Received: 19 February 2023 | Revised: 10 October 2023 | Accepted: 23 October 2023

DOI: 10.1111/jan.15938

EMPIRICAL RESEARCH QUALITATIVE

JAN Leading Global Nursing Research WILEY

The process of nurses' role negotiation in general practice: A grounded theory study

Sarah Louise Hewitt[1] | Jane Elizabeth Mills[2] | Karen Jean Hoare[1] | Nicolette Fay Sheridan[1]

[1]School of Nursing, College of Health, Massey University, Albany, Auckland, New Zealand

[2]Office of La Trobe Rural Health, La Trobe University, Bendigo, Victoria, Australia

Correspondence
Sarah Louise Hewitt, School of Nursing, College of Health, Massey University, Albany, Auckland 0632, New Zealand.
Email: sarahlhewitt@gmail.com

Funding information
Massey University

Abstract

Aim: To explain the process by which nurses' roles are negotiated in general practice.

Background: Primary care nurses do important work within a social model of health to meet the needs of the populations they serve. Latterly, in the face of increased demand and workforce shortages, they are also taking on more medical responsibilities through task-shifting. Despite the increased complexity of their professional role, little is known about the processes by which it is negotiated.

Design: Constructivist grounded theory.

Methods: Semi-structured interviews were conducted with 22 participants from 17 New Zealand general practices between December 2020 and January 2022. Due to COVID-19, 11 interviews were via Zoom™. Concurrent data generation and analysis, using the constant comparative method and common grounded theory methods, identified the participants' main concern and led to the construction of a substantive explanatory theory around a core category.

Results: The substantive explanatory theory of *creating place* proposes that the negotiation of nurse roles within New Zealand general practice is a three-stage process involving *occupying space*, *positioning to do differently* and *leveraging opportunity*. Nurses and others act and interact in these stages, in accordance with their conceptualizations of *need-responsive nursing practice*, towards the outcome *defining place*. *Defining place* conceptualizes an accommodation between the values beliefs and expectations of individuals and pre-existing organizational norms, in which individual and group-normative concepts of *need-responsive nursing practice* are themselves developed.

Conclusion: The theory of *creating place* provides new insights into the process of nurses' role negotiation in general practice. Findings support strategies to enable nurses, employers and health system managers to better negotiate professional roles to meet the needs of the populations they serve, while making optimum use of nursing skills and competencies.

Implications for the Profession and/or Patient Care: Findings can inform nurses to better negotiate the complexities of the primary care environment, balancing systemic exigencies with the health needs of populations.

Impact

What Problem Did the Study Address?

- In the face of health inequity, general practice nurses in New Zealand, as elsewhere, are key to meeting complex primary health needs.
- There is an evidence gap regarding the processes by which nurses' roles are negotiated within provider organizations.
- A deeper understanding of such processes may enable better use of nursing skills to address unmet health need.

What Were the Main Findings?

- Nurses' roles in New Zealand general practice are determined through goal-driven negotiation in accordance with individual concepts of *need-responsive nursing practice*. Individuals progress from occupying workspaces defined by the care-philosophies of others to defining workplaces that incorporate their own professional beliefs, values and expectations.
- Negotiation is conditional upon access to role models, scheduled dialogue with mentors and decision-makers, and support for safe practice.
- Strong clinical and organizational governance and individuals' own positive personal self-efficacy are enablers of effective negotiation.

Where and on Whom Will the Research Have Impact?

- The theory of Creating Space can inform organizational and individual efforts to advance the roles of general practice nurses to meet the health needs of their communities.
- General practice organizations can provide safe, supported environments for effective negotiation; primary care leaders can promote strong governance and develop individuals' sense of self-efficacy by involving them in key decisions.
- Nurses themselves can use the theory as a framework to support critical reflection on how to engage in active negotiation of their professional roles.

Reporting Method: The authors adhered to relevant EQUATOR guidelines using the COREQ reporting method.

Patient or Public Contribution: Researchers and participants currently working in general practice were involved in the development of this study. By the process of theoretical sampling and constant comparison, participants' comments helped to shape the study design.

What Does this Paper Contribute to the Wider Global Clinical Community?An understanding of the processes by which health professionals negotiate their roles is important to support them to meet the challenges of increased complexity across all health sectors globally.

KEYWORDS

general practice, grounded theory, negotiation, nurses, nursing, primary care, primary health care, role

1 | INTRODUCTION

Internationally, primary care demand is exacerbated by the high incidence of chronic disease, ageing populations (Norful et al., 2017), the resurgence of vaccine-preventable disease (Fraser-bell, 2019) and latterly the COVID pandemic (Lim et al., 2021). With a concurrent shortage of primary care physicians, nurses are taking on a range of clinical tasks formerly vested in doctors, a trend termed task-shifting (Leong et al., 2021). While research shows that nurses are effective in these medicalized roles (Laurant et al., 2018), community nurses'

work as advocates for the needs of individuals and communities is also key to improving health outcomes (McCarthy & Jones, 2019). Understanding the processes by which nurses' roles are determined in general practice may help achieve a balance between these competing imperatives. This study addresses the question of how the roles of nurses in New Zealand general practice (NZGP) are negotiated using a constructivist grounded theory design.

2 | BACKGROUND

Globally, increasing numbers of nurses work in community settings (Halcomb et al., 2018). In NZ, 15% of nurses work in primary health care (PHC) (Nursing Council of New Zealand, 2020), including over 4000 in general practice. Most (97%) are bachelor's degree educated registered nurses (RN), but the number includes diploma-holding enrolled nurses (EN) (Hewitt et al., 2021). As in Australia, Netherlands and UK, they are termed practice nurses (Barrett et al., 2021) and traditionally have focused on vaccination, wound care, medication administration and clinical administration. Since the adoption of a primary health care policy (King, 2001), they also lead in population-based preventative health initiatives, including screening and health education (Finlayson et al., 2012). This is prioritized under NZ's founding document, the Treaty of Waitangi (1840) which underpins the drive towards equitable outcomes for Māori, NZ's Indigenous people. Following legislative changes (Key & Hoare, 2020), RNs have few absolute barriers to role development and practice nurses may undertake advanced assessment and prescribing, emergency first response and long-term condition care. By completing a clinical master's degree and practicum, experienced RNs may become nurse practitioners (NP), gaining rights of diagnosis and treatment equivalent to doctors. Increasing numbers of NPs work in NZGP (Hewitt et al., 2021).

Most NZGPs are small businesses within which nurses are employees and doctors are business owners or contractors. Others in corporate ownership employ both doctors and nurses across several locations with centralized business support. A number of NZGPs are publicly owned or are otherwise not-for-profit and, according to ethos and populations served, some identify as either Māori or Pacific entities. Although largely publicly funded, most practices have considerable freedom to decide how services are delivered (Sheridan et al., 2023). Hence, there is opportunity to tailor models of care and use the full scope of nursing practice to meet local health needs. However, the ephemeral nature of general practice funding for nurse-led care, the tension between profit and care delivery and the predominance of the medical model militate against this (Greatbanks et al., 2017).

The main themes of the literature relevant to the negotiation of nurses' roles in primary care are interprofessional collaboration and the contextual facilitators and barriers of such. The medical-nursing boundary is greatly researched, and the negotiation of nurses' role parameters is reported to be negatively impacted by: the greater ability of doctors to command fees; the politics of labour relations when nurses are employed by doctors; and role confusion about professional designations (McInnes et al., 2015). Discussing competition for traditional and emerging roles from non-regulated health workers, Norful et al. (2017) emphasize the need for nurse participation in decision-making about their roles but observe that, globally, such participation is rare. Umbrella and systematic reviews of the literature on interprofessional collaboration in healthcare teams (Rawlinson et al., 2021; Sangaleti et al., 2017) highlight philosophical, structural, fiscal and interpersonal challenges faced by primary healthcare providers. The rationale for this research was to address a knowledge gap about how in the context of these challenges nursing roles are negotiated within NZGPs.

3 | THE STUDY

3.1 | Aim

The aim of this study was to construct a substantive theory of the processes used to negotiate the professional roles of nurses in NZGP, grounded in the experiences of those involved. The implications of findings on the development of nursing roles were also explored.

4 | METHODOLOGY

4.1 | Design

To accommodate the authors' primary care clinical and research experience, we used a constructivist grounded theory design in which researchers are positioned as co-constructors of knowledge. Reflecting the abductive logic of grounded theory (Reichertz, 2007), we defined our research terms loosely allowing the de facto processes of negotiation and pertinent facets of role to be determined through engagement with the data. Data were collected and analysed using constant comparative analysis and the common grounded theory methods: theoretical sensitivity; memo-writing; concurrent data generation; coding and categorizing of data, including theoretical sampling; theoretical saturation; and theoretical integration (Birks & Mills, 2023).

4.2 | Sample and participants

Participants capable of contributing meaningful data representative of the phenomena of interest were recruited by purposeful sampling (Morse & Clark, 2019). Initially, flyers were sent by e-mail to general practice networks, introducing the research and researchers. The first author contacted those who responded, by telephone, e-mailed them participant information sheets and invited them to complete consent forms. To identify those with characteristics and experience relevant to developing categories, further flyers were circulated to contacts in selected organizations. Thereby, the sample expanded beyond nurses, managers, general practitioners (GP), employers and nurse leaders within NZGPs, to include regional nurse leaders

and academics. In addition, men, Māori and Pacific participants, and those at differing career stages were theoretically sampled using similar recruitment methods.

4.3 | Data collection

Semi-structured one-to-one interviews each of around 60 min were conducted by the first author, using the protocol in Box 1. Where possible these were face-to-face in the participants' workplace. However, data collection occurred over the period December 2020 to January 2022 and, due to restrictions imposed during the COVID-19 pandemic, 11 of 22 interviews were conducted via Zoom™. All were audio recorded and transcribed by the first author, who also wrote reflective memos soon after each interview. Sampling stopped when categories were fully saturated, and properties and dimensions defined.

4.4 | Data analysis

The first author coded transcripts, identifying data of apparent significance to the research question. Iteratively, and in discussion with co-authors, initial or open codes were developed and collapsed to form abstract categories. Situational analysis was used to highlight the range of actors, cultural and symbolic elements, and contested viewpoints in the situation (Clarke et al., 2018). NVIVO12™ Software was used to manage the coding process and memos written to track analytic insights were recorded in Evernote™.

The potential significance of *space* was recognized during initial analysis as recorded by memo (Box 2). Space and similar terms occurred often in the data, relating to the interplay of physical, attitudinal, relational, temporal and systemic factors. *Uncertainty*, *vision* and *need* were considered contextually significant, and *autonomy* was considered the principal object of negotiation. We began to

BOX 1 Participant interview protocol.

Prior to recording:

- Answer any questions arising from Participant Information Sheet
- Confirm written consent
- Document contextual data (as per Table 2)
- Reminder: The purpose of the interview is to explore your experiences of nursing roles in general practice, how they are developed and to understand what is important to you in that regard.

1. For nurses in general practice settings:
   - Please describe your current roles
   - How did you come to undertake these roles
2. For nurses in general practice leadership roles, or for non-nursing participants:
   - Please describe the roles of nurses in your practice(s)
   - How did they come to undertake these roles?

Prompts:

A How was your (their) role decided when you (they) were first employed, in current role?
   - Have there been significant changes to your (their) role since then?
   - How did changes come about?
   - Compare experience with previous employment/career stages

B Can you (they) negotiate a change in your (their)role?
   - New services
   - Collective or individual negotiation
   - With whom do you (they) negotiate?

C What are the '*tasks that matter*' to you (them) and why?

D Who supports you (them) to do the things you (they) love?
   - Training
   - Mentoring
   - Professional supervision

E What does professional autonomy mean to you (them)?
   - How do you describe your personal scope of practice?
   - What influences this?

F For each question ask: *Can you give me an example?*

BOX 2 Memo written on 10 February 21.

Impression from initial coding is of a **space** for the negotiation of nursing roles in general practice arising from **uncertainty** of how to achieve or operationalize the **vision** of the organization within systemic parameters (funding, contracts, training) and constraints of work-force characteristics/aspirations/self-perception and enrolled population **need**. The degree to which individual nurses, or groups thereof, are able to negotiate is influenced by the hierarchy and the attitudes of those within it towards nurses' **autonomy** and tolerance for different ways of working. Examples of areas of uncertainty leading to negotiation: long-term conditions; nurse leadership; lack of awareness of nurses' capabilities; NP-integration; on-the-day issues; outreach; COVID; virtual consults; mental health; nurse specialization. Participants describe matters resolved in-house with limited external nurse-input other than post-graduate education.

conceptualize the negotiation as a transition from a pre-existing *space* to a re-constructed *place*. Finessed by comparison with other empirical instances and with other codes over successive phases of data collection and analysis, pertinent codes were grouped into categories. At each stage the validity of conceptual choices was tested against extant data and through theoretical sampling. Abductive reasoning was used to hypothesize and test processual links between categories, including the use of storyline (Birks et al., 2009), leading to the construction of the core category and consequent theory of *creating place*.

4.5 | Ethical considerations

University Research Human Ethics Committee approval was obtained (NOR 20/46 dated 10 November 2020). Participation was voluntary and identifying participant information was anonymized from the point of transcription. The Manchester Metropolitan University Distress Protocol for qualitative data collection was adopted in case of participants becoming distressed during interview (Haigh & Witham, 2013).

4.6 | Rigour and reflexivity

Quality criteria for constructivist grounded theory include originality, credibility, resonance and usefulness (Charmaz & Thornberg, 2020). Developing categories were discussed with participants and experienced researchers throughout the analysis, and the final-draft theory was presented to academic and clinical colleagues. Feedback demonstrated that the theory of *creating place* resonated with and had explanatory power regarding third-party experiences. For example, a non-participant EN endorsed the theory regarding her experience of developing a nurse-led palliative care role. The use of memos to record matters of procedural logic enhanced procedural precision (Birks et al., 2008).

5 | FINDINGS

Participants were drawn from 17 NZGP organizations, with a variety of business and care models and in both urban and rural locations. The characteristics and order of recruitment of the 22 participants are presented in Table 1.

The data evidenced differing norms of practice across general practices. However, participants' main concerns across the dataset were conceptualized as the provision of *need-responsive nursing practice (NRNP)*. Nurses, and other members of the general practice team, understand *NRNP* according to the meaning they attach to their work, commensurate with their personal and professional circumstances, and position in the organization. Such context influences the interpretation of the range of needs arising from societal professional, individual and business imperatives. Properties and dimensions of the concept of *NRNP* in the context of meaning of work are shown in Table 2 with examples from the data.

5.1 | The grounded theory

The grounded theory of *creating place* proposes that general practice nursing roles are negotiated as individuals progress from *occupying* work*spaces* delimited by pre-existing norms of specific organizations, to *defining* work*places* that incorporate their own values, beliefs and expectations. The theory comprises the categories of *occupying space*, *positioning to do differently*, *leveraging opportunity* and *defining place* (see Figure 1).

The first two categories conceptualize phases where internal or self-negotiation predominates, the third category comprises mainly group-negotiation and the fourth represents outcomes of negotiation. Progression between phases occurs after the completion of subordinate activities. The conditions referred to in Figure 1 are contextual factors which influence the completion of steps within each phase (A) and the transition between phases (B).

The categories and conditions within the grounded theory are abstracted from person, place and time. Behaviours attributed to actors are conceptualizations from the data and are not intended to have universal validity outside the substantive area. For brevity, the theory is described from the perspective of nurses as the principal enactors of the role being studied. However, all general practice team members act towards the process in accordance with personal concepts of *NRNP*.

TABLE 1 Characteristics of study participants.

Participant number	Profession	Role	Years in general practice	Sex	Age	Ethnicity
1	RN	Manager[a]/Clinician[b]	11–15	Female	35–44	Pacific
2	NP	Clinician	6–10	Female	35–44	NZ European
3	RN	Lead[c]/Clinician	1–5	Female	≤34	NZ European
4	RN	Lead/Clinician	1–5	Female	35–44	NZ European
5	RN	Clinician	6–10	Female	35–44	NZ European
6	GP	Owner[d]/Clinician	21–25	Female	45–54	NZ European
7	Manager	Manager	1–5	Male	35–44	Asian
8	RN	Clinician	1–5	Female	≤34	Asian
9	RN	Executive[e]	21–25	Female	55–64	European
10	RN	Owner/Clinician	16–20	Female	55–64	European
11	RN	Executive	21–25	Female	55–64	European
12	RN	Lead/Clinician	21–25	Female	45–54	Pacific
13	GP	Clinician	6–10	Female	35–44	NZ European
14	RN	Clinician	11–15	Female	45–54	Māori
15	NP	Clinician	1–5	Female	≤34	NZ European
16	RN	Clinician	1–5	Female	45–54	Pacific
17	EN	Clinician	11–15	Female	65+	Pacific
18	RN	Lead/Clinician	16–20	Female	55–64	Māori
19	RN	Executive	1–5	Female	65+	Māori
20	RN	Lead/Clinician	11–15	Male	55–64	European
21	GP	Owner/Manager/Clinician	26–30	Male	55–64	NZ European
22	RN	Clinician	6–10	Female	55–64	NZ European

[a]Manager—Undertakes operational management role at practice level.
[b]Clinician—Provides direct patient care.
[c]Lead—Has formal leadership role within the practice, other than as business owner.
[d]Owner—Owns the business within which they work.
[e]Executive—Has a primary care role outside individual general practices.

5.1.1 | Category 1: Occupying space

When new to the team, nurses react to the norms they encounter in the light of past experiences. Aspects of *norms* may challenge individual beliefs but initially they strive to fit in.

> **Participant 18**: 'I needed to learn their way before I could start thinking about any improvements …'.

This involves the process of *occupying space* in which individuals transition through *consolidating skills* and *building relationships*, to *establishing an area of autonomous practice*.

Individuals work to *consolidate their skills* and knowledge and become orientated to local ways of working. In this period of self-reflection, nurses critically compare their own performance with that of colleagues and take time to settle in, fearing damage to reputation if they fall short of expectations.

> **Participant 12**: 'There was always a fear that you might make a mistake and it's going to be your fault …'.

Therefore, only when they feel both technically adept and supported are they confident to perform tasks autonomously. Nurses recognize the interdependence of members of the wider team and carefully *build* mutually supportive interpersonal *relationships*.

> **Participant 9**: 'You can do anything if you have a good working relationship, and you have respect for the professions … It's just so important …'.

They strive to understand hierarchical and peer-to-peer norms and rules about the division of work; workloads are negotiated day-to-day to make use of differing skills and knowledge within the team and to adapt one-to-another as team composition changes. Describing the experience of a new staff member unused to group-working, one participant recalled:

> **Participant 9**, 'And so, she felt all the work that came in was her work … and now she had to rely on others. She found that really hard … she said it was like going to a completely different job'.

TABLE 2 Properties and dimensions of the concept of need-responsive nursing practice in the context of meaning of work, with examples.

	Need-responsive nursing practice	
Meaning of work (context)	**Properties**	**Dimensions**
Personal meaning (Life-stage) Work–life balance Personal ethics, worldview *Professional meaning* (Career Stage) Professional ethics Professional ethos *Meaning in the organization* *(Position in the Organization)* Profit Efficiency Clinical outcomes Relationships Status	Societal need	Social justice Affordability Safe practice—Competence: clinical and cultural
	Professional need	Professional purpose: status, reputation, legacy Workforce structure and sustainability
	Individual patient need	Choice: Health status, accessibility Care: Preventive, acute, chronic, rehabilitative, palliative Standard of care
	Individual staff need	Job-satisfaction: Income security, work–life balance, self-perception Supported autonomy for safe practice: Resource, staffing, workload, training, team skill-mix
	Business imperative	Profit, non-profit Risk appetite Resource: material and human

Example 1. An RN cited promoting health equity as giving her work meaning: '*I have a very strong interest in how we work with equity…*'. Consequently, she considered outreach to be central to need-responsive nursing practice: '*…most of us are European middle-class and commonly female. So, so, the, the, hardest population for me to access is the middle-aged Māori, Pacific Island male population … and they're well known to be the group that least commonly accesses healthcare … that's something I want to look into and work on…*'. **Participant 3**

Example 2. An RN in a lead role, found meaning in professional autonomy and patient contact: '*…we have been encouraged to think for ourselves, to ask questions, to um broaden our scope of practice, to enlighten and lighten a patient's load around their own journey around their health….*'. Consequently, she rejected a new model of care as inappropriate on grounds of felt professional need: '*….and yet now, we were being asked to be in a room, make phone calls, ask them to go and get a blood test and book an appointment and then that's it!*'. **Participant 18**

Example 3. For an RN-clinician and business owner, the idea of professional legacy was meaningful: '*So, for me it's about wanting to retire and leave nursing as an RN who has pushed the boat out on what that looks like, and how RNs can practice…*'. Consequently, she created a model of care within which need-responsive nursing practice was defined in the broadest terms: '*a model where my patient appointment list … and a doctors list, would, would, be about 75 to 80% identical*'. She distinguished between diagnostic and nursing care roles, valuing the latter in the context of population need: '*ultimately … my patient community doesn't need a nurse practitioner. They don't need access to more diagnostic expertise, they need nursing. We don't have 24-hour palliative care nurses doing physical mouth care in a house. That worries me more than whether someone else gets to refer for CT colonography…*'. **Participant 10**

Example 4. For a GP and owner, independence was key to their mode of practice which they felt was meaningful and offered choice to patients: '*…a really good thing about general practice in New Zealand is that it is private businesses, so we can choose to do things the way we choose to do …*'. Consequently, for them need-responsive nursing practice was any care that supported their chosen ways of doing: '*…whatever she's (the nurse) has got an interest in it's generally something that's going to be of value to the business*'. **Participant 6**

Example 5. To a practice manager, customers, resourcing and staff moral were meaningful: '*…it's about people, that's why I'm in this job, I'm about my customer, my supplies and my team*'. Consequently, he considered need-responsive nursing practice to be that which met customer demand, was financially viable and was acceptable to the nurses: '*I was actually gob-smacked that I had like female nurses weren't doing [contraceptive implants] and there's a male doctor doing it … I know my female customers want to go to the nurses … I can devolve activity, so I can go and chase the bigger fruit and that top of scope stuff… I can actually devolve, nice, engaging work to a nurse*'. **Participant 7**

However, where outcomes are not compromised, and individuals respond constructively to feedback, variation in practice is tolerated.

> **Participant 21**: '…every practitioner has strengths and weaknesses, and it can't be oh you're a nurse and this is what you are going to do. It's more like, this is what they are good at and … are motivated to do, and we are all fairly flexible. And then we back each other up if things change or there's a problem'.

Throughout, intensity of feeling engendered by the demands of primary care nursing and self-imposed expectations of coping are challenging. These and other issues not solvable in the course of daily work are discussed informally with peers and during *scheduled dialogue*, including one-to-one sessions with supervisors, group meetings, clinical peer-review sessions and working groups.

> **Participant 20**: '… we always share ideas, nurses meeting every day, you present your case. OK this is what I struggle with, this is what came up the other day … we take it to the peers …'

In this context, reflective self-confidence, openness and reliability are valued and rewarded by colleagues' supportive behaviour.

> **Participant 1**: '…we had a nurse who did not realize she wasn't good at taking feedback. She became defensive and we have worked with her, and she's changed it around. She's become amazing …'.

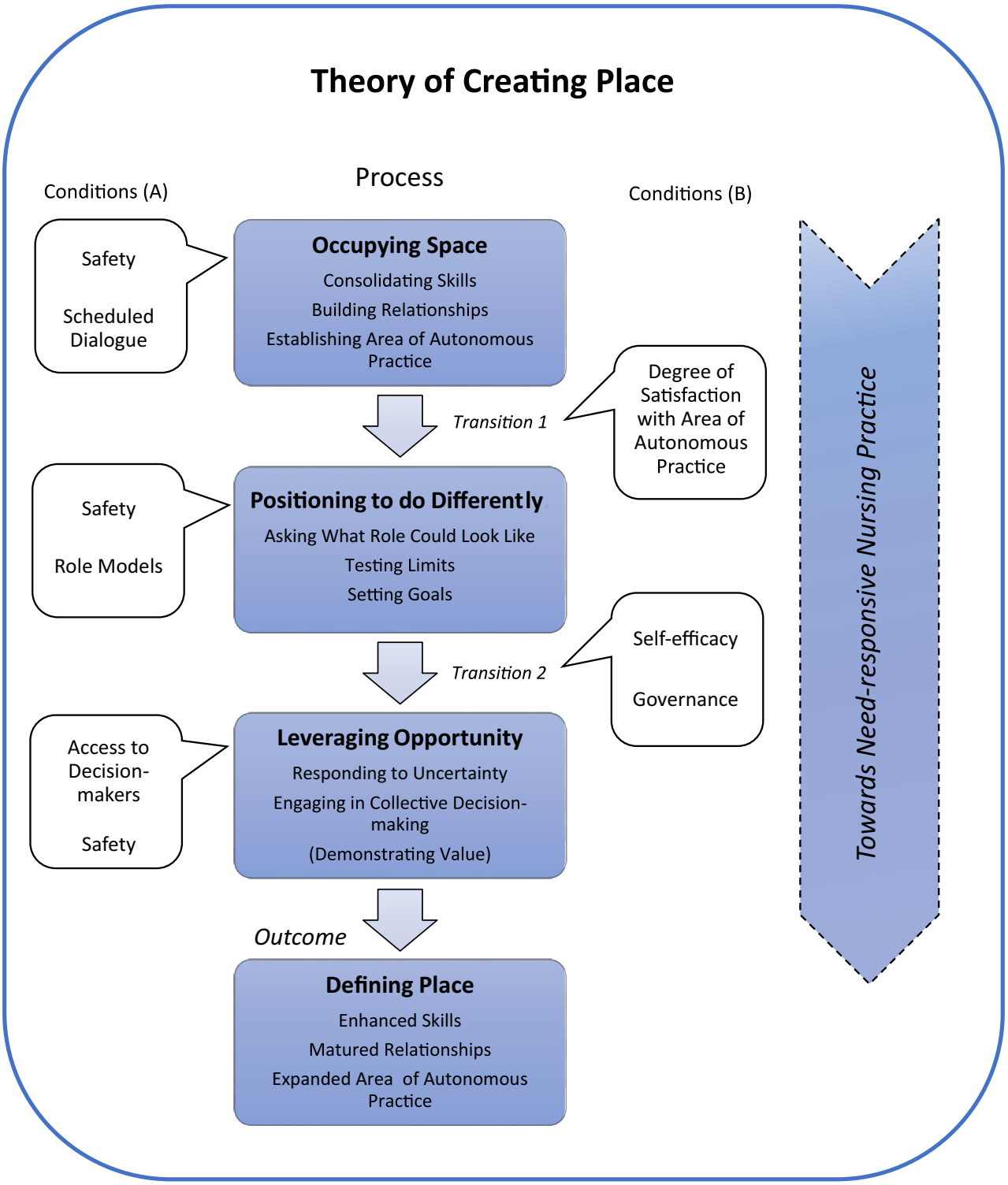

FIGURE 1 Model illustrating the theory of creating place.

Once accepted as team members, and when competent in core skills, nurses can practice with increased autonomy. Thus, with experience and after reflecting on the *skills* they have *consolidated* and the *relationships* they have *built*, nurses *establish an area of autonomous practice*. This is bounded by organizational norms and individual constructs of *NRNP* and represents what they feel they can safely do day-to-day to *occupy a space* in the organization.

> **Participant 2**: 'I have very firm beliefs in my own boundaries of competence, which I think is probably quite a good thing … It is me negotiating my own role with myself a little bit as well …'.

The *area of autonomous practice* is a baseline. Where it does not satisfy expectations regarding *NRNP*, individuals seek opportunities to vary

their practice and prepare to realize them by *positioning to do differently*. Conversely, where the *area of autonomous practice* is fulfilling, variation is not sought.

5.1.2 | Category 2: Positioning to do differently

When experienced in the operating environment and so motivated, nurses begin to consider ways of practicing which better fit their concepts of *NRNP*. This may involve broadening the area of practice or focusing on key activities. They reflectively consider possibilities, within the organization or beyond, and look for the *next step*. They ask themselves, '*What could my role look like?*'. They *test the limits* of the norm and *set personal goals*.

To identify opportunities, nurses look for role models and to available post-graduate education.

> **Participant 2:** '...being able to stand up and say, 'Yep!', that's what I want to do, how do I do that? I can see other people are doing it. I want to do it as well.'

Within the profession, those in advanced nursing roles provide inspiration. Community leaders, equity champions and health advocates are also influential. Locally, supervisors and employers may support post-graduate education or otherwise encourage potential.

> **Participant 1**: '... she said there's no growth here ... so she actually started looking for [opportunities], so that's a sign of a very good nurse manager isn't it, like recognizing that I had aspirations wanting to go further and she could see that I could not achieve it there in my current job ... I really respect her for that, yeah'.

After exploring possibilities, the feasibility of realizing change is considered in the next phase, *testing limits*. This establishes the art of the possible within the situational constraints, systemic, organizational or personal, of the norm-defined space individuals have come to occupy. As nurses try things out beliefs, values and expectations inherent in the local norm become clearer.

> **Participant 3**: '... If I wanted to start doing, I don't know – casting. You know, if I could come up with an appropriate kind of business model, as well as the safety confines ..., then they might look at doing it but if I wanted to start doing ... Botox! That doesn't sort of fit with the belief system of the practice ...'.

For individuals, considerable effort is needed to effect change and challenging the norm may compromise existing relationships. Therefore, they first consider the consequences of acting. This is an emotional and self-reflective process: professional values are weighed against personal needs and obligations, issues of work–life balance, career stage and job security.

> **Participant 10**: 'I decided that I either just have to ... suck it up, and say it is what it is ... I'm just going to carry on. It's really easy, I come to work, I go home. I'm six minutes from my job, I'm in the community that I live in, I'll just get on with it! But then there's always this bit of me that's like, you can do better, you can, you're settling'.

Over time, individuals determine the potential costs and benefits of challenging the norm and *set personal goals*. *Goal setting* is the outcome of self-negotiation and provides an agenda for group engagement.

> **Participant 12**: 'Women's health is my thing. I like smear, STI, contraceptive, all those stuffs, so why not add on. So, I put up my hand and they paid for the training and that's how I come to be doing it now'.

When confident to do so, and using their goal-agenda, nurses engage with the group in the next phase, *leveraging opportunity*.

5.1.3 | Category 3: Leveraging opportunity

Opportunities to achieve goals arise when norms of practice are disrupted, creating uncertainty. External *disruptors* include changes to service contracts, new training opportunities, legislative change and changing patient need. Internally, staff turn-over proposed new ways of working or the acquisition of new knowledge create disruption.

> **Participant 4**: 'So. when I came on, I was the first new staff in 10 years, so, it was quite a process, and I do not think they knew how to take on new staff ...'.

Critical insight and self-reflection are required to recognize opportunity. Humility on the part of those being asked to change and audacity from those challenging the *status quo* is called for.

> **Participant 7** '...to show that humility and say there's a different way to work ... and sometimes you need to be provocative and bold'.

Leveraging opportunity involves two steps: *responding to uncertainty*; *and engaging in collective decision-making* which includes *demonstrating worth*.

Nurses respond positively to uncertainty where they see opportunity to work towards their personal goals and vice versa.

> **Participant 1**: '... Dr ... says, 'I have to do IV antibiotics for this patient'. [He is] basically requesting me to help him prepare for the IV antibiotics, and I'm like very confused ... I can do it! I can do it! And he was like, "What? You can do it?". And I said, "Yes, I have got certification, I have done this, many times". So, what

had happened, the other nurse who had been working there, never let the doctors know that she can do that. So, she decided, she chose her scope of practice …'.

Similarly, in response to uncertainties arising from the COVID-19, differing attitudes were observed in response to the delegation of vaccination administration from nurses to non-regulated health workers. Moreover, the influence of pre-existing norms was apparent. In practices with a history of clinical delegation, such innovation was more readily accepted:

> **Participant 21**: '…we [had] started getting the receptionists doing blood tests … we started them doing ECGs and spirometry ages before … and now they are doing all the vaccinations and they are doing the nasal swabs'.

Having broadened their knowledge and reflected on their goals, nurses use evidence to scope gaps in service and develop potential solutions. Following individual responses to disruption, the utility and acceptability of embedding nascent change into new team norms is considered.

> **Participant 10**: 'We put together a programme … the 'winterizing warrant of fitness' and we linked it to flu vaccinations … when they came for flu vaccinations, we made sure they had had spirometry in living memory, that their inhalers were fine, we checked their technique, gave them new spacers, looked at the exacerbation plan, arranged repeat scripts and exacerbation backups and with the education around when to use those, and we noticed that winter rates of late presentations plummeted … and that's something now that's carried on'.

Individuals capitalize on the relationships they have built to promote change. They identify key team members and seek to engage them in *collective decision-making*. Nurse input to decision-making may be limited in forums such as owners' meetings. To overcome this lack of representation, nurses may act through proxies, often practice managers.

> **Participant 14**: 'But [practice manager] is really driving the move towards nurse-led clinics which we are absolutely feeding her around … so she has driven that business model with upper management'.

Some take on management and ownership roles to gain influence. Others decide their own clinical practice using personal professional judgement.

> **Participant 10**: '…it's a not asking for permission model effectively. So, if we decide that something new is something that we need to do … we just sort of announce it at a clinical meeting, we don't ask, unless it materially impacts the business, in which case those discussions we have as a group …'.

Where process efficiencies, team cohesion and/or improved care outcomes are seen to stem from any changes, *worth is demonstrated*.

> **Participant 1**: 'I think what it happened with my other nurses was because I was already doing diabetes and COPD and others … they could see the success of it. Yes! … that's how they got interested … in other nurse-led clinics'.

5.1.4 | Category 4: Defining place

Having established their worth, nurses become highly trusted members of the general practice team. By optimizing the relationships they have fostered, and the skills and knowledge they have actively developed, they are able to reshape the boundaries of their professional autonomy, *defining a place* for themselves within the organization and creating new norms of practice.

> **Participant 10**: 'Which is why we … decided to scope the role in … it's a little bit about claiming that role in that space and naming it'.

Completion of each phase of *creating place* and transition between phases are mediated by the six intervening conditions illustrated in Figure 1. Where participants successfully completed the process, there was evidence that personal *self-efficacy* had been encouraged through strong organizational *governance* in which conditions of *safety*, *scheduled dialogue* and *access to role models* and *decision-makers* were operationalized. To participants, safety meant the avoidance of physical, emotional or reputational harm to nurse, patient or team member. Participants' sense of safety was enhanced through support for skill-development, by access to leaders and mentors and through collegial support. Under these conditions, and where individuals had a clear personal conceptualization of NRNP, they felt able to proactively seek change as evidenced in areas including, but not limited to, travel medicine; laboratory testing; outreach; and nurse-led long-term condition care.

6 | DISCUSSION

The theoretical model *creating place* fills a knowledge gap about how nursing roles are negotiated in NZGP. Our finding that the negotiation is heavily influenced by local norms is consistent with international primary care literature. This shows that norms of practice vary between organizations according to local funding models, team composition, population health needs and with individual nurses' professional competency (Barrett et al., 2021). Experience in Australia, where business models are similar to NZ, suggests that practice nurses must 'navigate the preferences of individual employers' (Halcomb & Ashley, 2019,

p. 523). We found that the preferences of individual nurses and managers, expressed through the concept of *NRNP*, are also central to the negotiation of roles. As expected, participants were motivated by the meaning found in their work. Previous nursing research has identified meaning in work as an essential motivator, promoting physical, emotional and cognitive engagement in the workplace (Gómez-Salgado et al., 2019; Lee, 2015). Whilst all our participants gave examples of their proactive and subjectively successful negotiation of role, they also reported experiences which were demotivating, and which led them to disengage. Since we specifically sought participants with experience of negotiation, it is likely that disengagement from processes of negotiation is higher among the practice nursing population than within the sample. Certainly, in Halcomb and Ashley's (2019) study, which included 950 Australian practice nurses, only around 50% of primary care nurses had engaged their employers in discussion about role development, despite feeling they could use their skills more fully. Hence, the intervening conditions we identified have relevance when seeking to promote proactivity.

We found that high personal *self-efficacy* encouraged by strong organizational *governance* enabled the process of *creating place*. Positive self-efficacy is a belief in one's ability to exert control over self and the environment. It is engendered by experiencing success and mediates the desire to act on conviction. However, it is situation dependent. 'Under forcible disincentives or imposed social and physical constraints' even those who perceive themselves highly capable may chose inaction (Bandura, 2012, p. 10). The relevance of self-efficacy as a predictor of performance in general nursing practice has been previously established (Caruso et al., 2016). In primary care, we know that nurses' freedom to act is constrained by systemic factors including legislative and funding barriers, role confusion and inter-professional power struggles (Busca et al., 2021). However, the literature also indicates this may be mitigated by creating an inclusive organizational culture and positive attitude towards innovation (Rawlinson et al., 2021). An organization's governance regime sets out how and by whom decisions will be made and implemented in pursuit of defined objectives (International Standards Organization, 2010). We propose that organizational governance settings can enable transition from *positioning to do differently* to *leveraging opportunity* when they provide clear rules of engagement, and expectation of participation without fear of censure for speaking up.

We conceptualized this negotiation as an accommodation between the values beliefs and expectations of individuals and those inherent in organizational norms. In addition to the personal positionality that underpins these attitudinal factors, professional identity based on discipline-specific values (Godfrey & Young, 2020) is also influential. NZ nursing practice competencies are informed by the Treaty of Waitangi (1840), all nurses are charged with advocating for patients and NPs have the specific remit to improve population health outcomes (Ministry of Health, 2018). We have highlighted the importance of safety as an intervening condition on the process of creating place. Cultural safety, originating in the institutional racism experienced by Māori in nursing education (Richardson, 2004), is considered a core component of safe NZ nursing practice, facilitating understanding of how culture mediates health outcomes. The importance nurse participants attached to improving health outcomes for disadvantaged populations showed internalization of these national professional values. However, their identification of patient need was largely through observation of patient behaviour or recognition of differential outcomes between populations, rather than through consultation with patients themselves.

The study findings are untested beyond their situational context. Nevertheless, aspects of *creating place* are consistent with established role theory. Role theory hypothesizes how behaviours arise in response to normative expectations with perspectives that see roles as more or less fixed or negotiable (Anglin et al., 2022). It has been used in nursing to explore interaction between individuals and organizations (Brookes et al., 2007). Addressing the phenomenon of role transition, Duchscher's Transition Shock (2009) and Benner's Novice to Expert (1984) Models are well-known. Focusing on adaptation to normative role expectations, these theories include concepts like those in our category *occupying space*. Hence, insofar as it represents a resolution of the conflict between personal and organizational expectations, the establishment of an *area of autonomous practice* may be likened to the outcome of Duchsher's stages of 'doing, being and knowing' (Duchscher & Windey, 2018, p. 229). Whilst transition shock relates to the new graduate experience, Benner's Model highlights that when transitioning between settings and roles, even experienced nurses take time to recover prior levels of felt competency (Benner, 1984). Primary care role theory includes reference to 'shaping roles' (Holt, 2008, p. 123). This involves role holders developing roles and the theory of *creating space* builds on this premise. It highlights that the accommodation represented by completing the process of role transition is provisional, and through the further processes of *positioning to do differently* and *leveraging opportunity*, new role parameters may be established.

6.1 | Strengths and limitations

The integration of our findings with extant role theory increases their generalizability, which is otherwise untested outside the substantive area. The use of videoconferencing for some interviews precluded observation of participants in their work environments. However, participants speaking to us from their homes were relaxed and candid and provided rich data. This is in keeping with other researchers' experiences (Oliffe et al., 2021). Due to the inductive natures of the method, other researchers may have derived different constructions from the data.

6.2 | Recommendations for further research

There would be benefit in future research to investigate the applicability of the theory of *creating place*, in other general practice settings in NZ and elsewhere. Our data showed that participants considered patient needs to be influential in the negotiation and, consistent with

ground theory method, we included extant literature as data in our exploration of this issue. However, there would be merit in further research specifically exploring the patient perspective.

7 | CONCLUSION

Our concept of *need-responsive nursing practice* includes recognition that matters of personal gain, convenience and status are influential. Therefore, no moral assumption that individuals are necessarily and invariably working towards a greater good is inherent in the *process* of creating place. However, reflecting NZ nursing values, our participants demonstrated a patient-centred approach and successfully negotiated changes to their roles to include an expanded range of biomedical and social-model tasks and responsibilities. Therefore, our findings demonstrate that despite constraining systemic factors, local action can be taken to address unmet health need using nurses' broad scopes of practice. Whilst task-shifting may be implemented in a top-down fashion, through regulatory change, how it is implemented within practices is key. Here, it is important that policy settings and organizational governance, the principal intervening condition in our model, are such that nurses are empowered to own and develop their roles and to retain and express their nursing ethos to meet health needs. Critical reflection on what *need-responsive nursing practice* means to them and on the process of creating space may help nurses engage proactively in professional role development.

ACKNOWLEDGEMENTS

We acknowledge the contribution of all participants. The first author was in receipt of a Massey University Vice-Chancellor's Doctoral Scholarship over the period February 2019 to February 2022. Open access publishing facilitated by Massey University, as part of the Wiley ‐ Massey University agreement via the Council of Australian University Librarians.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

PEER REVIEW

The peer review history for this article is available at https://www.webofscience.com/api/gateway/wos/peer-review/10.1111/jan.15938.

DATA AVAILABILITY STATEMENT

Data available on request due to privacy/ethical restrictions.

ETHICS STATEMENT

Ethics approval was granted by the Massey University Human Ethics Northern Committee, on 10 November 2020, reference NOR 20/46. No genetic resources were utilized in the submitted manuscript.

ORCID

Sarah Louise Hewitt https://orcid.org/0000-0001-7876-5212

TWITTER

Sarah Louise Hewitt MasseyUniHealth
Jane Elizabeth Mills profjanemills latroberhs
Karen Jean Hoare khoare43 MasseyUniHealth
Nicolette Fay Sheridan MasseyUniHealth

REFERENCES

Anglin, A. H., Kincaid, P. A., Short, J. C., & Allen, D. G. (2022). Role theory perspectives: Past, present, and future applications of role theories in management research. *Journal of Management*, *48*(6), 1469–1502.

Bandura, A. (2012). On the functional properties of perceived self-efficacy revisited. *Journal of Management*, *38*(1), 9–44.

Barrett, C., Mathews, M., Poitras, M.-E., Norful, A. A., Martin-Misener, R., Tranmer, J., Ryan, D., & Lukewich, J. (2021). Job titles and education requirements of registered nurses in primary care: An international document analysis. *International Journal of Nursing Studies Advances*, *3*, 100044. https://doi.org/10.1016/j.ijnsa.2021.100044

Benner, P. (1984). From novice to expert. *Menlo Park*, *84*(1480), 130–139.

Birks, M., Chapman, Y., & Francis, K. (2008). Memoing in qualitative research: Probing data and processes. *Journal of Research in Nursing*, *13*(1), 68–75.

Birks, M., & Mills, J. (2023). *Grounded theory: A practical guide*. SAGE Publications Ltd.

Birks, M., Mills, J., Francis, K., & Chapman, Y. (2009). A thousand words paint a picture: The use of storyline in grounded theory research. *Journal of Research in Nursing*, *14*(5), 405–417. https://doi.org/10.1177/1744987109104675

Brookes, K., Davidson, P. M., Daly, J., & Halcomb, E. J. (2007). Role theory: A framework to investigate the community nurse role in contemporary health care systems. *Contemporary Nurse*, *25*(1–2), 146–155.

Busca, E., Savatteri, A., Calafato, T. L., Mazzoleni, B., Barisone, M., & Dal Molin, A. (2021). Barriers and facilitators to the implementation of nurse's role in primary care settings: An integrative review. *BMC Nursing*, *20*(1), 1–12.

Caruso, R., Pittella, F., Zaghini, F., Fida, R., & Sili, A. (2016). Development and validation of the Nursing Profession Self-Efficacy Scale. *International Nursing Review*, *63*(3), 455–464. https://doi.org/10.1111/inr.12291

Charmaz, K., & Thornberg, R. (2020). The pursuit of quality in grounded theory. *Qualitative Research in Psychology*, *18*, 1–23.

Clarke, A. E., Friese, C., & Washburn, R. (2018). *Situational analysis grounded theory after the interpretive turn* (2nd ed.). Sage Publications Inc.

Duchscher, J. B., & Windey, M. (2018). Stages of transition and transition shock. *Journal for Nurses in Professional Development*, *34*(4), 228–232.

Duchscher, J. E. B. (2009). Transition shock: The initial stage of role adaptation for newly graduated registered nurses. *Journal of Advanced Nursing*, *65*(5), 1103–1113.

Finlayson, M. P., Sheridan, N. F., Cumming, J. M., & Fowler, S. (2012). The impact of funding changes on the implementation of primary health care policy. *Primary Health Care Research & Development*, *13*(2), 120–129.

Fraser-bell, C. (2019). Global re-emergence of measles-2019 update. *Global Biosecurity*, *1*(3). https://doi.org/10.31646/gbio.43/

Godfrey, N., & Young, E. (2020). Professional identity. In J. F. Giddens (Ed.), *Concepts of nursing practice* (3rd ed.). Elsevier Publishing.

Gómez-Salgado, J., Navarro-Abal, Y., López-López, M. J., Romero-Martín, M., & Climent-Rodríguez, J. A. (2019). Engagement, passion and meaning of work as modulating variables in nursing: A theoretical analysis. *International Journal of Environmental Research and Public Health*, *16*(1), 108. https://doi.org/10.3390/ijerph16010108

Greatbanks, R., Doolan-Noble, F., & McKenna, A. (2017). Cheques and challenges: Business performance in New Zealand general practice. *Journal of Primary Health Care*, *9*(3), 185–190.

Haigh, C., & Witham, G. (2013). Distress protocol for qualitative data collection. *Archives of Psychiatric Nursing*, *23*(5), 343–350.

Halcomb, E., & Ashley, C. (2019). Are Australian general practice nurses underutilised?: An examination of current roles and task satisfaction. *Collegian*, *26*(5), 522–527. https://doi.org/10.1016/j.colegn.2019.02.005

Halcomb, E., Smyth, E., & McInnes, S. (2018). Job satisfaction and career intentions of registered nurses in primary health care: An integrative review. *BMC Family Practice*, *19*(1), 1–14.

Hewitt, S. L., Sheridan, N. F., Hoare, K., & Mills, J. E. (2021). Understanding the general practice nursing workforce in New Zealand: An overview of characteristics 2015–19. *Australian Journal of Primary Health*, *27*(1), 22–29.

Holt, I. G. (2008). Role transition in primary care settings. *Quality in Primary Care*, *16*(2), 117–126.

International Standards Organization. (2010). Guidance on social responsibility, Issue. https://www.iso.org/obp/ui/#iso:std:iso:26000:ed-1:v1:en

Key, J., & Hoare, K. (2020). Nurse prescribing in New Zealand—The difference in levels of prescribing explained. *The New Zealand Medical Journal*, *133*(1524), 111–118.

King, A. (2001). *The primary health care strategy*. Ministry of Health.

Laurant, M., van der Biezen, M., Wijers, N., Watananirun, K., Kontopantelis, E., & van Vught, A. J. A. H. (2018). Nurses as substitutes for doctors in primary care. *Cochrane Database of Systematic Reviews*, *2018*(7), CD001271. https://doi.org/10.1002/14651858.CD001271.pub3

Lee, S. (2015). A concept analysis of 'Meaning in work' and its implications for nursing. *Journal of Advanced Nursing*, *71*(10), 2258–2267.

Leong, S. L., Teoh, S. L., Fun, W. H., & Lee, S. W. H. (2021). Task shifting in primary care to tackle healthcare worker shortages: An umbrella review. *European Journal of General Practice*, *27*(1), 198–210.

Lim, J., Broughan, J., Crowley, D., O'Kelly, B., Fawsitt, R., Burke, M. C., McCombe, G., Lambert, J. S., & Cullen, W. (2021). COVID-19's impact on primary care and related mitigation strategies: A scoping review. *European Journal of General Practice*, *27*(1), 166–175.

McCarthy, M. P., & Jones, J. S. (2019). The medicalization of nursing: The loss of a Discipline's unique identity. *International Journal for Human Caring*, *23*(1), 101–108.

McInnes, S., Peters, K., Bonney, A., & Halcomb, E. (2015). An integrative review of facilitators and barriers influencing collaboration and teamwork between general practitioners and nurses working in general practice. *Journal of Advanced Nursing*, *71*(9), 1973–1985.

Ministry of Health. (2018). *Nurse practitioners in New Zealand*. Author. Retrieved 8 July 2020 from https://www.health.govt.nz/our-work/nursing/nurses-new-zealand/nurse-practitioners-new-zealand

Morse, J. M., & Clark, L. (2019). The nuances of grounded theory sampling and the pivotal role of theoretical sampling. In B. C. Bryant & K. Charmaz (Eds.), *The SAGE handbook of current developments in grounded theory* (pp. 145–166). SAGE Publications Ltd.

Norful, A., Martsolf, G., de Jacq, K., & Poghosyan, L. (2017). Utilization of registered nurses in primary care teams: A systematic review. *International Journal of Nursing Studies*, *74*, 15–23.

Nursing Council of New Zealand. (2020). *Te Ohu Mahi Tapuhi o Aotearoa: The New Zealand nursing workforce: A profile of nurse practitioners, registered nurses and enrolled nurses 2018–2019*. Author. https://www.nursingcouncil.org.nz/Public/Publications/Workforce_Statistics/NCNZ/publications-section/Workforce_statistics.aspx

Oliffe, J. L., Kelly, M. T., Gonzalez Montaner, G., & Yu Ko, W. F. (2021). Zoom interviews: Benefits and concessions. *International Journal of Qualitative Methods*, *20*, 16094069211053522.

Rawlinson, C., Carron, T., Cohidon, C., Arditi, C., Hong, Q. N., Pluye, P., Peytremann-Bridevaux, I., & Gilles, I. (2021). An overview of reviews on interprofessional collaboration in primary care: Barriers and facilitators. *International Journal of Integrated Care*, *21*(2), 32.

Reichertz, J. (2007). Abduction: The logic of discovery of grounded theory. In A. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory*. SAGE Publications Ltd.

Richardson, S. (2004). Aoteaoroa/New Zealand nursing: From eugenics to cultural safety. *Nursing Inquiry*, *11*(1), 35–42.

Sangaleti, C., Schveitzer, M. C., Peduzzi, M., Zoboli, E. L. C. P., & Soares, C. B. (2017). Experiences and shared meaning of teamwork and interprofessional collaboration among health care professionals in primary health care settings: A systematic review. *JBI Database of Systematic Reviews and Implementation Reports*, *15*(11), 2723–2788. https://doi.org/10.11124/JBISRIR-2016-003016

Sheridan, N., Love, T., & Kenealy, T. (2023). Is there equity of patient health outcomes across models of general practice in Aotearoa New Zealand? A national cross-sectional study. *International Journal for Equity in Health*, *22*(1), 79.

Treaty of Waitangi, 1840.

How to cite this article: Hewitt, S. L., Mills, J. E., Hoare, K. J., & Sheridan, N. F. (2024). The process of nurses' role negotiation in general practice: A grounded theory study. *Journal of Advanced Nursing*, *80*, 1914–1926. https://doi.org/10.1111/jan.15938