

A nurse practitioner model of care in maintenance dialysis: a personal and professional reflective journey.

(PART A)

Stanley, MJ. (2005). A nurse practitioner model of care in maintenance dialysis: a personal and professional reflective journey. (Part A). *Ren Soc Aust J* 1(1) 25-32

Abstract

The current study uses content analysis methodology to analyse a professional journal and open-ended interviews with two Australian nurse practitioner candidates (NPCs) over the 12-month period in implementing a dialysis nurse practitioner (NP) model to identify conceptual categories best describing the transitional experience.

Four themes with various sub-themes were identified: 'Finding a balance', 'The public face', 'Finding a personal version of the NP role' and 'Nurturing'. These themes were also consistent with the United States (US) and United Kingdom (UK) experience. However, unlike early international NPs, NPs in the current study were well supported by key stakeholders and encountered fewer political and organisational barriers.

The key themes identified in the study were used to make recommendations to assist role transition for future NPs in Australia. Exploring the experiences of pioneer NPs in Australia begins to fill a literature gap and equip nurses with knowledge to assist them in their professional and personal challenge to become an NP.

Key Words

nurse practitioner, transition, (haemo/peritoneal) dialysis, experience, novice

important because although data from the US and UK has contributed to a growing body of knowledge regarding the transition into this challenging new role, no Australian literature on the subject was identified.

Literature Review

The aim of the literature search was to analyse papers outlining the professional experiences of NPs implementing their roles, both mentored and unmentored in the US and the UK because no literature describing the Australian context was identified. A literature search of Medline, CINAHL and Psychlit databases using the keywords 'transition', 'nurse practitioner', 'advanced practice nurse', 'novice', 'experience' and 'mentor' identified papers suitable to answer the current study's research questions.

Because the NP role is new to Australian health care, knowledge pertaining to the lived transitional experience of nurses thrust into the NP role, challenging traditional role boundaries,

Introduction

Changes occurring in Australian health care aimed at cost-effective, high quality and well-coordinated care resulted in the evolution of the NP role. The NP role aims to address increasingly complex patient care needs by providing another choice of health service and legitimise advanced nursing practice. The concept of a NP in nephrology was debated and supported by nursing communities in Australia over 11 years ago (Stewart, 1993). Victorian Government sponsorship

of a nephrology NP demonstration project finally occurred in 2002 by approving a submission from St. Vincent's Health, Melbourne. The Department of Nephrology at St. Vincent's Health planned to develop an NP model of care overseen by a team of professionals in an advisory capacity for the specialty of maintenance dialysis.

The current study aims to describe the professional experiences of the NPCs implementing their role. Examining the experiences of NPC transition is

Authors

Melissa J. Stanley

Correspondence to: Melissa J Stanley. Department of Nephrology
St Vincent's Health Melbourne. Melissa.STANLEY@svhm.org.au

Editor's Note: Part B of this manuscript will appear in the next issue of Renal Society of Australasia Journal.

A nurse practitioner model of care in maintenance dialysis: a personal and professional reflective journey. (Part A)

and redefining clinical nursing practice, is limited. Although it is difficult to generalise from international studies to the Australian context, some studies are relevant to Australian models of practice. Papers describing pioneer NPs in the 1960s and 1970s developing the role without nursing mentors were found to be most relevant to Australian practice. No studies to the author's knowledge describe the transitional experiences of developing NP models of care in nephrology.

Chick and Meleis (1986) described transition as a dynamic movement between two relatively stable states with phases of entry, passage and exit, requiring life pattern changes. Transition has been associated with feelings of disconnectedness, insecurity and disequilibrium, all of which were identified by pioneer NPs in the early US literature (Anderson, Leonard & Yates, 1974).

In order for potential Australian NPs to gain a conceptual understanding of the experiences of individual registered nurses entering NP roles, it is worth examining the older US literature. The US literature spans over 30 years of NP care from the original primary care nurses working in community clinics, to the newer roles of the late 1990s when the acute care NP (ACNP) role was introduced (Kleinpell, 1997; Knaus et al, 1997; Roberts, Tabloski, & Bova, 1997; Kleinpell, 1998; Kleinpell-Nowell, 1999 & 2001).

Anderson et al (1974) described the experiences of novice NPs being exposed to a new tertiary education program in the University of Minnesota in a health care system that was just beginning to accept the new and innovative role. They described NP students as experiencing an "identity crisis". When confident, independent and respected clinical

nurses with firm nursing identities start down the road toward NP care, they lose their nursing identity along with their professional confidence and competence (Anderson et al, 1974). Anderson et al (1974), also concluded that these 'lost' NP student nurses tried to find a new identity by modelling themselves on their preceptor, a physician, but became disenchanted when they realised they were not like physicians, either. Only when the NP students became competent at performing their newly acquired skills and felt comfortable in their new extended role, were they able to effectively draw on both nursing expertise and medical knowledge to articulate their NP role.

Interestingly, Roberts et al (1997) also identified role confusion and loss of identity when analysing the reflective journals of NP students over 20 years later. Although Roberts et al (1997) did not strictly adhere to a particular research methodology, the descriptive/narrative approach included input from 100 students over a six-year period. Students described losing their "ability to nurse" as they fumbled through new responsibilities such as taking an accurate patient history and performing cardiovascular assessment. Their feelings of role confusion were inversely proportional to their feelings of professional competence.

Students initially felt consumed with the desire to become expert in the skill of physical assessment and did not place priority on other assessments of equal importance that had no tangible evidence of outcome, such as the cultural and psychosocial aspects of wellness in the individual. Completing task-focused care and practicing new skills that value experience in all things medical often increases novice NPs feelings of professional competence (Jacobs & Kreamer, 1997; Roberts et al, 1997).

Role confusion, focusing on tasks and seeking new experiences, are common themes in the literature describing the novice RN entering the profession, and in the literature describing novice NP feelings. Oliver and Butler (2004) analysed field notes and observational recordings of themes in a study of 30 novice, competent and expert registered nurses' clinical judgment and problem solving. They found novice RNs immersed themselves in gathering experiences of everyday practice because it was novel to them. Each new experience was charged with learning and was seen as exciting to the novice RN. Similarly to novice NP experiences, novice RNs hurried through or did not complete those activities deemed less important to learning in order to spend more time on activities deemed critical to learning. Benner (1984) also found novice nurses focussed on completing tasks and working to a set of rules to guide their performance which bears similarity to literature describing novice NP experiences.

Roberts et al. (1997) argued that role confusion and feelings of incompetency may not be related to feeling like a novice in a new practice role, and attributed it to the intense scrutiny of the NPs knowledge and skill acquisition, by the NP's peers, managers, physician colleagues and the NP's own personal standards. The intense scrutiny was described by 50 pioneer NPs in a descriptive study undertaken to explore NP's experience of establishing the NP role in Washington, USA (Brown & Draye, 2003). Using content analysis they elicited a core theme, "surviving the proving ground", which described how the NP's performance was under constant scrutiny, which pushed them to establish credibility with sceptics, and fight for role legitimacy, as survival strategies (Brown & Draye, 2003, p. 392). Turning their

A nurse practitioner model of care in maintenance dialysis: a personal and professional reflective journey. (Part A)

critics into supporters was essential in the transition to role acceptance.

Brown and Draye (2003) and Tye and Ross (2000) highlighted resentment and outright opposition toward the NP role from nursing and medical colleagues as novice NPs struggled to identify where they sat within the organisational structure. The lack of 'organisational fit' was correlated with decreased professional respect and less active decision-making (Kelly & Mathews, 2001). Kelly and Mathews (2001) undertook a qualitative analysis of the experiences of 30 recent NP graduates in Illinois. Beliefs that the NP role was a 'doctor substitute' and 'de-skilled' junior medical staff, resulted in resentment from doctors. Concerns that the NP would abandon nursing theory for the medical model after decades of struggle for professional independence, created apprehension amongst nursing colleagues (Jacobs & Kreamer, 1997; Tye & Ross, 2000; Brown & Draye, 2003).

There was a strong need to forge new relationships with employers, nurse colleagues and physicians as these authority structures shifted and NPs took on new extended care responsibilities. Brown and Draye (2003) described how nurses tried to find a new type of 'collegiality' with physicians by sharing information, seeking their opinion and participating in collaborative decision-making. Kosowski and Roberts (2003) studied how 10 NPs used intuition in practice and discovered NPs often needed to "play the game" with doctors. This involved changing their vocabulary from using "soft language" or intuition to using dialogue containing objective data such as laboratory values and formulas to gain respect for their clinical decisions. A point that signifies the new NP's successful transition into the role, is being able to maintain a holistic nursing philosophy with patients and nursing

colleagues, whilst being able to survive or "play the game" within a medical framework (Kosowski & Roberts, 2003).

Along with feelings of role confusion and loss of identity, the increasing burden of responsibility becomes evident as NP students begin to try out their new skills and competencies (Roberts et al, 1997; Jarvis, 1999; Cusson & Viggiano, 2002). The shift in responsibility from carrying out, to actually writing orders, is a recurring issue in most NP studies. Most new NPs found basic activities such as writing up a medication chart for a patient or completing a discharge summary so strenuous, they were left with little reserve to complete the day's activities. As NPs began to accept the responsibility for writing orders they began to feel completely responsible for their patient's outcomes. This transitional phase was described by Martin (1999, p. 70) as "morte vitae" where the novice NP fears that the simplest order or action on their part will result in patient injury.

Another common theme in the literature is the novice NP's unrealistic expectations about their ability as beginning NPs, and their aspirations for perfection, which compounded the burden. They often had difficulty releasing themselves from their 'expert' status and felt very uncomfortable when decisions were difficult to make and required constant, undivided attention (Cusson & Viggiano, 2002). They believed they should be able to function proficiently as soon as they began working in the NP role (Brown & Olshansky, 1997). Rather than taking orders, the NP must "synthesize incredibly complex information and decide on a plan of action... simple low-risk decisions loom large to the inexperienced..." (Cusson & Viggiano, 2002, p. 24). Novice NPs take time to develop routines and gather enough experience to allow them to behave automatically (Brown & Olshansky, 1998).

Cusson and Viggiano (2002) suggested that novice NPs had unrealistic expectations of their performance that could make them susceptible to the "imposter phenomenon". This phenomenon was first described by Clance and Imes (1978) and Topping and Kimmel (1985) when studying high achieving professional women. The imposter phenomenon refers to a situation where an individual feels phoney, not intelligent enough or not deserving of a professional role, and is particularly evident in high achieving women, who, unlike men,

...tend to project the cause of success outward to an external cause (luck) or to a temporary internal quality (effort) that they do not equate with inherent ability.

(Clance & Imes, 1978, p. 242)

Cusson and Viggiano (2002) argued that novice NPs, particularly pioneers, are also susceptible to the imposter phenomenon when they constantly strive to please others and achieve perfection, which leaves them feeling they will never be able to achieve expertise again. Brown and Olshansky (1998) also use the imposter phenomenon to describe the novice NP's reluctance to consider them legitimate or 'feel real'.

The anxiety experienced by new NPs diminishes over time in all transitional studies, and the reduction in anxiety levels corresponded with increased competence and confidence. NP competence and confidence responded positively to skill repetition and caring for people with the same clinical issues over time as this allowed for the development of pattern recognition. With experience, NPs start to observe their roles from a broader perspective, acknowledge their achievement, and reflect on experiences in a more positive light. Brown and Olshansky (1998) found

A nurse practitioner model of care in maintenance dialysis: a personal and professional reflective journey.(Part A)

that with newly obtained competence and confidence, new NPs are able to focus beyond the attainment of clinical skills and consider changes that may enhance the effectiveness of and support for their role, such as educating the wider community about the contributions NPs make to health care.

During this phase of the transition, positive patient relationships were viewed with enormous satisfaction, particularly in the primary care specialty where patients are seen repeatedly. Managing patients over time allows rapport and a therapeutic relationship to develop. Early in the transitional experience role confusion, loss of identity and skill attainment eclipsed the importance of the nurse-patient relationship. As confidence increases the NP is able to identify the special bond they share with their patients and are encouraged, through their patient's feedback, to continue helping and making a difference to people's lives (Kelly & Mathews, 2001; Brown & Draye, 2003). NPs are able to consider the psychological aspects of care and their 'ability to nurse' returns (Roberts et al 1997).

Method

The study was set within a qualitative research framework and consisted of three components:

1. Reflective journal
2. Personal interviews
3. Data analysis of the reflective journal and personal interviews

Reflective journal

The author kept a personal professional journal from September 2002, just prior to implementing the role, until the end of the evaluation period in January 2004. Applying learning through journaling specifically in nursing has been found

to be an effective tool to develop the human science of nursing and separate it from the biomedical model of modern health care delivery (Callister, 1993). Reflective journaling has also been shown to assist linking theory to practice with a focus on lived experience.

Personal interview

Two evaluators guided by some open-ended questions developed from the NP role implementation literature, completed a joint interview with both NPCs. The interview was carried out in a quiet, neutral environment without interruption where the NPCs felt comfortable. Using a semi-structured format, each NPC was asked the same questions with probing used to create expansion and exploration. Each NPC was encouraged to provide examples of their experiences. The interviews took approximately one hour in total with one evaluator facilitating and the other evaluator transcribing the NPCs answers.

Data analysis

Each narrative script from the journal was subjected to a detailed analysis with notes used to summarise the points raised. Analysis ceased when no new themes arose from the journal text. The journal contents were analysed by the author and two evaluators independently who read the contents line-by-line and identified a key response, feeling or event in each sentence or paragraph. Data were analysed using a framework proposed by Ritchie and Spencer (1994) using a five-stage process, which involved familiarization, theme identification to form a framework, indexing, mapping and interpreting the findings. Saturation of themes and key concepts was achieved by re-reading the journal a number of times. The themes identified independently from the journal transcript by the three evaluators were then compared for consistency and consensus.

In the findings where NPC singular is used, this refers to the personal-professional journal as the data source and quotations from this journal are included to substantiate the themes. Where NPCs plural is used, this refers to the interview themes where both NPCs contributed data.

Results

Six transitional phases emerged from the journal transcript and interview data. The phases show the progressive professional development of the NPCs over time in a forward movement. Each phase was clustered into four major themes and various sub-themes that occurred throughout all phases of the candidature and consistently recurred in the interview. The themes and sub-themes are listed in Table One below. Each theme independently demonstrates the personal and professional socialisation of the NPC.

The patient names contained in the quotations from the NPC's journal quotations are fictitious to ensure the individuals privacy.

Theme 1: Finding a Balance

"Finding a balance" was the largest of the four themes, spanning all phases of the NPC transition. The NPCs were consistently discovering how to balance nursing philosophy with newly acquired medical knowledge and skills, when to play the medical game and when they needed to nurse, how to implement prescriptive protocols whilst individualising care and where the NPC fitted within the organisation at any given time.

A nurse practitioner model of care in maintenance dialysis: a personal and professional reflective journey.(Part A)

Table 1: Themes and sub-themes identified from the personal professional journal of a nurse practitioner candidate and open-ended interview of both candidates.

Themes	Finding a Balance	Finding a Personal Version of the NP Role	The Public Face	Being Nurtured
Sub-themes	The doctor-nurse dichotomy	Selling self short	The imposter phenomenon	Thriving on patient relationships
	Playing the game & learning the lingo	Perfectionism	Multiple role demands & differing expectations	Being valued
	Protocol-driven vs. individualised care	Lonely wolf in the wilderness	Impact on personal life	Internalising positive feedback
	Organisational fit	Making a difference		

Sub-theme - The Doctor-Nurse Dichotomy

This sub-theme represents the role confusion the NPCs faced when needing to move from a nursing role where they were viewed as competent professionals with advanced knowledge and expertise in a nursing specialty into a role where they were required to blend two health philosophies into one. At times one NPC felt she was neither a nurse nor a doctor and found it difficult to develop the role without a nursing mentor or role model. She faced both personal and professional responsibilities to ensure that the advanced nursing role did not result in 'medicalisation' of the role, a fear of nursing critics of the NP role, but ensured a respected clinical career path for Australian nurses. Keeping a nursing focus was more difficult because the NPC education was taught by and competence examined by, medical colleagues.

The NPCs struggled to fit the medical knowledge into a nursing philosophy and found medical skill and knowledge attainment all consuming. One of the NPCs described temporarily pushing her nursing care to the side and being driven to understand and apply critical thinking

to biochemical analysis of her patients, making slow and deliberate decisions, which frustrated her and threatened her intelligence and credibility as an 'expert' nurse. She described feelings of 'losing her nursing identity'.

The NPCs were taught certain aspects of nephrology with medical colleagues. The professional burden of maintaining a nursing perspective was ever present. It evoked confusion about whether NPCs should feel privileged to learn medicine with the registrar and residents, or feel insulted that their nursing experience was discounted when they were relegated to learning with medical interns, the novice medical practitioners. This dichotomy is illustrated in the following transcript from an NPC's journal:

Speaking of med school, our education session on Friday provoked mixed responses/feelings in me. I could not decide whether I felt proud or angry at needing to share my PD (peritoneal dialysis) session with Andrew (renal registrar) and Tara (renal intern). On one hand, it was a pleasant team-building activity... on the other hand, I wasn't an undergraduate - I had a postgraduate diploma and nearly a

Master's education and 10 years renal nursing experience and here I am being taught in the same group as an intern with 3 months renal experience. (Stanley, 2003, p. 60)

At this stage, the NPC was unable to rationalise how the teaching added to, rather than replaced, her nursing expertise and that she was indeed a novice in medical philosophy. She felt learning with less experienced colleagues was a threat to her intellectual credibility. At the same time it was difficult to keep up with the amount of learning required by the course content, which further sabotaged her feeling of professional competence. When she felt that her intelligence was under threat, she was driven to prove she was worthy of being an NPC.

Sub-theme - Playing the game and learning the lingo

It is only through reflecting on clinical scenarios through the eyes of a doctor and learning medicine that NPCs learned to balance professional responsibilities to nursing and medicine. NPCs eventually realised that because they were learning 'medicine' there was a need to complete assessment tasks consistent with the medical information being learned, which involved "playing the game" and "learning the lingo".

Over time the NPCs began to develop 'political savvy', choose words carefully and involve doctors in the decision-making process in order to 'get them on side'. In this process they resorted to 'crunching numbers' and concentrated on pathology results when discussing patients with medical staff to objectively justify clinical decisions.

Sub-theme - Protocol-driven vs. individualised care

Initially the NPCs were surprised at how prescriptive the clinical practice guidelines were, and worried that protocols would limit their ability to

A nurse practitioner model of care in maintenance dialysis: a personal and professional reflective journey. (Part A)

make clinical judgements, or that they would not cover all the situations the NPCs were likely to face.

I have always been one to use the philosophy of individualising care so the protocols may actually limit my options for resolution of an issue. What would happen if we stepped outside the protocol and maybe alter the dialysate flow or temperature? Both legitimate responses to certain problems, but not included in the current protocols.

(Stanley, 2003, p. 15)

Then NPCs quickly learned that, although working according to a protocol, the protocol can be interpreted in several ways – although not every doctor would agree with all of the interpretations. Therefore, the NPC chose with whom they consulted prior to making a protocol-based decision, and when they were able to make an autonomous decision.

Sub-theme - Organisational Fit

Re-defining professional boundaries was discussed in the sub-theme 'the doctor-nurse dichotomy', but it is also applicable in a purely nursing context. The NPCs found it difficult to find a balance between assisting the patient's primary nurse in care issues and not wanting to "take over".

I am reluctant to do this as this defeats the purpose of having an NPC, but I am also torn not wanting to take away the primary nurses' control and autonomy to make decisions surrounding their patient's care.

(Stanley, 2003, p. 28)

The Australian NP role is a new advanced clinical nursing role, which made it difficult for the NPCs to visualise where they fitted in the hierarchy of the organization. The NP position was classified as a grade five nursing position,

and the NPCs were managed by a nurse. The NPCs found themselves in the rare position of being managed by a grade four nurse unit manager, who was also unclear about how these new clinical professionals should be managed and what the role entailed.

The collegial relationships the NPCs developed with their medical counterparts assisted them to feel comfortable in their new roles and find their place in the organisational scheme.

Theme 2: Finding a Personal Version of the NP Role

Theme Two describes the individual pressures one NPC faced trying to create a role consistent with her nursing philosophy and standards whilst struggling to find a personal version of the NP role. By striving for perfection she set herself up for failure because she was unable to live up to her own high expectations and consistently 'sold herself short'. She considered herself to be a 'lonely wolf in the wilderness' after she realised she did not have a mentor to assist with her transition into the NP role.

Sub-theme - Selling Self Short and Perfectionism

Concepts of poor self-confidence and perceived lack of ability to perform the NP role began early in the candidature of one of the NPCs when she compared herself to her more experienced colleague who was the other NPC taking part in the current study. The more experienced NPC was initially a role model for the less experienced NPC and she aspired to be like this person. At the same time the less experienced NPC felt unworthy of being a candidate alongside her colleague. Aside from comparing herself to a more experienced colleague, the less experienced NPC set an unachievable 100% success rate

for decisions and care outcomes at the beginning of the project. In the process she set herself a standard she was unlikely to be able to meet.

Sub-theme - Lonely Wolf in the Wilderness

Because the less experienced NPC initially wondered how she could compare with her nursing colleague, she avoided her colleague's offer to study together. She felt she would not be able to contribute to the study relationship and viewed herself as a parasite or sponge with little to contribute to her colleague's learning. This left the NPC feeling alone, unsupported and unable to communicate effectively.

The less experienced NPC, with help from the project manager, recognised that she had different skills and contributions to patient care and that she should not compare herself with her colleague but look for personal positive attributes. The less experienced NPC ceased to concern herself with solely biomedical care and accepted that those skills could be learned with time and repetition. Instead of aspiring to be like her colleague she developed rich nurse-patient relationships and concentrated on her counselling and interpersonal skills to feel comfortable with her role.

Sub-theme - Making a Difference

Contentment comes with being able to recognise unique contributions and positive impacts on patient's lives. The less experienced NPC developed an understanding of each person's individuality and was able to recognise a significant change in her patient's condition before any major symptoms occurred without needing to refer to pathology results. Thus she was able to combine clinical skills, intuition and pattern recognition to assist in her clinical decision-making. She was content to travel the journey alone when she realised that her colleague would find a different version of the role.

A nurse practitioner model of care in maintenance dialysis: a personal and professional reflective journey. (Part A)

Theme 3: The Public face

This theme represents the enormous personal and professional pressure placed on NPCs as they embarked on the journey toward becoming an endorsed NP. The NPCs began to practice as an NP whilst still learning the skills and information required to function in an advanced role and felt the pressure they put on themselves, and from colleagues, to be immediately competent. Thus the NPCs felt they were imposters in a role they didn't know how to play.

Sub-theme - The imposter phenomenon

When the NPCs were asked by nursing colleagues to assess a patient's fluid status before they were confident with their skills they asked themselves "When did I move from learning to assess to being responsible for assessment?" (Stanley, 2003, p. 27). The NPCs felt the burden of responsibility in the early stages of the role implementation and felt the transition period from their usual role to NPC was inadequate.

In order to cope and survive the NPCs put on a public face of competency because they recognised the need to appear to be in control, whilst they felt like imposters. The NPCs spent most of the initial implementation period 'winging it' and 'going with the flow' outwardly exhibiting confidence to establish their credibility and earn the trust of the patients they cared for.

Sub-theme - Multiple Role Demands and Differing Expectations

Because the NP role is considered to be the apex of clinical nursing, NPCs are burdened with many expectations depending on the perspective of the discipline involved. The NPC is regarded as an educator, researcher, clinician and leader. These multiple functions had a negative impact on the NPCs already

experiencing role confusion and loss of nursing identity. The NPCs felt they were being pulled in many directions, which left them feeling they would never achieve any of the goals for these role components because they were merely skimming the surface.

In addition, nursing and medical colleagues had different expectations of the role, which made it difficult to find a balance and meet the multiple demands of the role. Nursing colleagues viewed the NPC role as mainly supporting them with education and professional development. Medical colleagues saw the role as having purely a clinical focus and hoped that NPC care would ease the burden in outpatient clinics (Stanley, 2003, p. 5).

Not only were there multiple role demands from medical and nursing colleagues, study demands, which constituted a large part of the NPC role initially, were also a constant burden.

I am doing 10 or 11-hour days and then getting home only to start thinking about catching up on my journaling, my lit. searches or going over pharmacology notes. I decided to drop back to a 9-day fortnight to help me cope with the workload. I don't know how I will cope this year with the pressure of work and home life. (Stanley, 2003, p. 38)

Because the NPCs were pioneers in Australia, they felt a professional responsibility for the project success; therefore, they had to demonstrate the value of advanced clinical nursing practice. The NPCs knew they had to demonstrate positive outcomes for the patients they were caring for in order to honour the commitment St. Vincent's Health had made to the project and to prove that renal nurses can competently care for patients with complex needs in an extended role.

Sub-theme - Impact on Personal Life

The constant pressure to perform at a high level and self-doubt took its toll on the NPCs personal life, often manifesting in physical illness. The NPCs reported a lack of socialising and constant need for study and long working days. They felt they had to put everything else aside to undertake the project in order to succeed professionally. Sleep disturbance, anxiety, guilt, withdrawal, fatigue, and poor lifestyle habits occurred.

There are many indicators relating to the overwhelming impact this year's project has had on me. My starting at 6.30 in the morning and walking out always after 5pm, my one haircut and colour in 12 months, my skipping showers, not washing my hair for days on end.... I am embarrassed to admit that I let myself slide so much and didn't take the time to care for myself. (Stanley, 2003, p. 65)

Theme 4: Being Nurtured

The NPC's lack of confidence, vulnerability and energy depletion were revitalised when their value was recognised through paperwork with the doctors and the relationships they continued to form with their patients.

I am thriving on being around patients again. I love absorbing their individual lives, being their confidante, having them seek me out to ask a question or just talk about the weather. I am loving talking about people again instead of procedures/ practices. (Stanley, 2003, p. 23)

The incredible highs and lows of the roller-coaster ride that is the NPC journey were identified in the journal. As the NPC entered the black hole at

A nurse practitioner model of care in maintenance dialysis: a personal and professional reflective journey.(Part A)

a time when two of her patients died and another two required admission to hospital, the NPC felt she was not making a difference to patient care and actually complicated matters. She wanted to leave the project, but was reassured when the project manager, who has also worked on another NP project, told her that the candidates in her previous project also went through a black hole stage after about nine months into the project. The knowledge that her feelings were not unusual lifted her spirits, as did the positive feedback from her patients.

When another patient was admitted to hospital feelings of guilt and responsibility recurred. Thus a balancing act began as seemingly small successes were constantly outweighed by the perceived failures, only to be followed by success when a patient gave her flowers, and she received positive feedback from a sceptical doctor.

The time this particular NPC put into forming relationships allowed her to rekindle her nursing identity and focus on what really mattered to her – patient's perceptions. That is, the quality of patient care improved in her patient's eyes. Positive feedback from the medical staff also nurtured the NPCs enthusiasm and drive. The feedback came as written comments in the patient's clinic letters when doctors agreed with the NPC's decisions or acknowledged the NPC's involvement in caring for each patient between clinic visits. The letters directed to each patient's GP acknowledged and highlighted the collaborative relationship between the NPC and the nephrologist.

It was only when NPCs were comfortable with their personal version of the NP role and were able to recognise the paradigm shift from nursing to the biomedical perspective and back again, that they were able to internalise the positive feedback and allow it to outweigh negatively perceived events.

References

- Anderson, E., Leonard, B., & Yates, J. (1974). Epigenesis of the Nurse Practitioner Role. *American Journal of Nursing*, 74 (10), 1812-1816.
- Benner, P. (1984). *From Novice to Expert Excellence and Power in Clinical Nursing Practice*. California: Addison-Wesley Publishing Company Inc.
- Brown, A., & Olshansky, E. (1997). From Limbo to Legitimacy: A Theoretical Model of the Transition to the Primary Care Nurse Practitioner Role. *Nursing Research*, 46 (1), 46-51.
- Brown, A., & Olshansky, E. (1998). Becoming a Primary Care Nurse Practitioner: Challenges of the Initial Year of Practice. *The Nurse Practitioner*, 23 (7), 46-66.
- Brown, M.A., & Draye, M.A. (2003). Experiences of Pioneer Nurse Practitioners in Establishing Advanced Practice Roles. *Journal of Nursing Scholarship, Fourth Quarter*, 391-397.
- Callister, A. (1993). The Use of Student Journals in Nursing Education: Making Meaning out of Clinical Experience. *Journal of Nursing Education*, 32, 185-186.
- Chick, N., & Meleis, A.I. (1986). Transitions: A nursing concern. In P.L Chinn (Ed.), *Nursing research methodology: Issues and implementation* (pp. 237-257). Maryland: Aspen Publishers, Inc.
- Clance, P.R., & Imes, S.A. (1978). The Imposter Phenomenon in High Achieving Women: Dynamics and Therapeutic Intervention. *Psychotherapy: Theory, Research and Practice*, 15 (3), 241-247.
- Cusson, R.M., & Viggiano, N.M. (2002). Transition to the Neonatal Nurse Practitioner Role: Making the Change from the Side to the Head of the Bed. *Neonatal Network*, 21 (2), 21-28.
- Jacobs, L.A., & Kreamer, K.M. (1997). The Oncology Clinical Nurse Specialist in a Post-Master's Nurse Practitioner Program: A Personal and Professional Journey. *Oncology Nursing Forum*, 24 (8), 1387-1392.
- Jarvis, S. (1999). Personal Journal of a Surgical Intensive Care Unit Nurse Practitioner. *Critical Care Nursing Quarterly*, 21 (4), 59-68.
- Kelly, N.R., & Mathews, M. (2001). The Transition to First Position as Nurse Practitioner. *Journal of Nursing Education*, 40 (4), 156-162.
- Kleinpell, R. (1997). Acute-Care Nurse Practitioners: Roles and Practice Profiles. *Advanced Practice in Acute and Critical Care*, 8 (1), 156-162.
- Kleinpell, R. (1998). Reports of Role Descriptions of Acute Care Nurse Practitioners. *Advanced Practice in Acute & Critical Care*, 9 (2), 290-295.
- Kleinpell-Nowell, R. (1999). Longitudinal Survey of Acute Care Nurse Practitioner Practice: Year 1. *Advanced Practice in Acute and Critical Care*, 10 (4), 515-520.
- Kleinpell-Nowell, R. (2001). Longitudinal Survey of Acute Care Nurse Practitioner Practice: Year 2. *Advanced Practice in Acute & Critical Care*, 12 (3), 447-452.
- Knaus, V., Felten, S., Burton, S., Fobes, P., & Davis, K. (1997). The Use of Nurse Practitioners in the Acute Care Setting. *Journal of Nursing Administration*, 27 (2), 20-27.
- Kosowski, M., & Roberts, V. (2003). When Protocols are Not Enough Intuitive Decision Making by Novice Nurse Practitioners. *American Journal of Holistic Nurses' Association*, 21 (1), 52-72.
- Martin, R.K. (1999). The Role of the Transplant Advanced Practice Nurse: A Professional and Personal Evolution. *Critical Care Nursing Quarterly*, 21 (4), 69-76.
- Oliver, M., & Butler, J. (2004). Contextualising the trajectory of experience of expert, competent and novice nurses in making decisions and solving problems. *Collegian*, 11 (1), 21-27.
- Ritchie, J., & Spencer, L. (1994). Qualitative Data Analysis for Applied Policy Research. In Bryman, A., & Burgess, R (Eds), *Analysing Qualitative Data* (pp.173-194). London: Routledge.
- Roberts, S., Tabloski, P., & Bova, C. (1997). Epigenesis of the Nurse Practitioner Role Revisited. *Journal of Nursing Education*, 36 (2), 67-73.
- Stanley, M. (2003). *Personal Professional Journal*, Unpublished Thesis. 1-70.
- Stewart, G. (1993). The Nurse Practitioner: Implications for Nephrology Nursing. *Renal Educator*, 13 (3), 43-47.
- Topping, M., & Kimmel, E. (1985). The Imposter Phenomenon: Feeling Phoney. *Academic Psychology Bulletin*, 7, 213-226.
- Tye, C., & Ross, F. (2000). Blurring Boundaries: professional perspectives of the emergency nurse practitioner role in a major accident and emergency department. *Journal of Advanced Nursing*, 31 (5), 1089-1096.