APPENDIX F
SUMMARY OF FOCUS GROUP AND KEY INFORMANT INTERVIEWS

In general, very similar themes emerged from the interviews with key informants. There were few differences in responses of key informants across the professions interviewed, though some issues raised were unique to particular settings and professions. Results are reported as presented across all key informants, unless otherwise specified.

IMPACT OF NURSE PRACTITIONER IN LONG-TERM CARE

1. Improved Quality of Resident Care

There was general consensus among all of the key informants interviewed that the Nurse Practitioner's expertise, especially in the areas of pain and symptom management, psychogeriatrics, behaviour management, wound care, palliative care and the assessment and treatment of episodic and chronic illnesses, has resulted in improved quality of care for residents in Long-term care facilities. Moreover, Nurse Practitioners have been credited with getting residents the resources they need whether its arranging for special consultations, or accessing High Intensity Funding for special treatments or equipment. Compliance Advisors reported that facilities that have a Nurse Practitioner have better wound care, assessment of behavioural difficulties, staff education, palliative care, and family counselling, and there have been fewer complaints from family members about the medical care that residents receive.

A significant aspect of quality of care raised by all of the Administrators was that of timely access to medical care. Nurse Practitioners have provided residents with more timely access to medical care because they are able to conduct more thorough assessments than Registered Nurses, and to respond to referrals quicker than physicians because they are often already in the facility and do not have the time constraints of a medical practice outside the facility as do most of the physicians who attend to residents in Long-term care. Even in cases where a resident needs to be seen by a physician, the Nurse Practitioner is able to conduct some of the necessary diagnostic tests prior to the physicians arrival, thus allowing for more timely treatment and efficient use of the physicians time. Nurse Practitioners are also able to provide continuity of care of residents.

As a member of the medical team, Nurse Practitioners have been available to spend time reviewing resident care protocols, including medication reviews. Key informants reported that this has resulted in more thorough reviews and better decision-making. For example, one Director of Care reported that with the assistance of the Nurse Practitioner they have been able to conduct more thorough medication reviews and as a result they have been able to reduce the number of unnecessary or redundant medications prescribed to residents, they have reduced the use of PRN (as necessary) dosing in favour of scheduled dosing, which for many conditions, including pain and symptom management, provides better treatment, and they have been able to conduct a more thorough analysis of the relationship between medication use and falls.

Facilities whose Nurse Practitioner has access to the local hospital computer system report that resident care is improved because there is a more thorough and detailed sharing of information

between the facility and the hospital. Thus, when a resident is hospitalized the Nurse Practitioner has access to medical chart information that can assist in treatment planning once the resident is discharged back to the facility. Similarly, if a new resident is being admitted to the facility from hospital, chart information can assist them to develop fully informed and thus, appropriate treatment plans, especially in cases where it is necessary to access High Intensity Funds. Several key informants indicated that this is particularly relevant because often times there is disparity between the written admission information they receive about a new resident and what they assess upon admission to the facility.

> Nurse Practitioner: *"The timeliness of it, and the other I think is the thoroughness of it. I have the time to go through the charts and say, oh that hemoglobin is low or gee we haven't done blood work in a year on this person, and I've run across things that should have been done and its not poor medical care, its that a physician comes in for 2-3 hours and in that 2-3 hours is trying to see everybody. They need the nursing staff to prioritize and pull together what they need and give it to them. And things get missed and so I think that in terms of thoroughness of quality of care is another issue. Like dig levels and things like that. I think in terms of care its speeding up processes, like if someone is sick and the physician is going to be in on Friday and I know there's blood work being done tomorrow, I will do some of the pre-work up so that by the time the physician gets here to deal with the problem we have a lot more information to deal with so even speeding up that process."*
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> Nurse Practitioner: *"Yesterday I had the staff say to me, 'you know so and so has a sore throat, would you mind going and looking at her'. And she had a sore throat for two days. Her physician wouldn't be back in the facility for five days and when I was there she had a horrible thrush. She had such a sore throat she was having a hard time swallowing and how well she would have been in two or three more days, she would have deteriorated very quickly. So I think it's the being there more often."*
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> Director of Care: "*And you may ask the nurse practitioner to see somebody when you just have, when there's not a lot of data. This person is not participating their ADLs* (activities of daily living) *for example like they normally would. You may grab the nurse practitioner and say, you know I'm not sure what's going on with this person but there is a change, and you may have her see that person. You wouldn't call the physician. They've got a normal temp, normal respirations, there's not a lot for me to tell you but there is something going on. So that prevention, and it is timeliness but it does prevent other things from happening because her assessment may be broader than the one I may have made. She has more skills than I do to make that assessment, and she may find something that I wouldn't have found until maybe ten hours later or the next day. And can intervene more quickly I think."*
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> Administrator: "*I think that this has made a difference to us to have her here and support them* (physicians)*... I think we have more timely intervention now for residents than we did before because if you have, certainly the doctors have other lives, they have offices and things, now we have somebody here, that's why a full time person would be better than half time person. I could get more timely intervention. And but when she is here she*

can see a resident right away and do an assessment and decide with the nurses, you know two heads are always better than one, whether you need to ship or not and what you need to do because we don't send residents to the hospital unless we have to."

Director of Care: *"Absolutely the falls. And with behavioural issues, and behaviour modification and she has been able to, with her intervention, help us modify the behaviours of some of our most troubled and problem people. And it sort of is reassuring to staff. The staff feel supported so they in turn support the nurse practitioner and value the contribution the individual makes. But I would say that it has improved resident care through, I can't say the docs weren't doing good assessments, but they didn't always have the time and they weren't always here to intervene and assess the situations, so I think its just given us more, more timely and more comprehensive."*

Compliance Advisor: "*She* (the Nurse Practitioner) *has organized a wound care program second to none, the best I've ever seen"*.

2. More Efficient Use of Medical Resources

Key informants reported that the collaborative nature of the work between Nurse Practitioners and physicians, has resulted in a more efficient use of physician resources. Nurse Practitioner are able to take care of a large portion of referrals for medical care, such as episodic illness, wound care, and psychogeriatric assessment, and routine care such as, admission and annual physicals, thereby allowing physicians more time to deal with more complicated resident needs. Physician confidence with Nurse Practitioner ability to assess, treat, and monitor a medical condition, allows them act as a consult rather than a front-line care provider. One physician referred to the Nurse Practitioner as his "eyes and ears" when he is unable, or it is unnecessary for him to be at the facility. A Director of Care suggested that many physicians enter work in Long-term care as a transition period prior to retirement and are unprepared for and overwhelmed by the complexity of the care needs of the elderly. Thus, in these situations Nurse Practitioners possess expertise in geriatrics that can compliment the expertise of physicians. Several key informants suggested that the presence of Nurse Practitioner will improve physician retention in Long-term care by reducing their burden of responsibility for resident care. Although, it was generally reported that physicians have greatly benefited from their collaboration with Nurse Practitioners, this has been limited to only the days the Nurse Practitioners are present in the facility and could be maximized by having full-time Nurse Practitioners in all Long-term care facilities.

Physician: "*I still have the same length of time here, I just do different things because she does all my medicals and so on and I just review them and sign them off. She does a lot of the med reviews, I have to sign them and make sure they're okay. When she is not here I go and see the patients and deal with them, when she's here she deals with them."*

Nurse Practitioner: "*...physicians are more satisfied. I've had comments to indicate that they would have difficulty coping or dealing with the work load right now if the role* (Nurse Practitioner) *was not present, and they feel more confident when conducting treatments over the phone based on my assessments and/or having confidence that the*

issue will be followed up that week, that they're more likely to institute treatments versus transfer out."

Physician: "*here's not a lot here that I do, that a Nurse Practitioner can't do. There may be only 20% of what I do that a Nurse Practitioner can't do."*

Physician: *"She's here more than doctors. She has more hands-on care and she deals a lot with minor stuff that the doctor hasn't really got the time to do, like wound care and sitting down chatting with the patient and explaining about what the situation is. We don't have time for that, the Nurse Practitioner does, or at least we hope they do.".*

Physician: "*...'putting out fires' on a daily basis because the doctor can't always be there. She can handle things that should be dealt with in a timely manner. For example, does the patient need to go to the hospital? I can't drop everything at the office to run over to assess this but the Nurse Practitioner can do this."*

Administrator: "*I think the docs are really very happy. I think they feel supported with her. I think they feel that maybe a little bit of their demand has been removed from them because we run a pretty thin number of docs now...so it's been difficult trying to stay on top of all the medical demands and I think a lot of long-term care facilities are going through this and are losing their physicians because of it."*

Administrator: "*So like today, one of our medical advisors had to cancel at the last minute and we have a multi-disciplinary committee meeting scheduled and he asked that she* (the Nurse Practitioner) *do them for him. So she would have been there anyhow with him and now he has asked her to run them and sit in for him which six months ago maybe he wouldn't have felt comfortable doing that. But I feel now that the families too, know her well enough and if there are any things that need to be dealt with specifically by the physician we can do that afterwards. But probably 90% of it can be handled quite nicely by her and the nursing staff here and it won't be a problem today. And that allows him to deal with other emergencies that he has had to deal with."*

Administrator: *"Before the doctors only had so much time, so what gets done gets done. Now they can focus on complex care cases."*

Director of Care: "*They can do a whole lot that a physician doesn't have to do, but that's too much for a registered nurse."*

Director of Care: "*I think it* (the Nurse Practitioner role) *has a positive impact on my physician retention within my facility. I think that she because of the collaboration and because of the trust that she has built up with our physicians, she can call, they know the kind of assessment she does, she is treated more like a peer so that if she calls and says I've made this assessment and this is what I think, they place great value on that assessment and can then make an informed decision maybe by not coming to the facility, maybe over the phone in a collaborative fashion. I think that's been very positive for my*

physicians. We do have a physician shortage. Anything we can do as a health system to support them in their role and to not have them all burn out and retire at 40."

3. Improved Use of Acute Care Facilities

Key informants reported that the Nurse Practitioner's ability to provide timely assessment and treatment has improved resident care so that there is a better use of acute care facilities. Timely diagnosis and treatment may be preventing complications and more lengthy hospital stays. Nurse Practitioner intervention has prevented transfers to hospitals either by diagnosing conditions that could be treated within the facility, or by diagnosing and treating a condition to prevent the need for hospitalization. Moreover, the Nurse Practitioners have assisted nursing staff to conduct more thorough assessments and to do so with greater confidence, thereby allowing them to make more informed decisions about the need for residents to be transferred to hospital, which particularly important when Nurse Practitioners are not present in the facility.

In some cases, assessments by Nurse Practitioners have allowed residents to be transferred to hospital for more timely treatment, thereby preventing the worsening of the problem. In many instances when residents are transferred to hospitals, the facility has already conducted some of the necessary diagnostic tests and, in some cases, have already started the first line treatment. Even in cases where the first line treatment has been unsuccessful and the resident is ultimately transferred to hospital, the Nurse Practitioner's intervention has possibly has reduced the length of hospital stay because the initial treatment was conducted in the facility. In some cases, the Nurse Practitioner have been able to better access High Intensity Needs funding to obtain the equipment necessary to treat residents within the facility, thereby preventing transfers to other facilities.

> Administrator: "*Specifically, in our facility*, (the Nurse Practitioner has made the greatest difference) *preventing transfers to emerg. She comes here on Fridays, we have 2 physicians already but we were a little short when she first came so having the additional person, but even still we're about 20 miles from the nearest hospital, so for a physician to come out here; it doesn't happen so they have to be taken to hospital to be seen. But having her come out on Friday we're able to catch people usually early enough that she can see them and know if something is brewing so you don't have to wait until Saturday and you have to send them."*
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> Director of Care: "*Having her there to make the assessment where previously perhaps the nurse would assess to the degree that she could, then if the physician wasn't available then and there that resident often went down to the Emergency Department to the hospital, wherever for further assessment whereas the nurse practitioner can take care of it."*
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> Administrator: "(Transfers to hospital) *are now mostly just truly emergency cases. Whereas before you'd see patients coming in for assessments and 'just in case'."*

4. Improved Communication with Residents and Families

As a member of the medical team, Nurse Practitioner are often the most accessible to families and residents. In comparison to physicians who have less time to spend in the facility and a greater patient caseload overall, Nurse Practitioners often have more time to spend addressing family and resident concerns and educating them about medical conditions and treatments. Many Nurse Practitioners have taken active roles in Family Care Conferences. Nurse Practitioners have been described as being able to •talk the same language• as families and residents, thereby improving communication and reducing concern and anxiety.

> Nurse Practitioner: "*You hear over and over again: 'you take your time to find out what's going on with me and you don't treat me like a symptom that needs medication'. It's the time you're able to spend with them* (residents) *that's critical."*
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> Administrator: "*...I mean the resident is the only reason we're here, and they have to feel comfortable. You're dealing with an elderly population where the doctor was God and you know, that's where you went, and you didn't go to a nurse to get those answers, you went to the doctor. But unfortunately with things changing the way they are now, doctors don't have the time to spend and you know, often nurses are often much better at health teaching and the compassionate role and bed side manner, and they tend to take the time, its sort of a forte that nurses have and I think the nurse practitioner brings the best of that so she has that plus she has the enhanced knowledge base, and I think we have had nothing but positive responses from families and residents...."*
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> Nurse Practitioner: "*Physicians can do that as well* (assessments), *but I find that they just don't have the time to come over here. Its in the middle of office hours, they can't pop over. That's not going to happen. Then all these families are very needy and the nurse practitioner has that extra twenty minutes that the physician just doesn't."*

5. Improved Skill Level of Staff

Nurse Practitioners have been credited with increasing the skill level of Long-term care facility staff by improving their assessment skills and bringing evidenced-based or new care approaches to facilities. A registered nurse reported that while they have sometimes been able to learn about new care approaches or equipment from company representatives who tend to focus on their own products, (e.g., new wound care products), the Nurse Practitioner is resident-focussed not product focussed, so that she is able to inform nursing staff which types of products are best which kinds of problems and residents. Nurse Practitioners have been able to educate nursing staff, either informally at the bedside or in more formal educational sessions, about conditions and treatments for which they have little knowledge or experience. Although most nurses have some access to continuing education, the timeliness of the Nurse Practitioner education means that residents benefit immediately. For example, when a resident is admitted with a condition the staff are unfamiliar with, the Nurse Practitioner can immediately provide them with information. Most of the key informants reported that nursing staff, as a result of Nurse Practitioner education, are better able to conduct assessments, thereby improving resident access to treatment. Moreover, staff confidence in their nursing skills has increased and they seem to be less frustrated because they are better able to make decisions in difficult situations.

Administrator: "She's (Nurse Practitioner) *moved the bar and elevated the level of professionalism for the team."*

Compliance Advisor: "*She's raised the level of accountability."*

Director of Care: "*..she is also able to teach staff how to deal with some of our problem behaviours you know, and also the warning signs to watch for and she has worked really closely with the nursing staff, and we have also introduced a behavioural support nurse and she and our nurse practitioner worked very closely because we have a partnership now with CAMH for mental health issues. There is a really good partnership so that we've had a significant reduction in our incidents of aggressive from one quarter, I mean it was really very significant. We had 33 incidents of aggression for the first half of this year, and this is sort of unprovoked, and it dropped to 15 with the involvement of this sort of team approach. And a lot of it had to do with the monitoring, the interventions, and the staff education you know, because the staff were afraid of people like this and often missed signals they shouldn't have missed. And with education from the nurse practitioner and the support given through the behavioural support person, the closer monitoring has really made a big difference in dealing with our behaviours. So we're very pleased with the results."*

Nurse Practitioner: *"I do think I've made a difference in terms of staff, in terms of how they approach situations and I have staff who say to me now, 'well I've listened to so and so's chest'. Well you know, that wouldn't have happened a year ago. A year and a half ago they would have told the physician there was a cough. They wouldn't have got the stethoscope out and listened to the chest. So even just setting the standard a little higher and saying, she's a nurse and she can do that, so I'm a nurse and I can do that too."*

Nurse Practitioner*: "A decreased frustration among health care professionals. No longer are they finding delirium being sent out because of an acute confusion and it ends up being a UTI* (urinary tract infection) *or a pneumonia or an adverse reaction to a med. That has all been treated or ruled out and what we end up sending out there is a psychosis, an acute psychosis that's pathologically related but requires a different environment in order to get the person to get along."*

Nurse Practitioner: "*I find now that there is improved assessment by the RNs, even for these people that develop pneumonias, they won't be transferred out as they would have been in the past. The RNs' skills are now up there and the physicians are much more confident so the person gets treated in the home. So its had that impact as well so it isn't totally dependent on me being there in order to prevent that transfer over to acute care. Now that's part of the educational process an impact as well."*

Nurse Practitioner: *"I've received feedback from* (a geriatric acute care facility) *that conducts assessments and runs treatments within the community in Long-term care facilities, and what they've commented on is that assessment quality has enhanced tenfold from the staff development's point of view and what's been handled, but what*

we're handling and managing and preventing on site prior to them actually arriving has changed significantly as well. So again, using the correct meds or not, or utilizing the assessment techniques to identify appropriate behavioural interventions has prevented I think a large number of acute psychotic admissions or transfers."

Administrator: *"I think maybe two heads are better than one, though, and the RNs I think appreciate the back up of a nurse practitioner, but remember, she's only here half time. So we still have to manage the rest of the time. But I think she has helped them, some of the interpretation of the lab results, chest assessments, some of the things that she has been able to do, some teaching with them has helped with their confidence level too."*

Director of Care: "S*he's an excellent, excellent support for staff...Open discussion makes RNs really think and to strategize, to discuss different alternatives and to buy some ownership in whatever orders come out and so they are able to implement them, assess them and evaluate whether it worked. It's phenomenal."*

6. Improved communication with community and government agencies

Nurse Practitioners have been credited with improving communication between Long-term care facilities and various groups such as Community Care Access Centres, and with MOH compliance advisors. For example, Nurse Practitioners have been able to discuss and resolve any concerns arising from the functional assessments conducted by the local Community Care Access Centres prior to a resident being admitted to the facility.

Director of Care: "...(the Nurse Practitioner has acted) *as a liaison between the Ministry of Health, our compliance advisor.* (The compliance advisor) *will call* (the Nurse Practitioner) *and discuss any issues that we feel we're unsure about and she is able to do that, she has a good rapport with the compliance advisor, and that really helps administratively, you know, when you're in a crunch and you've got an application for somebody and you're not quite sure whether we should be taking them, you don't know whether High Intensity Needs will the fit the bill. She has been able to liaise that way..."*

LINKAGES WITH COMMUNITY AGENCIES

Many opportunities were identified for Nurse Practitioners to link with community agencies, such as Community Care Access Centres. Although some Nurse Practitioners and other key informants felt that these are opportunities that should be explored further, others felt that caution was needed not to expand the Nurse Practitioner role further to the point that it is "spread too thin" and the primary care of residents is negatively affected. Several key informants commented on the need to use the expertise of the Nurse Practitioner wisely and to determine what job related activities were most appropriate and cost effective. For example, while several key informants suggested that Nurse Practitioners could work with their local Community Care Access Centres to assess admission applications for residents with complex care needs to ensure that their treatment needs are adequately met. Others believe that it is not a good use of the Nurse Practitioner time and resources since it is the Community Care Access Centre's responsibility to conduct thorough pre-placement assessments.

Opportunities for Nurse Practitioner in the community: The following activities were identified as potential opportunities for Nurse Practitioners to work in the community:

- To work with Psychogeriatric consultants across the province.
- To work with Community Care Access Centres to conduct pre-placement assessments for residents with complex care needs.
- To act as a liaison between Long-term care facilities and community resources
- To work on local health care related committees (e.g., local district Health Council).
- To act as a liaison between Long-term care facilities and local hospitals (e.g., Emergency Departments, Geriatric Programs, Acquired Brain Injury Programs).
- To teach in psychogeriatric training programs (e.g., PIECES).

Challenges for Nurse Practitioner working in the community: The following challenges Nurse Practitioners to working in the community were identified:

- Establishing collaborative relationships within the community: currently some agencies, including Community Care Access Centres, will not take referrals from Nurse Practitioners.
- Obtaining services and resources for the aboriginal population because the Native Health Insurance Branch (NHIB) will not recognize a Nurse Practitioner signature (the same applies to obtaining special services for Veterans).
- Practising to the full scope of practice because Nurse Practitioners are limited by Public Hospitals Act, which does not recognize the Nurse Practitioner signature for ordering diagnostic tests (Nurse Practitioners are unable to order X-rays conducted in hospitals and while some hospitals will do the X-rays, they will always send the results to the primary care physicians) and not all Nurse Practitioner have courtesy privileges at their local hospital.

The following suggestions were proposed to facilitate Nurse Practitioner activities in the community:

- Community Care Access Centres need to be better educated about the Nurse Practitioner scope of practice and to accept referrals from Nurse Practitioners as they do physicians.
- Government agencies (e.g., NHIB, Veteran Affairs) providing funding for supportive care services need to be better educated about the Nurse Practitioner scope of practice and to recognize Nurse Practitioner signatures.
- Changes need to be made to the Long-term care Act and Public Hospitals Act to recognize Nurse Practitioners, so that they are able to work within the full scope of their practice.
- Computer linkages between community groups (Community Care Access Centres), Long-term care facilities and acute care facilities need to be created to facilitate communication among health care providers.
- If community outreach activities are deemed necessary to the Nurse Practitioners role, then time should be allotted in their schedule for these kinds of activities.

Nurse Practitioner: "*Community Care Access Centres I think are the biggest, well I think there's a huge opportunity, the transition from another facility or community into long-term care, I think that's invaluable help.*"

Director of Care: "*We have different computer systems. Its been a great help for us here, she* (Nurse Practitioner) *has the linkage with Meditech at hospital and she is able to bring up information that has greatly helped us in deciding you know, whether the client is appropriate for the home. And deciding care needs, things that just aren't always when you get the functionals through Community Care Access Centres, it's just not always the real true picture. We've also been looking at with the psychogeriatric group. Emerg now does what they call an ER Alert, so if somebody comes in that is in a psychogeriatric crisis, and Emerg can put them in the Alert so then they can link at the hospital between Emerg and the psychogeriatric facility at the hospital, but it would be great if* (the Nurse Practitioner) *had the ability to pick up the alerts so we would know when we're looking at admission and we see this guy has been in on the psych floor four times in the last year for violent behaviour. Where does it say that on the functional - you know when the fellow's at home. It's the Community Care Access Centre's nurse from the community going in, she doesn't have the information. So those kinds of linkages, linkages with Community Care Access Centres for you know their documentation, their paper work. I think because we're in the age of technology it would make it, it would really make life easier for her if we had those computer linkages between the homes, between facilities that Community Care Access Centres and acute care.*"

Administrator: "*I wonder if that's the best use of their time because many of the, by the time, the waiting lists now are still fairly lengthy so if they do pre-placement assessments, is it going to be when they first go on the waiting list because they could be on there for six months and their condition is going to change. Is that the best use of a nurse practitioner's time? We have lots of nurses that can easily do those assessments. I just wonder, we don't have enough nurse practitioners. Are you taking the great big guns to the little wee fly to do that, or is that necessary, or are you getting, you can have nurses and you can have social workers and people who are trained in those realms to do those pre-placement assessments and do a lot of the teaching that goes with it. Somebody said to me would it be good to have a nurse practitioner as an administrator in long-term care, and I said why. Why would you take those skills and waste them on paperwork? Don't do that. To me why would you want a nurse practitioner to do an assessment?*"

UNDER-SERVICED AREAS

It was generally agreed across key informants that there are great opportunities for Nurse Practitioners to work to their full scope of practice in under-serviced areas. However, it was felt that these opportunities came with many difficult challenges. While many of the comments generated by key informants regarding under-serviced areas apply primarily to rural or remote areas, many apply also to under-serviced areas in urban communities. The challenges identified were:

- Difficulty accessing medical supports: Nurse Practitioners are unable to work in areas

where they do not have adequate medical support (access to registered nurses, physicians and specialists); many physicians are unwilling to do phone consults about patients with whom they are not familiar.
- Difficulty recruiting people to work in remote, under-serviced areas.
- High risk for burn-out: work load is overwhelming; lack of supportive resources is frustrating.
- Nurse Practitioner isolation: difficulty connecting with other nurse practitioners; under-serviced projects do not have the same kinds of networking opportunities as the Nurse Practitioner in the Long-term care project.
- Difficulty accessing educational resources: library access, conference and workshop opportunities.

Nurse Practitioner: "*It's a wonderful role for nurse practitioners to use their skill. When you use your full skill for practice you want to use those skills. This is the place to be! Because its an under serviced group, and people want the help, they're begging for the help. Even if they don't know they need the help they're so grateful when they get it, its just amazing."*

Nurse Practitioner: "*From what I've read and heard from my colleagues in under-serviced areas, it may not even just be specialists, but perhaps someone up on Manitoulin Island trying to access a physician in an emerg just for advice and consult. Some physicians are refusing to take those calls, whether it's because of the role, the billing, or concerns of liabilities. I know that they had trouble even finding someone who would work in that manner.*

Nurse Practitioner: *"It's more of the medical legal where the physician is supposed to have a relationship with that patient before he can give a consult on that care. That's where it's coming into play where we're phoning in to emerg and they won't accept the phone calls because they don't have a relationship with that resident, or patient."*

Director of Care: "*Sometimes the challenge is getting a position to work with. If the area is severely under serviced she really needs that part of her team, and if that person isn't available that makes it difficult. Certainly, I see that there is lots of opportunities for expanding the nurse practitioner role and involving her in under-serviced areas, and trying to meet peoples needs through that role because we don't have physicians to meet that need."*

Administrator: "*The other problem is, some of the newer facilities don't even have the medical back up. So you, and some of them don't have, like one of the qualifiers was you must have RNs around the clock. Well some of the facilities cannot attract RNs. With the* (human resource) *issues the way they are today you can't get an RN in a long term care facility. I'm extremely lucky here to have the staffing that I do, but some of them don't have RNs around the clock. So if you don't have an RN around the clock and you don't have a medical staff, how can you attract an Nurse Practitioner? You can't because she has to have certain qualifiers there before she can work. She can't work without a doctor to back her up and you may get a nurse practitioner that would be willing, but if you*

have a distance doctor that you can only access by phone, if I'm a new nurse practitioner I'm not going to put my license on the line by going into a facility where I get no support. So why would I do that, so I'm not going to go there because I know that I can sell my wares in many other venues and I'm not going to do that. And I think that's really hard for some of the under serviced areas. They need them more than anybody else."

Several suggestions were proposed to facilitate the work of Nurse Practitioner in under-serviced areas:

- Provide physicians adequate remuneration for consulting to under-serviced areas.
- Increase funding to support those working in under-serviced .
- Increase funding to recruit people to work in under-serviced areas.
- Create local educational opportunities for people living in under-serviced areas to get the training necessary to meet the needs of the community.
- Use available technology for education and specialist consultation.

Administrator: "*Some of the places like Temiskaming has been working to support a person in the community to take the nurse practitioner course. So that may be something that the Ministry can come up with in the under serviced areas, is if they would help with the educational costs or somehow have the distance education by some of the media, long distance education things to actually educate nurse practitioners who live there. If I grew up in Timbuktu and I liked it there and my family lived there, hey, I'm going to stay there. But I'm not going to leave metro Toronto to go to Kapuskasing in the middle of winter. No way! So if I can, if the Ministry can come up with venues of educating people who live there and there are many nurses that would love to take that opportunity but how are they going to get to York University and U of T to do this sort of thing and take the course. So if they bring the course to them and they can take it, you're going to get people who will take it and will work in those under serviced areas."*

Nurse Practitioner: "*I think the world is the oyster and I think if we can deal well with a few of the challenges that exist, such as the acts, the remuneration, and make it a permanent, we will go a long way to improve recruitment, retention and I believe this role can be developed well beyond what it is at the moment with a significant impact across the long term care system."*

CHALLENGES FOR NURSE PRACTITIONERS WORKING IN LONG-TERM CARE

Unmet expectations

In general, very few of the key informants identified any unmet expectations, with most of them indicating that their expectations for the Nurse Practitioners in Long-term care project were surpassed. One Administrator commented: "We're getting what we asked for in spades". Key informants expressed desires for the Nurse Practitioner to spend more time on tasks they are currently unable to do because of either heavy workload or because it was never assigned a priority in the project. These tasks were: 1) consistent and timely follow ups, 2) referral, or pre-placement, assessments, 3) involvement in all care planning sessions with an emphasis on looking at quality issues around care planning, 4) more intense work on issues relevant to a

particular facility, e.g., falls, psychogeriatric issues, 5) more time with families, and 6) more time networking with community agencies. The general consensus was that Nurse Practitioner would be in a better position to complete additional tasks if they had a more reasonable workload and specifically if they were assigned to only one or two facilities, because the more facilities a Nurse Practitioner is responsible for, the less she is able to accomplish.

When asked if there were any areas in which they thought they would have make a difference but did not, the Nurse Practitioners indicated that they would have liked to establish more collaborative relationships with all the community physicians attending to residents in their facilities, not just the Medical Director. Lack of time and resources were identified as the key barriers to establishing effective and trusting working relationships with physicians. Nurse Practitioners felt that this could be overcome, in part, by better educating physicians about the role of the Nurse Practitioner and perhaps starting this in medical schools where medical students could learn to develop partnership relationships with Nurse Practitioner and by getting physicians associated with the COUPN (Council of University Programs in Nursing).

Several Nurse Practitioners and physicians indicated that they would like to have had more time to develop evidence-based assessment and treatment protocols for facility staff to follow. However, doing this well requires the Nurse Practitioner to have access to library material, consultation with medical staff and specialists, specialized equipment, clerical support, and the time necessary to do this, all of which are limited resources for many Nurse Practitioners. Several Nurse Practitioners also identified personal professional development goals, such as getting more experience with suturing, that they have been unable to achieve because other issues have taken a priority.

Main Role Challenges

1. Excessive Workload

There was a general consensus among all key informants that Nurse Practitioners have an excessive workload and that this is the main challenge they face working in Long-term care. Nurse Practitioners reported that are many opportunities for Nurse Practitioner to function within the full of scope in Long-term care, however there is often not enough time for them to do so.

Several challenges related to workload were identified by key informants:

- Nurse Practitioners are stretched across ('spread too thin') too many facilities, thus reducing their ability to maximize their potential in any one facility.
- Nurse Practitioners do not have the time necessary to adequately establish collaborative relationships with physicians, staff, and administrators across several facilities.
- Nurse Practitioners do not the time necessary to conduct consistent or timely follow-up visits with residents.
- As a result of having too many facilities to attend to, when Nurse Practitioners are not consistently visible in the facility some staff tend to forget about their availability and call a physician for something that the Nurse Practitioner is better suited to handle.
- Nurse Practitioners assume a variety of tasks, so that when engaged in those that are

not directly resident-care related (e.g., staff education, conference presentations, committee and community work) then resident medical needs are not met.

- When Nurse Practitioners are assigned to more than one facility, geographical distance means that they are spending much time travelling between facilities, or that facilities' access to them is limited.
- Nurse Practitioners are required to be an "expert" in the issues relevant to each facility (e.g., wound care, psychogeriatrics). When the key issues vary across facilities, it may be unrealistic to expect Nurse Practitioner to be "all things to all places", so that they become "intellectually" "spread out too thin".
- The complicated health status of residents in Long-term care, requires much of the Nurse Practitioners attention and time, particularly when residents are unable to communicate clearly their symptoms.
- Nurse Practitioners are challenged to do their jobs thoroughly when diagnostic testing is not always feasible, either because of the patient's mobility or cost (e.g., it is difficult to send ill residents out of the facility for chest x-rays).
- Nurse Practitioners have difficulty keeping track of demands from the high number of staff they work with across facilities ("multiple bosses")

Registered Nurse: "*There is probably a lot more that she could be doing here, but can't because there just isn't enough time*".

Physician: "*I suspect it's to a large part of it's just the shear volume of work. That's part of it. I'm not sure there's anything that's particular to her challenges that's maybe any different from mine. I think volume of work, the complicatedness of the patients, are probably still the big ones. I'm not sure the things she faces are necessarily that much different from me.*

Administrator: "*Well, I really don't think that the dilution is a plus for the Nurse Practitioner role. I think in all reality one or two facilities is as much as you're going to get a major bang for your buck."*

Administrator: "*On an ongoing basis, we need more of them* (Nurse Practitioners). *I think that to be able to meet the demands of what we are, our resident care is continuously increasing. Our staffing needs are not, our resident level of service study that come out from the Ministry showed that we don't have enough staff in long-term care to meet the needs of the types of residents that we have here. And I think It's the same thing with a Nurse Practitioner. There is so much that could be done and there is so much that you always want to do that the numbers of them just don't meet the demand."*

Nurse Practitioner: "*And also there's this whole issue of the lack of continuity, so you start working with an individual and with the staff and then you're not back there for a couple days, and you lose ground."*

Nurse Practitioner: "*I think part of the frustration for me is that when I'm going from facility to facility, the people where I'm not get used to calling the doctor again. And you*

know, being spread thin and when I do come back they've checked my time table and they will forget I'm there and call the physician for a UTI (Urinary Tract Infection).•

Nurse Practitioner: "*I used to say that if I could have been a Nurse Practitioner twenty years from now because everybody else would have paved the way for us...I think that forging a new role is a challenge all the time."*

In general, there were great concerns that overloading the Nurse Practitioners would limit their activities in Long-term care facilities and would, in essence, result in their assuming more "physician-like" patterns of working (i.e., high case load, minimal time to interact and educate staff, residents, and families).

Nurse Practitioner: *"You become like the physician. He just drops in and drops out again."*

Nurse Practitioner: *"If you want me to be more time efficient it means sometimes acting more like the doctor. Being more direct and saying 'I want this done.'"*

Key informants suggested that workload issues could be resolved by

- Increasing the number of Nurse Practitioner working in Long-term care.
- Creating a better ratio of Nurse Practitioner per facility or resident workload. (Most key informants reported that the ideal ratio of Nurse Practitioner to facility should be 1: 1, but no greater than 1: 3; or one Nurse Practitioner per 200 - 300 residents - but this should vary based on the number of facilities covered and their unique needs and geographical locations).
- Developing a flexible work schedule to allow for periods of time when there are increased demands on Nurse Practitioner time (e.g., annual and admission physicals) and to provide weekend and evening coverage to reduce on-call burden to physicians and to increase family access to the Nurse Practitioner.
- Improving the use of computers in Long-term care to make documentation and monitoring more efficient.
- Developing logic models to assess facility needs and to help Nurse Practitioner organize and prioritize tasks and programs.
- Conducting regular reviews of Nurse Practitioner priorities.
- Providing Nurse Practitioners with communication resources such as telephone, pager, and voice mail to facilitate efficient communication.

2. System-Wide Issues in Long-Term Care

Many system-wide problems inherent in Long-term care were raised as contributing to the challenges that Nurse Practitioners face:

- Long-term care is desperately under-resourced: limited funding and access to medical resources.
- Changes to the types of residents entering Long-term care (increasingly complicated health care problems) has not been accompanied by sufficient changes to the resources available to Long-term care facilities

- Overworked and underpaid nursing staff (in comparison to their colleagues working in acute care settings).
- Low staff morale.
- Pervasive myths about health care for the elderly, including the need for pain and symptom management, and palliative care, prevent residents from getting the care they need.
- Minimal or inadequate physical space; some facilities had difficulty finding an office or work space for the Nurse Practitioner; some facilities were described as being in a poor state of repair.

Nurse Practitioner: *"They are hugely under-serviced in rural areas... but actually I think everywhere it's under-serviced. There's just different degrees of it."*

Nurse Practitioner: *"Workload is an issue for RNs too in long-term care. There can be 50 - 100 residents per RN, so they tend to be lax in following orders. Their jobs are stressful and they're underpaid in comparison to RNs working in acute care. They have little motivation to change or improve their qualifications."*.

Nurse Practitioner: *"There are too many residents in there. They're like rats in cages.*

Compliance Advisor: *"We will never have enough Nurse Practitioners to do what needs to be done in Long-term care. The system really has no idea of the complicated needs of the elderly in this sector."*
Director of Care: *"The type of resident in long-term care has changed over the past 10 years. They are much heavier and more require more care needs. We used to, 10 years ago, admit nice little old ladies who were very cooperative, they were 80 years old. Now we're admitting 37-year-olds with Huntington's Chorea and MS. We're admitting residents with strokes and paranoid schizophrenia, who are 45* (years old). *So we're admitting a different type of resident. Now 13% of our population is under the age of 65 years... And the funding, it's important to remember for Nurse Practitioners, to realize that the difference in funding between acute care, complex care and long-term care. Acute care gets $600 a day, complex gets $300 and we get $100. Now remember we have 50 residents under that age of 65. Our funding is that a resident gets one bath a week. Well, when you're 37, when you're 40* (years old) *one bath ain't going to cut it a week . These guys want a bath everyday or every two days. The same thing with ordering programming or if you're going to make recommendations regarding exercise, or muscle strengthening, or physio, you've got to look at what we're capable of doing in this facility. And if we're not able to meet that residents requirements or needs than we have to look at placing the resident in complex continuing care because we can't meet those needs here."*

Physician: "*Probably the people that were admitted to retirement that we're admitting to long term care 25 years ago are now being admitted to retirement homes. Whether that's right or wrong is not really the issue. The issue is that it has changed and that has been in my view, the government and the medical profession has not really been focused on*

putting in the help that is needed and changing the paradigm of how you provide the care. They just expect it to happen."

Physician: "*The issue of retention and recruitment of physicians in long term care is a very complicated and very multi-factorial dimensional issue. Nurse practitioners can't solve it. If the government expects this to solve that problem, then they've got their head in the, there is la-la land. It just will not. There are too many other issues."*

Physician: "*I think there is an opportunity to work with another health professional that clearly expands, you put the two roles together, its sort of one and one equals four. You know, you've got one nurse practitioner and one physician and you end up with double the amount of ability to provide care because of the interaction and the flexibility and everything else, and that's where it should be going. But there are so many barriers to things, the systems and issues are so complicated that it often is difficult to see how they can resolve it. The biggest is there aren't enough nurse practitioners. There are 500 facilities in Ontario. Hello!"*

3. Collaborative Relationships and Support

Several key informants, primarily administrators and directors of care, indicated that developing collaborative relationships and essentially changing how people work and interface in the work environment was a challenge inherent in establishing a new role in Long-term care. Key informants described an initial hesitance, and sometimes resistance, to the Nurse Practitioner that was attributed to a lack of understanding of the role, fear of the Nurse Practitioner monitoring their work, fear that the Nurse Practitioner would take over their jobs or would create more work for them. Administrators and physicians reported that there was fear that Nurse Practitioners would have a negative impact on physicians financial remuneration. However, anxiety about the role of the Nurse Practitioner has reduced as people became familiar with the roles and responsibilities of the Nurse Practitioner, experienced the benefits to resident care, and when their personal fears not realized. It was reported that although this resistance to the Nurse Practitioner has reduced as people become familiar with the role, it is reoccurs when new staff, including physicians, enter Long-term care from areas that do not have Nurse Practitioners or as new work challenges develop.

Educating staff, and particularly physicians about the role of the Nurse Practitioner and dispelling any negative myths about Nurse Practitioners was identified as crucial to establishing collaborative and supportive relationships with Nurse Practitioners in Long-term care. It was suggested that physicians would be more responsive to Nurse Practitioner if they were able to speak to other physicians about the role to voice their concerns and dispel myths that impede their ability to work collaboratively with Nurse Practitioners. Physicians who work with Nurse Practitioners could publish, in journals that are widely read by physicians, their experiences and address the myths that act as a barrier to physician support. It was suggested that staff would be more likely to establish collaborative working relationships if facility administration develops an work environment that is supportive of the Nurse Practitioner and emphasizes the building of strong teams so that everyone has the opportunity to function and decision-make as part of that team.

Nurse Practitioner: "*They* (Nursing staff) *still need to do their role even though there's a Nurse Practitioner. They can't assume they can call me to do it. They need to do the initial assessments. Its part of any nurses job to do it, not just to hand over the responsibility to the Nurse Practitioner. Because you're there and have more expertise doesn't disqualify them from doing it."*

Nurse Practitioner: "*If I had the resources to be able to consistently approach each physician that is associated with both of the facilities in the manner that I have approached and been able to develop a relationship with, as a medical director, maybe it would be different, but I don't have the resources to be able to that, so its shorter consults, different type of role, but the physician, my primary partner where I was able to attend rounds for frequent, explain the role, and develop a gradual and a start up date for my clinical practice, it was quite beneficial. But if I could approach every physician in that way perhaps I'd see a bit of a difference."*

Director of Care: "*So to clarify where she fits into all of that because I don't think it's really helpful to have a whole lot of layering, one person determining a plan of action, and then another one determining another one. So, it has to be a collaborative effort but it's a bit challenging to get all those parties together some times."*

Registered Nurse: "*Figuring out what she does, what he (physician) does and figuring out the grey area in between."*

Director of Care: "*The other challenge is to get physicians on board...She is not allowed to see some the physician's clients, and I think that's a detriment to the home, definitely...I think education is a big part of it, but I think to get physicians to go to anything you've either got to feed them or pay them and we know that. They're time is valuable...we all do things on our own time to enhance our quality of care and professional development, but for some reason they expect that they should get paid to enhance their professional accountability and I think that there needs to be legitimate meetings set up with small groups of physicians. I'm just thinking of how I would do it. I would use you know something to keep their attention. Different attention grabbing and they remind me of school kids, and you've got to do that with them and very simple. This is how I can help you, bang, bang, bang. These are the advantages, bang, bang, bang. You're myths, what are your myths? Tell me what your myths are. Have a working group, have them working at boards where you write down all your myths, tell me what they are so that we can speak about some of them so that I can give you the answer. You're* (physicians) *sitting around saying to each other, well they're going to take saying to each other, well they're going to take our money, and they're going to end up getting paid for doing those medicals and we're not. Those kinds of things that they would say to each other, but they won't say with the nurse practitioner there. So perhaps even having a Ministry person at the education in service session with the nurse practitioner to say okay, lets get these myths on the table now so that we can identify to you what are your concerns, and you have to be able to manipulate, unfortunately, the physician group, to get them to buy into things, so if you make it sound like its going to be a plus for them, and you're not taking out of their pocket, then they'll buy in."*

Nurse Practitioner: "*We've really come a long way in year and a half. Even to the point where we had one physician who isn't, who I'm not directly involved with, who came to me and said, you know, it's not fair that you go to these facilities in the county. There's two you don't go to and it's not fair to those of us who have residents in the other two facilities that you're not there. Well, I thought, isn't that a change! Because we've gone from the anxiety, not sure we want you there, to now it's not fair if you're not there."*

Administrator: *"The doctors who have been working with it* (the Nurse Practitioner) *now, I think are totally converted. And I think the big fear was it was going to cut into their financial intake, it would cut into their authority, perhaps it would be, how would they work with these people?"*

Physician: "Well, actually at the beginning I thought she was going take over my job. I thought she was going to do everything. I didn't know how I was going to take it... We did feel a little bit under pressure... I waited and saw what she did and it really didn't."