Swedish stakeholders’ views of the preparatory work needed before introducing the nurse practitioner role in municipal healthcare – A focus group study

Birgitta Ljungbeck RN, MNSc1,2 | Elisabeth Carlson RN, PhD, Professor1 | Katarina Sjögren Forss MPH, PhD, Associated Professor1

1Department of Care Science, Faculty of Health and Society, Malmö University, Malmö, Sweden
2Municipal Healthcare in Hässleholm, Management of Care and Welfare, Malmö, Sweden

Abstract

**Background:** The nurse practitioner role has become important globally in handling the growing healthcare needs of older adults with chronic diseases. Nevertheless, research shows that introducing the role is a complex process, and more studies are needed to prepare for its introduction into different healthcare contexts, such as municipal healthcare.

**Aim:** The aim is to investigate what Swedish stakeholders identify as the preparatory work needed before introducing the nurse practitioner role into municipal healthcare.

**Methods:** Data were collected through four focus group interviews conducted virtually on the TEAMS digital platform, with three to six participants in each group and 18 participants total. The transcribed interviews were analysed using a six-step thematic approach: familiarisation with the data, coding the data, generating initial themes, reviewing themes, defining and naming the themes and producing the report.

**Findings:** The findings are divided into two main themes, each with two sub-themes. In the first, clarifying why the nurse practitioner role is needed, participants stressed the importance of having a clear intention for introducing the role. The second, ensure a national framework to bolster the introduction at the local level, demonstrates the need for collaboration among national actors to clarify the role’s mandate and authority before its introduction.

**Conclusions:** Adding the nurse practitioner role to municipal healthcare can help increase the supply of nursing competence and the quality of patient care, but preparation for introducing the role requires extensive work. The development of the nurse practitioner role requires decision-makers and leaders to take primary responsibility for its introduction. This study can support countries in the early phase of developing the nurse practitioner role by identifying both best practices and pitfalls.

**KEYWORDS**
focus group interviews, introduction, municipal healthcare, nurse practitioner, thematic analysis

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INTRODUCTION

The nurse practitioner (NP) role is being expanded globally as an innovative solution to managing the increasing healthcare demands of older adults with chronic diseases [1–3], a group that often has complex healthcare needs requiring provider continuity. NPs’ unique advanced nursing and extended medical skills are important in caring for this group. NPs work autonomously in clinical practice, managing both nursing and medical needs, leading to a high continuity of healthcare providers and genuinely person-centred care [4, 5]. Studies have shown that NPs contribute to increased patient safety, facilitate access to healthcare and improve quality of care [6–8], are cost-effective [9] and reduce hospital admissions and readmissions [10].

In addition, research demonstrates that patients deeply appreciate NPs’ holistic care, feeling more comfortable when meeting NPs than physicians. They perceive that NPs take more time for conversation and examination, contributing to a pleasant and relaxing meeting and the experience of genuinely being heard [11, 12].

Despite these positive effects, especially in the care of older adults [1, 4, 13], previous research indicates that introducing the NP role is complex [14–16]. Several factors affect its introduction, including educational ambiguities regarding the length, content and academic level of NP education [13, 15, 17]. Typically, an NP is educated at the master’s level, but this is not uniform, and deviations exist [18, 19]. The International Council of Nurses (ICN), which supports developing the NP role, states that the minimum standard for entry-level NP practice should be a master’s degree [20]. Other factors affecting its introduction are uncertainty regarding the mandate, authority and title protection for NPs, ambiguity in regulation and legislation, and acceptance of the NP role by organisations and among healthcare teams [21, 22]. Introducing the NP role tends to falter when jurisdictions are inadequately prepared [23–25]. According to previous research, politicians, healthcare organisations, managers and healthcare teams must clearly understand the NP’s functions to avoid failure in the development process [23, 24].

In Sweden, the development of the NP roles remains in its infancy and has been developed in local settings, mainly in surgical care and at a few healthcare centres, primarily in the north, but it is neither a regulated role nor a protected title [26–28]. However, the Swedish government is interested in formalising the NP role according to the on-going healthcare reform, named ‘good and close care’. This reform implies a transfer from hospital care to care at home, which leads to increased responsibility on the municipal healthcare to ensure a high level of nursing competence. Furthermore, the reform has a clear focus on developing the healthcare system to promote continuity and person-centred care. Accordingly, the NP role is expected to have an important function for the growing group of older adults with complex needs who are primarily cared for in municipal healthcare [29, 30]. However, introducing the NP role into municipal healthcare requires preparation, but research concerning the preparatory phase is scant. A previous study has demonstrated the challenges that must be overcome to successfully introduce the NP role [31], but more research is needed to concretise them. Therefore, the present study aims to investigate what Swedish stakeholders identify as the preparatory work needed before introducing the nurse practitioner role into municipal healthcare.

METHODS

Following Liamputtong’s framework, the present study applies the focus group methodology, which is useful for obtaining a wide range of views about a topic and allows individuals to become more involved in a research project [32].

Participants and the recruitment process

Recruitment was conducted using purposive sampling, meaning that potential participants were expected to have adequate knowledge of the NP role. The inclusion criteria were that participants held decision-making positions or could be considered stakeholders in developing that role. They also had to represent organisations at the national level—the government of Sweden, the National Board of Health and Welfare, the Swedish Association of Local Authorities and Regions, the University Chancellor’s Office and nurses’ and physicians’ trade unions—or be heads of administration in municipal healthcare, individuals from universities or managers from healthcare organisations that had introduced the NP role at the local level. To find potential participants, the first author conducted Internet searches on the relevant organisations’ websites. This resulted in 46 potential participants who, as agreed by the authors, met the inclusion criteria. Potential participants’ e-mail addresses were identified on the websites; all were emailed an informational letter about the study, suggestions for dates and times to conduct the focus group interviews and a consent form. All potential participants provided informed consent online via a web survey. A reminder was sent out a week after the first invitation. Initially, 25 participants agreed to participate, returned a signed consent form and responded with their preferred dates and times.

Participants included representatives from the government of Sweden, the National Board of Health and Welfare, the Swedish Association of Local Authorities and Regions, the University Chancellor’s Office and healthcare organisations at the national level, as well as representatives from universities and managers from healthcare organisations at the municipal level. The participation of participants from the municipal level was decided after an organisational review by the study’s principal investigators. The participants represented various areas of municipal healthcare in Sweden, including primary care, hospital care, and elderly care. The participants were also asked to provide suggestions for the focus group discussions, which were included in the study’s research plan.

The focus group methodology was selected because it allows for a rich and deep understanding of the participants’ views. Focus group discussions are a qualitative research method that involves small groups of people discussing a topic in a structured way. The discussions are facilitated by a trained moderator who guides the conversation to ensure that all participants have the opportunity to share their views. Focus group discussions are particularly useful for obtaining a wide range of views about a topic and allowing individuals to become more involved in a research project.

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The focus groups and data collection

The data were collected in March and April 2022, and the focus group interviews were conducted virtually on the TEAMS digital platform. To the greatest extent possible, each group represented a mix of participants from different kinds of organisations. Four focus groups were formed, three with six participants each and one with seven. When the sessions were held, however, late cancellations among participants due to illness or other acute causes meant that the total number of participants decreased from 25 to 18.

The focus group interviews began with the first author welcoming participants and briefly informing them about the NP role, the purpose of the study and the interview structure. The co-authors participated as observers in the first and second focus group interviews, respectively. The interviews followed a semi-structured interview guide, structured according to the identified challenges to introducing the NP role in previous research [31] and included three overarching themes regarding the NP role: (a) education issues; (b) legislation and mandates for the NP role and (c) preparing for the role in organisations and on healthcare teams. The interview guide involved follow-up and probing questions.

Data analysis

The data were analysed using the six steps in the thematic analysis described by Braun and Clarke [33]: familiarisation with the data, coding the data, generating initial themes, reviewing themes, defining and naming the themes, and producing the report. These steps were not linear but were used iteratively until a thorough analysis was completed. The first author started the analytical process by transcribing the interviews, reading the text several times and making notes. Next, meaning units were identified and condensed without losing their content, then sorted into initial codes and gradually placed in clusters when similarities and differences were discerned. The coded clusters were then sorted into potential themes. This back-and-forth approach generated new themes, and potential themes were changed to sub-themes. The final thematic map comprises two main themes with two sub-themes each (Table 1). Codes and themes were regularly discussed with the third author; finally, consensus was reached among all authors. In addition, Braun and Clarke’s [34] updated description of the thematic analysis method was considered in terms of the importance of reflexivity in the analytical process and how codes and themes were generated. They stress that analytical processes in qualitative research are always affected by paradigm affiliation and epistemological assumptions. It is thus essential that the researchers’ existing understanding be made conscious to relate to the data with true curiosity and achieve high coding reliability (34).

Ethical considerations

In line with the requirement of the Declaration of Helsinki [35], the participants were informed orally and in writing that the interviews would be recorded and transcribed verbatim; written consent was collected from all participants. They were informed that participation was voluntary and of their right to withdraw at any time without explanation. To protect individuals’ anonymity, participants are referred to solely by their organisations because some held highly specific national positions.

FINDINGS

The findings are presented in two main themes with two sub-themes each (Table 1) and reflect preparatory work to consider when introducing the NP role into Swedish municipal healthcare.

Clarifying why the nurse practitioner role is needed

To identify the need for the NP role in municipal healthcare, the participants repeatedly expressed the necessity

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of considering the intention of the role. The starting point requires promoting a patient perspective and, from there, carefully mapping the need for the NP role. Accordingly, the first sub-theme reflects participants' descriptions of the needs for the NP role to ensure a high level of nursing competence in clinical patient care. The second sub-theme states the participants' reflections that the NP role is necessary to lead and develop the person-centred approach in municipal healthcare.

An innovative role to enhance the quality and supply of nursing competence in a necessary healthcare reform

The participants stated that healthcare is in a constant process of change that requires increased accessibility to healthcare and new competencies among nurses. Furthermore, the participants emphasised that a major part of the care for older adults with complex nursing and medical needs is provided by municipalities. Consequently, municipal healthcare needs a high level of nursing competence, which the participants meant the NP role could ensure. Participants expressed concern that the supply of nursing competence has not kept up with the rapidly increasing demands in this area. Moreover, different aspects of quality and efficiency regarding the NP role in municipal healthcare were discussed. For example, participants argued that NPs will be important to improving the continuity of care for older adults, which should reduce the risk of care injuries and decrease hospital admissions. Participants who had worked with NPs emphasised the closer relationship between NPs and patients compared to physicians and the resulting benefits for older adults' health. For example, older adults may not always understand a physician's instructions and may consequently take medicine incorrectly. By contrast, participants perceived that the closer relationship between patients and NPs made patients more relaxed, potentially contributing to an increased understanding of and adherence to treatment and likely preventing serious medical episodes. To increase efficiency, some participants suggested that NPs be permitted to manage some patients independently of physicians. However, the discussions made clear that introducing the NP role must emphasise that it is primarily a nursing role and not a substitute for physicians:

I think it is important to not forget the nurse’s foundation, which is to be a nursing expert. And should we compensated because we have a shortage of physicians, or should we work toward getting really sharp nurses on the basis that they are nursing experts? For me, these are two different things. (Focus group 1)

Bridging nursing and medicine to capture the holistic approach

The participants stated that the NP role is necessary to lead the entire healthcare team to adopt a more person-centred approach. Participants experienced working with NPs described how they bridge the disciplines of nursing and medicine, strengthening their connection to both professions and creating unity in the healthcare team. This contributes to a deeper understanding within the team of how to jointly create conditions to provide person-centred healthcare. The discussions showed that not only nurses but also physicians gained a deeper understanding of person-centred care:

Because [the NP] conducts rounds together with our physicians, [the physicians] have opened up their minds like that; wait a bit here – what does the home situation look like and so on? It has actually become different, I think in a positive way, that [the physicians] also start to reflect and consider the full picture. (Focus group 4)

Participants experienced working with NPs stated that their NPs had contributed to improved teamwork and establishing a shared holistic approach among nursing and medical staff. This has eliminated much of the previous
disconnection between professions and yielded closer collaboration based on each patient’s individual needs. The NPs’ supervisory function was highly appreciated by members of the healthcare team. Participants stated that their NPs support both nurses and physicians, creating a spin-off effect of increased safety and competence on the team:

[The NP] is really the bridge between the medical team and the nurses, offering advice and safety. She is available and is a supervisor in different situations for both nurses and physicians, so she has a very broad role.

(Focus group 3)

Participants experienced working with NPs stated that NPs work more closely with physicians than other nurses do. Therefore, they can naturally share the person-centred approach with the physicians, raising their awareness of making patients’ further care plans from a holistic perspective. One participant described a physician who observed an NP taking a patient’s history. After some reflection, the physician observed that the history was more comprehensive when the NP collected it and that the NP asked more questions that captured a holistic perspective, all in the same amount of time.

Ensure a national framework to bolster the introduction at the local level

This theme describes the importance of national cooperation before the NP role is introduced at the local level. The participants felt that the absence of a clear national framework led to different local solutions, that would not serve the aims of the NP role.

Collaboration among national actors to determine nurse practitioner educational requirements, mandate and authority

The participants believed that the legislature should determine a degree system for NP education. Furthermore, collaboration among different national actors was seen as essential to creating high-quality NP education programmes; without that kind of collaboration, there is a risk that universities will shape NP education in different ways, making it more difficult to ensure quality. Additionally, the participants noted that it could be challenging to ensure academic competence among teachers if NP programmes were offered at too many universities; therefore, they felt it was necessary for national actors to collaborate.

It is not only the employer but also the National Board of Health and Welfare, the education system, the professional association and so on…. It must be a composite team that is going to build this… this is not something you can do alone.

(Focus group 2)

The participants also felt that important decisions should be made before introducing the NP role into practice, including whether there should be NPs in different areas, such as municipal healthcare, healthcare centres and hospital care, and whether there should be different types of NP education for different medical specialties. Still, participants found it important for people to be given the opportunity to retrain in another specialist area. Therefore, a suggestion was that NP education should consist of two phases: a general part and an in-depth specialist phase available to NPs who want to change direction.

The participants emphasised the importance of NP becoming a protected professional title to ensure a certain level of quality and competence for several reasons: it would help the role be more readily accepted by the medical profession, ensure that NPs would fulfil nationally similar functions based on a common framework and underline NPs rights to prescribe medications, which participants considered crucial for NPs for any conditions they are authorised to diagnose.

Furthermore, the participants unanimously agreed that it is essential to establish which mandates should be included in the NP role to avoid NPs ending up in situations where they are not allowed to operate fully, with some NPs allowed to do certain things and others not. While participants considered it necessary for NPs, based on their area of specialisation, to have the authority to independently manage patients’ nursing and medical needs, they also argued that NPs’ level of independent practice and the boundaries between NPs’ and physicians’ responsibilities should be properly defined.

Prepare leaders to take responsibility when introducing the nurse practitioner role into the healthcare team

This theme demonstrates the importance of creating an understanding of the NP role at the organisational and managerial levels and among healthcare teams for it to be accepted. The participants emphasised that accepting the NP role would be easier in an environment that focused on the competence of different healthcare provider roles instead of strict hierarchies about who does what. Participants experienced in working with NPs
expressed some initial difficulties in gaining acceptance from managers and healthcare teams when NPs were introduced in hospitals. To overcome this difficulty, they had comprehensive dialogues with managers and the healthcare teams in their own and other hospital wards. They described this promotion of the NP role as crucial to creating the right conditions for its introduction. They felt that those dialogues yielded positive results, with those on healthcare teams who had been sceptical changing their minds and now being able to see the benefits of NPs. Some participants thought it was more difficult for other nurses than for physicians to accept the NP role, but once the aim of the NP role was clear to everyone in the healthcare team, NPs became important for both physicians and other nurses. The participants also described the importance of ensuring that NPs were aware that they might face doubts in the initial stage and should be prepared to manage this as it can take time to reach acceptance.

The participants indicated the need for an overarching job description shaped at the national level to bolster the development of the NP role at the local level. Local job descriptions would detail the NP’s mandate and authority, with a foundation in the national framework. It is important for job descriptions to state clearly what NPs are allowed to do on their own when dealing with patients because of the need to clarify boundaries not only between NPs and physicians but also between NPs and other nursing roles. Another reason involved practical circumstances, which participants described as challenges. For example, the X-ray ward reacted disapprovingly when referrals were signed by NPs instead of physicians, and the laboratory questioned blood samples ordered by NPs. One participant, a manager in a hospital ward where the NP role is being introduced, reported:

The problem has been, I think... like what kind of mandate does [the NP] have and what can [the NP] do; we talk about a lot of that stuff. Some things [such as an operating system] she can’t write, she must do it in the physician’s name because [NPs] are not allowed to admit patients to hospital.

(Focus group 4)

**DISCUSSION**

The findings reveal the preparatory work needed before introducing the NP role in municipal healthcare. Notably, this work includes different steps at both the local and national levels. Primarily, it was believed that this work must proceed from a patient perspective and focus on how the NP role can benefit the quality of patient care. The findings detail the motivations for introducing the NP role and thus improving patient care. One motivator was linked to the apparent influence of NPs within healthcare teams, increasing both nurses’ and physicians’ ability to provide person-centred care. For example, the findings demonstrate that the NP role is necessary in municipal healthcare since there are not enough nurses with relevant competence to handle the complex nursing and medical needs of older adults. Evidence from previous research confirms this, stating that nurses in municipal healthcare are inadequately prepared [36–38]. With the support of NPs in the healthcare team, however, their competencies can be strengthened [39, 40]. Participants experienced in working with NPs also described how their NPs not only support the physicians’ ability to think in terms of medicine but also contribute to their understanding of providing person-centred care when planning the patients’ further care needs. Person-centred care improves quality of life for older adults and decreases their overall need for healthcare, contributing to cost effectiveness. These findings are supported by previous research stating that NPs’ ability to improve teamwork and benefit person-centred care is an important reason to develop the role [26, 31, 41]. For example, an evaluation of a local project to develop the NP role within Swedish primary care demonstrates similar advantages of adding the NP role to the healthcare team. In particular, it was highlighted how the NPs contributed to increased access to holistic healthcare and promoted competence in the healthcare team [26, 28].

Nevertheless, the findings demonstrate that before the NP role can be developed in different contexts, such as municipal healthcare, a regulatory national framework is necessary. Not least, the significance of this is demonstrated in the previous Swedish studies mentioned above. In these studies, it is stated that the unclear regulation affected the usefulness of having NPs in the healthcare team [26, 28]. Our findings identify two key reasons explaining the necessity for a national framework: first, to ensure a consistent NP education regardless of which university a student attends, and second, to bolster local development processes. These results are consistent with the framework of the ICN, which notes that a key factor in introducing the NP role is to establish consistent professional standards for NPs that include regular structures for NP education, with due consideration for title protection. Furthermore, professional standards help establish practical guidelines for the scope of practice. The guidelines should clearly define the mandate and authority of NPs in clinical practice to make it easier to distinguish the NP role from
other nursing categories and levels of nursing practice [20]. A previous study found barriers at the macro, meso and micro levels that affect NPs’ scope of practice. These findings reinforce the importance of clarifying the mandate and authority of NPs through a national regulatory framework before the introduction of the NP role into healthcare settings [42].

Another important factor in regulating the NP role nationally that emerged in the findings was connected to the NPs’ ability to prescribe medication. NPs’ proficiency at performing in-depth clinical assessments and diagnosing requires that they be able to prescribe medication effectively in order to get flow in the care chain. This is in accordance with previous research in Sweden, which stated that the NP role was limited due to a lack of opportunities to prescribe medications [26, 28]. Furthermore, similar circumstances are confirmed in the Kraus and Dubois study [43] as barriers to NPs’ independence. The NPs in that study expressed concern that patients must wait in the waiting room for physicians to bring their prescriptions, because the NPs cannot prescribe medications [43]. Our finding is also supported by the ICN, which regards prescription rights for NPs as central to their autonomous clinical practice [20]. International research has found significant variations in NPs’ prescribing rights, however. There are also differences in the level to which NPs can prescribe autonomously, that is, without requiring a physician’s approval [17]. We argue, however, that it is crucial that NPs have the right to prescribe medications to enable their independent management of patients. Otherwise, it will be difficult to take full advantage of NPs’ training and competence and realise the efficiency in the care chain that the introduction of NPs is intended to bring.

Furthermore, the findings highlight management’s responsibility when introducing the NP role into local healthcare teams, such as municipalities. This finding is consistent with previous research, in which the lack of managerial support was a key factor in failures to introduce the NP role into the healthcare team [24, 44]. Managers must understand the factors that can facilitate or impede the introduction of the NP role so that they can lead their healthcare teams through the development and adjustment phases [45, 46]. Our findings demonstrate factors important to creating the conditions that will allow NPs to be accepted by healthcare teams. One essential factor was managers’ engagement in comprehensive dialogues with individuals in the healthcare team and other managers to encourage mutual understanding. This finding is in line with the work of Sangster-Gormley et al. [47], who identified three factors as influencing the development of the NP role in the healthcare team – intention, involvement and acceptance – that need to be understood in an interconnected way. To encourage their acceptance of and willingness to work with NPs, team members must be clearly informed about the aim of the NP role and involved in how NPs would function on their team. The authors caution that if any of these factors are lacking, the implementation phase will be difficult for both NPs and the broader healthcare team. We regard managerial engagement as crucial to shaping the acceptance of a new nursing role in the healthcare team, without which there is a risk that traditional organisational structures and hierarchies in healthcare teams will simply be too entrenched to be overcome. Therefore, we are convinced that the introduction of the NP role into healthcare will require humility from both top management and healthcare team members. Only then can the increased nursing competence that comes with the NP role be fully taken advantage of.

STRENGTHS AND LIMITATIONS

There is limited experience with the NP role in Sweden, so this study is to some extent based on assumptions about the preparatory work needed to precede its introduction. Nevertheless, three of the four focus groups included participants with personal experience of NPs in clinical practice. In addition, each focus group contained participants who were deeply knowledgeable about the NP role at a more comprehensive decision-making level. The findings are also supported by previous research describing the introduction of the NP role as inherently complex. Furthermore, focus groups were judged to be the most appropriate method to learn the work that the participants viewed as a necessary prerequisite to the introduction of the NP role into the Swedish municipal healthcare context. While focus groups have been criticised for offering only a shallow understanding of an issue compared with individual interviews [32], the authors believe that the NP role’s being still relatively unknown in the Swedish context means that focus group discussions can contribute to more content-rich data collection than individual interviews. Since the participants were spread across Sweden, however, the digital platform TEAMS was used. The literature highlights both the strengths and weaknesses of using digital platforms to collect data. Advantages include that any inhibitions of the participants are reduced as anonymity is strengthened when they do not meet physically. Not only are ideas and solutions captured, but critical comments are easier to express, providing a richer data collection. Physical distance can also balance unequal power relations. Critics of online focus groups state that body language and other non-verbal cues are lost [48].
CONCLUSION

This study reflects a national perspective on aspects to consider when developing the NP role in Sweden. Previous studies that have evaluated the NP role, reflected a local perspective; hence, this study can add important knowledge from a national perspective to take the next step in developing the NP role in Sweden. Furthermore, this study helps concretising the work needed before introducing the NP role into municipal healthcare. It requires significant elementary work and an acceptance of responsibility by decision-makers and leaders at both the national and local levels. Before the NP role is further developed, the right conditions must be created for its introduction. We have identified that a careful map of the needs the NP role is expected to meet, national collaboration to create governing guidelines, significant management responsibility and commitment are necessary to properly plan for the introduction of the NP role. Although this study was performed in Sweden, other countries in the early phase of NP adoption can find support and help avoid pitfalls through the findings that we have reported. Still, more research is necessary, preferably focused on how NP education should be structured and clarifying the mandate and authority of the NP role at the national level.

AUTHOR CONTRIBUTIONS

All authors (BL, EC and KSF) contributed to conception, design and data analysis. BL was primarily responsible for the acquisition of data and drafting the article. BL and KSF continuously discussed the analysis, and when agreement was reached, the themes were discussed until consensus was reached with the second author, EC. EC and KSF revised the article critically for important intellectual content. BL, EC and KSF approved the final version to be submitted.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Research data are not shared.

ETHICS STATEMENT

An advisory opinion was provided by the Swedish Ethical Review Board (2020–02631) that no formal ethical review was necessary under the Declaration of Helsinki [30].

ORCID

Birgitta Ljungbeck https://orcid.org/0000-0002-4714-4752

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