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Publication Date

1997

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**Facilitators and Constraints to Neonatal Nurse Practitioner Practice
Comparing Nursing and Medical Models**

by

Valerie Ruth Sanchez

THESIS

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF SCIENCE

in

NURSING

in the

GRADUATE DIVISION

of the

UNIVERSITY OF CALIFORNIA

San Francisco



ABSTRACT

**FACILITATORS AND CONSTRAINTS TO NEONATAL NURSE
PRACTITIONER PRACTICE**

Comparing Nursing and Medical Models

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The rapid increase in the number of neonatal nurse practitioners (NNPs) that has been required to meet the deficit in skilled medical providers in the neonatal intensive care nursery (NICU) has afforded little time for the profession to examine its goals and secure career longevity. A descriptive study design was employed to identify perceived facilitators and constraints to neonatal nurse practitioner (NNP) practice. The adapted ten page questionnaire was mailed to all NNPs identified by the National Certifying Corporation as holding current certification in the U.S. and Canada (n=1528). The response rate was 48%. Data were analyzed by the type of model within which the NNP reported practicing. Results demonstrated that those NNPs who practiced within a medical model were significantly more facilitated in their practice than those who practiced within a nursing model. Inadequate support from the nursing profession for the attributes that facilitate NNP practice can result in an unbalanced relationship of NNPs to medicine. Support from both disciplines will facilitate the balance of nursing and medical qualities that can provide a unique dimension to healthcare delivery in the NICU. Failure to achieve this

balance will result in a role that is interchangeable and replaceable by the practice of other healthcare providers.

Acknowledgements

Most worthwhile endeavors are not possible without the support and guidance of others. First, I would like to thank my husband, Gary, who tolerated this distraction from our already limited time together simply because it was important to me. His sense of humor and general tolerance make all things seem easy and possible. I would also like to thank Kathy Lee and Elena Bosque, two nurses and teachers whose careers are dedicated to elevating nursing practice through research and teaching. As with all great teachers, their guidance has inspired me to continue learning.

I am also grateful to the other members of my thesis committee, Mary Lynch and Christine Kennedy, for their expert opinions and to my friends and colleagues who participated in the pilot study (Annette Carley, Donna Levinson, Julie Marcus, Trish Trahey, Elias Vasquez & Linda Weaver) and content committee (Jean Reimer, Augusto Sola, Paula Timoney and Julie Vilardi) for their input and expert advice in adapting the survey instrument. Finally, I would like to thank Barbara Connelly and Maggie Pena and the many others who participated in the extensive mailing process.

This research was supported in part by funds from the James and Marjorie Livingston Endowed Chair position, the Office of Student Affairs in the School of Nursing at the University of California, San Francisco, and a training grant from the Division of Nursing (5D23NU01007).

TABLE OF CONTENTS

	Page
TITLE PAGE	i
ABSTRACT	iii-iv
ACKNOWLEDGEMENTS	v
TABLE OF CONTENTS	vi
LIST OF FIGURES & TABLES	vii
CHAPTER I STUDY PROBLEM	1-8
CHAPTER II LITERATURE REVIEW	9-20
CHAPTER III METHODOLOGY	21-25
CHAPTER IV RESULTS	26-42
CHAPTER V DISCUSSION	43-53
REFERENCES	54-58
APPENDICES	
Appendix A Approval from the Committee on Human Research	59-61
Appendix B Original Tool Ventura, Feldman & Crosby	62-82
Appendix C Adapted Tool Sanchez, Lee, Bosque, Lynch & Vilardi	83-91

LIST OF TABLES & FIGURES

	Page
FIGURE 1 NNP Certified by NCC 1983-1993	3
TABLE 1 Internal Consistency of Themes	24
TABLE 2 Geographic Regions and Response Rates	27
TABLE 3 Demographic Comparisons by Type of Practice Model	29
TABLE 4 Facilitation Scores by Geographic Region	31
TABLE 5 Facilitation by Role Theme Subscale	34
TABLE 6 Time Spent by Group	36
TABLE 7 Top Facilitators to NNP Practice by Type of Practice Model	37
TABLE 8 Top Constraints to NNP Practice by Type of Practice Model	38

FACILITATORS AND CONSTRAINTS TO NEONATAL NURSE PRACTITIONER PRACTICE

Comparing Nursing and Medical Models

Chapter I

The Study Problem

Statement of the Problem

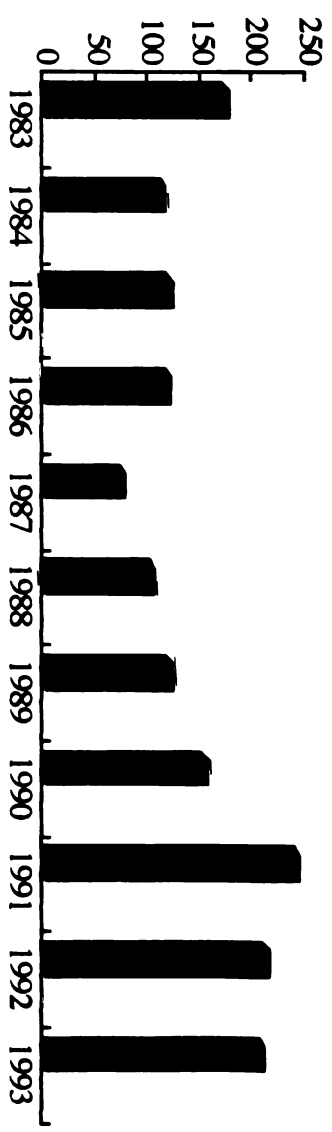
The role of the neonatal nurse practitioner (NNP) was implemented in the 1970's. Many of the earliest NNPs were trained on-the-job for this expanded role. One of the first formal training programs for neonatal nurse practitioners (then known as neonatal nurse clinicians) began in 1977 at The New York Hospital-Cornell Medical Center. It was directed from within the Continuing Education Division of the School of Nursing and offered a certificate degree upon completion (Bellig, 1980). The program's curriculum consisted of an eight-month training program that included didactic as well as clinical training. This typified NNP training programs that began to open around the country (Alberti, 1991; Bellig, 1983; Zurowsky & Coburn, 1990). The philosophy supporting the establishment of these programs was that patient outcomes in the neonatal intensive care unit could be greatly influenced by the quality of nursing practice. It was believed that an expanded nursing role would "enhance the practice of both nurses and physicians, allowing them to function in complementary roles" (Bellig, 1980, p. 160).

In the twenty years that the NNP has been utilized in neonatal intensive care units (NICUs), there has been tremendous growth in the number of NNPs now practicing and in the expansion of the role. Since the inception of the NNP certifying exam by the National Certifying Corporation (NCC) in 1983, seventeen hundred and thirty seven individuals have passed the neonatal nurse practitioner exam and there are currently fifteen hundred and twenty eight advanced practice nurses who are certified as NNPs. The number of NNPs continues to steadily grow and the current rate is approximately two hundred NNPs who successfully pass the NCC exam annually. Passage rate averages 80%. (National Certifying Corporation, personal communication, October 26, 1994; See Figure 1). The continued growth of the role has been influenced by numerous factors. The most influential of these has been the increase in the overall number of patients admitted to intensive care nurseries and deficits in neonatology and medical resident coverage (Alberti, 1991; Bellig, 1980; Bellig, 1983; Hall, Smith, Jackson & Perkins, 1992).

Increased infant survival rates through advanced knowledge and technology has expanded the field of neonatology to the current level of highly technical skilled care. This has lead to an overall increase the number of beds and skilled personnel required to provide care for these patients (Alberti, 1991; Mitchell et al., 1991; National Association of Neonatal Nurses, SIG-AP Role Definition Committee, 1992). Deficits in the amount of time supported by medical resident coverage are the result of reductions in time that pediatric residents spend in the NICU during their

Figure 1

NNPs certified by NCC 1983-1993



Note.

Information obtained from the NCC, telephone contact, October 1994.

residency program (Bellig, 1980; Hunsberger, et al., 1992; Mitchell, et al., 1991).

These reductions have been imposed by the American Medical Association in an effort to increase the quality of the residency experience for primary care pediatricians who will not routinely encounter these complicated patients in their practice and therefore require limited exposure to them during training (Mitchell et al., 1991; Watkins, Kirchhoff, Hartigan & Karp, 1992). Hence, one solution to the demand for providers of clinical coverage has been the expanded use of the neonatal nurse practitioner (Bellig, 1980; Hunsberger, et al., 1992; Mitchell, et al. 1991; Tschetter & Sorenson, 1991). The rapid increase in the number of NNPs that has been required to meet this deficit in healthcare delivery has greatly detracted from the original intent of the NNP role and has afforded little time for the profession to examine its goals and secure career longevity. This has led to the development of a group of individuals who are highly skilled in the delivery of complex medical management, but who have had little opportunity to examine and define their professional contribution, role viability and career goals.

The evaluation of NNP practice has primarily been conducted from the perspective of a medical model; specifically, comparing graduating NNP services to the second-year pediatric resident (Mitchell et al., 1991). The long-term survival of a role that utilizes a medical model for a nursing-based practice is tenuous. The professional satisfaction of persons trained under a nursing philosophy, yet practicing in an arena where their professional

attributes are not formally integrated into their role, is also in jeopardy (Dachelet & Sullivan, 1979; Roberts, 1983). It is unrealistic to expect that a position developed for the temporary practice of medical residents can be a career-worthy, long-term option for advanced practice nurses. The rigorous schedule, emotional stress, fast pace, and degree of accountability that the role demands on a daily basis may limit an individual's long-term ability to function in the role. Additionally, the feasibility of achieving professional satisfaction and professional growth in a role developed outside one's own profession and as a temporary position seems bleak (Roberts, 1983).

Purpose

The purpose of this study was to describe the role of the NNP in current practice and identify facilitators and constraints to practice as perceived by individuals currently practicing as NNPs. Facilitators and constraints were identified from the work of Ventura, et al. (1989) and categorized according to four pre-determined themes: a) professional development, b) role perception, c) role autonomy, and d) role value. These themes were identified by Ventura, et al. (1989) as integral components of professional viability. They were based on a review of relevant literature on the components of a professional role and then substantiated by three expert NNPs during pilot work on this project. From a description of the NNP role, characteristics that support a nursing-based model can be identified.

Significance

From this study data a theoretical model specific to NNP practice in tertiary care settings can be established that will support NNPs and allow them to

contribute a unique dimension to neonatal intensive care that engenders expertise in advanced nursing practice (Alberti, 1991; Dachelet & Sullivan, 1979; Hall, Smith, Jackson, Perkins & Walton, 1992; Schultz, Liptak & Ioravanti, 1994; Zurowsky & Coburn, 1990). Data generated by the study will contribute important information for shaping the future role of NNPs, for developing appropriate curriculum, and for the potential that future practice will be personally and professionally satisfying as well as integral to patient care in the intensive care nursery.

Practicing in a role that simply replaces others does not qualify as a profession (Roberts, 1983). For an adequate professional contribution and for professional security, NNPs must define their practice and provide proof of its efficacy to healthcare delivery in the NICU. Without defining their specific contribution to the total care of the neonatal intensive care patient, NNPs can not be seen as integral to their care. NNP status will continue to be analogous to "resident replacements" and the role will be continually threatened by the ease with which their practice can be replaced or displaced by the practice of others (Roberts, 1983). Establishing and defining a unique professional identity is paramount to securing a future as healthcare providers.

Without maintaining a foundation in nursing practice, NNPs will be unable to become experts in nursing practice or to realize the full potential of their contribution to neonatal intensive care. Additionally, they will be unable to establish a defined avenue for advancement within the practice of nursing (Dachelet & Sullivan, 1979; Roberts, 1983). For NNPs to become experts in

practice, a model for practice that is unique to both medicine and nursing is necessary. Critical to this model is that the role contribute to both medicine and nursing and that support for the role come from both disciplines. For equal support, the role must be viewed as an investment in healthcare in general and not as a benefit to one group of healthcare providers over another. Compartmentalizing the roles of healthcare providers will inhibit the fluidity of collaborative healthcare provision. NNPs must decide what characteristics of the role support professional growth and longevity as well as recognize the characteristics that impede growth and ultimately affect longevity. With this information, the medical management skills achieved through formal NNP training and the nursing skills and philosophies of practice acquired throughout nursing education and practice can be articulated. Effective unification of these practices will allow the NNP role to evolve into a unique contribution to neonatal intensive care that cannot be replaced by the practice of others. Establishing and defining this unique professional identity is paramount to securing a future as healthcare providers.

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Definition of terms

1. **Facilitators-** those factors or conditions that enhance NNP function and practice
2. **Constraints-** those factors or conditions that impede or are barriers to NNP function or practice
3. **Nursing model (x_1)-** those participants who indicated in the demographic section of the questionnaire that they were hired by, paid by and work for the Department of Nursing
4. **Medical model (x_2)-** those participants who indicated in the demographic section of the questionnaire that they were hired by, paid by and work for the Department of Medicine

Chapter 2

Literature Review and Theoretical Framework

Educational Preparation of the Advanced Practice Neonatal Nurse

The first NNPs were trained informally in on-the-job training programs and precepted by the physicians with whom they would be working post-training in an apprenticeship-like arrangement (Bellig, 1980). Training ranged from 30 hours to twelve weeks in length. As the need for individuals who could provide this level of service outgrew the supply, formal training programs where several NNP'S could be trained at one time were developed (Bellig, 1983; NANN, SIG-AP for Advanced Practice Education, 1994; Trotter & Danaher, 1994). From the mid-1970's through the early 1990's, development of formal training programs for NNPs proliferated. Criteria for entry into these programs was a minimum of an Associate degree in nursing, state certification as a registered nurse and one year of experience as a staff nurse in the neonatal intensive care unit (Bellig, 1980; Tschetter & Sorenson, 1991).

In 1975, the American Nurse's Association formally offered their support of advanced neonatal nurse training and established guidelines for hospital-based training programs with medical center affiliations ranging from eight to nine months in length. The programs were taught by physicians and nurses functioning in the practice area. Minimal support for this training was available from advanced practice nurses themselves, and specifically from NNPs, because of the limited number of individuals trained beyond the

clinical arena (Bellig, 1983; Tschetter & Sorenson, 1991). The focus of these programs was to address the management and procedural functions of medical practice. Training was heavily weighted with regard to procedural expertise. Minimal support for developing the philosophical aspects of the nursing role or for skill development in nursing leadership was included in the curriculum (NANN, SIG-AP for Advanced Practice Education, 1994; Trotter & Danaher, 1994). Many of the programs were developed temporarily to meet an acute or specific need (Bellig, 1983; NANN, SIG-AP for Advanced Practice Education, 1994; Trotter & Danaher, 1994). These factors, as well as the continued expansion of the NNP role, have directed leaders in neonatal nursing to develop educational standards for NNP training.

In 1983, the National Certifying Corporation for Neonatal and Obstetrical Nurses (NCC) began to offer a certifying exam for nurses functioning in this expanded nursing role. Specific criteria required nurses to have at least two thousand hours of practice as an NNP to be eligible to take the certifying exam. Passage certified these individuals as a neonatal nurse practitioner (NNP). To maintain current certification, renewal is required every three years (NCC, personal communication, March 20, 1994). Limiting national certification to those NNPs who have completed the minimum educational requirements has contributed to standardization of the NNP role.

For many years Master's preparation has been the goal of advanced practice nursing. Bellig (1983) described the future of the NNP role stating that: "graduate level programs can complement the certificate programs by

adding leadership skills and research sophistication as well as additional depth to the role" (p.60). In more recent years, advanced practice nursing groups have sought to standardize NNP education to gain control of educational preparation (NANN, SIG-AP for Advanced Practice Education, 1994; Tschetter & Sorenson, 1991).

As of 1993, there were 11 continuing education, certificate, or undergraduate training programs for NNPs and 24 graduate programs for neonatal nurse practitioners. The programs range from 9-24 months in length (Trotter & Danaher, 1994). Curriculum requirements for certificate programs are approximately 160 hours of didactic/classroom training and 500-700 hours of clinical preceptorship. Master's preparation generally requires two years of advanced education and includes a minimum of 500 hours of clinical preceptorship (NANN, SIG-AP for Advanced Practice Education, 1994; Tschetter & Sorenson, 1991). One of the primary goals of Master's preparation in advanced practice nursing is to prepare nurses for leadership roles (Tschetter & Sorenson, 1991). Preparation at the Master's level offers opportunity and support for the development of the professional aspects of the role and provides the nurse with guidance for leadership development. Additionally, opportunities to explore nursing research through participation and/or critical analysis is offered (NANN, SIG-AP for Advanced Practice Education, 1994 & Tschetter & Sorenson, 1991).

According to the guidelines published in 1994 by the National Association of Neonatal Nurses Education Task Force, the goal for future NNP training is that all educational preparation be at the Master's level by the year 2000.

The guidelines were established to set a minimum standard for NNP education. Their purpose is to assure that the education and practice of NNPs is governed by a nursing body who will assure that educational preparation is standardized and that the practice of all NNPs meets minimum competency requirements (Program Guidelines for NNP Educational Preparation, 1994). Master's programs must equal the quality of the certificate training programs in preparing the practitioner for the practical aspects of acute care management yet surpass these programs in preparing leaders in nursing.

NNP Role and Scope of Practice

Originally, the role of the NNP was intended for those nurseries where there was a deficit in physician coverage and it was felt that nursing could provide the continuity of care necessary for improved patient outcomes (Bellig, 1983; Hall, Smith, Jackson, Perks & Walton, 1992; Schultz, Liptak & Ioravanti, 1994). The NNP role has been structured primarily after the resident's role. It is this position and the duties that this role entails that the graduating NNP is expected to fulfill (Mitchell et al., 1991). The National Association of Neonatal Nurses Sub-Specialty Interest Group for Advanced Practice (NANN, SIG-AP) defines the role of the NNP as "a registered nurse with clinical expertise in neonatal nursing who has received formal education with supervised clinical experience in the management of sick newborns and their families" (SIG-AP Role Definition Committee, 1992). The role of the NNP was developed to provide continuity and consistency of

care that was felt to be crucial to improve overall morbidity and mortality rates in neonatal intensive care units (Bellig, 1980).

Functioning within specific protocols under the direction of a neonatologist and in collaboration with the healthcare team, NNPs can perform many emergency as well as routine procedures in the newborn intensive care nursery (NICU). This includes making more independent routine decisions and collaborating with neonatologists and other providers for making more complex decisions regarding healthcare management (Bellig, 1983; NANN, 1994; Zurowsky & Coburn, 1990). The American Nursing Association (1973) defined the NNP scope of practice as including "participation in the identification, planning and implementation of care for high-risk neonates and their families in cooperation and consultation with other healthcare team members" (Bellig, 1983, p.60). In response to the increased acuity and complexity of patients now seen in the NICU, the NNP has evolved into a more complex healthcare provider. The scope of NNP practice has expanded to maintain the pace that advanced technology and increased knowledge has set in the NICU. Currently, NNPs are used in a variety of acute care settings from well baby nurseries to Level III NICU's. NNPs, according to their educational training, are qualified to care for infants up to one year of age (NANN, 1994). Recently, NNPs have emerged in the community in various roles to support the care of these fragile patients following their hospital discharge (Schultz, Liptak & Ioravanti, 1994).

Components of the Professional Role

In a review of relevant literature, four themes emerged as integral to a professional role. They are: 1) role autonomy, 2) role value, 3) role perception and 4) professional development. (Alberti, 1991; Bellig, 1983; Caruso & Payne, 1990; Dachelet & Sullivan, 1979; Dwyer & Schwartz, 1993; Koelbel, Fuller & Misener, 1991).

Role Autonomy. "Autonomy implies independence, responsibility, accountability, self-determination and self-regulation" (Dachelet & Sullivan, 1979, p.15). In the presence of autonomy, control and direction over professional practice are engendered. Conversely, in the absence of autonomy, the professional role is indistinguishable from the occupational role and the professional responsibility that is derived from autonomous practice, can not exist. (Caruso & Payne, 1990; Dachelet & Sullivan, 1979; Dwyer, Schwartz & Fox, 1992). According to Dachelet & Sullivan (1979), the motivation for professional contribution and the innovation for contributing to the scientific base of a profession are derived from autonomy.

Role Value. Acknowledgement of the role and the perceived value of the role by those outside of it influences its viability. If the role is not perceived as valuable, those in the profession will be continually threatened by replacement. Therefore, a necessary and demonstrable service must be provided for the worth of the role to be formally recognized (Strasen, 1989).

Role Perception. A positive perception by those practicing in the role is dependent upon the perception of others. Full professional potential can not be realized until individuals within the role have a positive self-concept. According to Strasen (1989), "until we believe that we are 'in control' and

are professionals who can truly achieve great things we will act as if we are 'not in control.' We will be constrained from achieving major accomplishments by external factors" (p. 4).

Professional Development. Professional growth is derived from the internal growth of the profession; it cannot be granted by an external source. "Only after a profession achieves control over the content of its work can it proceed to gain control over the context of its work (Dachelet & Sullivan, 1979, p. 22)." Without defining professional contribution, there can be no defined area in which to develop expertise, full potential of professional contribution cannot be realized, nor will it be recognized (Caruso & Payne, 1990; Dachelet & Sullivan, 1979; Lawson, 1989). Without the opportunity for professional development there is no incentive for contribution.

NNP Role Satisfaction: Facilitators and Constraints to Practice

The majority of nurse researchers who have sought to identify facilitating and constraining factors related to satisfaction in nurse practitioner practice have focused on nurse practitioners in primary care settings (Hayden, Davies, & Clore, 1982; Koelbel, Fuller & Misener, 1991; Koelbel, Fuller & Misener, 1991; Lancaster & Lancaster, 1993 Manderino, Brown, Peters & Wirtz, 1994; Rogers, Sweeting and Davis, 1989; Tri, 1991; Ventura, Feldman & Crosby, 1989). These populations are not representative of NNP practice considering the distinct differences in practice environment and focus of healthcare delivery. The NNP delivers care in the acute care environment generally within a tertiary care environment whereas most other nurse practitioners (NPs) deliver care in the primary care setting with health

promotion and health protection as their direction for intervention. Although clinical nurse specialists work primarily in tertiary care settings, their primary role is to provide nursing education. Their delivery of direct patient care is generally limited to nursing care and management. They are limited from providing NNP-type management by their educational preparation which is focused on educating staff nurses in bedside nursing management and care. The primary role of the NNP is to provide direct patient management ideally, by incorporating nursing and medical qualities. These fundamental differences in scope of practice and practice setting limit the generalizability of previous research findings from tertiary care settings.

Antonelli (1985) sought to determine specific work-related stressors perceived by NNPs and clinical nurse specialists (CNS) through the use of a questionnaire. The stressors were ranked to identify those associated with the greatest degree of stress to those associated with negligible stress. Antonelli (1985) believed that by identifying these stressors, they could be reduced or eliminated and job satisfaction and productivity of the NNP would be increased. It was found that nurse/physician conflict, not enough time to complete work, and differing ethical perspectives were areas that created stress for the NNP/CNS. The theoretical framework upon which the study was based employed three stress theories. The theories were useful in describing many of the characteristics of NNP practice that the researcher sought to examine. The theories were: 1) Selye's stress theory which states that continued exposure to even moderate stressors can exhaust individuals to the point that their job effectiveness is compromised, 2) Gherman's theory

that work related stresses culminate in unhappiness and conflict which can lead to a decrease in self-confidence and productivity, and 3) Lucak's theory which states that role expectations that differ from personal job expectations create role conflict and decrease overall performance of nurse practitioners. The strength of the study was in the attempt to identify stressors specific to NNP practice and recognize that neonatal nurse practitioners and primary care nurse practitioners differ in their scope of practice. However, the study is limited in its implications for NNP practice because NNPs and CNSs were surveyed together and no distinction was made between their responses. Additionally, the questionnaire was distributed at a conference and therefore may have targeted a biased sample. The entire sample consisted of 68 NNPs/CNSs with a response rate of 54%.

Ventura, Feldman and Crosby (1989) surveyed 257 Veteran's Administration nurse practitioners (VA NP's) to determine perceived facilitators and constraints to their practice. Response rate for this study was 92%. They found that VA NP's were, in general, more facilitated than constrained in their practice and that VA NP's perceived their job as facilitated when they perceived a sense of status in their role, felt that there was opportunity for professional advancement in the role, and when they reported feeling personal satisfaction from their work. The group identified as particularly influential to VA NP practice were top nursing administrators. Support or lack of support from this group influenced the VA NP's perception of facilitation in their role. Continuing education, participation in research, adequate physician back-up and committee membership in medical center

planning were factors that were reported as supporting professional growth. Factors that enhanced personal satisfaction included job security, independence in practice, fringe benefits, continuity of caseload and the opportunity for promotion. This study provides the critical foundation upon which the current study is based. Themes relevant to all advanced practice nursing roles are identified in this study. The primary limitation of this study from NNP practice is that the sample population includes only primary care practitioners.

There have been no studies that specifically examine NNPs with regard to the impact of role stress or constraints to practice on job satisfaction. Many researchers have examined the effect of stress on staff nurses and primary care practitioners, but again, their utility and generalizability among NNPs is limited by the differences in practice settings and responsibilities (Consolvo, 1979; Diamond, & Fox, 1958; Hayden, Davies & Clore, 1982; Tri, 1991; Ventura, Feldman & Crosby, 1989). These studies conclude that dissatisfied NPs have increased attrition rates and decreased job proficiency. Satisfied staff nurses were significantly more motivated, more productive, delivered better patient care, and had decreased job turnover and absenteeism rates than unsatisfied staff nurses (Consolvo, 1979; Diamond, & Fox, 1958). Koelbel (1991) proposed that greater job satisfaction of nurse practitioners may lead to increased cost-savings, improved patient access, and enhanced quality of care. These outcomes would directly impact cost-savings for the healthcare facility.

Theoretical Framework

Oppressed group behavior theory

Oppressed group behavior theory supports that in order to achieve the characteristics and status of the dominant group, individuals feel that they must reject their own characteristics because these are negatively valued by the dominant group. Thus, the subordinate group believes that taking on the attributes of the dominant group, and rejecting the attributes that the dominant group places a negative value on, will lead to more power and control (Roberts, 1983).

"Persons who are successful at assimilating become known as 'marginal' because they do not belong to either group but rather are on the fringes of their own group and unable to be a full member of the dominant group as a result of their heritage. This marginality leaves the person without a cultural identity" (Roberts, 1983, p 22).

According to this theory, individuals who practice outside their framework of practice can never achieve greater than marginal status whereas individuals who are growing and developing within their profession can eventually become experts in practice (Roberts, 1983). Extrapolating from this theory and applying it to NNP practice, it can be theorized that nurses practicing in a purely medical model can never achieve the professional status as an expert in practice. Since NNP practice is unique to both medicine and nursing disciplines, the model for NNP practice must also be unique. It is not acceptable or feasible for the NNP to entirely adopt or mimic the practice of other NPs who typically practice in primary care settings or to entirely mimic the practice of pediatric residents. Practicing in this manner will lead to a

lack of professional identity and a job that is limited to the confines of the group with whom that the particular NNP group chooses to affiliate.

Furthermore, NNP practice may become marginalized and ineffective in future role development, role autonomy, role value and role perception.

Summary/Conclusion

Without a standardized practice model for the NNP role, contribution to the professional practice and to patient care is curtailed. According to Bellig (1980), developing a standardized model for NNP practice should involve:

"evaluation by a central body and a standard must be set for the education and function of the expanded role in the NICU. The standard should not be so rigid that further growth and change become difficult. However, specification of this role by nursing is necessary to avoid role stress experienced by nursing as a professional discipline, by other health professionals, or by the public" (p. 171).

Therefore, the results of this descriptive study will provide an initial in-depth examination of current NNP practice as well as factors that facilitate and constrain their practice. Identifying these factors will facilitate development of a practice model that can minimize role stress and increase NNP motivation and productivity.

Chapter 3

METHODOLOGY

Study Design, Setting, and Sample

Procedures

A descriptive study design was employed for the purpose of determining perceived facilitators and constraints to NNP practice. A complete list of 1528 NNPs in the United States and Canada who had obtained NCC certification and held active membership in the organization, was purchased from NCC after approval from the Committee on Human Research at UCSF and NCC.

Study participants were mailed a questionnaire packet that included a cover sheet, the 118-item questionnaire, a complimentary mechanical pencil with the UCSF School of Nursing insignia as a token of appreciation for their participation, a stamped self-addressed return envelope and a blank index card on which participants could include their name and address if they wanted to receive the results of the study. The cover sheet stated the purpose of the study and contained the Subject's Bill of Rights as well as a statement promising anonymity (See Appendix A). Return of the completed study signified consent. Participants were requested to return the completed questionnaire within two weeks of receiving it in June 1994.

Facilitators and Constraints to Practice: Instrument Validity and Reliability

The survey tool was adapted from an instrument developed by Ventura, Crosby and Feldman (1989) to test the facilitators and constraints of Veteran's Administration Nurse Practitioner practice (see Appendix B). A

Likert-type scale was used for respondents to identify specific conditions of practice as either a facilitator or constraint. The scale ranges from +3 (strongly facilitates) to -3 (strongly constrains) allowing respondents to indicate the extent to which each item affects their practice. A clarification section is also included for each item to allow respondents the option of clarifying the reason that they felt practice was affected by the particular item (clarification terms included: None, Too little, Enough, Too much, and Other.

For the tool used in the original study by Ventura, Crosby & Feldman, items were selected from a literature search from which barriers to practice were identified. A stratified sample of 50 NPs who were not included in the study sample was also used. This group was requested to submit factors that they felt influenced their practice. Content validity was established through administration of the questionnaire to four different groups of nurses. One group included ten in-house NPs, a second group included six of ten NPs who were randomly selected from the original group of 50 who had submitted the initial items for the questionnaire. The third group consisted of ten professional nurses with research expertise and the fourth group included six nurses in policy-making positions. From this pre-testing a final questionnaire that consisted of twenty pages and 98 items was developed (Ventura, Feldman & Crosby, 1989).

For the purpose of the current study, the tool was adapted (with verbal permission, Darlene Ventura to Valerie Ruth Sanchez, January 22, 1993) from its use with VA NPs to NNP practice. A literature search for specific items believed influential to NNP practice was conducted. Many of the

questions from the original questionnaire were used either in their original form or were modified to accommodate differences in NNP practice settings. A pilot study of six NNPs was used to establish content validity of the items. The tool was further adapted following input offered by pilot study participants, members of the expert content committee and two other experts in NNP practice (see Appendix C).

Validity of the four themes categorized from the questionnaire items was established through the use of an expert content committee. The committee was comprised of three individuals who had been practicing in the NNP role for greater than three years. Each of these individuals categorized the 88 questions in the facilitation section of the questionnaire according to the four pre-determined themes of 1) role value, 2) role perception, 3) role autonomy, and 4) professional development. Responses of the committee were compiled and the modal response was taken to determine the final category for each of the 88 items. In situations where the three committee members did not agree on any one category, consensus of the researchers was used for final categorization. Only one question required this form of decision making. Cronbach's alpha coefficient was used to establish internal consistency reliability of the 4 pre-established themes. Alpha reliability of >0.7 was demonstrated for all four themes (see Table 1).

Data were analyzed using descriptive statistics and measures of central tendency (means \pm SD and percentages). Group comparisons on continuous variables were analyzed by t-tests for independent samples to

Table 1

Internal Consistency of Themes

Theme	number of items in theme	Cronbach's alpha coefficient
Professional Development	23	.8086
Role Autonomy	7	.7071
Role Perception	15	.7327
Role Value	35	.8728

test for differences between groups. Group comparisons on dichotomous variables were analyzed by Chi-square tests for differences in proportions. A pilot study of six NNPs who had been practicing as NNPs for greater than one year and in more than one setting was conducted. Results demonstrated that individuals practiced as staff nurses for an average of 5.5 years before returning for NNP training. Half were certificate trained and half had received Master's preparation for their NNP. One individual had gone on to attain a doctorate in nursing. The majority were employed in level three nurseries (83%) and University Hospitals (66%). No individuals participated in follow-up clinic or in the management of ECMO patients although five of six individuals reported that ECMO was performed at their institution. All individuals were salaried and all reported that they were not compensated for overtime. The majority (66%) of participants reported that they were paid by, hired by and, worked for the department of nursing and the remainder (33%) reported that they were paid by, hired by, and worked for the department of medicine. All individuals reported that medicine had a great deal to total input into NNP practice whereas nursing had a great deal to no input into NNP practice. NNPs themselves reported having a great deal (50%) or shared control with medicine (50%) over their practice. Shift hours varied greatly ranging from 10 to 26 hours in length. Individuals worked an average of two weekends/month. The average facilitation score demonstrated that NNPs were slightly more facilitated than constrained in their practice.

Chapter 4

Results

Demographic Characteristics

Of the questionnaires mailed to NCC members in the US (N=1528) and Canada (n=4), 42 were returned from individuals who were no longer practicing as NNPs and 15 were returned due to inaccurate or unknown address. These were deducted from the original 1528 mailed to potential participants for a final response rate of 48%. Nine geographic regions were identified according to the U.S. census tract areas (see Table 2 for geographic regions and response rates). Questionnaires had been numerically coded prior to mailing in order to track geographic region. The response rate from each region ranged from 58% from the New England region to 42% from the Pacific region.

Most individuals held a Baccalaureate degree (37%) or a Master's degree (39%) as their highest nursing degree and the majority had received their educational preparation as an NNP from a certificate program (73%). The average individual had been practicing as an NNP for six years, but the range was one year to 19 years. Average years in the current practice setting was seven, with a range of less than one year to 23 years. Most individuals worked in level three nurseries (81%) and in teaching hospitals (77%). Almost all centers in which NNPs practiced offered general surgery (88%), one-half (50%) offered cardiac surgery and one-quarter (27%) offered Extracorporeal membrane oxygenation (ECMO).

Table 2

Geographic Regions and Response Rates

Region	States Included in Region	Number of Respondents	
		N	%
New England	Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut	38	58
Middle Atlantic	New York, New Jersey, Pennsylvania	58	48
East North Central	Ohio, Indiana, Illinois, Michigan, Wisconsin	109	50
West North Central	Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas	78	50
South Atlantic	Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida	162	44
East South Central	Kentucky, Tennessee, Alabama, Mississippi	33	47
West South Central	Arkansas, Louisiana, Oklahoma, Texas	63	46
Mountain	Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada	86	54
Pacific	Washington, Oregon, California, Alaska, Hawaii	46	42
Canada	Canada	4	50

The average full-time salary for all NNPs was \$52,825 with a range of \$19,000-\$150,000. The majority (68%) of respondents were supervised by neonatologists. Most individuals (54%) reported that their primary role was in the intensive care nursery but 30% rotated through many roles.

Shifts varied widely with 12 hour (27%) and 24 hour shifts (21%) being the most common. Almost half of respondents (49%) reported that they worked rotating shifts, 30% worked permanent days, 7% worked permanent nights, and 11% worked permanent 24 hour shifts. The majority of individuals reported that they worked one (22%) or two weekends (38%) per month.

Only 14% of respondents participated in follow-up clinic, while ECMO was offered in 27% of sites, only 11% of NNPs reported participating in the management of these patients. The average age of the respondents was 38 \pm 5 years and 97% of respondents were female. Most NNPs (92%) practiced in an urban setting and only 8% practiced in a rural setting (See Table 3 for additional demographic comparisons by type of practice model).

Medical versus Nursing Model of Practice

Data were analyzed by the type of model within which the NNP reported practicing. The model was operationalized as "nursing" if the NNP was hired by, paid by, and worked for nursing (X_1). The model was operationalized as "medicine" if the NNP was hired by, paid by, and worked for medicine (X_2). There were 216 (33.3%) individuals identified as practicing in the nursing model and 308 individuals (47.5%) identified as practicing in the medical model. Individuals who responded that they were

Table 3.
Demographic Comparisons by Type of Practice Model

Demographic Variable	Nursing	Medicine	χ^2
Certificate preparation as NNP	77%	66%	12.4**
Graduate preparation as NNP	18%	31%	12.4**
Children's Hospital	28%	17%	7.3*
Private Hospital	26%	25%	.03
University Hospital	21%	30%	4.3*
Community Hospital	31%	31%	.004
Level I nursery	2%	1%	.28
Level II nursery	17%	19%	.9
Level III nursery	81%	80%	1.5
Teaching hospital	75%	78%	.37
Non-teaching hospital	21%	18%	.48
General surgery	88%	90%	1.2
Cardiac surgery	51%	49%	.85
ECMO	28%	25%	.48
Follow-up Clinic	45%	55%	12.9**
24 hour shifts	53%	47%	15.8*
Supervised by medicine	68%	82%	12.9*
Evaluated by nursing	94%	51%	147.5**
Evaluated by medicine	4%	47%	147.5**
Work with pediatric medical residents	57%	43%	1.1

Note. * p < .05, **p<.01

hired jointly or did not answer all three questions (hired by, work for, paid by), were excluded from the comparisons.

Facilitation Scores by Type of Practice Model

A total facilitation score was calculated by adding all 75 items in the facilitation/constraint portion of the questionnaire. The score was established from the total number of answered questions. If a respondent did not respond to an item, it was most likely because of the non-applicability of that particular item to their practice. Therefore the item could not contribute to their practice in a facilitating or constraining manner. If there were more than ten items without a response, the participant was deleted from the analysis.

The scale for response was +3 to -3 for a possible range of +225 to -225. The actual range of scores from the respondents was +195 to -114. A significant difference in mean facilitation scores between NNPs in the medical and nursing model was found ($t = -2.26, p = .02$). Individuals who worked in a medical model had a mean facilitation score of 65 ($SD \pm 41$) while individuals working within the nursing model had a mean facilitation score of 56 ($SD \pm 45$). This indicates that individuals who worked in the medical model perceived significantly more facilitation in their role than those who worked in the nursing model. There were no significant differences in facilitation scores by region (See Table 4). Respondents from New England had the lowest mean facilitation scores (52 ± 44) whereas individuals practicing in the mountain region had the highest mean facilitation score (72 ± 37).

Table 4
Facilitation Scores by Geographic Region

Region (N)	Mean Facilitation Score (\pm SD)
Mountain (86)	71.7 \pm 36.74
West South Central (63)	66.3 \pm 44.93
Middle Atlantic (58)	65.6 \pm 46.20
South Atlantic (162)	61.1 \pm 41.89
East South Central (33)	60.6 \pm 51.99
Pacific (46)	60.3 \pm 50.30
West North Central (78)	59.2 \pm 43.12
East North Central (109)	55.9 \pm 40.21
New England (38)	51.7 \pm 44.08

Role Theme Subscale Scores by type of Practice Model

A subscale facilitation score for each role theme was calculated from responses on items within the theme. The themes were: professional development, role autonomy, role value, and role perception.

Professional Development. This theme contained 15 items therefore, the possible score in this theme was 45 to -45. The mean facilitation score for this theme was 7.6 ± 9.4 for those NNPs working in a nursing model, and 8.8 ± 10.3 for those in the medical model. There was no significant difference in scores between the 2 groups ($t = -1.1$, $p = .27$), but facilitation perceived within this theme was minimal for both groups.

Role Autonomy. This theme contained 7 items for a possible score of 21 to -21. The mean facilitation score was 10.3 ± 6.5 for the nursing model and 11.1 ± 6.6 for medical model. Of the four role themes, role autonomy was perceived as the most highly facilitated theme for both groups ($t = -1.28$, $p = .20$).

Role Value. There were 23 items in the theme related to role value, thus allowing for a possible score of 69 to -69. For the group in the nursing model of practice, the mean facilitation score was 22.1 ± 19.2 and for medicine, a mean facilitation score of 25.6 ± 17.6 . There was no significant difference between the two groups ($t = -1.86$, $p = .07$).

Role Perception. For the final theme there were 35 items in the category which gave a total possible score of 105 to -105. The mean facilitation score for nursing was 28.1 ± 22.8 and the medicine group had a mean facilitation

score of 30.6 ± 16.6 , ($t = -1.04$, $p = .32$). Facilitation perceived in this theme was comparable to the theme Role Value for both groups. (See Table 5).

Demographic Differences by Type of Practice Model

A significant difference in salary ($t = -2.20$, $p = .0284$) between the two groups was found. Individuals who worked under a nursing model earned a mean salary of $\$51,746.00 \pm \$8,091.00$ while individuals who worked under a medical model earned a mean salary of $\$53,628.00 \pm \$11,326.00$. Work hours per week was also significantly different ($t = -3$, $p = .003$) between the two groups. The nursing group averaged 40.2 ± 10.5 hours/week while the group working under medicine averaged 43.5 ± 8.3 hours/week.

Educational preparation as a NNP was also significantly different between the two groups. NNPs in the medicine group (31%) held a graduate degree compared to the nursing group (18%, $p = .006$). In addition, significantly ($p = .037$) more NNPs who worked for medicine (30%) worked at a University hospital compared to the percentage by nursing (21%). While significantly ($p = .007$) more (28%) in the nursing group worked in Children's hospitals compared to the medicine group (17%). A significant difference was also found for the item, participation in follow-up clinic. Significantly ($p = <.0001$) fewer (10%) in the group who worked for nursing reported participation in the follow-up clinic compared to the medicine group (18%). Finally, a significant difference ($p < .0001$) was demonstrated when using evaluation by nursing and evaluation by medicine as the dependent variable: 68% of the individuals in the nursing model were supervised by medicine and 82% of the individuals in the medical model were supervised

Table 5.
Facilitation by Role Theme Subscale (N=677)

Theme	number of items in theme	range of possible score	mean score \pm SD X ₁	mean score \pm SD X ₂
Professional Development	15	+45 - -45	7.61 \pm 9.42	8.79 \pm 10.33
Role Autonomy	7	+21 - -21	10.27 \pm 6.51	11.10 \pm 6.62
Role Perception	35	+105 - -105	28.10 \pm 22.79	30.6 \pm 16.78
Role Value	23	+69 - -69	22.10 \pm 19.06	25.590 \pm 17.64

Note.

X₁=nursing group X₂=medical group

by medicine. Approximately 94% of individuals in the nursing model were evaluated by nursing and only 4% were evaluated by medicine, whereas 51% of the medicine group were evaluated by nursing and 46% were evaluated by medicine.

No significant differences were found between the two groups when compared on proportions practicing in: Community Hospital or Private Hospital, acuity level of the nursery in which they practiced or type of services offered by the nursery, hours/week spent in direct patient care, time spent in patient rounds, time spent with parents, time spent participating in research activity, and time spent in outreach education (See Table 6). There were also no significant regional differences in the proportion of NNPs practicing in the two models.

Most Facilitating/Constraining Items

Data were also analyzed for the most facilitating and the least facilitating (or most constraining) factors. The top eleven facilitators and the top eleven constraints to NNP practice are identified in Table 7 and Table 8. The eleventh facilitator and constraint were retained for discussion as they seemed particularly pertinent to NNP practice. A mean facilitation score was computed to determine the ranking (highest to lowest) of each of the variables. The top 11 and lowest 11 variables were then compared for differences between the two practice groups using t-tests for independent samples. Respondents were most likely to use the "clarification" section if they had indicated that a particular item was a constraint to practice. If the

Table 6.
Time Spent by Groups

Variable	Nursing	Medicine	t value
work hours/wk	40.9 ± 6.8	43.5 ± 8.3	-3.01
hours patient care/wk	13.4 ± 11.6	15.7 ± 12.3	-2.08
hours rounds/wk	6.3 ± 5.3	6.9 ± 5.7	-1.22
hrs parents/wk	3.2 ± 2.6	3.6 ± 4.6	-1.26
hrs research/wk	.5 ± 1.3	.5 ± 1.4	.64
hrs outreach/wk	.6 ± 3.5	.4 ± 1.6	1.02
hrs consulting/wk	.9 ± 1.4	1.1 ± 1.4	-1.17*
hrs referral/wk	.9 ± 1.9	.9 ± 1.1	-.2
hrs delivery/wk	4.5 ± 5.3	5.1 ± 6.4	-1.08
hrs writing notes/wk	7.9 ± 6.1	9.1 ± 6.7	-1.98*
hrs meetings/week	1.9 ± 2.4	1.7 ± 1.5	0.65
hrs clerical work/week	1.1 ± 1.7	1.1 ± 2.6	.01
hrs projects/week	1.7 ± 3.1	1.2 ± 2.1	1.98*
hrs precepting/week	3.4 ± 6.4	2.9 ± 5.3	.94
hrs procedures/wk	3.3 ± 3.1	4.1 ± 4.2	-2.21*
hrs lecturing/week	.9 ± 1.8	.7 ± 1.2	1.49
hrs of prep time/week	.8 ± 1.8	.5 ± .9	1.78
wks intermediate nsy/yr	25.5 ± 23.6	27.3 ± 23.5	-0.86
wks ICN/yr	37.2 ± 20.0	42.4 ± 15.4	-3.35**
wks well baby/yr	10.8 ± 20.0	12.8 ± 21.2	-1.01
wks admin/yr	5.7 ± 15.4	3.8 ± 12.5	1.53
wk research/yr	2.8 ± 10.8	3.3 ± 11.4	-.51
wk transport/year	14.6 ± 21.8	12.9 ± 21.3	.86
wks chronic nsy/yr	7.9 ± 17.9	12.3 ± 20.8	-2.43*
wks follow-up clinic/yr	1.5 ± 7.8	4.5 ± 13.0	-2.84**

Note. * p < .05, ** p < .01

Table 7.

Top Eleven Facilitators to NNP Practice by Type of Practice Model

Facilitating Factor	Nursing	Medicine	Theme
personal satisfaction as a NNP	2.05	2.21	role value
key people who affect your NNP practice: neonatologists	1.94	2.13	role perception
key people who affect your NNP practice: MDs I work most closely with	1.94	2.1	role perception
my access to patients	1.99	2.04	role value
parent satisfaction	1.87		role value
responsibility I have for patient care	1.87		role autonomy
independence associated with my NNP role	1.61*	1.9*	role autonomy
person (medical) responsible for evaluating my performance	1.55	1.85	role perception
key people who affect your NNP practice: staff nurses	1.65	1.7	role perception
patient's families	1.58	1.74	role perception
flexibility inherent in my NNP position	1.5*	1.77*	role autonomy

Note. * p < .05

Table 8.
Top Eleven Constraints to NNP Practice by Type of Practice Model

Constraining Factor	Nursing	Medicine	p value	Theme	Clarification
participation in medical center planning and decision making	-.54	-.19	.005	role perception	too little
mechanisms to resolve professional and practice issues	-.45*	.14	.04	professional development	too little
collective bargaining for NPs at my center	-.43	.23		role value	none
non-clinical duties assigned to me	-.38*	.14	.048	role value	too much
promotion as a NNP	-.17	.2		professional development	none
participation in nursing service planning and decisions	-.21	.08		role professional	too little
participation in follow-up clinic	.08	.05		professional development	none
physical space available	-.04	.02		role value	too little
working with physician's assistants	.02	.1	.046	professional development	none
clerical support available	< .0001	.42	.009	role value	too little
research participation	.02	.12		professional development	too little

item was indicated as a facilitator or as having no effect on their practice, this section, in general, was left blank.

The most frequent facilitator to practice was "personal satisfaction as a NNP." There was no significant difference between groups for this item ($t = -1.49$, $p = .1302$). Other facilitating items were "People who may affect your NNP practice: Neonatologists" and "MD's I work most closely with." There are no significant differences between the two groups with respect to these items. The fourth through the sixth facilitators included: "My access to patients," "Parent Satisfaction," and "Responsibility I have for patient care." Again, there were no significant differences between groups for any of these items. The seventh most facilitating factor was "Independence associated with my NNP role." The mean facilitation score for nursing was 1.613 and 1.896 for medicine. There was a significant difference ($t = 2.0$, $p = .038$) between the groups on this item; individuals who worked for medicine experienced greater facilitation from this item than individuals who "worked" for nursing. The clarification most frequently chosen for this item was "Too little" indicating that it was the lack of independence that constrained the role for those who perceived it as a constraint. The ninth most facilitating factor was "Persons who may affect your NNP practice: staff nurses." There was no significant difference in the facilitation that this item represented to either group ($p = .7$). The eleventh most facilitating item was "Flexibility inherent in my NNP position." The mean facilitation score on this item was 1.5 for nursing and for medicine was 1.8 indicating that those

individuals in the medicine group experienced greater facilitation from this item than those in the nursing group ($p = .049$).

The number one constraint to practice identified by the respondents was "Participation in medical center decision making and planning." The mean facilitation score for this item was $-.54$ for the nursing group and $-.19$ for the medical group ($t = -2.8$, $p = .005$). This significant difference between the two groups indicates that the nursing group perceived this as a greater constraint to practice than those in the medical group. The most frequently chosen clarification for this item was "too little." The second most constraining item was "Mechanisms to resolve professional and practice issues/conflict." The mean facilitation score of for the nursing group was $-.448$ and $-.138$ for the medical group ($t = -1.07$, $p = .04$) indicating a significant difference, with those individuals in the nursing group experiencing greater constraint from this item than those working for medicine. The third most constraining factor was "Collective bargaining for NNPs at my center." No significant difference was found in the amount of constraint that this item represented for either group ($p = .12$). The fourth most constraining factor "Non-clinical duties assigned to me," had a mean facilitation score of $-.38$ for the nursing group and $-.14$ for the medicine group ($t = -2$, $p = .048$). There was a statistically significant difference between the two groups on this item suggesting that the NNPs who worked for nursing experienced more constraint from this factor than those who work for medicine. The clarification most frequently offered for this item was "too much." "Promotion as a NNP" was the fifth most constraining factor. No

significant difference ($t = .22, p = .83$) was found between the two groups. The clarification most frequently chosen for this item was "none." The seventh most constraining factor, "Participation in follow-up clinics," demonstrated no significant difference between groups ($t = -.37, p = .79$). Clarification most frequently chosen for this item was "too little." The eleventh most constraining factor was "Research participation." No significant difference in the amount of constraint that this factor posed for either group was found ($t = -.72, p = .47$). The clarification most frequently offered for this item was "too little."

The most facilitating and constraining items were further examined for their categorization according to the four role themes. Of the 11 most facilitating factors, the most dominant theme was Role Perception, with five of the 11 items in this category. The themes Role Value and Role Autonomy were equally represented with three items in each category. Of the 11 most constraining factors, the most prevalent theme was Professional Development, with five of the 11 items belonging to this category. The second most prevalent theme was Role Value with five items. The remaining two items were under the theme Role Perception.

Input into Practice by Type of Practice Model

Chi-square analysis was used to test for group differences regarding input into practice. A significant difference was found between groups regarding general input into practice. NNPs who worked for nursing reported significantly ($\chi^2 = 107, p < .0001$) greater input into practice ($t = .2 \pm .5$) than those who worked for medicine ($t = .08 \pm .26$).

A significant group difference ($\chi^2 = 31, p < .0001$) was also found in the amount of input that neonatologists had into NNP practice. Over half (55%) of NNPs working in the nursing model reported that neonatologists had a "great deal" to "total control" over their practice whereas three-quarters (77%) working in the medical model reported that neonatologists had a "great deal" to "total control" over their practice. A significant difference was also found ($\chi^2 = 9.5, p = .009$) for the item "NNP input into practice." The majority (84%) of NNPs working in a nursing model reported that they had very little control over their practice or shared control with medicine. The majority (93%) who worked for medicine reported that, they too, had very little control over their practice or shared control with medicine.

Chapter 5

Discussion

Differences between Medical and Nursing Model

The actual range of scores for all respondents was + 195 - -114 (range of possible score +225 - -225) suggesting that NNPs are more facilitated in their practice than constrained. The facilitation score was significantly higher for individuals in the medical model. Thus, it may be interpreted that individuals working in the medical model receive greater support for those components which facilitate practice than individuals working in the nursing model. Other factors that may support this explanation are that individuals in the medical model were paid a significantly higher salary although, this could simply reflect the greater work hours/week reported by these individuals. It may be further explained by the fact that University hospitals paid the highest salaries and individuals who worked at a University hospital were more likely to work for medicine.

Differences in Demographic Variables by Practice Model

The fact that Master's prepared NNPs were more likely to work for medicine might be explained by various factors found in this study. One such explanation may be that NNPs who worked for medicine were more likely to work in a University hospital and these hospitals may be more likely to have graduate NNP programs attached to them making Master's prepared NNPs more accessible to these institutions. It may also be that NNPs with a Master's degree are more drawn to the opportunities that are available in a

University setting and are therefore more likely to seek employment there. The increased salary that was reported by individuals in the medical group may also be explained by the greater number of Master's prepared NNPs working in that group.

A significant difference was also found comparing the variable "participation in follow-up clinic." Non-participation in follow-up clinic was one of the top constraints to practice identified by both groups, but was perceived as a significantly greater constraint by the nursing group. This may be related to the fact that follow-up clinic is generally run by the medical team and therefore, there may be less opportunity for participation if the NNP works in the nursing model.

With regard to evaluation, the majority of NNPs in both groups were supervised by medicine yet evaluated by nursing. This inconsistency may contribute to the inaccurate perceptions of the role and the perceived lack of support that both groups reported from upper level nursing management. It seems logical that consistency in supervision and evaluation would lead to a more accurate perception of the role.

Differences by Region

Although no significant differences were found between the groups using grouped t-tests to compare neighboring regions, comparing the region with the lowest facilitation score to the region with the highest facilitation score may yield more information about regional differences.

Differences in Facilitation Subscale Role Themes

No significant differences were found between groups with regard to subscale facilitation role themes. Further analysis of these themes and specific comparisons of individuals who scored highly in the themes to those who scored the lowest may be useful in identifying demographic variables that influence facilitation within the theme.

The theme Professional Development was the least facilitated theme for both groups. The second least facilitated was Role Value followed by Role Perception. The difference between groups was not significant ($p = .07$) for the theme "role value" with the nursing group experiencing less facilitation from this role theme than the medical group. For a better understanding of how this impacts the NNP role, further exploration with regard to data analysis and future study is necessary.

The most facilitated theme for both groups was Role Autonomy. "To the extent that autonomy is a reality in the nurse practitioner role, there is the opportunity to improve and develop the unique scientific basis of nursing; thus capitalizing on a legitimate use of autonomy" (Dechelet & Sullivan, 1979, p. 18.). Further exploration into the themes looking for those items that are most influential within the theme will provide guidance for assuring that these items are included in future practice.

Most Facilitating Items

The number one facilitator for both groups, "personal satisfaction as a NNP," suggests that NNPs are personally satisfied in their role. This may

prove to be the most significant contributing factor to longevity of the role. Individuals who were identified as highly facilitating to NNP practice neonatologists, MDs I work most closely with, and staff nurse are those individuals with whom NNPs have the most contact on a daily basis. This support is crucial to all aspects of the role. Support from these individuals will facilitate a more collaborative practice that will serve to further enhance patient care and the success of the NNP role.

The items, "Independence associated with my NNP role" and "Flexibility inherent in my NNP position" were among the most facilitating items to practice. The clarification for these items for individuals who reported them as a constraint was "not enough." The significant difference demonstrated between the two practice models on these seemingly related items is important. Further study that explores the increased independence perceived by those individuals in the medical model is necessary for achieving this same balance for those working in the nursing model.

Most Constraining Items

Of the eleven most constraining factors, there were five items with significant differences between the two practice models: 1) "Participation in medical center planning and decision making," 2) "Mechanisms to resolve professional and practice related issues," 3) "non-clinical duties assigned to me," 4) "working with PA's," and 5) "clerical support available to me." These five items were significantly more constraining for those in the nursing model compared to the medical model. Again, further study is necessary to understand these differences.

Input into Practice

Neonatologist's input into practice was significantly greater when the individual reported working under the medical model. NNPs input into practice was significantly greater for individuals working in the nursing practice model. NNPs who worked for nursing had greater or at least shared input in their practice as neonatologists. The fact that NNPs had more control over their practice when working for nursing, yet have significantly lower facilitation scores, seems to indicate that input into practice alone is not a powerful an indicator of facilitation.

Significance

This study has shown that a sample of NNPs employed in a medical model of practice are significantly more facilitated in their practice than those employed in a nursing model of practice. This suggests that support for the characteristics of the role that contribute to facilitation are enhanced when the individual is employed in a medical model of practice. The implications of this are that NNPs may "follow the path of least resistance" and choose to affiliate and focus their contributions towards the medical group. According to oppressed group behavior theory, lack of support from the nursing group and strong support from medicine may cause NNPs to simply adopt the characteristics of the more supportive group. Support from both groups will provide the balance necessary for NNPs to discover and direct their contributions and thereby create a unique and dimension to healthcare delivery in the NICU.

"The freedom to develop nursing's own destiny can only come from nursing's own initiative; it will not be freely granted by other groups" (Roberts, 1983, p.29). Inadequate support for this group of advanced practice nurses by the discipline of nursing will deny NNPs the opportunity for contribution and advancement in the discipline of nursing. By affiliating with medicine nurses devalue the qualities of their basic philosophical training therefore, efforts to incorporate these qualities that establish the NNP role as unique are not made. The concept of defining the role as unique is also devalued as NNPs feel that they have affiliated with a more powerful group and therefore, this is not necessary. The long term implications of this are that NNPs will be unable to achieve a status greater than resident replacements and NNP practice will continue to provide a service that can readily be replaced by surplus physicians.

NNPs must acknowledge, accept and continue to foster this support from the discipline of medicine as it is equally important to the success of establishing the role. The difference is that this support from medicine seems to exist whereas, according to this data, support from the nursing group is seemingly lacking.

Limitations

Because nursing is usually managed within a hospital institution in contrast to medicine which, historically, has been more independent of the institution, the nursing model may reflect more "organizational" types of constraints than actual nursing constraints. It is difficult and perhaps

impossible to neatly delineate groups or models without asking many more questions that might help to further define the practice model.

Unfortunately, the length of the questionnaire was constraining. A less lengthy questionnaire may have increased the response rate. The overall response rate of 48% indicates that the results may be biased toward those who felt strongly enough to complete and return the questionnaire. Results may not be generalizable to the entire population of NNPs. The utility of the tool, as modified for this study, is limited to NNP practice. The questions are unique to the NNP role. For use in groups other than NNPs, the tool would require further adaptation.

Implications for Nursing

Data from this study indicates that increased support from the discipline of nursing may further facilitate NNPs in defining their unique contribution to healthcare delivery in the NICU. The theoretical framework upon which this study is based describes the critical role that support from the discipline of nursing may have on defining the future of the NNP role. In the absence of this support NNP practice may become inappropriately aligned with the discipline of medicine and the philosophies of nursing practice may fail to be integrated into the role. This may result in role confusion and a lack of professional unity. Lack of unity within the profession will dilute the power and motivation necessary to lead NNPs to direct and define their professional future in healthcare.

Future Research

In conclusion, only describing NNP practice will delay what is truly necessary for securing the future of NNP practice. This study has provided the necessary preliminary work of describing the NNP role. Establishing and securing the future of NNPs as innovative and efficient healthcare providers is the next step. Once the NNP role has been defined, the scientific base of NNP practice must be expanded to provide tangible proof of the efficiency and effectiveness of NNPs as healthcare providers in the NICU. NNPs must acknowledge, define and demonstrate their value as healthcare providers and then move on to improve their professional practice. Through increased control over practice, NNPs will assume responsibility for their professional future and continue to refine their practice to offer even greater contributions. Professional viability in today's healthcare climate will require NNPs to define their contribution to healthcare delivery and prove its measurable impact on patient care and cost-efficiency.

Future research should include identifying the most powerful indicators of facilitation so that NNPs may build on them. Once identified, these indicators can be incorporated into daily practice. Future research is also necessary for prioritizing the focus of future change.

Bellig (1983) offers additional information regarding NNP utilization and areas for future research. The survey was distributed to a random sample of 21 U.S. hospitals that employed NNPs. The questionnaire included such

issues as: scheduling, supervision, educational preparation, salary, clinical responsibilities, and departmental and unit employment. The survey found that 82% of clinicians were employed by nursing with the remaining percentage employed by medicine. Our survey found that 47.5% of respondents worked for medicine and 33.3% worked for nursing. With regard to scheduling, 82% of Bellig's sample worked 37.5 to 40 hour work weeks and the range of hours extended to 60 hours per week. This survey found that NNPs worked an average of 41.2 hours per week with a range from 40 to 60 hours (to eliminate part-time individuals, NNPs who reported working <40 hours/week were considered part-time). A more recent survey, "Economic issues and Advanced Practice" conducted by the SIG-AP group from NANN (1994), found that NNPs average years of practice was 6.3 years comparable to this survey's finding of 6.1 years. The majority of respondents held a bachelors degree or higher. These findings were confirmed by this study which found that 37% of respondents held a bachelors degree and 39% held a Master's degree. Bellig's study (1983) found that twelve of seventeen hospitals surveyed had clinicians who were certificate prepared only. The remaining five hospitals had a combination of Master's and certificate prepared NNPs and the average number of NNPs at each site was five. About one in four NNPs (27%) in the NANN SIG-AP survey reported practicing in multiple roles, similar to the 30% of respondents in this study who reported that they rotated through many roles. Eighty percent worked in level III nurseries which correlates with the 81% that this survey

found. The NANN-SIG AP survey reported that 55% of respondents reported working with housestaff as did respondents to this study.

Schultz, Liptak, and Avanti (1994) compared length of stay of neonates cared for by NNPs to those cared for by pediatric medical residents, in the transitional care nursery and found that "care by the nurse practitioners reduced length of stay in the transitional care nursery by 2.4 days and charges by \$3,491.00/per patient." (1994, p.52). Further research that continues to support and expand on these findings is necessary.

Conclusion/Summary

NNP practice must contribute to the discipline of nursing as well as the discipline of medicine. The nursing role should be enhanced and further developed by the practitioner's medical management skills. For NNPs to allow their nursing attributes to become diluted or rejected as inferior to their newly acquired medical skills is submissive and will contribute to the "marginality" of the profession (Roberts, 1983). To prevent this, NNPs must be supported at all levels of nursing. The support for NNP practice cannot come solely from medicine, but must come equally from the discipline of nursing for nursing to acknowledge professional gain from this advanced practice role. Lack of support from the profession and philosophy under which the individual has been trained will lead to role confusion and oppression (Roberts, 1983). The value of the role must be acknowledged by nursing before the contributions of the role can be fully realized.

For NNP practice to develop its own course and unique contribution to healthcare, the subordinate relationship that is fostered and perpetuated

through the apprenticeship model of NNP training by physicians requires redefining and reorganizing to allow a more collaborative relationship that will permit the skills and philosophies valued by nursing to be as much a part of the NNP role as the patient's medical management. MD supervision at all levels (from intern to attending) is not appropriate and will further contribute to the subordination of the role. Collaboration rather than supervision will enhance and support the development of the NNP role and will ultimately result in a practitioner who successfully combines these equally valuable skills and is an asset to both medicine and nursing. A practitioner who successfully combines these attributes will offer the greatest contribution to patient care and to the healthcare delivery system.

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COMMITTEE ON HUMAN RESEARCH
INITIAL SUBCOMMITTEE REVIEW APPLICATION
COVER PAGE

PRINCIPAL INVESTIGATOR (UCSF Faculty)
(Name & Degree) Kathryn A. Lee, RN, PhD

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University
Title Associate Professor Dept Family Health Care
Phone Number 476-4442 Is P.I. Sponsor/
Advisor Only? yes

CO-P.I.
(Name & Degree) Valerie Ruth-Sanchez, RN, NNP

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University
Title Student Dept Family Health Care
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SUBMISSION
DATE April 19, 19

PROJECT
TITLE Neonatal Nurse Practitioners: Facilitators and Constraints to Practice

EXPEDITED REVIEW CATEGORY NUMBER 11 (from PART V-B of the UCSF Guidelines for Research Involving Human Subjects, October 1987)

NAMES/DEGREES OF ALL OTHER INVESTIGATORS:

- Elena Bosque, RN, PhD
Mary Lynch, RN, MSN
Julie Villardi, RN, MSN, NNP

HISTORY OF THIS PROJECT:

- Previous CHR approval #
[X] New
Modification (Highlight changes in protocol.)
Renewal Expiration Date

PROCEDURES (List all procedures to be done for purposes of the study):

- 9-page questionnaire

SUBJECTS (Discuss in protocol. If exact number is not known please estimate.):

- Experimental Subjects:
Number (This Year) 1600 (Total for Study) 1600
Source(s) Mailing list
Reimbursement mechanical pencil
Controls/Normals:
Number (This Year) N/A (Total for Study)
Source(s)
Reimbursement

Special Subject Populations (Check and discuss in protocol See Appendix G of CHR Guidelines.)

- AIDS/HIV-Infected Individuals
Minors Fetuses, Pregnant Women
Those Unable to Speak or Read English
Those Unable to Consent for Themselves
Prisoners

SITE (Check and discuss in protocol):

- Parnassus VAMC SFGH MtZIO
Other UCSF site
Other National survey

FUNDING:

- Will this study be funded? [X] Yes [] No [] Pending
[] Federal [] Pharmaceutical/Device Co. [X] Other
Agency/Sponsor Name (Grant/Contract #, if known):
discretionary departmental funds

Kathryn A Lee 4/19/94
PRINCIPAL INVESTIGATOR'S SIGNATURE &
DATE

**NEONATAL NURSE PRACTITIONERS:
FACILITATORS AND CONSTRAINTS TO PRACTICE**

1. Study Aims, Background and Design

The majority of studies that have sought to identify factors related to stress in Nurse Practitioner practice have focused on Nurse Practitioners in primary care settings. One study included Neonatal Nurse Practitioners (NNPs), but that study had a limited sample of attendees at a conference that also included Clinical Nurse Specialists (Antonelli, 1985). The purpose of this descriptive study is to identify facilitators and constraints to practice as perceived by the NNP and then describe these factors according to identified categories of professional development, role perception, role autonomy, and role value. Data generated from this study will provide important information for shaping the future role of the NNP.

2. Subject Population: Inclusion/Exclusion Criteria, Use of Special Subjects Groups, and Methods of Access

The population to be studied is a group of Neonatal Nurse Practitioners. The Association for Women's Health, Obstetrics, and Neonatal Nurses (AWHONN) is the certifying board for NNPs. This organization has the largest group of NNPs, with a mailing list of approximately 1600 NNP from which a sample can be obtained.

The mailed packet will include a cover letter, the survey, a gift of a mechanical pencil with the School of Nursing inscription. Participants who would like to have the results of this study sent to them are requested to self-address an enclosed postcard and include it within the stamped envelope provided for the questionnaire to be returned to the research team. These postcards will be separated from the completed questionnaires upon arrival to the research team.

3. Procedures to be Done for the Purposes of the Study

A survey questionnaire has been adapted from a tool previously used to test the stresses of primary care nurse practitioners (Ventura, et al., 1989). A Likert-type scale will be used to allow respondents to identify specific conditions of practice as either a constraint or a facilitator to their practice. The tool includes items related to professional development, role perception, role autonomy, and role value. All statements relate to one of these categories (see attached copy of questionnaire).

The adapted tool will be evaluated for content validity by six neonatal experts from the San Francisco Bay area. The group will include 5 nurses and 1 physician. The tool will then be used in a pilot study of 6 NNPs who have been practicing for greater than 1 year and in more than one setting. Final revision of the tool will be based on the suggestions of the expert committee and the results of the pilot study.

The results will be reported using descriptive statistics (i.e., measures of central tendency and frequencies/percentages). The demographic variables related to the work environment will be examined for relationships to facilitators/constraints in the categories of role development, perception, autonomy, and value. Data pertaining to these four aspects of NNP practice will provide guidance in the refinement of a model of practice for NNPs.

4. **Risks: Potential Risks/Discomforts to Subjects, Including Possible Loss of Confidentiality, and Methods for Minimizing These Risks**

Subjects may experience some inconvenience because of the time involved to complete the questionnaire. Participants already experiencing role conflict may experience discomfort when completing the study. Confidentiality will be ensured by identifying returned questionnaires by code number only.

5. **Benefits: Potential Direct Benefits to Subjects and General Benefits to Subject Group, Medical Science, and/or Society**

Subjects experiencing role conflict may find participation beneficial and cathartic. Professional benefits include developing a framework for NNPs that contributes to general nursing practice. Maintenance of nursing identity in this role allows for the development of experts in practice.

6. **Consent Process and Documentation**

A waiver of signed consent is requested under category XC-1 because the risk of study participation is minimal and the subjects will be completely anonymous. Return of the survey will imply consent.

7. **Qualifications of Investigators**

Kathryn Lee, RN, PhD is Associate Professor in Family Health Care Nursing in the School of Nursing at UCSF. She has been a P.I. on many grant proposals, including a survey of over 800 nurses using a 35-page questionnaire which resulted in a 69% response rate (Lee, 1992; Lee & DeJoseph, 1992; Lee & Rittenhouse, 1991, 1992, 1993). She is the P.I. of a training grant from the Division of Nursing for Neonatal Advance Practice training. Her expertise in formulating the questionnaire is based on past experience with this type of research. She is serving as Advisor for Valerie Ruth-Sanchez.

Valerie Ruth-Sanchez, RN, NNP is a second year Master of Science in Nursing student in the Department of Family Health Care Nursing, School of Nursing, UCSF. She has been actively working as an NNP. She has provided the substantive content within the questionnaire. The others members of the research team are clinical faculty in the Neonatal Advanced Practice Training Grant (K.Lee, P.I.)

References:

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NURSE PRACTITIONER SURVEY



**Veterans
Administration
MEDICAL CENTER
Buffalo, New York**

Supported by funds from Veterans Admin. Health Services
Research and Development Service, Wash. D.C. (IIR-84 075)

VETERANS ADMINISTRATION
NURSE PRACTITIONER SURVEY

The NP survey is presented in four parts. Part I specifies conditions that may influence NP practice. Part II considers influence of key persons. Part III specifies general issues. Part IV addresses background information.

Directions: Part I

Conditions can affect your role as a nurse practitioner (NP) in a positive or negative way. FACILITATORS are positive influences which enhance your role. CONSTRAINTS are negative influences which impede your role. Some conditions may personally not affect your role at all.

Part I lists items to address these conditions. It requires a two step response. Section A represents a scale with a response continuum ranging from "strongly facilitates" to "strongly constrains." You are requested to CIRCLE ONE of the seven options to indicate the degree to which the condition FACILITATES (3,2,1), has NO EFFECT (0), or CONSTRAINS (-1,-2,-3) your practice.

Section B provides an opportunity to clarify or describe the option selected in Section A. Section B options may vary from page to page, based upon the items. Please CIRCLE the option in Section B that best represents your response for each item. If you select the Section B option "OTHER", please specify your response in the margin or where space is available.

Example:

	Section A							Section B				
	Extent item affects my practice							Because it is:				
	Facilitates			NO EFFECT	Constrains			Clarification				
	Strongly	Moderately	Mildly		Mildly	Moderately	Strongly	None	Too Little	Enough	Too Much	Other (Specify)
	(3)	(2)	(1)	(0)	(-1)	(-2)	(-3)	(1)	(2)	(3)	(4)	(5)
CLERICAL SUPPORT available	3	2	1	0	-1	-2	-3	1	2	3	4	5

This indicates the NP considered the clerical support to be a mild constraint, because there was too little available to him/her.

Definition of Nurse Practitioner:

For the purpose of this study, a NURSE PRACTITIONER (NP) is defined as a registered nurse who has completed a formal, organized nurse practitioner program, resulting in a certificate or academic degree and is prepared with advanced competencies and skills in assessing and managing the physical and psychosocial status of individuals, families, and groups.

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The scope of the nurse practitioner practice may include, but is not limited to the following:

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- (1) health promotion, maintenance and restoration;
- (2) management of stable chronic diseases in ambulatory, long term care settings;
- (3) assessment, treatment, and/or referral of patients with various acute conditions; and/or
- (4) provision of services in employee health.

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If the above NP definition is in accordance with your VA responsibilities, please complete and return the following questionnaire.

If you feel the above definition is not in accordance with your VA responsibilities, please indicate so on the enclosed post card and return it to us.

cc

Part I

(For each of the following items, CIRCLE ONE option in Section A to indicate the extent the condition influences your NP practice and CIRCLE ONE option in Section B to clarify how the item affects your practice).

Items 1-24 describe conditions about your NP role that may affect your practice.	Section A							Section B				
	Extent item affects my practice							Because it is:				
	Facilitates			NO EFFECT	Constrains			Clarification				
	Strongly	Moderately	Mildly	NO EFFECT	Mildly	Moderately	Strongly	None	Too Little	Enough	Too Much	Other (Specify)
	(3)	(2)	(1)	(0)	(-1)	(-2)	(-3)	(1)	(2)	(3)	(4)	(5)
1. The INDEPENDENCE associated with my NP role.....	3	2	1	0	-1	-2	-3	1	2	3	4	5
2. The RESPONSIBILITY I have for patient care.....	3	2	1	0	-1	-2	-3	1	2	3	4	5
3. The amount of MD SUPERVISION I receive.....	3	2	1	0	-1	-2	-3	1	2	3	4	5
4. The amount of SUPERVISION I receive from NURSING....	3	2	1	0	-1	-2	-3	1	2	3	4	5
5. NUMBER OF PATIENTS assigned to my care.....	3	2	1	0	-1	-2	-3	1	2	3	4	5
6. Amount of CLINICAL DUTIES assigned to me.....	3	2	1	0	-1	-2	-3	1	2	3	4	5
7. NON-CLINICAL DUTIES assigned to me	3	2	1	0	-1	-2	-3	1	2	3	4	5
8. The FLEXIBILITY inherent in my NP position.....	3	2	1	0	-1	-2	-3	1	2	3	4	5
9. CLERICAL SUPPORT available.....	3	2	1	0	-1	-2	-3	1	2	3	4	5
10. PHYSICAL SPACE available.	3	2	1	0	-1	-2	-3	1	2	3	4	5
11. SUPPLIES available to me.	3	2	1	0	-1	-2	-3	1	2	3	4	5
12. AUTHORITY for me to PRESCRIBE MEDICATION.....	3	2	1	0	-1	-2	-3	1	2	3	4	5

(For each of the following items, CIRCLE ONE option in Section A to indicate the extent the condition influences your NP practice and CIRCLE ONE option in Section B to clarify how the item affects your practice).

Items 25-33 present VA practices that may affect NPs.

Section A

Extent item affects my practice

Section B

Because it is:

	Facilitates				Constrains			Clarification				
	Strongly (3)	Moderately (2)	Mildly (1)	NO EFFECT (0)	Mildly (-1)	Moderately (-2)	Strongly (-3)	None (1)	Too Limiting (2)	Appropriate (3)	Too Broad (4)	Other (Specify) (5)
25. Scope of my CLINICAL PRIVILEGES	3	2	1	0	-1	-2	-3	1	2	3	4	5
26. The FUNCTIONAL STATEMENT DESCRIBING my position.....	3	2	1	0	-1	-2	-3	1	2	3	4	5
27. Use of PROTOCOLS.....	3	2	1	0	-1	-2	-3	1	2	3	4	5
28. Procedure for a NURSE to EVALUATE performance.	3	2	1	0	-1	-2	-3	1	2	3	4	5
29. Procedure for a PHYSICIAN to EVALUATE my performance.....	3	2	1	0	-1	-2	-3	1	2	3	4	5
30. Mechanism to settle PROFESSIONAL and PRACTICE RELATED issues.....	3	2	1	0	-1	-2	-3	1	2	3	4	5
31. COLLECTIVE BARGAINING for NPs at my center....	3	2	1	0	-1	-2	-3	1	2	3	4	5
32. Local VAMC Trends re: UTILIZATION of NPs.....	3	2	1	0	-1	-2	-3	1	2	3	4	5
33. VA mandatory CONTINUING EDUCATION REVIEWS.....	3	2	1	0	-1	-2	-3	1	2	3	4	5

indicate the extent the condition influences your NP practice and CIRCLE ONE option in Section B to clarify how the item affects your practice).

B is:

Section A

Section B

Extent item affects my practice

Because it is:

Items 34-43 refer to personal feedback that NPs may experience.

Facilitates

Constrains

Clarification

Strongly	Moderately	Mildly	NO EFFECT	Mildly	Moderately	Strongly
(3)	(2)	(1)	(0)	(-1)	(-2)	(-3)
3	2	1	0	-1	-2	-3
3	2	1	0	-1	-2	-3
3	2	1	0	-1	-2	-3
3	2	1	0	-1	-2	-3
3	2	1	0	-1	-2	-3
3	2	1	0	-1	-2	-3
3	2	1	0	-1	-2	-3
3	2	1	0	-1	-2	-3
3	2	1	0	-1	-2	-3
3	2	1	0	-1	-2	-3

None	Too Little	Enough	Ideal	Other (Specify)
(1)	(2)	(3)	(4)	(5)
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5

- 34. MY SALARY.....
- 35. FRINGE BENEFITS allocated to me.....
- 36. PERSONAL SATISFACTION as a VA NP.....
- 37. STATUS in my NP role....
- 38. RECOGNITION from other providers.....
- 39. CONTINUITY of my caseload
- 40. My ACCESS to patients...
- 41. My JOB SECURITY
- 42. PROMOTION as an NP.....
- 43. PATIENT SATISFACTION.....

ion
Other (Specify)
(5)
5
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5
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Directions: Part II

Now that you have reached this part of the survey, Part II lists key people who may affect your NP practice. You are requested to indicate the extent that the person affects your practice by CIRCLING ONE option in Section A, as before.

However, Section B considers TWO aspects of clarification: (1) SUPPORT given by person to you; and (2) accuracy of the person's PERCEPTION of your NP role. Your Section B response includes CIRCLING ONE option from EACH category.

Example:

	<u>Section A</u>							<u>Section B</u>						
	Extent person affects my practice							Because:						
	Facilitates				Constrains			Clarification						
	Strongly	Moderately	Mildly	NO EFFECT	Mildly	Moderately	Strongly	Support				Perception		
	(3)	(2)	(1)	(0)	(-1)	(-2)	(-3)	Negative	Neutral	Positive	Unknown	Inaccurate	Accurate	Unknown
KEY PERSON	(3)	(2)	(1)	(0)	(-1)	(-2)	(-3)	(1)	(2)	(3)	(4)	(1)	(2)	(3)
Staff Nurses.....	3	2	1	0	-1	-2	-3	1	2	3	4	1	2	3

The above respondent indicated staff nurses MODERATELY FACILITATED his/her practice, because they were SUPPORTIVE of NPs. However, the respondent DID NOT KNOW about the accuracy of the STAFF NURSES' PERCEPTION of the NP's role.

Part II

people that e. (For each of the following, CIRCLE ONE option in Section A to indicate the extent of influence on your role. CIRCLE ONE option in EACH CATEGORY in Section B for clarification.)

Section A

Section B

Extent item affects my practice

Because it is:

Items 44-50 consider the affect of interactions with others.

	Facilitates			NO EFFECT	Constrains		
	Strongly	Moderately	Mildly		Mildly	Moderately	Strongly
	(3)	(2)	(1)	(0)	(-1)	(-2)	(-3)
44. TOP NURSING ADMINISTRATOR.....	3	2	1	0	-1	-2	-3
45. MID-LEVEL Nursing MANAGEMENT.....	3	2	1	0	-1	-2	-3
46. HEAD NURSE/UNIT COORDINATOR.....	3	2	1	0	-1	-2	-3
47. CLINICAL SPECIALIST/ NURSING INSTRUCTOR..	3	2	1	0	-1	-2	-3
48. STAFF NURSES	3	2	1	0	-1	-2	-3
49. TOP HOSPITAL ADMINISTRATOR(s)....	3	2	1	0	-1	-2	-3
50. TOP MEDICAL ADMINISTRATOR(s)....	3	2	1	0	-1	-2	-3

		Clarification				
		Support		Perception		
Negative	Neutral	Positive	Unknown	Inaccurate	Accurate	Unknown
(1)	(2)	(3)	(4)	(1)	(2)	(3)
1	2	3	4	1	2	3
1	2	3	4	1	2	3
1	2	3	4	1	2	3
1	2	3	4	1	2	3
1	2	3	4	1	2	3
1	2	3	4	1	2	3
1	2	3	4	1	2	3

KEY PERSONS:

- 44. TOP NURSING ADMINISTRATOR.....
- 45. MID-LEVEL Nursing MANAGEMENT.....
- 46. HEAD NURSE/UNIT COORDINATOR.....
- 47. CLINICAL SPECIALIST/ NURSING INSTRUCTOR..
- 48. STAFF NURSES
- 49. TOP HOSPITAL ADMINISTRATOR(s)....
- 50. TOP MEDICAL ADMINISTRATOR(s)....

Section A

Extent items affect
my practice

Section B

Because it is:

KEY PERSONS: (Cont'd.)	Facilitates			NO EFFECT	Constrains			Clarification						
	Strongly (3)	Moderately (2)	Mildly (1)		Mildly (-1)	Moderately (-2)	Strongly (-3)	Support				Perception		
								Negative (1)	Neutral (2)	Positive (3)	Unknown (4)	Inaccurate (1)	Accurate (2)	Unknown (3)
51. PERMANENT HOUSE MDs..	3	2	1	0	-1	-2	-3	1	2	3	4	1	2	3
52. MDs I work closely with	3	2	1	0	-1	-2	-3	1	2	3	4	1	2	3
53. RESIDENTS.....	3	2	1	0	-1	-2	-3	1	2	3	4	1	2	3
54. MEDICAL STUDENTS.....	3	2	1	0	-1	-2	-3	1	2	3	4	1	2	3
55. CONSULTANT MDs.....	3	2	1	0	-1	-2	-3	1	2	3	4	1	2	3
56. PATIENTS/FAMILIES....	3	2	1	0	-1	-2	-3	1	2	3	4	1	2	3
57. ALLIED HEALTH PROFESSIONALS.....	3	2	1	0	-1	-2	-3	1	2	3	4	1	2	3
58. VOLUNTEERS/AUXILIARY SERVICE.....	3	2	1	0	-1	-2	-3	1	2	3	4	1	2	3
59. Person responsible for my EVALUATION....	3	2	1	0	-1	-2	-3	1	2	3	4	1	2	3

Directions: Part III

The next group of items specify conditions that, if they occur, suggest a facilitating or constraining influence. You are being asked, first, if the specified condition has occurred, then if it has a personal impact upon your NP practice.

Section A presents options to indicate if the listed condition has occurred, in terms of Yes (1), No (2) or Unknown (3). Please CIRCLE ONE Section A response per item.

Section B presents the response continuum to indicate the kind of impact you feel the specific condition has upon NP practice, from STRONGLY FACILITATES (3) to STRONGLY CONSTRAINS (-3). (This response set is similar to the Section A response for previous items.) Please CIRCLE ONE Section B response.

1 on
Unknown
(3)
3
3
3
3
3
3
3
3
3

Example:

	Section A			Section B						
	Occurs:			Facilitates			Constrains			
	Yes	No	Unknown	Strongly	Moderately	Mildly	NO EFFECT	Mildly	Moderately	Strongly
	(1)	(2)	(3)	(3)	(2)	(1)	(0)	(-1)	(-2)	(-3)
NPs FAVORED over MDs to fill vacancies.....	1	2	3	3	2	1	0	-1	-2	-3

The NP respondent indicated that NPs were not favored over MDs to fill vacancies, but felt that it had no effect on his/her practice personally.

(Please CIRCLE ONE Section A option and ONE Section B option per item.)

	<u>Section A</u>			<u>Section B</u>						
	Occurs:			Facilitates			Constrains			
	Yes (1)	No (2)	Unknown (3)	Strongly (3)	Moderately (2)	Mildly (1)	NO EFFECT (0)	Mildly (-1)	Moderately (-2)	Strongly (-3)
60. NPs favored over MDs to fill vacancies.....	1	2	3	3	2	1	0	-1	-2	-3
62. MDs favored over NPs to fill vacancies.....	1	2	3	3	2	1	0	-1	-2	-3
64. NPs favored over PAs to fill vacancies	1	2	3	3	2	1	0	-1	-2	-3
68. PAs favored over NPs to fill vacancies.....	1	2	3	3	2	1	0	-1	-2	-3
64. NP positions CONVERTED to STAFF NURSE positions....	1	2	3	3	2	1	0	-1	-2	-3
66. NPs with specific EDUCATION PREPARATION favored.....	1	2	3	3	2	1	0	-1	-2	-3
66. Working alongside NPs with VARYING PREPARATION..	1	2	3	3	2	1	0	-1	-2	-3
67 STATE MANDATORY CONTINUING EDUCATION requirement for licensure.....	1	2	3	3	2	1	0	-1	-2	-3
68. NP CERTIFICATION requirement.....	1	2	3	3	2	1	0	-1	-2	-3
69. Role distinction between NPs and CLINICAL SPECIALISTS blurred.....	1	2	3	3	2	1	0	-1	-2	-3
70. Role distinction between NPs and PAs blurred.....	1	2	3	3	2	1	0	-1	-2	-3
71. Effects of shift to DIAGNOSTIC RELATED GROUPINGS (DRG's).....	1	2	3	3	2	1	0	-1	-2	-3

ins

Strongly

(-3)

-3

-3

-3

-3

-3

-3

-3

-3

-3

-3

-3

-3

-3

-3

(Please indicate your answer to the following general statements by writing in your response to each in the space provided).

PLEASE ADD ANY ADDITIONAL FACTORS THAT MAY INFLUENCE YOUR PRACTICE THAT HAVE NOT BEEN IDENTIFIED.

Section A

Extent item affects my practice

Facilitates

Constrains

Clarification

Conditions: (List)

Strongly Moderately Mildly (3)(2)(1)	NO EFFECT (0)	Mildly Moderately Strongly (-1)(-2)(-3)			
3 2 1	0	-1 -2 -3			
3 2 1	0	-1 -2 -3			
3 2 1	0	-1 -2 -3			

Because it is: (Please fill in)

72.

73.

74.

Directions: Part IV

Items in Part IV seek to obtain information about such things as your RN preparation, your NP preparation, your professional experience and some personal demographic information in order to describe the NPs sampled. Answers are recorded either by circling an associated number in a multiple choice option, or by directly filling in your answer as indicated.

Example:

(a) Site of Nurse Practitioner Program I attended was:

1. on the job
2. hospital based/medical center
3. university based/continuing education
- ④ Masters' degree program
5. Other (Specify) _____

(b) The length of the theoretical component of my NP program was
0 years, 9 months.

The above respondent identified that he/she attended a master's degree NP preparation program with a 9 month theoretical component.

Part IV

The following items address both your basic nursing preparation and your nurse practitioner preparation.

EDUCATIONAL BACKGROUND

(CIRCLE ONE number to the left of the option that best represents your response to each of the following).

75. Basic nursing program attended resulted in:

1. ASSOCIATE DEGREE
2. HOSPITAL DIPLOMA
3. BACCALAUREATE DEGREE
4. MASTER'S DEGREE (MS or MSN)
5. OTHER (specify) _____

76. Highest nursing degree held:

1. ASSOCIATE DEGREE
2. HOSPITAL DIPLOMA
3. BACCALAUREATE
4. MASTERS
5. DOCTORATE

77. Highest non-nursing degree held is:

1. ASSOCIATE
2. BACCALAUREATE
3. MASTERS
4. DOCTORATE
5. OTHER (specify) _____

78. Site of the nurse practitioner program attended was:

1. ON-THE-JOB
2. HOSPITAL-BASED/MEDICAL CENTER
3. UNIVERSITY-BASED/CONTINUING EDUCATION
4. MASTER'S PROGRAM
5. OTHER (specify) _____

79. NNP certification held:

1. ANA
2. NACOG
3. NAPNAP
4. STATE CERTIFICATION
5. NONE
6. OTHER (specify) _____

(Fill in your answer for each of the following. If none, please indicate by "zero").

NURSE PRACTITIONER PREPARATION

you

- 80. The length of the theoretical component of my NP program was ____ years, ____ months.
- 81. Length of the preceptorship, or clinical component of my NP program was ____ years, ____ months.
- 82. Discipline of my major preceptor in my NP program was _____.
- 83. The year I completed my NP program was _____.
- 84. My NP program specialty area was _____.

EMPLOYMENT PROFILE

- 85. Length of time I've been employed as an NP in a non-VA setting has been ____ years, ____ months.
- 86. Length of time I've been employed as an NP in the VA system is ____ years, ____ months.
- 87. Length of time I've been employed in the current VA facility is ____ years, ____ months.
- 88. Number of positions held as an NP in all settings is _____.
- 89. Number of NPs employed in current setting (yourself included) is ____.
- 90. Length of time employed in the VA other than as an NP has been ____ years, ____ months.
- 91. NP specialty area currently employed in is _____.

EMPLOYMENT PROFILE (cont'd.)

(Circle ALL numbers to the left of the answer choice(s) that best represent your response(s) to each of the following statements.)

92. The VA setting(s) of my current employment is:

- | | | |
|----------------------------------|--|---------------------------|
| 1. ACUTE CARE - ICU - MICU - CCU | | 9. OPERATING ROOM |
| 2. SURGICAL UNIT | | 10. EMERGENCY ROOM |
| 3. MEDICAL UNIT | | 11. EMPLOYEE HEALTH |
| 4. INTERMEDIATE UNIT | | 12. OUTPATIENT |
| 5. NURSING HOME CARE | | 13. HBHC |
| 6. PSYCHIATRY | | 14. SATELLITE CLINIC |
| 7. ALCOHOL/DRUG TREATMENT | | 15. DOMICILIARY |
| 8. HEMODIALYSIS | | 16. OTHER (specify) _____ |

93. Supervision is most frequently provided to me by the following person:

1. NURSE, NON-NP
2. NURSE PRACTITIONER
3. PHYSICIAN
4. RESIDENT
5. NO ONE
6. OTHER (specify) _____

94. The following person completes and signs my yearly proficiency report:

1. CHIEF NURSE
2. ASSISTANT CHIEF NURSE
3. ACNS for EDUCATION
4. PHYSICIAN
5. OTHER (specify) _____

Directions:

The last few items describe the nature of your NP role. The KINDS of activities performed and the GUIDELINES within which you perform, or the characteristics of your practice style, are the focus of the last four items.

Please recall the activities that you usually engage in within a typical weeks' time in order to answer the following items. Answers are recorded in terms of the percentage of the total that each category, i.e., KIND OF ACTIVITY and STYLE OF PERFORMANCE, best represents your personal experiences in performance of your NP activities.

Definitions have been included as a frame of reference for each category.

Example:

What approximate percentage of your typical week's activities do you ACTUALLY spend in the following kinds of activities?

(Please fill in percentage of:)

I. TREATMENT OF ILLNESS	<u>35 %</u>
II. PROMOTION OF HEALTH	<u>30 %</u>
III. ADMINISTRATION	<u>15 %</u>
IV. EDUCATION	<u>10 %</u>
V. RESEARCH	<u>10 %</u>
VI. OTHER (specify) _____	<u>0 %</u>

DEFINITIONS

Definitions are included for standard interpretation of the terms used as the response options for items 95-98.

KINDS OF ACTIVITIES:

- I. TREATMENT OF ILLNESS: performance of activities often referred to as the curative component of health care delivery; provision of direct patient care related to the diagnoses or management of common medical conditions or impaired health states. Included in Category I are taking a medical history, performing a physical exam; ordering, performing, and/or interpreting diagnostic tests; prescribing medications; evaluating and managing symptomatology.
- II. PROMOTION OF HEALTH: performance of activities often referred to as the care component of health care delivery; provision of activities that include physiopsychosocially based assessment and supportive interventions administered directly to patients and/or families, or indirectly on behalf of patient or family. Included in Category II are patient teaching; supportive counseling; anticipatory guidance; and consultation with or referral to other providers.
- III. ADMINISTRATION: performance of activities within the management process; participating in functions directed at the organization of health care delivery. Included in Category III are planning and organizing the structural and procedural components in health care delivery. Some examples include: staff planning, task delegation, employee supervision, establishment of performance standards.
- IV. EDUCATION: planning and/or conducting informal staff development experiences for staff or students or formal programs such as, inservice education classes, workshops, continuing education programs, or clinical demonstrations of procedures, or preparation of educational materials.
- V. RESEARCH: conducting or participating in the conduct of scientific investigation of a specific aspect of health care or testing nursing theory.

CHARACTERISTICS OF PRACTICE STYLE

- I. INDEPENDENT/COLLABORATIVE: actions based entirely upon own judgment and assessment, or upon discussion of decisions or alternatives with another health care provider.
- II. UNDER INDIRECT SUPERVISION: NP assessment and evaluation made, then M.D. must be called or conferred with regarding treatment order or an M.D. specified usual plan of care followed.
- III. UNDER DIRECT SUPERVISION: M.D. required to briefly see patient or review chart after NP evaluation prior to decision regarding patient assessment and/or treatment, then cosign order.

(Please fill in your answer in the space provided for each of the following, referring to the previous definitions.)

95. What approximate percentage of your typical week's activities do you ACTUALLY spend in the following kinds of activities?

TREATMENT OF ILLNESS	_____	%
PROMOTION OF HEALTH	_____	%
ADMINISTRATION	_____	%
EDUCATION	_____	%
RESEARCH	_____	%

(total=100%)

96. What approximate percent of your typical week's activities would you PREFER to spend in the following kinds of activities?

TREATMENT OF ILLNESS	_____	%
PROMOTION OF HEALTH	_____	%
ADMINISTRATION	_____	%
EDUCATION	_____	%
RESEARCH	_____	%

(total=100%)

97. What approximate percentage of your typical week is ACTUALLY best described by the following characteristics of practice styles?

INDEPENDENT/COLLABORATIVE	_____	%
UNDER INDIRECT SUPERVISION	_____	%
UNDER DIRECT SUPERVISION	_____	%

(total=100%)

98. What approximate percentage of your typical week would you PREFER to be best described by the following characteristics of practice styles?

INDEPENDENT/COLLABORATIVE	_____	%
UNDER INDIRECT SUPERVISION	_____	%
UNDER DIRECT SUPERVISION	_____	%

(total=100%)

Your participation in this survey is greatly appreciated. Upon completion of the analysis of the information, a copy of the results will be sent to you for your information.

Any additional reactions or suggestions that you would like to make are welcome. Please use the space below for your comments.

**NEONATAL NURSE PRACTITIONERS:
FACILITATORS AND CONSTRAINTS TO PRACTICE**

**A STUDY TO DEVELOP A FRAMEWORK
FOR PRACTICE**

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Supported in part by funds from the James and Marjorie Livingston Endowed Chair position, the Office of Student Affairs in the School of Nursing at the University of California, San Francisco, and a training grant from the Division of Nursing (5D23NU01007).

EDUCATION AND EMPLOYMENT PROFILE
(Who are we? What do we do?)

Circle the number of the option that best represents your response to each of the following questions:

1. Basic nursing program attended resulted in:
- | | |
|--------------------------------|---|
| Associate degree | 1 |
| Hospital diploma | 2 |
| Baccalaureate degree. | 3 |
| Master's (MS or MSN) | 4 |
| Other (specify) _____ | 5 |
- Year completed: 19 _____

2. Highest nursing degree obtained:
- | | |
|-------------------------------|---|
| Associate degree | 1 |
| Hospital diploma | 2 |
| Baccalaureate degree. | 3 |
| Master's (MS or MSN). | 4 |
| Doctorate | 5 |
- Year obtained: 19 _____

3. Educational preparation as an NNP was:
- | | |
|------------------------------|---|
| On-the-job | 1 |
| Certificate program. | 2 |
| Master's program | 3 |
| Other (specify) _____ | 4 |
- Year obtained: 19 _____

4. I hold membership in the following organization(s): (Check all that apply)
- | | |
|--|--|
| <input type="checkbox"/> NANN
<input type="checkbox"/> AWHONN
<input type="checkbox"/> State Nursing Association | <input type="checkbox"/> ANA
<input type="checkbox"/> Sigma Theta Tau
<input type="checkbox"/> Other (specify) _____ |
|--|--|

5. I am currently employed in a: (Check all that apply)
- | | | |
|--|--|--|
| <input type="checkbox"/> Community Hospital
<input type="checkbox"/> Children's Hospital
<input type="checkbox"/> Private Hospital
<input type="checkbox"/> University Hospital | <input type="checkbox"/> Level 1 nursery
<input type="checkbox"/> Level 2 nursery
<input type="checkbox"/> Level 3 nursery
<input type="checkbox"/> Other (specify) _____ | <input type="checkbox"/> Teaching hospital
<input type="checkbox"/> Non-teaching hospital |
|--|--|--|

6. I have been working in my current setting for: _____ or _____
months months years

7. I have been working as an NNP for: _____ or _____
months months years

16. My primary role in my current NNP position is in:

- Intensive care nursery 1
- Intermediate care nursery 2
- Well baby nursery 3
- Chronic care nursery 4
- Transport 5
- CNS 6
- Educator 7
- NNP Program coordinator 8
- Administration 9
- Research 10
- Rotating through many roles 11

17. How much input into NNP practice do Neonatologists have in your setting?

- No control 0
- Very little 1
- Shared with nursing 2
- A great deal 3
- Total control 4

18. How much input into NNP practice does Nursing have in your setting?

- No control 0
- Very little 1
- Shared with medicine 2
- A great deal 3
- Total control 4

19. How much input into NNP practice do NNPs have in your setting?

- No control 0
- Very little 1
- Shared with medicine 2
- A great deal 3
- Total control 4

20. In my facility, I work:

- 8-hr shifts 1
- 10-hr shifts 2
- 12-hr shifts 3
- other length 4
- (specify) _____

21. My work shift is best described as:

- Permanent days 1
- Permanent evenings 2
- Permanent nights 3
- Rotating shifts 4
- every _____ weeks
- Other (specify) _____

22. I work _____ weekends per month.

23. Considering the last 2 work weeks, I worked an average of _____ hours per week.

FACILITATORS AND CONSTRAINTS TO PRACTICE

Adapted from Ventura, Feldman, & Crosby. Nurse Practitioner Survey
 Veterans Administration Medical Center
 Buffalo, New York, 1989

(What helps us? What hinders us?)

Directions:

Section A contains items that address Facilitators (positive influences that enhance your role) and CONSTRAINTS (negative influences that impede your role). You are asked to circle ONE of the seven options to indicate the degree to which the item FACILITATES (3, 2, 1), has NO EFFECT (0), or CONSTRAINS (-1, -2, -3) your practice.

Section B provides an opportunity to clarify the option you selected in Section A. If you feel this section helps to clarify your answer in Section A, please use it, otherwise feel free to leave it blank. If you select the option "OTHER" feel free to specify your response in the margin or where space is available.

These items describe conditions about your NNP role that may affect your practice:	SECTION A Extent item affects my practice							SECTION B Because it is: (Clarification)				
	Facilitates			NO EFFECT	Constrains			None	Too little	Enough	Too much	Other (specify)
	Strongly	Moderately	Mildly		Mildly	Moderately	Strongly					
Sample Question												
The opportunity for bathroom breaks	3	2	1	0	-1	-2	-3	1	2	3	4	5
Thus, my example response would read:	"The opportunity for bathroom breaks strongly constrains my practice							because it is too little'				

1. Number of patients assigned to my care	3	2	1	0	-1	-2	-3	1	2	3	4	5
2. Participating in rounds	3	2	1	0	-1	-2	-3	1	2	3	4	5
3. My access to patients	3	2	1	0	-1	-2	-3	1	2	3	4	5
4. Continuity of my caseload	3	2	1	0	-1	-2	-3	1	2	3	4	5
5. Responsibility I have for patient care	3	2	1	0	-1	-2	-3	1	2	3	4	5
6. Parent satisfaction	3	2	1	0	-1	-2	-3	1	2	3	4	5
7. Amount of MD supervision I receive	3	2	1	0	-1	-2	-3	1	2	3	4	5
8. Amount of nursing support I receive	3	2	1	0	-1	-2	-3	1	2	3	4	5
9. Use of protocols	3	2	1	0	-1	-2	-3	1	2	3	4	5
10. Mechanisms to resolve professional and practice issues/conflicts	3	2	1	0	-1	-2	-3	1	2	3	4	5
11. Scope of my clinical privileges	3	2	1	0	-1	-2	-3	1	2	3	4	5
12. Clerical support available	3	2	1	0	-1	-2	-3	1	2	3	4	5
13. Physical space available	3	2	1	0	-1	-2	-3	1	2	3	4	5
14. Supplies available to me	3	2	1	0	-1	-2	-3	1	2	3	4	5

SECTION A
Extent item affects
my practice

SECTION B

Facilitates Constrains

Because it is:
(Clarification)

	<u>Facilitates</u>			NO EFFECT	<u>Constrains</u>			Because it is: (Clarification)				
	<i>Strongly</i>	<i>Moderately</i>	<i>Mildly</i>		<i>Mildly</i>	<i>Moderately</i>	<i>Strongly</i>	<i>None</i>	<i>Too little</i>	<i>Enough</i>	<i>Too much</i>	<i>Other (specify)</i>
15. Amount of clinical duties assigned to me	3	2	1	0	-1	-2	-3	1	2	3	4	5
16. Non-clinical duties assigned to me	3	2	1	0	-1	-2	-3	1	2	3	4	5
17. Input into ethical dilemmas	3	2	1	0	-1	-2	-3	1	2	3	4	5
18. Nurses' awareness of NP role	3	2	1	0	-1	-2	-3	1	2	3	4	5
19. Physicians' awareness of NP role	3	2	1	0	-1	-2	-3	1	2	3	4	5
20. MD, PA, or NNP encounters at referral hospitals during transport	3	2	1	0	-1	-2	-3	1	2	3	4	5
21. Nurses' support of NP role	3	2	1	0	-1	-2	-3	1	2	3	4	5
22. Physicians' support of NP role	3	2	1	0	-1	-2	-3	1	2	3	4	5
23. Precepting NP students	3	2	1	0	-1	-2	-3	1	2	3	4	5
24. Precepting interns/residents	3	2	1	0	-1	-2	-3	1	2	3	4	5
25. Independence associated with my NNP role	3	2	1	0	-1	-2	-3	1	2	3	4	5
26. Flexibility inherent in my position	3	2	1	0	-1	-2	-3	1	2	3	4	5
27. Status in my NP role	3	2	1	0	-1	-2	-3	1	2	3	4	5
28. Participating in follow-up clinics	3	2	1	0	-1	-2	-3	1	2	3	4	5
29. Working with PAs	3	2	1	0	-1	-2	-3	1	2	3	4	5
30. Working with NPs at different levels of experience or education	3	2	1	0	-1	-2	-3	1	2	3	4	5
31. Recognition from other providers	3	2	1	0	-1	-2	-3	1	2	3	4	5
32. Fringe benefits allocated to me	3	2	1	0	-1	-2	-3	1	2	3	4	5
33. My salary	3	2	1	0	-1	-2	-3	1	2	3	4	5
34. Personal satisfaction as an NNP	3	2	1	0	-1	-2	-3	1	2	3	4	5
35. My job security	3	2	1	0	-1	-2	-3	1	2	3	4	5
36. Arranging for vacation coverage	3	2	1	0	-1	-2	-3	1	2	3	4	5

SECTION A
Extent item affects
my practice

SECTION B

Because it is:
(Clarification)

COMMITTEE MEMBERSHIP IN:

- 37. Joint practice
- 38. Ethics
- 39. Nursing service
- 40. Medical center
- 41. Other (specify) _____

	Facilitates			NO EFFECT	Constrains		
	Strongly	Moderately	Mildly		Mildly	Moderately	Strongly
37. Joint practice	3	2	1	0	-1	-2	-3
38. Ethics	3	2	1	0	-1	-2	-3
39. Nursing service	3	2	1	0	-1	-2	-3
40. Medical center	3	2	1	0	-1	-2	-3
41. Other (specify) _____	3	2	1	0	-1	-2	-3

OPPORTUNITY FOR:

- 42. Professional growth
- 43. Continuing education
- 44. Research participation
- 45. Associations with peers
- 46. Collective bargaining for NPs at my center
- 47. Promotion as an NP
- 48. Participation in nursing service planning and decisions
- 49. Participation in medical center planning and decisions
- 50. Nurses to evaluate NP role (formal or informal)
- 51. Physicians to evaluate NP role (formal or informal)
- 52. Attending neonatology faculty meetings
- 53. Attending nursing management committee meetings

	None	Too little	Enough	Too much	Other (specify)
42. Professional growth	1	2	3	4	5
43. Continuing education	1	2	3	4	5
44. Research participation	1	2	3	4	5
45. Associations with peers	1	2	3	4	5
46. Collective bargaining for NPs at my center	1	2	3	4	5
47. Promotion as an NP	1	2	3	4	5
48. Participation in nursing service planning and decisions	1	2	3	4	5
49. Participation in medical center planning and decisions	1	2	3	4	5
50. Nurses to evaluate NP role (formal or informal)	1	2	3	4	5
51. Physicians to evaluate NP role (formal or informal)	1	2	3	4	5
52. Attending neonatology faculty meetings	1	2	3	4	5
53. Attending nursing management committee meetings	1	2	3	4	5

SECTION A
Extent person affects my practice

SECTION B

Their
Perception of
my NNP
role

Support
they offer
me

These items list key people who may affect your NNP practice:

	<u>Facilitates</u>			<u>NO EFFECT</u>	<u>Constrains</u>			<u>Support they offer me</u>				<u>Their Perception of my NNP role</u>		
	<u>Strongly</u>	<u>Moderately</u>	<u>Mildly</u>		<u>Mildly</u>	<u>Moderately</u>	<u>Strongly</u>	<u>Negative</u>	<u>Neutral</u>	<u>Positive</u>	<u>Unknown</u>	<u>Inaccurate</u>	<u>Accurate</u>	<u>Unknown</u>
54. Head nurse of ICN	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?
55. Neonatologists	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?
56. MDs I work most closely with	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?
57. Consulting specialty physicians	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?
58. Top/midlevel nursing administrator(s)	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?
59. Top medical administrator(s)	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?
60. Private Pediatricians	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?
61. Family Practice MDs	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?
62. Obstetricians	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?
63. Allied health professionals (Pharm. RT, OT, PT, etc.)	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?
64. Medical students	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?
65. Residents/Interns	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?
66. Unit secretary	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?
67. Patients' families	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?
68. Person (medical) responsible for evaluating my performance	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?
69. Person (nursing) responsible for evaluating my performance	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?
70. NNP Coordinator (medical)	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?
71. NNP Coordinator (nursing)	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?
72. Person who arranges coverage for sick time and vacation	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?
73. Clinical Specialist	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?
74. Nursing School Instructor(s)	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?
75. Staff nurses	3	2	1	0	-1	-2	-3	-	0	-	?	1	2	?

Directions:

In Section A, indicate No (0), Yes (1) or Unknown (?) as to whether the situation occurred.

In Section B, indicate the effect this situation would have on your NP practice.

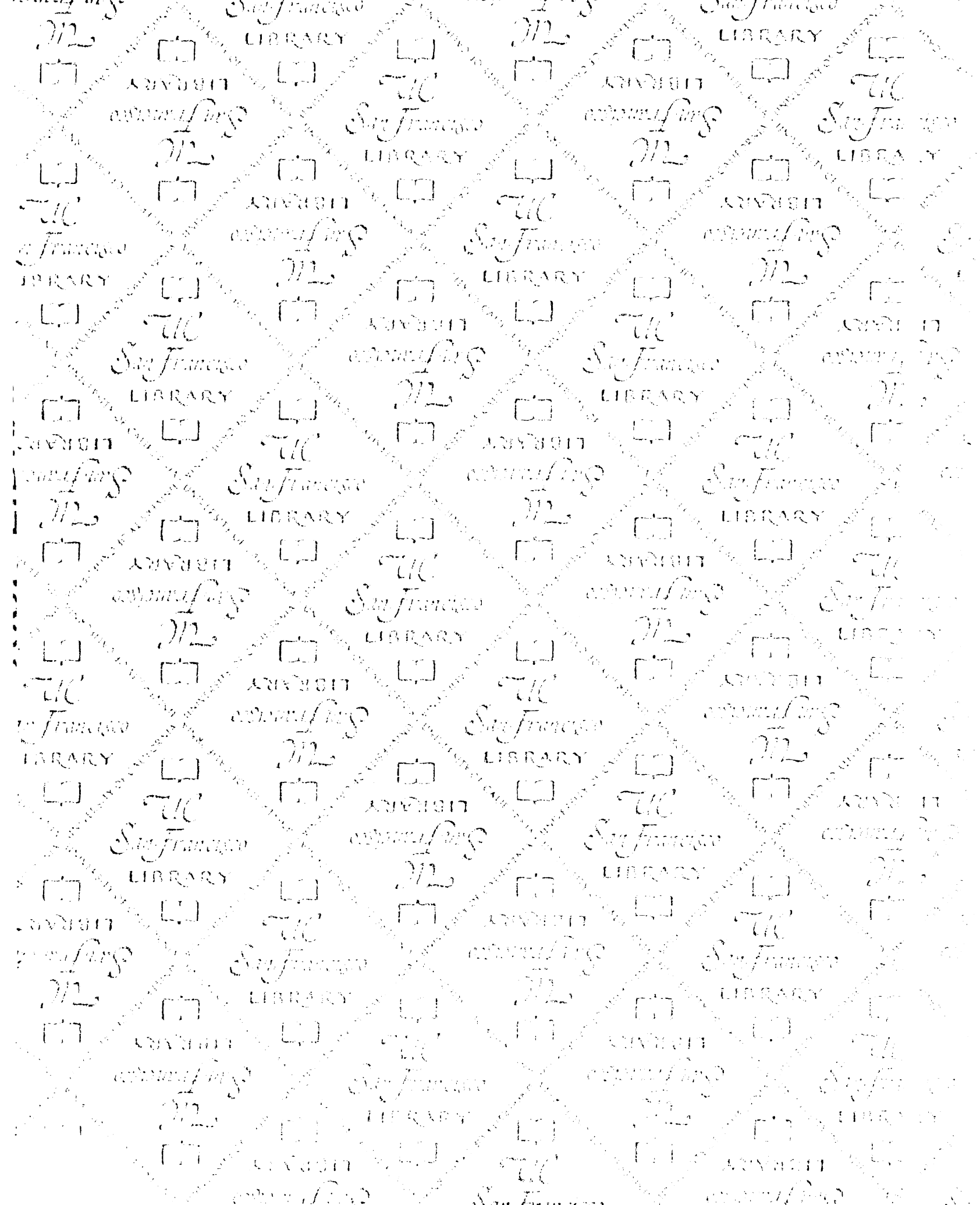
	SECTION A Did occur			SECTION B						
	No	Yes	Unknown	Facilitates			NO EFFECT	Constrains		
				Strongly	Moderately	Mildly		Mildly	Moderately	Strongly
76. NPs favored over PAs to fill vacancies	0	1	?	3	2	1	0	-1	-2	-3
77. PAs favored over NPs to fill vacancies	0	1	?	3	2	1	0	-1	-2	-3
78. NPs with specific education preparation favored	0	1	?	3	2	1	0	-1	-2	-3
79. My State's mandatory continuing education requirement for licensure	0	1	?	3	2	1	0	-1	-2	-3
80. My State's NP certification requirement	0	1	?	3	2	1	0	-1	-2	-3
81. Role distinction between NPs and CNSs blurred	0	1	?	3	2	1	0	-1	-2	-3
82. Role distinction between NPs and PAs blurred	0	1	?	3	2	1	0	-1	-2	-3
ATTENDING DELIVERIES:										
83. Equipment available	0	1	?	3	2	1	0	-1	-2	-3
84. Nursing support	0	1	?	3	2	1	0	-1	-2	-3
85. Physician back-up	0	1	?	3	2	1	0	-1	-2	-3
DURING TRANSPORT:										
86. Equipment available	0	1	?	3	2	1	0	-1	-2	-3
87. Nursing support	0	1	?	3	2	1	0	-1	-2	-3
88. Physician back-up	0	1	?	3	2	1	0	-1	-2	-3

We appreciate your time to complete these items. If you would like the results of this study sent to you, please write your name and address on the enclosed index card and include it in your return envelope with the questionnaire.

Please keep the mechanical pencil as a small token of our appreciation for your participation.

Thank you very much for participating!

COMMENTS?



For reference

Not to be taken from the room.

