

Position Statement on The Role of the Nurse Practitioner in Trauma

Due to dramatic changes in health care both political and technological, communities and hospitals are faced with increasingly complex patient populations without associated financial reimbursements. It is in this dynamic setting that the role of the Nurse Practitioner continues to evolve. Nurse Practitioners (NP's) were conceptualized in the early 1960's and have since helped expand the scope of nursing practice. Today's NP practices in a variety of settings and specialties. It is unclear when the introduction of NPs began into Trauma Programs. However, what is evident from the literature is that more Trauma Programs are beginning to utilize NP's in various capacities. As a result, NP's quickly have become valuable members of trauma teams. They provide comprehensive medical care complimented by a holistic nursing approach. As more and more Trauma Programs turn toward utilizing physician extenders to augment their programs it is the opinion of the Society of Trauma Nurses (STN) that Nurse Practitioners are capable of these challenging trauma roles.

The Society of Trauma Nurses:

Endorses the utilization of NP's as clinicians for trauma services.

Believes that NP's provide comprehensive, evidence based care to trauma patients and work with all members of the health care team to promote continuity.

Understands that NP's continue to respond to the changing health care arena and respond accordingly to function as clinician, educator, researcher and administrator.

Recommends that all NP's working within trauma settings have a collaborative practice agreement with a trauma surgeon.

Support that NP's are cost effective practitioners.

Agrees with the American Association of Colleges of Nursing {AACN}

recommendations that all NP's be certified by their perspective professional organization.

Advanced Practice Nurses

Formation of the Advanced Practice role in Nursing began long before nurses gave thought to the concept of Advanced Practice. The emergence of the nurse providing advanced skills first appeared in the literature in 1877 where Sister Mary Bernard gave anesthesia at St Vincent's Hospital in Erie, Pennsylvania (Bear, 1995). Hence the birth of the Advanced Practice Nursing role began in the form of Nurse Anesthetist. By the 1950's three Advanced Practice Nursing roles existed; the Nurse Anesthetist, the Nurse Midwife and the Clinical Nurse Specialist (CNS). It wasn't until the 1960's that heralded the entry of the Nurse Practitioner (NP) into the Advanced Practice Nursing (APN) category.

The Nurse Practitioner

In 1965 Henry K. Silver, MD and Professor Loretta Ford, RN developed and opened the first Nurse Practitioner program at the University of Colorado. This role was conceptualized by a handful of nursing leaders to provide the nurse with a venue for expanded education and clinical practice as well as provide primary care and health promotion to the underserved populations in the United States.

Since 1965 the growth of the Nurse Practitioner movement was influenced by economic and societal needs as well as collaborative relationships with physician colleagues (Sheehy & McCarthy, in press). Due to changes in reimbursement, hospital restructuring, a reduction in the number of medical residency programs and an expanded scope of practice, Nurse Practitioners have rapidly progressed from practicing in primary care settings to include secondary and tertiary environments (Keane & Becker, in press).

Education, Licensure and Certification

Entry-level education for the Nurse Practitioner is a master's degree. Each NP completes didactic and clinical courses preparing nurses with advanced knowledge and clinical competency within their practice specialty. Development of role autonomy in medical diagnosis and decision-making is a hallmark of NP curricula (Mick & Ackerman, 2002). Nurse Practitioners are educated in a variety of specialty areas, including family, adult, acute, pediatric, neonatal and gerontologic.

Nurse Practitioners practice under their individual state's legislative/regulatory body. The National Council of State Boards of Nursing (NCSBN) determines the standards for basic licensure, which varies from state to state. Some states require a second license other than the registered nurse license to practice as a nurse practitioner.

In addition to education on a master's level, NP's can become certified in their particular specialty. This certification process consists of a standardized national examination that tests the NP's basic knowledge. It is not required by all state boards of nursing in order to practice, however it is strongly recommended by the American Association of Colleges of Nursing (American Association of Colleges of Nursing {AACN}, 1998).

Credentialing and Privileges

Credentialing and privileging of the Nurse Practitioner is a process institutions use to ensure professional and technical competence. The Credentialing process includes an application submitted by the NP with specific data regarding education, certification, licensure, DEA certificates, liability insurance information as well as demographic history (Cary & Smolenski, in press). This application is then reviewed by the institution to ensure that the applicant is consistent with federal and state standards. Privileging is a component of the credentialing process that defines a broadened scope of practice including specific skills the NP is allowed and competent to perform within the institution. This must be consistent with state definitions regarding scope of practice for the Nurse Practitioner.

Nurse Practitioners in Trauma

Nurse Practitioners practice autonomously and in collaboration with health care professionals to diagnose, treat and manage patient's health problems. NP's derive their diagnostic decision-making skills in part from their educational training which is rooted in the medical model and through patient-centered, diagnostic reasoning and care planning, which is holistic and consistent with nursing theory and philosophy (Burman, Stephans, Jansa & Steiner, 2002). For this reason NP's are well suited to care for patients

and make them ideal for trauma programs challenged by complex patient needs and decreased manpower.

Nurse Practitioners who work on trauma services have various backgrounds, levels of responsibility and job descriptions consistent with their state nursing practice act and their physician collaborative agreements. Trauma Nurse Practitioners (TNP) can be Adult, Family, Pediatric or Acute Care Certified. Some work independently managing a caseload of trauma patients (Harrahill & Eastes, 1999) while others work in conjunction with house staff to augment house staff roles (Spisso et al., 1990). Nurse Practitioners practice in population, service and within physician based models. Population-based NP's follow trauma patients throughout the continuum of care inpatient and outpatient (Spisso, O'Callaghan, McKennan & Holcroft, 1990, Cupuro & Alperovich, 1997). In a service-based practice, NP's follow only inpatient trauma patients. And in a physician-based model, NP's provide care for a specific physician's patient population regardless of where they are in the continuum.

Trauma Nurse Practitioners provide continuity of care as well as comprehensive medical care to trauma patients. They achieve this by attending daily trauma team rounds, facilitating team plans, making individualized care plans, evaluating and altering care plans depending on patient condition and ancillary service input as well as coordinating follow up care. TNP's interface with nurses, other APN's, therapists, social workers, physicians and other staff involved in trauma patient care. They assist house-staff in communicating with consultants, patients, and families as well as are able to document and dictate discharge physicals and summaries (Spisso et al, 1990). The vast majority of TNP's, based on their individual state practice acts, have order writing abilities and prescriptive privileges (Pearson, 2002).

TNP's are capable of performing minor procedures depending upon their individualized privileges obtained through their state and institution. Some of these procedures are; invasive catheter and chest tube removals or insertions, suturing, foreign body removal, incision and drainage of wounds, complex wound care, ventilator management and first assisting in the operating room as Registered Nurse First Assistants (RNFA) (Spisso, et al, 1990, Harrahill & Eastes, 1999 & Cupuro & Alperovich, 1997).

In Summary

Nurse Practitioner's are being increasingly utilized in hospitals in various roles due to improved quality of care afforded by full-time, permanent workers as well as recent changes in the number of residency slots and hour limitations (Riportella-Muller, Libby & Kindig, 1995). The Trauma Nurse Practitioner has been proven to decrease patient length of stay, decrease outpatient waiting times as well as patient complaints, decrease residency workload, and increase quality documentation (Spisso et al 1990). In addition to their clinical value, TNP's also participate in education of staff, research projects, protocol and programmatic development.

References

- Bear, E (1995). Advanced Practice Nurses: How Did We Get Here Anyway? *Advanced Practice Nursing Quarterly* 1(1), 10-14.
- Kommenich, Pauline (In press). The Evolution of Advanced Practice in Nursing. In Sheehy, C.M, & McCarthy M.C. (Eds.). *Advanced Practice Nursing: Emphasizing Common Roles*, ed 1. Philadelphia, F.A. Davis Company.
- Keane, A. & Becker, D (In press). Emerging Roles of the Advanced Practice Nurse. In Joel, L. A. (Ed.). *Advanced Practice Nursing: Essentials for Role Development*, ed 1. Philadelphia, F. A. Davis Company.
- Mick, D. J. & Ackerman, M. H. (2002). Deconstructing the myth of the advanced practice blended role: Support for role divergence. *Heart & Lung* 31 (6), 393-398.
- American Association of Colleges of Nursing {AACN}. (1998). Certification and Regulation of Advanced Practice Nurses. At <http://www.aacn.nche.edu/Publications/positions/cerreg.htm>. Retrieved 6/1/2004.
- Cary, A. H. & Smolenski, M. C (In press). Credentialing and Clinical Privileges and the Advanced Practice Nurse. In Joel, L.A. (Ed.). *Advanced Practice Nursing: Essentials for Role Development*, ed 1. Philadelphia, F. A. Davis Company.
- Burman, M. D., Stephans, M. B., Jansa, N. & Steiner, S. (2002). How do NPs make clinical decisions? *The Nurse Practitioner* 27 (5), 57-64.
- Spisso, J., O'Callaghan, C., McKennan, M. & Holcroft, J. W. (1990). Improved Quality of Care and Reduction of Housestaff Workload Using Trauma Nurse Practitioners. *The Journal of Trauma* 30 (6), 660-665.
- Cupuro, P. A., Alperovich, C. G. (1997). Letters to the Editor. *The Journal of Trauma Injury, Infections and Critical Care* 43 (6), 988.
- Harrahill, M. & Eastes, L (1999). Trauma Nurse Practitioner: The perfect job? *Journal of Emergency Nursing* 25 (4), 337-338.
- Pearson, L. (2002). Fourteenth Annual Legislative Update: How Each State Stands on Legislative Issues Affecting Advanced Nursing Practice. *The Nurse Practitioner* 27 (1), 10-52.
- Riportella_Muller, R., Libby, D. and Kindig, D. (1995). The Substitution Of Physician Assitants And Nurse Practitioners For Physician Residents In Teaching Hospitals. *Health Affairs* 14, 181-191.