The Neuroscience Acute Care Nurse Practitioner: Role Development, Implementation, and Improvement

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Changes in society and decreased access to care have driven the nursing profession to evolve creatively. This evolution resulted in the development of the role of the nurse practitioner (NP), successfully integrated in ambulatory settings since the 1960s.[1] With time, additional factors influenced the scope of NP practice. In the early 1990s, factors such as escalating health care costs and increased consumer demands for accountability led to evaluation of and changes in health care delivery.[2]

Health care reform was another factor that increased the scrutiny of medical school education and resident work hours.[3] As a result, hospitals have witnessed a shift of medical student training from tertiary to primary care sites.[2,4,5] Around this same time, legislation was passed that limited resident work hours to 80 per week.[6] These educational and legislative changes resulted in a void in care delivery in the early 1990s the role of acute care nurse practitioner (ACNP) evolved to fill this void. Since that time, studies have demonstrated the ability of ACNPs to provide high-quality, efficient care to patients in a variety of settings.[5,7–17]

With quality data supporting a positive role impact, opportunities for ACNP practice have expanded. For example, in a baseline study of 125 ACNPs, results indicated that practice occurred in tertiary and secondary health care settings[18] in a follow-up study of 384 ACNPs, the role had expanded to include a variety of specialty practice settings, such as step-down units, units without house staff coverage, oncology, transplant, cardiology, and radiology units.[19] By 2005, more than 3500 ACNPs were

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certified. In a 5-year longitudinal study from that time, the role had continued to expand from the traditional acute and critical care setting to outside the hospital setting.[20] Currently, 4500 of the nation's 195,000 advanced practice nurses (APNs) are ACNPs with 62% of their care delivered in the hospital setting.[21]

As the numbers and opportunities for ACNPs have increased, the successful integration of these providers into the health care setting has become a greater challenge. With approximately 4500 total ACNPs, role models to assist with this assimilation are scarce, leaving the responsibility of role integration in the hands of novice NPs, hospital administrators, or physician colleagues. With few role models, entrance into the new role can lead to feelings of isolation,[22] disorganization, uncertainty, and insecurity.[23] This article outlines role development, implementation, and evaluation strategies to optimize the transition of neuroscience NPs into the inpatient setting. Although this article focuses specifically on the neuroscience NP, the strategies presented may be applied to assist ACNPs in all inpatient practice settings assume significant roles that enhance patient and hospital outcomes.

THEORETICAL SUPPORT FOR ACTUALIZATION OF THE ROLE OF THE ACUTE CARE NURSE PRACTITIONER

Actualizing the ACNP role should be considered a journey that transcends a novice-to-expert framework. Along the path to optimal role performance, ACNPs commonly encounter challenges that relate to the imposter syndrome and the need to develop skills in change mastery.

Benner Novice-to-expert Model

Literature reports indicate that the first year as an APN is a year of transition.[24] As the APN assimilates the responsibilities of the new role, maximum potential generally is not reached until approximately 5 or more years of practice.[25] Obtaining maximal potential requires the ACNP to progress through the phases from novice to expert. These skill stages were described first in 1977 by Dreyfus and Dreyfus (Dreyfus HL, Dreyfus SE. Uses and abuses of multi-attribute and multi-aspect model of decision making. Unpublished manuscript, Department of Industrial Engineering and Operations Research, University of California at Berkeley, 1977.) and were validated by Benner[26] in 1985.

In Benner's model, novice nurses are beginners who lack an experiential context in which to apply the rules they have been taught. Novices can be directed but tend to be inflexible in the way they provide care.[26] In contrast, the expert nurse has an enormous experiential base on which to draw; this experience affords a deep understanding of the total situation, enabling fluid, flexible, and highly skilled expert care.[26] The major implication of the novice-to-expert model for advanced practice nursing is the claim that many ACNPs go into their advanced training identified as clinical experts. Although these individuals may be clinically proficient or expert bedside providers, they can be expected to perform at a lower skill level or at a novice level when they enter the new ACNP role.[27] Therefore, new ACNPs who previously were experienced practitioners can expect to go from their former expert level to novice as they begin their new roles.

The new neuroscience ACNP may be surprised to realize the uncertainty regarding decision making that may occur with entry into practice. While working in the role of experienced bedside nurse, the ACNP probably collaborated with prescribers to obtain orders for needed interventions, but when the new ACNP is placed in the role of the prescriber, uncertainty often prevails. In a survey of 135 new ACNPs,