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ORIGINAL ARTICLE

Nurse practitioner in Swedish municipal elderly care: A Delphi study of challenges and opportunities

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Abstract

Introduction: Worldwide, countries are struggling with strained healthcare systems, especially due to the growing number of frail elderly. Developing the role of nurse practitioner in the care of the frail elderly is therefore of interest to make the care chain more efficient. In Sweden, the role is in an early development phase, but more research is needed.

Aim: The aim was to investigate how stakeholders at the national level express the challenges and opportunities of the evolving nurse practitioner role in Swedish municipal elderly care.

Method: A Delphi survey technique with three rounds of electronic questionnaires was used. Twenty-seven experts responded to the first questionnaire, containing two open questions; what opportunities respectively challenges do you see in developing and implementing the nurse practitioner role in municipal elderly care? The following questionnaires consisted of statements to rate using a four-grade Likert scale, and 20 and 17 responded to the second and third, respectively. The first round was analysed using content analysis, and the other two with descriptive statistics.

Results: Thirty-four statements about challenges and opportunities related to the nurse practitioner role in municipal elderly care were identified and rated as important.

Conclusion: The findings provide knowledge that can contribute to discussions and decisions to refine the nurse practitioner role in Swedish municipal elderly care. The nurse practitioner role may contribute with much-needed competence to the elderly care. However, it is important to consider the challenges that need to be overcome before the development of the role. To solve this, it is necessary to have clear national guidelines concerning issues of education, title protection and the mandate and authority of the NP role.

KEYWORDS

Delphi technique, frail elderly, municipal elderly care, nurse practitioner

INTRODUCTION

The role of nurse practitioner (NP) is evolving in healthcare systems worldwide [1]. An NP is defined as 'an Advanced Practice Nurse who integrates clinical skills associated with nursing and medicine in order to assess, diagnose and manage patients in primary healthcare settings and acute care populations as well as ongoing care for populations with chronic illness' [2]. In general, an NP is educated at the master's level and has the authority and competence to practice autonomously [2]. Their unique competence and autonomous role have become important to increasingly strained healthcare systems, especially due to the growing number of frail elderly [3–5] meaning those who are the most vulnerable and often have several chronic diseases, an increased risk of hospitalisation, readmission and dependency and a lower life expectancy [6]. Accordingly, they have complex needs for both advanced nursing and medical care that require high continuity and a holistic approach from their healthcare providers. Therefore, the NP role has been particularly important for this target group because NPs are trained to provide care from a holistic perspective [7–9]. Further, NPs have the competence to handle the frail elderly's care needs, taking into account their often-multiple chronic diseases and the need for support in their daily lives, including medical, social, environmental, functional and cultural issues [9–11]. Previous studies have shown that the NP role contributes to increased patient safety and improves quality of care, in addition to enhancing the continuity of and access to healthcare [12–14] and providing a cost-effective approach [15–17]. Additionally, the NP role in municipal elderly care has been shown to contribute to reduced hospital admissions and readmissions [10, 18, 19].

In addition to the improved quality of care that elderly experience when NPs care for them, the role has other values. For example, most healthcare systems globally are struggling to recruit and retain competent nurses [20, 21]. The NP role is expected to make it easier to retain competent nurses who want a fulfilling career without having to leave the clinical context [22–24] thus, the development of the NP role has benefited the healthcare sector, and its integration into healthcare organisations is considered valuable [4, 25, 26]. Despite this, there are difficulties with developing and implementing the NP role, characterised by a misunderstanding of and confusion over the role's placement in the healthcare context. NPs' entry into healthcare organisations has created changes in traditional organisational structures and hierarchical models, which has led to challenges for the nursing and medical disciplines [25, 26]. Other issues of importance to clarify include the educational preparation, organisation, legislation and regulation needed for a proper structural framework for the NP role, a structure that needs to be in place before it could be implemented on a widespread scale [27, 28].

In Sweden, the NP role remains in an early development phase and does not yet exist as a protected title or accredited profession. While attempts have been made at a few universities to develop NP programmes in collaboration with local healthcare organisations, they do not have a national focus [29–31]. Recently, Swedish government officials proposed developing the NP role, which led to national attention. One reason for developing the NP role is to help meet future healthcare demands, especially among the frail elderly [27]. This was evident already during the coronavirus pandemic which reinforced the need for higher nursing competence in municipal elderly care as the majority of health care staff are assistant nurses only holding degrees at pre-registration and vocational level [32].

Further, in Swedish municipal elderly care only a small part of Registered Nurses have a specialist education in geriatric care. However, handling the complex nursing and medical needs of the frail elderly requires specialised knowledge in geriatric nursing [32]. As part of meeting that need, the Swedish government has expressed interest in reforming elderly care by focusing on increasing competence among nurses [27] with the NP role able to play an important part [32].

Although there is international research reporting both positive and negative factors of the NP role's development [1, 2] a Swedish perspective on the role is lacking and therefore needs further elucidation. In order to raise awareness of factors that encourage adopting the NP role and to highlight factors that could negatively affect that development, it is necessary to collect the views of Swedish stakeholders. Thus, the aim of the present study is to investigate in what way stakeholders representing political, educational, professional and union organisations at the national level describe the challenges and opportunities associated with the development of the NP role in Swedish municipal elderly care.

METHODS

The present study applies the Delphi survey technique, following the framework of Kenney, Hasson and McKenna [33] to identify consensus views of the challenges and opportunities associated with developing the NP role in Swedish municipal elderly care. Consensus methods such as the Delphi survey technique are employed to help enhance effective decision making in health and social care. The Delphi survey is a group facilitation technique that uses an iterative process designed to transform multiple

individual opinions into group consensus. Data collection typically consists of rounds of questionnaires—whether two, three or more—until consensus is reached [33]. As the NP role is quite unexplored in the Swedish context, a Delphi study can help understand the parameters of a new professional role designed to help meet the challenge of providing sufficient resources and improving health care for frail elderly in municipal elderly care. A Delphi study can be constructed in different ways, but certain elements need to be explained and discussed to ensure credibility. Specifically, it is important to clarify the selection of participants, the percentage that will qualify as consensus, how anonymity (anonymity vs. quasi-anonymity) may affect the findings and the risk of bias [33].

Identifying and selecting the participants

A purposeful sampling strategy [33] was used to find potential participants who would constitute the expert panel. Inclusion criteria were that participants should represent organisations at the national level, such as the Government of Sweden, the National Board of Health and Welfare, the University Chancellor's Office, trade unions and the Swedish Society of Nursing, or be individuals from universities and healthcare organisations that have developed the NP role at the local level.

Additionally, participants had to have a decision-making position or be considered a stakeholder in the development of the NP role. The initial process of identifying potential participants was undertaken by the first author (BL) and consisted of internet searches of the websites of the organisations cited above. This yielded a list of 52 names which were discussed with the co-authors (KSF and EC). After that discussion and further internet searches, additional names emerged, with the final list of potential participants consisting of 77 names. When the list was completed, the e-mail addresses of all potential participants were sought on organisational websites. It was not possible to find valid e-mail addresses for two potential participants, who were therefore excluded from participation. In the selection, we assumed that several people in the same organisation could have awareness of the NP role. In those cases, then, multiple potential participants from the same organisation were invited to participate, which contributed to the large number of potential participants who would constitute the expert panel ($N = 75$).

Defining consensus

Before data collection began, the authors decided that consensus would be reached when at least 75% of the expert panel had rated the statements as agree or totally agree (round 2) and as important or very important (round 3); 75% is the most commonly used threshold for consensus [33–35]. There are no clear rules regarding what constitutes consensus, which can be accepted at as low as 51% but can also require 100%, depending on the topic and research question [33–35].

Data collection and analysis

Data were collected between February and June 2021 and consisted of three rounds of web-based electronic questionnaires. First, all invited panel members received an e-mail with information about the study and a short description of the NP role. The e-mail also contained a link to the first web-based questionnaire. They were given 3 weeks to complete the questionnaire; a reminder was sent to those who had not completed it about 1 week before that deadline. The round one questionnaire contained two open questions with unlimited space to respond: 'What opportunities do you see in developing and implementing the NP role in municipal elderly care?'; and 'What challenges do you see in developing and implementing the NP role in municipal elderly care?'. In addition to writing answers of whatever length they chose participants were asked to state their gender and occupation. Data for the first round were analysed using content analysis at the manifest level, as described by Hsieh and Shannon [36]. Initially, the analysis began with repeated naïve readings of all the responses by the first author (BL). Then, sentence units that reflected either an opportunity or challenge regarding the NP role were highlighted and condensed without losing their essential content. The condensed sentence units were gathered into codes and all authors read and discussed the coded text several times until agreement was reached. Next, the codes were transformed into 45 statements, which were grouped into categories by area of opportunity or challenge. The 45 statements were then used in the construction of questionnaires two and three. When questionnaire two was constructed, a pilot test was performed to ensure that the statements were clear and unambiguous. The pilot test includes seven participants: four PhD students, one manager from municipal elderly care and two Registered Nurses with specialist education in elderly care. Minor grammatical adjustments were made after the pilot test to clarify some statements.

The second-round questionnaire was then sent out to the expert panel, where they were asked to rate the statements using a four-point Likert scale (from 1 = totally disagree to 4 = totally agree). Data for this round were analysed descriptively using SPSS, version 27 [37]. Percentage, mean, and standard deviation scores were

calculated for each statement. The statements from the second-round questionnaire that reached consensus of at least 75% constituted the third-round questionnaire. In the third-round questionnaire, the expert panel were asked to prioritise the importance of each statement and rate it on a four-point Likert scale (from 1 = not at all important to 4 = very important). Data from the third questionnaire were also descriptively analysed using SPSS [37] to note when consensus was reached. Percentage, mean and standard deviation scores were calculated for each statement.

Ethical considerations

In line with the requirement in Declaration of Helsinki [38]. The panel members were informed that they gave their consent to participate in the study by completing the questionnaire, that their participation was voluntary, and that they were entitled to withdraw at any time without explanation. They were also assured that their answers would be analysed at the group level to protect individuals' anonymity. Therefore, all three questionnaires were sent out to all potential panel members who received the first questionnaire, whether or not they returned it, although the e-mails for the second and third questionnaires indicated that only those who responded to the first questionnaire should respond to the later ones. This approach was taken because several panel members have highly specific national positions, which makes it difficult to fully maintain true anonymity. For that reason, we present the expert panel solely based on the overall organisations they represent and provide some examples of positions held by experts. It is sometimes problematic to achieve true anonymity for participants in a Delphi study since their identity often is or becomes known to the researchers [33, 34]. However, with the above approach, we argue that this risk was reduced, although not completely eliminated.

RESULTS

A total of 27 (5 men and 22 women) of 75 invited panel members completed the round one questionnaire (Figure 1) which is a 36% response rate. Together, they represent the National Board of Health and Welfare, the University Chancellor's Office, the Swedish Society of Nursing and trade unions along with universities and healthcare organisations that have developed the role of NP at the local level. They held positions such as professor, associated professor, chief physician, chief nurse, top-level manager, chairmen in different level of trade unions and head of educations. In the second round, 20 of 27 panel members responded; in the third, 17 panel members remained and responded (Figure 1).

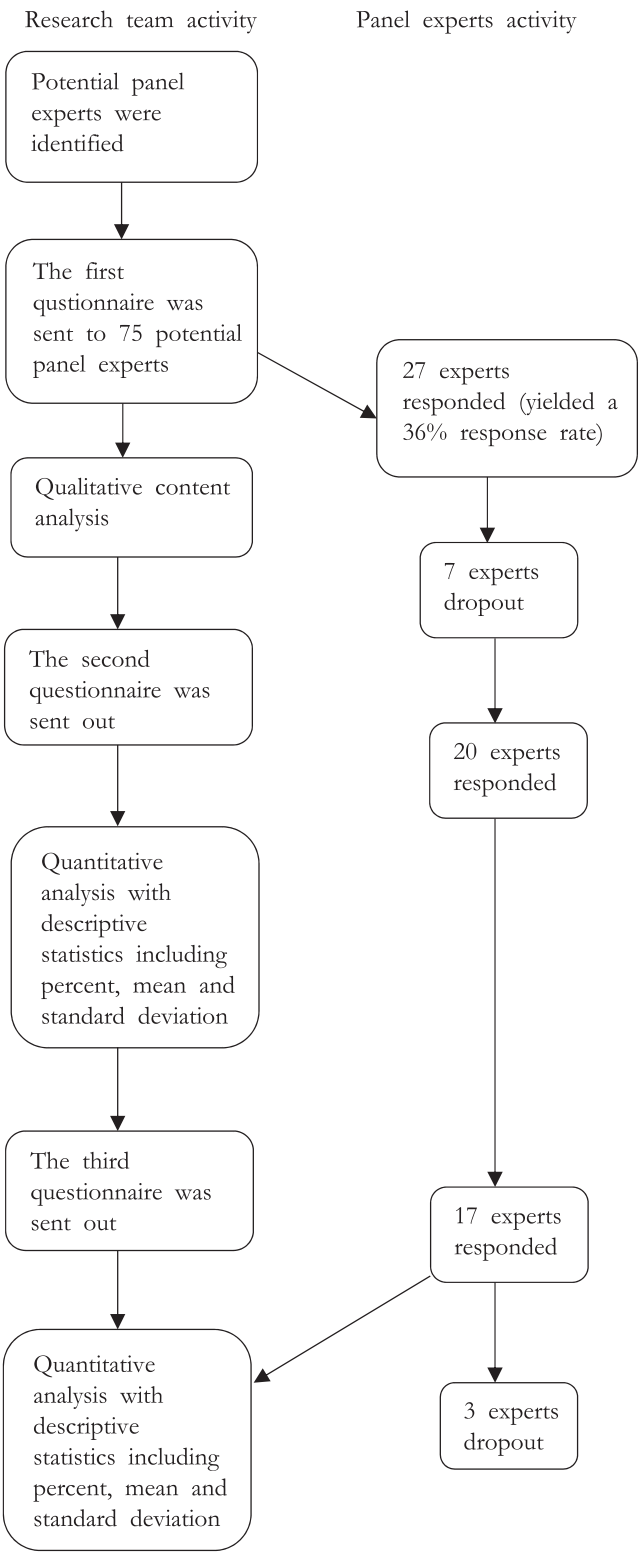

FIGURE 1 Overview of the study steps including activity of the expert panel and the research team, number of experts, response rate and dropouts.

Based on the written response from the first round, 45 statements about challenges and opportunities regarding the NP role in municipal elderly care were identified. Of those 45 statements sent to the panel members in questionnaire two, 35 attained the consensus level of 75% or higher. Thus, 10 statements were excluded before the third questionnaire was sent out. The statements were divided into categories based on the opportunity or challenge each reflected. The opportunities included 16 statements that met the consensus threshold, divided into four categories: (1) increased patient quality and patient safety, (2) increased efficiency and access to healthcare at home, (3) career opportunity for nurses and (4) the need for nurses with extended competence. The challenges included 19 statements that met the consensus threshold, again in four categories: (1) reaching consensus on what prior knowledge is required to be eligible to apply for NP education, (2) reaching consensus on educational issues of importance, (3) NP accreditation and mandate and (4) preparing for integrating the NP role into organisations and healthcare teams. Finally, in the third questionnaire where the panel members were asked to rate the importance of the remaining 35 statements, all reached the consensus level of 75% or higher, as is detailed below.

Opportunities of the NP role

The analyses of the third questionnaire demonstrated that there was 75% or higher consensus level for the 16 opportunity statements rated as important (Table 1). In the first category—increased patient quality and patient safety—there was 100% consensus for three of the six statements, indicating that the NP role could improve the quality of care and help increase patient safety. Furthermore, the 100% consensus level included the statement that NPs are expected to become important in care development through their high academic competence. The other three statements in this category, stating that NPs could be expected to increase healthcare quality and patient safety by acting as mentors for other nurses and providing person-centred and advanced health care to the frail elderly, reached high consensus levels (88%–94%). The second category—increased efficiency and access to healthcare at home—revealed that the NP role was expected to make the care chain more efficient through better use of healthcare resources. There was 100% consensus that the NP role could reduce the number of hospital admissions, so the NP role could be expected to increase cost efficiency when frail elderly was cared for at home instead of in the hospital. The third category reflected that the NP role was expected to enable a career path for nurses who wanted to remain in clinical practice. Interest in working in elderly care was expected to increase, which would make it easier to recruit and retain nurses. The fourth category—the need for nurses with extended competence—reflected that the NP role would contribute to greater competence, in line with the requirements of providing advanced, person-centred health care that the transition to high-quality and close health care in municipal elderly care entails. The panel members rated this to be of maximum importance.

Challenges of the NP role

The analyses of the third questionnaire demonstrated that there was 75% or higher consensus level for 19 statements regarding challenges with the NP role (Table 2). In the accreditation and mandate category, there was 100% consensus on all four statements, the essence of which is that it is necessary for the NP role to be made a protected title. Furthermore, the mandate and responsibility that NPs would have in relation to other professions, such as physicians and Registered Nurses without the NP qualification should be clearly explained. The category involving preparing for the NP role to be integrated into organisations and healthcare teams had nine statements, all of which reached 100% consensus. This unanimity reveals the importance of employers having a well-structured implementation plan for NPs and creating the platform necessary for successful implementation of the role in healthcare teams. The statements highlight the need for clear NP job descriptions and the importance of employers' understanding NPs' in-depth skills; otherwise, there would be a risk that NPs' heightened competence would not be fully utilised. In the category of reaching consensus on educational issues of importance, two of three statements reached 100% consensus, indicating that it is necessary to build NP education at the national level in terms of length, content and structure and to make it possible to have physicians serve as supervisors in the NPs' clinical training. The category of reaching consensus on what prior knowledge should be required to be eligible to apply for NP education had three statements; two reached 82% consensus, and one reached 94%. These statements concern the prerequisites for admission to NP education. There was consensus that it should not be possible to be admitted to NP education directly from undergraduate nurse education. Instead, the NP education should be a progression from specialist nurse education, and it should be mandatory to have working experience as a specialist nurse before being able to apply to NP education.

TABLE 1 Results—Level of consensus and rated importance for statements of opportunities regarding the NP role

		Round 2 ($n = 20$) level of consensus (sum of agree and totally agree)			Round 3 ($n = 17$) level of consensus on importance of the statements		
Categories	**Statements**	**%**	**M**	**SD**	**%**	**M**	**SD**
Increased patient quality and patient safety	NPs in municipal elderly care can improve the quality of care.	100	3.70	0.47	100	3.94	0.24
	NPs in municipal elderly care can contribute to increased patient safety.	95	3.70	0.57	100	3.94	0.24
	NPs enable person-centred care from a holistic perspective, as they have the competence needed to take care of patients' nursing and medical needs alike.	80	3.35	0.81	94	3.65	0.60
	NPs in municipal elderly care can increase continuity for patients.	75	3.05	0.88	94	3.65	0.60
	NPs can fulfil an important function as mentors to other nurses.	75	3.44	0.86	88	3.71	0.69
	NPs can contribute high academic competence to care development in municipal elderly care.	90	3.60	0.69	100	3.71	0.47
	NPs in municipal elderly care can increased the possibility of receiving advanced healthcare at home.	80	3.35	0.81	94	3.76	0.56
Increased efficiency and access to healthcare at home	NPs in municipal elderly care can reduce unnecessary hospital admissions.	85	3.45	0.89	100	3.76	0.44
	NPs can contribute to more efficient management of patients.	80	3.50	0.83	94	3.65	0.60
	NPs in municipal elderly care can be cost-effective in that they can assess and treat patients with complex healthcare needs at the appropriate level of care.	85	3.45	0.76	100	3.71	0.47
	NPs in municipal elderly care can contribute to a more efficient use of physician resources.	80	3.25	1.12	88	3.29	0.85
Career opportunity for nurses	NPs in municipal elderly care can increase interest among nurses in working in elderly care.	95	3.55	0.60	100	3.59	0.51
	One possibility with NPs in municipal elderly care is that the function can contribute to retaining development-oriented and competent nurses.	95	3.55	0.60	100	3.82	0.39
	NPs can create career paths for nurses in municipal elderly care without having to leave the clinical environment.	95	3.65	0.59	94	3.76	0.56
The need for nurses with extended competence	NPs can fulfil a competence need in municipal elderly care to respond to the increased number of frail elderly with complex care needs.	80	3.60	0.70	100	3.71	0.47
	The transition to 'good and close healthcare' with increasing demands to provide more advanced healthcare to the frail elderly creates a need for the NP function in municipal elderly care.	95	3.60	0.60	94	3.71	0.59

DISCUSSION

This study contributes by highlighting the key opportunities and challenges to consider in further discussions and decisions about developing the NP role in a Swedish context. It indicates that the NP role can be expected to contribute to increased quality of care and increased patient safety through both direct and indirect effects. One example of a direct effect involves NPs' ability to take care of the frail elderly's nursing and medical needs and thus ensure a high continuity of healthcare. This was expected to make the elderly feel that they were receiving person-centred, holistic health care, the importance of which for the frail elderly has been confirmed in previous studies [39–41]. Ploeg et al [41] demonstrate this point by reporting on how NPs take the time needed to examine and talk to the patients and their relatives to obtain an in-depth, multi-sided perspective of the elderly person's condition. The elderly therefore experiences more person-centred care than when examined by physicians [41].

Another example of the direct effect the NP role may have relates to making the care chain more efficient. NPs are expected to reduce the number of hospital admissions, a prediction in line with previous research [41–43]. This is obviously important from a socio-economic perspective, but the primary benefits will be for the frail elderly themselves [41–43] as Ploeg et al state very well [41]. With NPs employed in nursing homes, the frail elderly has a lower incidence of hospitalisations. It was especially important for elderly with dementia to avoid hospitalisations, as a change of environment can cause increased confusion [41]. It is evident that hospitalisations negatively affect the frail elderly, including increased risk of infections, confusion and pressure ulcers [44].

The indirect effects demonstrated in our results refer to the fact that NPs may play an important role as mentors for other nurses and thus benefit the overall quality of patient care. This result correlates with what previous research states as a strength of the NP role [26, 39, 40]. For instance, Kilpatrick et al [26] show that NPs act as mentors for other nurses on healthcare teams by teaching and coaching them, thus expanding their competence. The physicians who participated in that study confirmed an increased competence among other nurses in the form of more detailed reports of patient health status in settings where NPs were employed [26]. Our results demonstrate that there is a need for greater competence among nurses in municipalities if they are to handle the increased responsibility of providing more advanced healthcare at home. This result correlates with previous research [45–47] that revealed a need for more competence among nurses. For instance, Glad and Olsen's interview study [47] reported that nurses in home care and nursing homes felt that inadequately prepared or completely unprepared to face their many tasks [47]. One reason for this is that most nurses in municipal elderly care are Registered Nurses who lack the necessary in-depth skills in gerontology and geriatrics [24, 46].

Our results also indicate that the NP role was considered a possible career path for nurses who wish to remain in clinical practice. This result also confirms what previous research states as a strength of the NP role [48–50]. One challenge in municipal elderly care is that it is not considered a field in which to work; employers thus struggle to recruit and retain nurses. An important factor that affects this challenge is that nurses see no attractive career paths in municipal elderly care [51–53]. In a Finnish study, the authors emphasised that a clear career path is an important factor in increasing the attractiveness of working as a nurse and demonstrated a career path from Registered Nurse to nurse practitioner [54]. Consequently, we argue that the quality aspects mentioned above regarding what the NP role is expected to contribute to municipal elderly care are important findings. Due to the fact that most health care for frail elderly will be delivered at the municipal level in the future, it is essential to find ways to increase the attractiveness of this field for nurses and ensure increased quality of care. Otherwise, there is likely to be a persistent if not chronic shortage of qualified labour to provide the advanced care that municipalities are obliged to provide [27, 29].

Nevertheless, our study also confirms what previous international research [26, 28] has already demonstrated. The challenges that need to be overcome before the NP role can be successfully implemented mainly concern educational and legislative issues and the importance of understanding the NP role in organisations and healthcare teams. The results reveal agreement regarding the need for NP education to be developed at a national level, with a uniform length, content and structure. In the same way, there was agreement concerning the need for the NP role to be a protected professional title. This correlates well with the guidelines of the International Council of Nurses (ICN) [2] on developing the NP role. The ICN, which influences the development of the NP role worldwide, advocates for title protection and uniform educational programmes for NPs. Title protection also provides the important value of distinguishing NPs from other nursing categories and levels of nursing practice [2].

Our results also suggest the importance of properly preparing for integrating the NP role into organisations and healthcare teams. The panel members agreed on the importance of having a well-formulated implementation plan and clear job descriptions; otherwise, there would be a risk that NPs' competence would not be utilised to its fullest extent. Interestingly, and contrary

TABLE 2 Results—Level of consensus and rated importance for statements of challenges regarding the NP role

		Round 2 ($n = 20$) level of consensus (sum of agree and totally agree)			Round 3 ($n = 17$) level of consensus on importance of the statements		
Categories	**Statements**	**%**	**M**	**SD**	**%**	**M**	**SD**
Reaching consensus on what prior knowledge is required to be eligible to apply for NP education	It should not be possible to be admitted to NP education directly from undergraduate nurse education.	85	3.55	0.89	94	3.76	0.56
	It is important that NPs' education is a progression from specialist nurse education.	85	3.30	0.98	82	3.47	0.94
	It is important to have work experience as a specialist nurse before it is possible to apply for NP education.	75	3.20	0.95	82	3.53	0.94
Reaching consensus on educational issues of importance	It is important to obtain a national consensus on the length, content and structure of NP education.	100	3.85	0.37	100	3.82	0.39
	Education for NPs should be a constitutionally regulated education programme funded by the state.	95	3.79	0.42	94	3.47	0.62
	It is important to enable clinical training with a physician as a supervisor before there are enough NPs who can supervise NP students.	85	3.40	0.88	100	3.88	0.34
Accreditation and mandate for NPs	It is important to reach consensus on what title the NP role should have.	95	3.65	0.59	100	3.59	0.51
	It is necessary that NP (or whatever title is chosen) become a protected professional title.	95	3.65	0.75	100	3.94	0.24
	It is important to reach consensus on what mandate and autonomy NPs should have.	95	3.65	0.59	100	3.71	0.47
	It is important that NPs' responsibilities and mandates towards other functions, such as physicians and nurses, be clearly defined.	95	3.75	0.56	100	3.76	0.44

TABLE 2 (Continued)

Categories	Statements	Round 2 ($n = 20$) level of consensus (sum of agree and totally agree)			Round 3 ($n = 17$) level of consensus on importance of the statements		
		%	M	SD	%	M	SD
Prepare for the NP role in the organisations and in the healthcare teams	In order to motivate nurses to educate NPs, it is important that education leads to a well-paid career and altered work tasks.	100	3.90	0.31	100	3.88	0.33
	It is important that the difference in competence and mandate between NPs and specialist nurses be clearly defined and established in healthcare teams.	85	3.70	0.73	100	3.94	0.24
	NPs will be an important component in the future healthcare structure to manage the supply of competence.	90	3.50	0.69	100	3.53	0.51
	It is important that employers take advantage of the increased competence and see the benefits of NPs.	100	3.80	0.41	100	3.94	0.24
	It is necessary that politicians at both the national and local levels understand the meaning and be brave enough to invest in NPs as a function.	100	3.75	0.83	100	3.63	0.50
	A well-formulated implementation plan is important to enable the successful development of NPs.	90	3.50	0.41	100	3.76	0.44
	There must be clear job descriptions for NP assignments.	95	3.60	0.60	100	3.60	0.60
	There is a risk that NPs' in-depth skills will not be used optimally unless employers at the local level create space for this to happen.	85	3.55	0.69	100	3.88	0.33
	It is important that employers be aware that NPs can feel isolated if their function is not clearly described and anchored in the organisation.	75	3.25	0.85	100	3.94	0.24

to international studies, [55–57] our statements about gaining acceptance from other nurses and physicians did not attain consensus and were therefore excluded before round three. Nevertheless, we argue that acceptance of the NP role from the rest of the healthcare team is an important part of NP implementation. Even though there was no consensus about the specific statements we formulated on this point, we believe that the importance of acceptance appears implicitly in other statements, including those belonging to the category of preparing organisations and healthcare teams to integrate the NP role. The importance of gaining acceptance for the NP role has been widely researched; [55–57] in accordance with our results, prior studies reveal the necessity for organisations to have a well-grounded communication plan to explain the NP role to healthcare team members [55–57]. It is clear that a lack of understanding and acceptance could cause difficulties in the healthcare team's collaboration with NPs. For the NP role to be accepted by the healthcare team, it is essential that team members know what the role does—and does not—entail [43, 58, 59]. With support from previous research and the present study, we argue that both organisations and individual managers have the responsibility to create conditions for NPs to be able to develop in the healthcare team and to ensure that the role will be accepted by everyone on the team. Previous studies [58, 60, 61] state that an explicitly defined NP role with a clear delineation regarding mandate and authority as regards other professions is essential to successful implementation. Otherwise, there is a risk that NPs' unique competence will not be used to its full potential [58, 59, 61]. Previous international studies [58–60] also state that it is difficult for NPs to be accepted by healthcare teams if there is a lack of clarity regarding NPs' mandate and authority, especially from physicians but also from other nurses. This is often based on historical hierarchies of power, in which physicians have always been the undisputed leaders in clinical health care, with nurses below them; such firmly constructed realities are the most difficult to change [58, 59, 62].

Strength and limitations

The use of the Delphi technique is a key strength of the present study, as it has proven to be particularly suitable when a new topic needs to be researched by reaching consensus among policymakers and other stakeholders [33]. However, the Delphi methodology has the limitation that its several rounds of questionnaires require the participants' attention for a period of several months. This can affect potential participants' interest in contributing. In the present study, it was notable that the response rate decreased after each round. Nevertheless, it remains the case that the individuals who participated in all three rounds were people with knowledge about the NP role as and an interest in developing it in Sweden. The fact that was no participants who were explicitly hesitant about developing the NP role may be viewed as a limitation, since that perspective could have provided worthwhile insights to the results.

Conclusion

This study highlights the Swedish perspective on opportunities and challenges that may be of value for decisions makers and other stakeholders when further developing the NP role. The present study confirms earlier findings that the NP role is important for improving the quality of patient care and improving patient safety. We argue that these benefits should serve as a powerful motivation to further develop the NP role in Sweden. It will be important to have clear guidelines concerning issues of education, title protection and the mandate and authority of the NP role. It will be easier to gain acceptance if the meaning of the role is clearly understood at both the organisational level and among local healthcare teams. We are also convinced that it is essential to develop the NP role at a national level rather than trying to develop it in local contexts if it is to be accepted as a new protected nursing profession in Sweden. This requires a uniform NP educational programme, title protection and national guidelines in line with what the ICN recommends. Therefore, future studies should focus on how to move forward to overcome the challenges identified here (and others that may exist) and take the next step towards the development of a vibrant NP cohort in Sweden.

AUTHOR CONTRIBUTIONS

All authors (BL, KSF and EC) contributed to conception, design and data analysis. BL was primarily responsible for acquisition of data and drafting the article. KSF and EC revised the article critically for important intellectual content. BL, KSF and EC approved the final version to be submitted.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

ETHICAL APPROVAL

The authors have received an advisory opinion from the Swedish Ethical Review Board, diary number 2020-02631, stating that no formal ethical review is necessary under the Declaration of Helsinki [38].

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