care team during the evaluation period and evaluates NP competencies before the completion of a 6-month apprenticeship program. Thus the impact of a clinical orientation that allows the NP to progress from novice to expert is not assessed.

The recommendations identified in the preceding paragraphs are essential for evaluating the impact of the NP's role in individual, family and community health and wellness. Stakeholders are encouraged to review the work of Bryant-Lukosius and DiCenso[5] and the Canadian Nurse Practitioner Initiative (2006),[6] which provides further insight into the connection between nursing legislation, graduate nursing education and clinical practice. Furthermore, stakeholders who are considering implementing the role of the NP in the ED should critically evaluate Steiner and colleagues' recommendations for developing and implementing the role of the NP in the ED.

Persistent challenges to the NP scope of practice in the United States have recently resulted in the development of a Doctor of Nursing program that prepares NPs for entry to practice as specialists. By 2015, NPs in the United States will require a Doctor of Nursing for entry to practice. Nursing leaders in the United States anticipate that specialized NP programs will address obstacles preventing the full integration of NPs within the health care system and will improve individual, family and community access to care. If barriers to the NP scope of practice continue to exist in Canada, nursing scholars might want to consider a similar approach to NP education.

Lloyd Tapper, RN, BScN, MN, NP

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[The authors respond]

We thank Mr. Tapper for acknowledging the timeliness of this work for

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Canada. The article[1] is specific to nurse practitioner (NP) "expanded"[2] emergency clinical care roles in the setting of an urban Canadian emergency department (ED) and we refrain from discussing NPs in other clinical settings or countries.

We agree with colleagues,[2–4] as indicated in our methods section,[1] that adding any new type of health providers must be on a "value added," goal-related strategy basis and should not be used to replace current care providers.

From the start, similar to others,[3] we faced challenges arising from systemic problems. The grant for a new advanced practice nursing (APN) role was provided because of a perceived specific need and lacked the recommended analysis of health system's requirements.[2,3] Evidence about the quality of emergency clinical care provided by NPs potentially working in "expanded," autonomous roles was also lacking. Furthermore, validated educational benchmarks for this type of urban emergency practice in Canada did not exist.[1]

Mr. Tapper seems to suggest that our process of developing a starting scope of an NP "expanded" clinical practice is not valid because it is in contrast with existing nursing education and is inconsistent with the College and Association of Registered Nurses of Alberta (CARNA) mandate. He states that the selected NP was prevented from collaborating with the health care team during the evaluation period and the progress of NP from novice to expert was not assessed. We disagree.

In the points below, we provide our comments for clarification:

- The essential goal of all ED health care providers is to deliver the best patient care.
- Mr. Tapper seems to suggest that we are in breach of nursing educational approach and CARNA's right to self-regulate. The references he quotes, however, do not pertain to an "expanded" clinical role in emergency care by NPs in Canada. Nationally accepted educational guidelines or regulations specific to the specialty of emergency care for NPs do not exist.[5] Therefore, the development of a scope of practice for the purpose of diagnosing, investigating and treating undifferentiated patients in the ED becomes a collaborative effort between physicians, nurses and the ED administration, reaching beyond the exclusive domain of nursing. This is not a "turf" issue; rather, it is a "best patient care" issue.
- Published standards or tools to help create an NP "expanded" emergency clinical practice do not exist. We used the Canadian emergency physician (EP) as the current (imperfect) standard of care. We chose the benchmark of NP care to be "equivalent care to the EP" to determine a starting scope of clinical practice. We believe that this comparison is valid, because in the current system EPs diagnose and treat patients. In keeping with "best patient care" goal, NP autonomous practice must meet this benchmark until more valid and reliable benchmarks are developed.
- Data on the feedback provided to our NP and the clinical improvement over time was reported. We strongly believe in the physician–NP collaboration to facilitate clinical growth.

Publications clearly identify "lack of knowledge and skills" as the major barriers for overall NP implementation.[3,6] We believe this is the same for the area of emergency care. To date, the development of educational curricula for "expanded" emergency care for NPs seems to be taking place in isolation. Our perception is that faculties of nursing and medicine work without significant interdisciplinary communication and collaboration. Given that both faculties fit the role of "stakeholders" required for the development of NP,[3] we strongly encourage input from both. The need to include all stakeholders has since been validated by updated national recommendations targeting primary care NPs.[5]

Any future consideration for developing national, provincial or territorial plans for APN with "expanded" emergency clinical practice requires, at a minimum, systematic needs analysis, input from all stakeholders and outcome indicators that demonstrate a significant potential health benefit to the Canadian public.

Ivan P. Steiner, MD,
Darren N. Nichols, MD
Departments of Family Medicine and Emergency Medicine
University of Alberta
Edmonton, Alta.

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