Review of Contemporary Philosophy
ISSN: 1841-5261, e-ISSN: 2471-089X
Vol 22 (1), 2023
Pp 880 - 888

The Future of Nursing: Adapting to Changes in Healthcare Policies and Practices

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Abstract

Background: The nursing profession is critical in enhancing primary healthcare delivery, particularly through innovative models like Advanced Access (AA). As healthcare policies evolve, nurses, including Nurse Practitioners (NPs) and Registered Nurses (RNs), are increasingly positioned to improve patient access and care quality. However, gaps in understanding their roles within these frameworks persist, necessitating further investigation.

Methods: This study employed a qualitative approach to explore the experiences of NPs and RNs in adapting their practices following the implementation of the AA model. Data were collected through interviews with nursing staff across four healthcare settings in Quebec, focusing on the barriers and facilitators to practice transformation.

Results: Findings revealed significant differences in how RNs and NPs adapted to the AA model. NPs demonstrated a clearer understanding and effective restructuring of appointment systems, while RNs faced challenges due to insufficient engagement and leadership support. Key themes identified included

regulatory influences, the importance of leadership in facilitating change, and the necessity for improved interprofessional collaboration.

Conclusion: The successful integration of the AA model in primary care requires tailored training and support for both RNs and NPs. Enhancing collaborative practices and leadership roles is essential to optimize nursing contributions and improve patient care access. This research underscores the need for ongoing evaluation of nursing practices to inform policy and practice changes in primary healthcare settings.

Keywords: Nursing Practice, Advanced Access, Nurse Practitioners, Primary Care, Healthcare Policy.

Received: 10 october 2023 **Revised**: 24 November 2023 **Accepted**: 08 December 2023

1. Introduction

Enhancing nursing practice in primary healthcare environments is acknowledged as an effective approach to elevate the quality and efficiency of primary care while fulfilling the unfulfilled healthcare requirements of people, families, and communities [1, 2]. Researchers globally emphasize the significant role nurses might have in transitioning to innovative care models to enhance basic healthcare services [2, 3]. A substantial body of research underscores the pivotal role of nurses in enhancing the accessibility of primary care services, the quality of treatment, and the satisfaction of patients and other professionals. Two recent systematic reviews indicate that trained nurses (e.g., nurse practitioners [NPs], registered nurses [RNs]) provide care of equal or superior quality compared to primary care physicians, likely resulting in comparable health outcomes and enhanced patient satisfaction concerning urgent physical issues and chronic conditions. Contandriopoulos and Brousselle elucidate how the integration of nurse practitioners into primary care teams disrupts the existing paradigm and transforms primary care delivery paradigms [4, 5].

Nonetheless, despite the critical and strategic role of nurses in reforming primary care through reorganization and innovation, nursing practice has garnered insufficient focus in research concerning innovative models designed to decrease wait times for primary care appointments, such as advanced access (AA). The existing knowledge base does not facilitate comprehension of the necessary changes in nursing practice associated with these models or the issues they entail.

Advanced access is a well-established innovation concept aimed at enhancing prompt access to primary care services that align with patients' needs and choices in a timely manner [4, 6]. It is based on five fundamental principles: 1) balancing supply and demand, 2) mitigating work backlog (i.e., eradicating wait lists), 3) evaluating the appointment system, 4) enhancing inter-professional collaborative practice, and 5) formulating contingency plans. In AA, appointments are provided irrespective of the visit's purpose and the urgency of the need [7, 8].

The adoption of the AA model necessitates the reorganization of the practices of all team members, including diverse categories of nurses who must modify their roles and practices to guarantee successful and patient-centered implementation [9, 10]. Optimizing the role of nurses is a crucial technique for enhancing timely access and addressing health needs and expectations. Nurses may decrease the number of prescheduled appointments to provide more slots for same or next-day visits, so addressing demand, minimizing delays, and reinstating the necessary equilibrium for the model's performance [7, 11, 12]. They may rearrange appointments to address simple acute disorders, therefore allowing doctors to attend to more difficult cases, which enhances care team capacity and lowers appointment wait times [13]. Nurses may, via improved collaborative practice with family doctors and other clinicians, treat patients with chronic diseases, therefore decreasing the frequency of physician visits.

Although extensive literature examines the modifications in family physician (FP) practices to incorporate essential principles of AA and assess outcome indicators (such as reductions in wait times and missed appointments), there is a paucity of research regarding the alterations in various categories of nurses' practices concerning appointment rescheduling within this framework. Furthermore, the inter-

professional dimension of AA (4th principle), which underscores improved collaborative practice among RNs, NPs, doctors, and clerical personnel to optimize care efficiency and quality, has not been extensively researched.

Several studies indicate that modifications in nursing practice have facilitated the successful adoption of AA. Nevertheless, these studies seldom examine the mechanisms of transformation and its applicability to specific categories of nurses. Two studies [14, 15] recognize the utilization of Nurse Practitioners (NPs) and Registered Nurses (RNs) as a means to enhance practice efficiency in Alcoholics Anonymous (AA), yet they fail to delineate how the practices of each nursing type were optimized within AA regarding appointment rescheduling and interprofessional collaboration. Additionally, they do not identify success factors or derive lessons applicable to other contexts. Research done in Québec indicates that enhancing registered nurse practice by including patient management and pregnancy follow-up improves collaborative practice. However, there is little knowledge on the collaborative models and essential variables that facilitate effective changes in nursing practice [7, 16].

The only evaluation of team dynamics with AA, performed in a recently inaugurated nurse practitioner-led clinic in northern Ontario [17], highlights advantages including enhanced NP autonomy over their daily responsibilities, improved patient satisfaction and safety, and a reduction in walk-in and emergency department visits. The report highlights issues related to unfulfilled customer expectations due to discrepancies between supply and demand, the ongoing need to triage calls and build skills, and the requirement for flexibility in modifying operational procedures. The study advocates for more research to investigate the problems associated with nurses' practice that arise within AA. This request was reaffirmed in a recent evidence synthesis [18], which underscores significant information deficiencies about the techniques used by many stakeholders to apply the model. This research attempts to comprehend the changes occurring in the practices of RNs and NPs, who bear significant responsibility for delivering patient-centered primary care. The results will inform the restructuring of care procedures and the allocation of tasks to augment healthcare team capabilities, while also indicating adjustments in nursing practice to boost timely access to primary care.

This research is the first report on the experiences of Nurse Practitioners and Registered Nurses about practice changes subsequent to the implementation of the AA model. The primary goals are to examine the experiences of nurse practitioners and registered nurses on practice changes throughout the

implementation of the AA model, and to identify variables that either assist or hinder change.**Determinants affecting modifications in nursing practice regarding enhanced access**n the

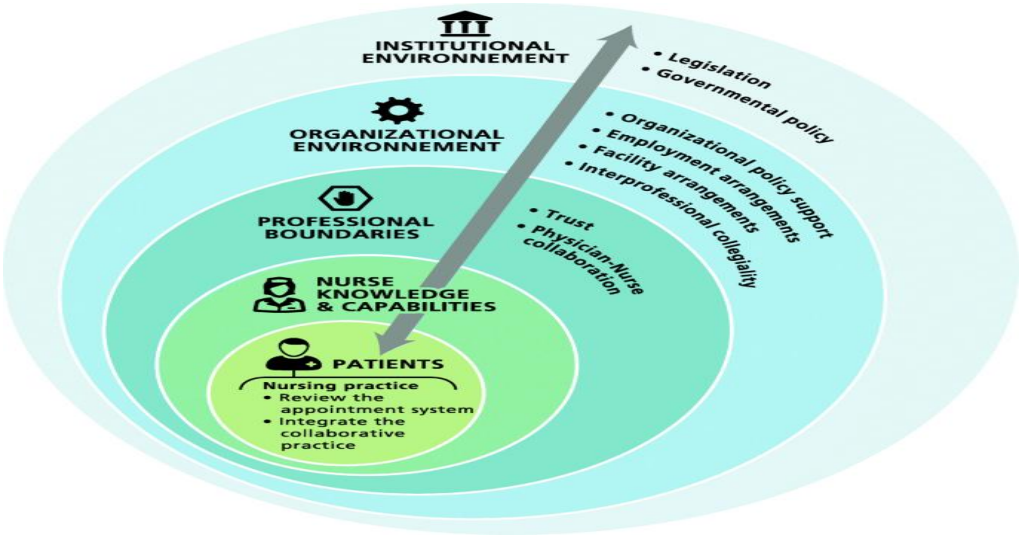

Figure 1. Determinants Affecting Modifications in Nursing Practices under the Advanced Access Model

subsequent phase of study, we discovered prevalent themes that served as obstacles or enablers to NP and RN practice transformation within AA. Figure 1 depicts the important elements based on the paradigm of Niezen and Mathijssen [19] on changes in nursing practice related to enhanced access.

Participants in the research identified a 2010 provincial strategy to deploy 500 Nurse Practitioners in primary healthcare as a direct catalyst for altering work processes inside the Family Medicine Unit and indirectly for reconfiguring nursing practices across the Academic Area [20,21]. This policy was seen by NPs as an enabler of practice transformation. Conversely, RNs saw it as hurting their practice. One NP emphasized that nurses are now not a priority for decision-makers. A registered nurse said that the implementation of a substantial number of nurse practitioners should have been accompanied by policies to reform registered nurse practice and establish professional practice limits.

2. Leadership

Physician leadership was emphasized as a significant element, but nurse leadership was seldom referenced. Nurses (RNs and NPs) identified supporting leadership from doctors as a crucial factor for the implementation of the AA model overall, and for modifications in nursing practices specifically. Participants articulated how leadership might function as either a facilitator or an impediment to adherence to the AA model. Leaders who advocate for the collaborative practice among team members by developing or reinforcing teams, such as pairing nurses with family practitioners and sharing accountability for specific patient panels, as well as fostering open communication channels (e.g., regular meetings) and feedback mechanisms among all team members, including nurses, were observed to facilitate changes in nursing practice [22-25]. The lack of medical leadership to advocate for AA and optimize nursing practices was seen by several RNs and NPs as a significant obstacle to change. An RN expressed disappointment at the retirement of an FP acknowledged as a significant player in advancing protocols to facilitate her practice transition within the AA paradigm. She articulated the regression of her practice in managing acute diseases after the departure of the family physician. The lack of a champion to promote team participation and efficient information exchange between FPs and RNs was seen as an obstacle to RN practice in AA [26-31].

3. Discussion

This research seeks to elucidate how registered nurses (RNs) and nurse practitioners (NPs) adapt their practices to conform to the advanced access (AA) model, while also identifying elements within the Quebec primary care setting that affect these practice modifications. We provide data on two fundamental concepts of AA: the modification of the appointment system and the incorporation of collaborative practice, which were the primary areas of change among nurses.

The installation of AA led to modifications in nursing practice by changing the appointment system to enhance responsiveness to urgent requirements and by streamlining demand to prevent prolonged scheduling delays. Tangible advancements were seen in collaborative practice, with ongoing efforts to enhance nurses' capabilities, optimize their contributions, and empower each primary care physician to use their full scope of practice. Our findings indicate that experiences of practice change differed across the two types of nurses. The impact of AA adoption on nursing practice was not uniformly recognized by nurses. Registered Nurses reported the most significant losses in the implementation of the AA model compared to Nurse Practitioners, due to their insufficient engagement in applying the model's fundamental principles.

Our findings indicate that they have made an effort to modify the appointment system by providing two to three free slots daily for unplanned treatment, although they concede that their operations do not fully adhere to AA principles; instead, they are executing a superficial version of the model. Their comprehension of appointment organization inside the model is limited, and this did not improve over the research period. Registered Nurses were uninformed that under Alcoholics Anonymous, patients have the option to schedule a same-day appointment with their healthcare practitioner for any issue, whether urgent, routine, or preventative.

Among NPs, some shown a superior comprehension and successfully restructured the appointment system in accordance with the AA concept, whilst others tailored this fundamental principle to their requirements

and the organizational context. Our results align with those of Goodall et al. [14] and Pope et al. [27], indicating widespread ambiguity about the operation of AA and a deficient comprehension of the model's conceptual basis, leading to altered iterations of the appointment system. There was a clear confusion between AA appointments and urgent access, since all RNs and several NPs used the terms interchangeably.

Modifications in RN and NP practice during first attempts to use the AA model seem to be continuing and are subject to further refinement. Nurses are attempting to acquire knowledge via trial and error because to the absence of formal preparation and training in the model. Furthermore, the need emphasized by several writers [10, 17, 27] for a transitional phase to apply this model partially elucidates why nurses require additional time to determine how to modify their scheduling system to accommodate various practice activities.

Concerning collaborative practice, RNs exerted little efforts while continuing to explore avenues to broaden their service scope and participate in team-based care. Designated patient panels were observed to enhance service capacity, patient access, and continuity of care both generally and within AA. Registered Nurses continued to grapple with fully using their abilities and redefining their limits within an established practice subsequent to the advent of Nurse Practitioners. Their professional identity seems to be challenged, leading them to feel the need to renegotiate their obligations after losing the right to engage in significant job activities, such as monitoring acute situations. Nurse practitioners seemed established and capable of exercising their competences and practicing in accordance with the AA model. They delivered autonomous and collaborative patient care, either consultative or in joint practice, while taking leadership in the management of patients with acute and chronic disorders.

Our findings, grounded on Niezen & Mathijssen's [19] network model, indicate several interrelated elements across various levels—institutional, organizational, professional, individual, and patient—that affect changes in nursing practice. Certain characteristics are not exclusive to the AA model, since it is integrated inside unit practice and cannot be detached from the broader system and operational procedures of the unit. These characteristics elucidate nurses' experiences in adopting and adapting elements of AA. The majority of the influencing factors identified aligned with the results of a qualitative evidence synthesis on doctor-nurse substitution strategies in primary care [27], particularly concerning organizational resources (e.g., staff shortages), leadership, defined roles, and sufficient training and supervision. All of these were referenced in interviews and align with the research about the implementation of novel care models [16], the reorganization of professional practice within these models [28], and the optimization of nursing practice in primary care [1, 29].

The organizational context, including policy support, leadership, and resources, together with professional boundaries, significantly influenced the transition to the AA model. An encouraging organizational environment characterized by adequate resources, effective strategies (such as tailored training for nurses), and tools (including standardized protocols for expedited prescription processing) is crucial for fostering collaborative practice, thereby facilitating the reorganization of nursing practice (RNs and NPs) and the establishment of team-based primary care and advanced practice roles. This corroborates results from further research [16, 26, 28, 30]. Training and assistance were deemed crucial, as was networking with early adopter clinics, due to the difficulty of using AA for access control. Leadership and resources were identified as significant determinants, which is unsurprising considering their substantial impact on AA implementation in previous studies [12, 31] and in the multiple case study [16] that encompasses the current research. Collective leadership for change, facilitated by teamwork, transparent communication, and the promotion of egalitarianism and shared responsibility among team members, constitutes a significant catalyst for the successful implementation of AA and the optimal utilization of the nursing workforce within this primary care model [16] . Registered Nurses should participate in the development and implementation of AA as essential and proactive members of the healthcare team. Our findings are corroborated by Beaulieu et al. [28], who demonstrated that shared leadership with nurse practitioners in the implementation of family medicine groups—a novel organizational model comprising family physicians collaborating closely with nurses—facilitated the rapid and intensive development of nursing practice.

Elvey and Bailey [32] emphasize the need of a dialogical approach in the implementation of new care models to enhance primary care access, allowing staff to be involved as active key stakeholders instead of passive participants. Involving all healthcare professionals in a horizontal implementation process is advised to address skill mix alterations and to maximize the contributions of each member, including nurses, which is emphasized as essential for high-performing teams.

It is essential to highlight the aspects of the Quebec healthcare system (the institutional environment) that significantly impact the organizational environment, even if they are hardly mentioned by research participants. Collective leadership within the nursing profession may be challenging when task delegation, case distribution, and practice scheduling occur in a context where the medical group wields authority over the advancement of other professional groups, and where changes could jeopardize fee-for-service payments. The recent legislative modifications are encouraging: Bill 43, enacted in October 2019, sought to enhance the authority of Nurse Practitioners to diagnose and formulate treatment regimens for certain diseases, in addition to managing low-risk pregnancies. This modification will alleviate professional challenges to a degree, enhance access to NP services, liberate FP and NP time, and reduce wait periods [33]. When introducing new primary care models, such as AA, it is essential to examine policies and action plans that maximize the abilities and competence of RNs within work teams and promote their transformation in primary care practice, as shown by our research and endorsed by others [2].

Regarding professional boundaries, our results indicate that NPs were seen to provide more value. Conversely, RNs often needed to maintain professional boundaries and preserve their professional identity within AA. The emergence of nurse practitioners altered the delineation of responsibilities between the two categories of nurses. Registered Nurses were encountering difficulties in filling their appointment calendars and were keen to maximize their abilities. This observation is corroborated by several research examining the integration of nurse practitioners in hospital environments [34, 35]. Numerous authors emphasize the necessity of expanding perspectives and fostering team dynamics, specifically by restructuring the overall functioning of the team and implementing team-oriented supports (e.g., redesigning task distribution and managing team relations) to optimize the qualifications of all providers (including RNs), enhance organizational capacity, and ultimately improve accessibility [34, 35]. Maximizing registered nurse opportunities to control demand via care coordination and team-based care delivery models is a key priority for enhancing primary care access and quality.

Our results underscore the influence patients have on nursing practices in AA, shown by their hesitance to embrace new appointment-scheduling systems and their reluctance to receive treatment from NPs and RNs. Considering the increasing trend of including patients as collaborators in enhancing healthcare delivery, it would be beneficial to enlist well-trained patients to assist others in comprehending and adapting to the service delivery methods within the AA model. This would also facilitate the integration of patients' choices, attitudes, and beliefs, therefore customizing the model to their requirements [36].

This research delineates targeted enhancements that may be implemented at the institutional, organizational, professional, and patient levels to facilitate the transformation of primary care nursing practice. Policies, professional training to translate theoretical principles into practice, networking with nurses who have developed AA practices, and fostering a supportive environment (leadership, resources, etc.) were proposed as methods to promote changes in nursing practice within AA. Furthermore, in striving to redefine professional boundaries, each individual must operate at their maximum capacity, and their contributions must be congruent with this revised organizational framework. Improvements may ultimately be developed together with patients to address their requirements within the AA model.

4. Advantages and drawbacks

A notable strength of this research is its use of a conceptual framework derived from the AA model by Murray & Tantau [8] and the multi-layered model by Niezen & Mathijssen [19]. It offers an extensive comprehension of the many levels (patient, individual, professional community, organization, etc.) that influence practice change within AA. The insights acquired from our research should be considered while

strategizing practice rearrangement to apply AA in analogous environments. Our qualitative methodology offers a comprehensive examination of nurses' experiences regarding the implementation of AA practice changes. The generalizability of our results is constrained due to the recruitment of a restricted sample of nurses from only four healthcare settings. A further drawback is that it fails to include the perspectives of doctors and patients about nurse practice in AA. Investigating their perspectives in the future will mitigate subjective bias and enhance the study's conclusions. Further study using a comparative approach or a mixed methods design is essential to elucidate the similarities and differences between the two groups of nurses. Such studies should ideally include diverse views (e.g., patients, healthcare professionals such as family physicians, residents, clerical staff) and mitigate bias stemming from variations in the research settings and the attributes of the questioned nurses.

The results of this study are currently pertinent for several reasons: there is an urgent necessity to guarantee prompt access to primary care services and transition to AA, a fundamental component of the patient-centered medical home; additionally, there is a requirement to reform nursing practice to optimize nurses' roles in augmenting primary care capacity and enhancing access and continuity of services in primary care. A more thorough examination is required, primarily focused on examining the practice modifications of nurses and other healthcare professionals (e.g., social workers, psychologists) under this new organizational framework across various healthcare environments. The results will aid in formulating implementation methods to enhance the practices of all healthcare practitioners within this primary care paradigm, so augmenting the ability to address patients' needs promptly.

5. Conclusions

Our study provides an initial empirical basis for further research about the transformation of nursing practices in AA. It indicates that healthcare organizations must tailor training to the specific needs of nurses and offer coaching suited to each nursing category, while also rigorously reassessing the professional boundaries of NPs and RNs within AA and establishing optimal professional and organizational environments to facilitate the transformation of nursing practice. A substantial investment is necessary to ensure that RNs are not sidelined, but instead engaged as pivotal participants in the execution of AA. Consequently, the research underscores the need to synchronize all team members throughout the ongoing transition to AA to attain the anticipated reductions in waiting times.

References

1. Nelson S, Turnbull J, Bainbridge L, Caulfield T, Hudon G, Kendel D, et al. Optimizing Scopes of Practice: New Models for a New Health Care System Ottawa, Ontario: Canadian Academy of Health Sciences; 2014 [Available from: https://cahs-acss.ca/wp-content/uploads/2015/07/Optimizing-Scopes-of-Practice_REPORT-English.pdf.
2. Bodenheimer T, Mason D. Registered Nurses: Partners in Transforming Primary Care Proceedings of a conference sponsored by the Josiah Macy Jr. Foundation in June 2016 New York: Josiah Macy Jr. Foundation; 2017 [Available from: www.macyfoundation.org.
3. Laurant M, van der Biezen M, Wijers N, Watananirun K, Kontopantelis E, van Vught AJ. Nurses as substitutes for doctors in primary care. Cochrane Database Syst Rev. 2018;7:Cd001271.
4. Ansell D, Crispo JAG, Simard B, Bjerre LM. Interventions to reduce wait times for primary care appointments: a systematic review. BMC Health Serv Res. 2017;17(1):295.
5. Contandriopoulos D, Brousselle A, Breton M, Sangster-Gormley E, Kilpatrick K, Dubois CA, et al. Nurse practitioners, canaries in the mine of primary care reform. Health Policy. 2016;120(6):682–9.
6. Murray M, Berwick DM. Advanced access: reducing waiting and delays in primary care. Jama. 2003;289:1035–40.
7. Breton M, Maillet L, Pare I, Abou Malham S, Touati N. Perceptions of the first family physicians to adopt advanced access in the province of Quebec, Canada. Int J Health Plann Manag. 2017;32(4):e316–e32.
8. Murray M, Tantau C. Same-day appointments: exploding the access paradigm. Fam Pract Manag. 2000;7(8):45–50.

9. Breton M, Maillet L, Duhoux A, Malham SA, Gaboury I, Manceau LM, et al. Evaluation of the implementation and associated effects of advanced access in university family medicine groups: a study protocol. BMC Fam Pract. 2020;21(1):41.
10. Murray M. Answers to your questions about same-day scheduling. Fam Pract Manag. 2005;12(3):59–64.
11. Tantau C. Accessing patient-centered care using the advanced access model. J Ambulatory Care Manage. 2009;32(1):32–43.
12. Witt MJ. Advanced access works! Improved patient satisfaction, access, and P4P scores. J Med Pract Manage. 2006;22(2):107–11.
13. Safety Net Medical Home Initiative, Neal R, Moore LG, Powell J. In: Phillips K, Weir V, editors. Enhanced Access: Providing the Care Patients Need, When They Need It. Seattle; 2013. http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Enhanced-Access.pdf.
14. Goodall S, Montgomery A, Banks J, Salisbury C, Sampson F, Pickin M. Implementation of advanced access in general practice: postal survey of practices. Br J Gen Pract. 2006;56(533):918–23.
15. Pickin M, O'Cathain A, Sampson FC, Dixon S. Evaluation of advanced access in the national primary care collaborative. Br J Gen Pract. 2004;54(502):334–40.
16. Abou Malham S, Touati N, Maillet L, Gaboury I, Loignon C, Breton M. What are the factors influencing implementation of advanced access in family medicine units? A Cross-Case Comparison of Four Early Adopters in Quebec. Int J Fam Med. 2017;2017:15.
17. Fournier J, Rainville A, Ingram J, Heale R. Implementation of an advanced access scheduling system in primary healthcare: one Clinic's experience. Healthc Q. 2015;18(1):60–4.
18. Rivas J. Advanced access scheduling in primary care: a synthesis of evidence. J Healthc Manag. 2020;65(3):171–84.
19. Niezen MG, Mathijssen JJ. Reframing professional boundaries in healthcare: a systematic review of facilitators and barriers to task reallocation from the domain of medicine to the nursing domain. Health Policy. 2014;117(2):151–69.
20. Gouvernement du Québec Ministère de la Santé et des Services sociaux. Cadre de gestion des groupes de médecine de famille universitaires (GMF-U) 2018 [Available from: https://publications.msss.gouv.qc.ca/msss/fichiers/2018/18-920-22W.pdf.
21. Pare-Plante AA, Boivin A, Berbiche D, Breton M, Guay M. Primary health care organizational characteristics associated with better accessibility: data from the QUALICO-PC survey in Quebec. BMC Fam Pract. 2018;19(1):188.
22. Abou Malham S, Touati N, Maillet L, Breton M. The challenges of implementing advanced access for residents in family medicine in Quebec. Do promising strategies exist? Med Educ Online. 2018;23(1):1438719.
23. Grossoehme D, Lipstein E. Analyzing longitudinal qualitative data: the application of trajectory and recurrent cross-sectional approaches. BMC Res Notes. 2016;9:136.
24. OIIQ and CMQ. Lignes directrices-Pratique clinique de l'infirmière praticienne spécialisée en soins de première ligne Juillet 2019 2018 [Available from: https://www.oiiq.org/documents/20147/237836/2505-lignes-directrices-IPSPL-web.pdf.
25. Gouvernement du Québec Ministère de la Santé et des Services sociaux. Guide d'intégration des professionnels en GMF-L'infirmière praticienne spécialisée en soins de première ligne. 2016.
26. Borges Da Silva R, Brault I, Pineault R, Chouinard MC, Prud'homme A, D'Amour D. Nursing Practice in Primary Care and Patients' Experience of Care. J Prim Care Community Health. 2018;9:2150131917747186.
27. Pope C, Banks J, Salisbury C, Lattimer V. Improving access to primary care: eight case studies of introducing advanced access in England. J Health Serv Res Policy. 2008;13(1):33–9.
28. Beaulieu MD, Denis JL, D'Amour D, Goudreau J, Haggerty J, Hudon É, et al. Implementing family medicine groups: a challenge in the reorganization of practice and interprofessional collaboration. Montreal. 2006.

https://www.academia.edu/13269093/Implementing_family_medicine_groups_The_challenge_in_the_reorganization_of_practice_and_interprofessional_collaboration.
29. Nelson P, Martindale AM, McBride A, Checkland K, Hodgson D. Skill-mix change and the general practice workforce challenge. Br J Gen Pract. 2018;68(667):66–7.
30. Poghosyan L, Liu J, Norful AA. Nurse practitioners as primary care providers with their own patient panels and organizational structures: a cross-sectional study. Int J Nurs Stud. 2017;74:1–7.
31. Mehrotra A, Keehl-Markowitz L, Ayanian JZ. Implementing open-access scheduling of visits in primary care practices: a cautionary tale. Ann Intern Med. 2008;148(12):915–22.
32. Elvey R, Bailey S, Checkland K, McBride A, Parkin S, Rothwell K, et al. Implementing new care models: learning from the greater Manchester demonstrator pilot experience. BMC Fam Pract. 2018;19(1):8
33. CBC News. Quebec moves to give more powers to province's nurse practitioners 2019 [Available from: https://www.cbc.ca/news/canada/montreal/quebec-nurse-practitioners-1.5315383.
34. Chouinard V, Contandriopoulos D, Perroux M, Larouche C. Supporting nurse practitioners' practice in primary healthcare settings: a three-level qualitative model. BMC Health Serv Res. 2017;17(1):437.
35. Reay T, Golden-Biddle K, Germann K. Challenges and leadership strategies for managers of nurse practitioners. J Nurs Manag. 2003;11(6):396–403.
36. Nickel WK, Weinberger SE, Guze PA. Principles for patient and family Partnership in Care: an American College of Physicians Position Paper. Ann Intern Med. 2018;169(11):796–9.

مستقبل التمريض: التكيف مع تغييرات السياسات والممارسات الصحية

الملخص

الخلفية :يلعب التمريض دورًا حاسمًا في تعزيز تقديم الرعاية الصحية الأولية، خاصة من خلال النماذج المبتكرة مثل نموذج الوصول المتقدم (Advanced Access - AA).ومع تطور السياسات الصحية، أصبح الممرضون، بما في ذلك الممارسون المتقدمون (NPs) والممرضون المسجلون(RNs) ، في موقع يتيح لهم تحسين الوصول إلى الرعاية وجودتها. ومع ذلك، لا تزال هناك فجوات في فهم أدوارهم ضمن هذه الأطر، مما يستدعي مزيدًا من البحث.

المنهجية :استخدمت هذه الدراسة منهجًا نوعيًا لاستكشاف تجارب الممارسين والممرضين المسجلين في تكييف ممارساتهم بعد تنفيذ نموذج الوصول المتقدم. تم جمع البيانات من خلال مقابلات مع طاقم التمريض في أربعة مراكز رعاية صحية في مقاطعة كيبيك، مع التركيز على الحواجز والعوامل الميسرة لتحول الممارسات.

النتائج :كشفت النتائج عن اختلافات كبيرة في كيفية تكيُّف الممرضين المسجلين والممارسين مع نموذج الوصول المتقدم. أظهر الممارسون المتقدمون فهمًا أعمق وإعادة هيكلة فعالة لأنظمة المواعيد، في حين واجه الممرضون المسجلون تحديات بسبب نقص المشاركة والدعم القيادي. تضمنت المواضيع الرئيسية التي تم تحديدها تأثير اللوائح التنظيمية، أهمية القيادة في تسهيل التغيير، والحاجة إلى تحسين التعاون بين المهنيين.

الخاتمة :يتطلب الدمج الناجح لنموذج الوصول المتقدم في الرعاية الأولية تدريبًا مخصصًا ودعمًا لكل من الممارسين المتقدمين والممرضين المسجلين. تعزيز الممارسات التعاونية وأدوار القيادة أمر ضروري لتحسين مساهمات التمريض وزيادة إمكانية الوصول إلى رعاية المرضى. تؤكد هذه الدراسة على الحاجة إلى التقييم المستمر لممارسات التمريض لإبلاغ التغييرات في السياسات والممارسات في بيئات الرعاية الصحية الأولية.

الكلمات المفتاحية :ممارسات التمريض، الوصول المتقدم، الممارسون المتقدمون، الرعاية الأولية، السياسات الصحية.