RECONSTRUCTING NURSING: A STUDY OF ROLE TRANSITION IN

ADVANCED NURSE PRACTITIONERS

LESLIE PETER WOODS

A thesis submitted in fulfilment of the requirements of Keele University for the

degree of Doctor of Philosophy

1998

ABSTRACT

As the demands on the NHS increase, nurses are facing the challenge of attempting to implement innovative and new roles in clinical practice. Changes such as the reduction in junior doctor hours, evidence based practice, and recognition of nursing's contribution to health care delivery, have acted as catalysts for professional development. At the same time, the UKCC's ongoing quest to have nursing establish itself as a major professional discipline has resulted in the recognition of different levels of nursing practice. The highest and most complex level is that of the "advanced nurse practitioner" (ANP), who is expected to be prepared at the Master's degree level.

This study set out to explore the transitional process of nurses undergoing the academic and clinical preparation to become ANPs. A qualitative design, utilising five case studies, was used as the main research strategy. In addition to the ANP, each case comprised a number of medical, managerial, educational, and nursing staff. Data was collected by individual interviews, observations and documentary analysis. Supplementary data was collected through the completion of role development diaries by an additional 8 ANPs. Data collection was completed over a two year period and analysed with the assistance of the NUD-IST computer program.

It was found that the transitional process of becoming an ANP involved the reconstruction of nursing in seven personal and practice domains. Both the transitional process and outcome were contingent upon the influence of key stakeholders within each institution. Consequently, role transition resulted in one of three operational outcomes: practice replication; practice fragmentation; or practice innovation. Regardless of outcome however, all ANPs sought to establish a new and unique identity as a way of escaping the organizational and occupational constraints placed upon them, and to gain recognition and professional empowerment.

CONTENTS

ACKNOWLEDGEMENT

My thanks are due to all the participants who took part in this study and willingly gave of their time, consideration and energy. I particularly owe a debt of gratitude to the five advanced nurse practitioners who were the main focus of the case studies, for without their help and tolerance this study would not have been possible.

My thanks are also extended to both my research supervisors, Professor John McLeod and Dr David Skidmore, whose critical comments, advice, guidance and words of support and encouragement, were crucial to the development and completion of this thesis.

I would also like to extend my gratitude to the West Midlands NHS Executive who funded the Research Fellowship which allowed me to concentrate all of my energies on the task in hand.

I would like to give special thanks to my wife Anne for her unwavering support, patient understanding, incredible tolerance, and continuing encouragement, which were essential to my survival during this study.

Finally, I would like to dedicate this thesis to my parents; especially my mother, whom while not surviving to see it come to fruition, would have taken great pleasure and pride in its completion.

ABBREVIATIONS

A&E:	Accident and Emergency Department
ACNP:	Acute Care Nurse Practitioner
ANP:	Advanced Nurse Practitioner
CNS:	Clinical Nurse Specialist
ENP:	Emergency Nurse Practitioner
ENT:	Ear Nose and Throat
ITU:	Intensive Therapy Unit
NNU:	Neonatal Unit
NP:	Nurse Practitioner
PAMs:	Professions Allied to Medicine
PREPP:	Post Registration Education and Practice Project
SHO:	Senior House Officer (Junior Doctor)
UKCC:	United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

LIST OF TABLES

(iii)

LIST OF FIGURES

CHAPTER ONE

BACKGROUND TO THE STUDY

CHAPTER 1. BACKGROUND TO THE STUDY.

Although specialisation in nursing has been slow to evolve in the UK (Castledine,1991), this is a situation that has begun to change. In recent years, a number of strategic developments both within and without the nursing profession have acted as a catalyst for nurses to reflect on the nature of their clinical practice and consider ways in which it might be developed. While the notion of 'extending' or 'expanding' clinical practice is not new in nursing, recent debate has focused on the concept of different levels of nursing practice and the expectation for nurses to develop new roles and working patterns (UKCC, 1993). This chapter provides the background to the study by examining the antecedents to the changes currently taking place. It is argued that the convergence of three key factors have acted to bring about a major change in the nature of nursing practice. These factors can be described as: the *desire by*, and *for* nurses to develop and advance their practice; the *recognition* for nurses to develop and advance their practice; and finally the *opportunity* for nurses to develop and advance their practice. In addition, the chapter highlights the problems faced by nursing's governing body, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), as it attempts to define and reach a general consensus regarding the differing levels of nursing practice and the concept of an advanced practitioner.

Whilst nursing is engaged in a period of immense change (Graham, 1992) it is asserted here that the reconstruction of nursing practice can be linked to two primary factors. The first concerns nursing's pre-occupation with shaking off its image as a "minor" profession (Retsas, 1995), whilst the second is associated with the needs

driven ethos that prevails within the present day National Health Service (Salussolia, 1997). It has been suggested that:

> "... the traditional concepts of nursing, together with the prescribed knowledge, values and skills, no longer seem to fit the experiences or desires of nurses who are increasingly being asked to identify their unique contribution to health care. Nurses are being faced with a conceptual and activity revision..." (Graham, 1992, p118).

Despite innovative nursing roles beginning to emerge in the UK (Cameron, 1998) little is known about the initial period of transition experienced by nurses who are required to reconstruct their practice to become 'advanced' nurse practitioners (Brown & Olshansky, 1997). The purpose of this thesis is to enhance understanding of how nurses engage in the transitional process when moving from a position of "experienced nurse" to one of "advanced nurse practitioner".

Recent years have seen initiatives both within higher education and the health service aimed at realising the potential of nurses to broaden the scope and sphere of their practice. In higher education for example, a number of universities have designed undergraduate and postgraduate programmes aimed specifically at equipping nurses with the knowledge and skills necessary to enable them to advance their practice. At the same time, in order to meet changing health care needs and the shift in service provision, hospital and community trusts have been creating new posts in which nurses have been employed as 'specialist' or 'advanced' practitioners. Whilst such developments create a sense of excitement and anticipation for the nursing profession, a number of questions remain unanswered. For instance: what is the nature of specialist or advanced nursing practice? Where and how does it occur? Do current university programmes adequately prepare nurses to take on such

new roles and responsibilities? What are the antecedents to the current changes in nurse education and practice if the idea of nurses extending and expanding their roles is not new? Whilst the first three questions are broadly the focus of this thesis, consideration of the latter helps to locate this subject into a present day context.

It is asserted here that three interrelated sets of conditions, occurring more or less simultaneously, either by design or coincidence, have given impetus to the drive for nurses to develop and advance their practice. Whilst these three conditions may have existed independently or in tandem in the past, it is conjectured that their simultaneous occurrence provides a basis for understanding the changes occurring in nursing practice and education at the current time. The three conditions can be described as: the *desire by,* and *for* nurses to develop and advance their practice; the *recognition* for nurses to develop and advance their practice; and finally the *opportunity* for nurses to develop and advance their practice.

1.1 THE DESIRE OF AND FOR NURSES TO ADVANCE THEIR PRACTICE

It has been posited that many nurses throughout the country would welcome the opportunity of expanding their roles (Cahill, 1996). This assertion is based not simply upon speculation, but on evidence which suggests that nurses have a genuine *desire* to advance their practice and to develop new roles (Last & Self, 1994; Barrett, 1995). Other professional groups, in particular medicine, are also eager that nurses should continue to develop their skills and abilities (Jewell & Turton, 1994; Barrett, 1995), although the motivation for them doing so has been questioned (Giles, 1993).

The desire for nurses to advance their practice is also implicit in a number of national strategic documents, including the Department of Health's, *A Vision for the Future* (1993a) and *The challenges for nursing and midwifery in the 21st century - the Heathrow debate* (1993b). Both documents explore the context of nursing and outline strategic target areas where developments in nursing practice could be made. More recently, the emergence of evidence based practice has implications for nurses to develop new roles in the drive for increased clinical effectiveness and efficiency (Kitson, 1997). Lastly, the UKCC (nursing's governing body) has explicitly stated that it fully supports the notion of nurses advancing their practice (1997b).

Consequently, the *desire* of and for nurses to advance their practice, whilst not being universally welcomed (Giles, 1993), is clearly evident. There are perhaps more profound motives for desiring nurses to advance their practice. It has been acknowledged that consumers are the group who should be the ultimate beneficiaries of nursing developments (Hunt & Wainwright, 1994). The benefits of nurse led primary care clinics and nurse practitioners in accident and emergency departments for example have already met with the approval of patients and helped reduce waiting times and improve efficiency (Jones, 1994).

Nurses then appear to have the support from all quarters of the professional and public domains to advance their practice in new and novel ways. Whilst the desire of and for nurses to advance their practice is evident, in itself, it is insufficient to fully account for all the changes currently taking place.

1.2 RECOGNITION FOR NURSES TO ADVANCE THEIR PRACTICE

It is suggested that the second condition that has facilitated the process of nurses developing their practice involves the concept of *recognition*. In 1990, the UKCC's *Post Registration Education and Practice Project* (PREPP) report (1990) formally recognised three different levels of nursing practice. These were provisionally termed, "primary", "advanced" and "consultant" practice. Differentiation between each level was provided in the form of a brief outline of the focus and scope of practice, as well as alluding to the level of educational preparation required. The UKCC later revised the titles corresponding to each level, preferring instead to call them "professional", "specialist" and "advanced" practice (UKCC, 1994c), with the advanced level perceived as being highest and most complex.

While for some the notion of an advanced practitioner is not necessarily new (Mirr, 1993; Holyoake, 1995), it has been acknowledged that professional bodies in the UK have been slow to define and recognise the concept fully (Holyoake,1995). Expectations that the concept of advanced practice would eventually be defined were raised when the PREPP report stated that the UKCC, at some later date, would produce specific details relating to the "standard, kind and content of preparation for advanced practice" (UKCC, 1990. p27). Following the UKCC's revision of the nomenclature related to each level of practice however, this statement was found to refer to specialist practice and not advanced practice as initially anticipated.

The precedent of acknowledging specialist and advanced levels of practice served to raise the expectations of nurses, managers and educationalists, and in effect

legitimated the notion of nurses advancing their practice to many both inside and outside of the nursing profession. Furthermore, the concepts of specialist and advanced practice were perceived to provide nurses with a clinical career pathway which would enable them to be rewarded (financially) for remaining in clinical practice, as opposed to seeking promotion via traditional routes into education or management.

Finally, the concepts of specialist and advanced practice were given academic currency and recognition when the UKCC later confirmed that it expected the educational preparation of specialist practitioners to be at first degree level and advanced practitioners to be at the Master's degree level (UKCC, 1994c). Thus, while the notion of specialist and advanced practitioners are not in themselves new ideas, the degree of recognition afforded these concepts, in particular by the UKCC, can be seen as a significant precursor to the developments that followed. Arguably, in formally recognising the concepts of specialist and advanced practice, the UKCC had provided an incentive for nurses to develop their practice and undertake further education and training. Moreover, it provided the impetus for universities to develop curricula that would provide the requisite educational programmes. In terms of health care providers, these developments allowed organizations to re-examine their service provision and explore ways in which specialist and advanced practitioners might be utilised in the delivery of health care in the future.

The inter-relationship, therefore, between the concept of *recognition* and the notion of *desire* of and for nurses to advance their practice, is clearly evident. While this

combination strengthens the explanation for the drive of nurses to develop their practice base, the third condition perceived to have provided the final stimulus relates to the *opportunity* for nurses to advance their practice.

1.3 OPPORTUNITY FOR NURSES TO ADVANCE THEIR PRACTICE

In the past, the opportunity for nurses to advance their practice was generally reliant upon locally agreed, ad hoc initiatives, which occurred sporadically in health care settings throughout the country. Whilst these developments provided nurses with the opportunity to broaden their scope and sphere of practice, they remained relatively few in number and were often of short-term duration. It is suggested here that the current opportunity for nurses to advance their practice is based upon a series of recent events which are likely to lead to more widespread and sustainable developments in nursing practice.

The first of these events relates to a series of professional documents produced by the UKCC which outline the principles upon which *any* nurse can base their decision to develop and advance his or her practice. The key documents are perceived to be; the Code of Professional Conduct (UKCC, 1992a); Exercising Accountability (UKCC, 1989); and of particular importance, the Scope of Professional Practice (UKCC, 1992b). These documents clearly set out the UKCC's expectations with regard to the conduct and accountability of nurses, whilst at the same time opening the door to further development and expansion of clinical practice (Castledine, 1991). Arguably, the most liberating of the UKCC's documents is the Scope of Professional Practice (UKCC,1992b) in which it is specifically stated that nurses are able to take on

8

additional roles and responsibilities, providing they have the appropriate knowledge and training to do so. The Scope of Professional Practice (UKCC, 1992b) serves not only to recognise that nurses are increasingly in positions whereby they are likely to advance and develop their practice, but could also be interpreted as providing the momentum for the move toward independent nursing practice (Rieu, 1994). As such, the Scope of Professional Practice (UKCC, 1992b) has been seen as an instrument offering nursing "endless opportunities" (Autar, 1996a, p984). These professional documents, then, provide a clear framework for nurses to work from and as such allow nurses the *opportunity* of developing their practice whilst being free from the shibboleths that have held them back in the past.

The second factor providing nurses with the opportunity to advance their practice relates to changes in nurse education. The move toward nursing becoming an academic discipline as well as a practical one was signalled by the introduction of Project 2000 (UKCC, 1986). This not only led to changes in pre-registration programmes of education, but also provided the platform for the subsequent development of post-registration education and training and the integration of colleges of nursing and midwifery into the Higher Education sector. Since these mergers have taken place, there has been a proliferation of academically accredited post-registration nursing programmes at both the undergraduate and postgraduate levels. The UKCC's declaration that the academic preparation for specialist and advanced practitioners is expected to be at the first and Master's degree levels respectively, has led a number of universities to design specific programmes aimed at preparing nurses to the requisite standard. As a result of such changes and new

initiatives, nurses have seen a huge increase in the educational opportunities available to them in recent years.

The third and perhaps most controversial factor that has led to the opportunity for nurses to develop and advance their practice concerns changes to the working practices of junior doctors. The NHS Management Executive (1991) proposed a 'New Deal' for junior doctors which involved a reduction in the number of hours they worked, whilst at the same time not increasing their number. This led health care trusts to confront the problem of how best they could meet the needs of the services they provided, whilst at the same time reducing the hours that junior medical staff worked. Inevitably, many trusts appeared keen to develop the route of nurses acting as partial substitutes for doctors (Cahill, 1996). However, it was not only at the individual trust level that this problem was being addressed. The Department of Health established a 'New Deal Task Force' to consider ways in which the anticipated shortfall in clinical service provision could be met. Along with the majority of health care providers, the Task Force also arrived at the conclusion that one solution to the problem was to consider the role that nurses could play in filling the gap created by doctors. As a result of these deliberations, part of the financial resources available to the Task Force was targeted at universities to encourage them to develop Master's degree programmes designed to prepare nurses as advanced practitioners. At the same time, the Task Force provided financial incentives (by way of payment of course fees and partial staff replacement costs) for trusts to release nursing staff to attend appropriate courses. The expectation of the Task Force was that subsequently, trusts would create new advanced nurse practitioner posts, which

in turn would help alleviate the problem created by the reduction in junior doctors hours. This study relates to one such initiative.

The adoption of this strategy has led to the suspicion that, the sole motivating factor for trusts to employ nurses as specialist or advanced practitioners will be for them to act primarily as *replacements* for junior doctors (Castledine, 1996). This argument is not new, as it has already been conceded that there is a trend for nurses to extend their roles and take on doctors' duties (Wright, 1991). An alternative view is that despite the potential for exploitation, a reduction in junior doctors hours can be seen as sufficient reason for nurses to expand their roles (MacAlister & Chiam, 1995). Thus, in response to those critics who view the 'New Deal' as being a strategy through which nurses can be exploited, there are those who consider that it legitimates the opportunity for nurses to develop their practice, whilst at the same time reducing junior doctor hours (Pickersgill, 1993).

These arguments draw attention to the contentious issue surrounding the difference between nurses "extending" their roles and "advancing" their practice. Extending practice, which has been the subject of a great deal of debate, is seen to be a task oriented activity undertaken for the convenience of other professionals and at their discretion (Mitchinson & Goodlad, 1996). Extending roles on such a basis could be considered to be undesirable in the continuing quest for nursing to be recognised as a professional discipline in its own right. Advanced practice on the other hand, is seen by some to centre on the core therapeutic nursing roles of nurturing and caring and is focused on the delivery of holistic patient care (MacAlister & Chiam, 1995).

Advancing practice on this basis is seen to be at the discretion of nursing and as such is viewed as being desirable professional development.

Interestingly, many of the concerns being expressed in the current debate were raised in the 1970s when there was a nationwide shortage of doctors and there were proposals that nurses might take over some of the doctor's clinical tasks and responsibilities (Castledine, 1991). The position of nursing, however, has significantly changed since the 1970s with regard to this whole issue. The UKCC have recognised that nurses are increasingly in positions whereby they could develop and advance their practice and have outlined a professional and educational framework to encourage them to do so. Furthermore, the desire of nurses themselves to advance their practice is evident from the many initiatives taking place nationwide. These have seen nurses establish new roles such as: nurse practitioners (Burgess, 1992); nurse anaesthetists (Carlisle, 1996); nurse led minor injury units (Beales & Baker, 1995); and the cardiac surgeon assistant (Holmes, 1994) to name but some. Whilst many of these developments can be linked to the political motivation of reducing junior doctors hours, they nonetheless serve to provide the *opportunity*, along with the *desire* and *recognition*, for nursing to develop and advance its own practice base.

Two further issues remain to be discussed in relation to the background of the study, namely, the differentiation between levels of nursing practice and, the absence of an agreed definition of advanced practice in the UK.

1.4 LEVELS OF NURSING PRACTICE AND THE UKCC'S POSITION ON ADVANCED PRACTICE

Following the publication of the PREPP report (UKCC, 1990) and subsequent consultation, the UKCC (1993) eventually recognized three spheres of nursing practice: primary; specialist; and advanced. The UKCC (1994c) claimed that the stratified model of nursing practice at which it had arrived was not to be viewed as a hierarchical model, but as a way of qualitatively describing the differences in the nature of nursing practice. In considering the different levels of practice, primary practice, which eventually became known as professional practice (UKCC, 1994c), relates to the level of clinical practice following initial registration and refers to the minimum level of competence required to register as a nurse. There is an expectation that this level of practitioner will continue to enhance and advance their practice in order to keep abreast of current developments. The UKCC suggested that the majority of nurses would remain in this category.

Specialist practice differs from professional practice in that it is said to require further education in order to provide the practitioner with additional knowledge and skills to be able to exercise a higher level of clinical judgement and decision making (UKCC, 1994a).

Finally, advanced practice was said to be:

> "... concerned with adjusting the boundaries for the development of future practice, pioneering and developing new roles which are responsive to changing needs and, with advancing clinical practice, research and education, to enrich professional practice as a whole". (UKCC, 1994b. p5)

The UKCC (1994c) emphasised that advanced practice is not an additional level of practice to be superimposed on specialist practice, but is more globally concerned with development of the profession in the interests of patients, clients and the health services. In describing the three levels of practice, the UKCC appeared to deliberately avoid using explicit terminology in terms of behavioural objectives, as a way of preventing the concepts from becoming rigid and fixed. Whilst this served to frustrate certain groups, the rationale for the UKCC doing so appears to be founded on a logical premise.

Following the production of a taxonomy for clinical nursing practice, the UKCC produced a set of standards for the specialist level of education and practice (UKCC, 1994a) designed at further clarifying the concept and its requirements. It was stated that the academic level of study should be no less than first degree level and that the duration of programmes leading to a specialist qualification should be no less than one academic year. Furthermore, it stated that the specialist standard of practice related to four broad areas; specialist clinical practice; care and programme management; clinical practice leadership; and clinical practice development. Each of these areas is perceived as being in accord with the clinical responsibilities of specialist practitioners and the likely demands and requirements of the organization in which they are employed (UKCC, 1994c).

Following the publication of the set of standards for specialist practice and education, there was an expectation that the UKCC would establish a similar set of standards relating to advanced practice. The UKCC set out on a long period of consultation

(Healy, 1996) in an attempt to achieve its goal of clarifying the concept of advanced practice. In the meantime, the continued absence of a set of agreed standards for advanced practice was increasingly seen to be adding to the confusion within the profession (Holyoake, 1995). Some nurses even considered the debate surrounding advanced practitioners to be nothing more than a "naval gazing" exercise and have urged for it to be dropped (Healy, 1996). Nevertheless, in the spring 1997, the UKCC publicised its agreed definitive position statement on advanced practice (UKCC, 1997a) in which it stated:

> "It was felt that there are neither agreed definitions of advanced practice nor criteria against which standards for advanced practice can be set. ... it was felt that the UKCC, while fully supporting the notion of advancing practice, should avoid setting explicit standards but should consider how specialist practice could embrace nurse practitioners and clinical nurse specialists". (p5).

It is evident from this statement that the UKCC had determined during its consultation process that most nurse practitioners and clinical nurse specialists (perceived of as 'advanced' practitioners in other countries), met the standards for specialist practice, but not advanced practice. Furthermore, the statement signalled a 'U' turn in the UKCC's position regarding the recognition of the whole concept of advanced practice. The Director of Policy Development at the UKCC is quoted as stating:

> "The notion of all practitioners advancing their practice is at the heart of the UKCC's remit of public protection through professional standards. It does not, however, make sense to label a particular activity as advanced. The UKCC is keen that specialist practice should embrace as many practitioners as possible rather than be exclusive". (UKCC, 1997a. p5).

In failing to arrive at a definition of advanced practice and subsequently, standards for advanced practice, the UKCC has sent out conflicting messages. On the one hand, it had signalled that it expects all nurses to advance their practice, whilst on the other, appears to remain ambivalent toward the concept of an advanced

practitioner. Whilst the debate concerning the concept of advanced practice seems set to continue events have overtaken the rhetoric and advanced nurse practitioners have now begun to be educated, trained and employed. The focus of this thesis concerns the transitional process of moving from a position of "experienced nurse" to "advanced nurse practitioner".

CHAPTER TWO

LITERATURE REVIEW I: THE CONCEPT OF ADVANCED PRACTICE

CHAPTER 2: LITERATURE REVIEW - THE CONCEPT OF ADVANCED PRACTICE

2.1 INTRODUCTION

The terms "advanced practice" and "advanced nurse practitioner" have and will

continue to be used extensively throughout this text. Whilst acknowledging that the

notion of advancing nursing practice appears to be generally welcomed in the UK,

the absence of an agreed definition of advanced practice and the failure to recognise

advanced practitioners, has proven problematic. In other countries, such as

Australia, Canada and the USA, these concepts have become widely accepted over

the past 30 years and during that time a substantial body of literature has evolved

relating to the many facets of advanced nursing practice. In the UK, however, there

is a dearth of empirical data and literature regarding this field of study given the

relatively early stage in the development of advanced nurse practitioners (ANPs) in

this country. Consequently, the first part of the literature review which addresses

definitions of advanced practice, models of advanced practice, and the attributes and

characteristics of advanced practitioners will by necessity draw heavily upon

international sources. Account will be taken of the trans-cultural nature of the

literature and the degree of valid transferability it has to a UK context. Relevant UK

literature will be incorporated into the review where available, however, it should be

noted that this is both limited in scope and quantity.

2.2 DEFINITIONS OF ADVANCED PRACTICE AND ADVANCED PRACTITIONERS

Defining the term advanced practice is not without difficulty (Patterson & Haddad,

1992; Davies & Hughes, 1995; Woods, 1997a). As nurses work in a wide variety

contexts and settings, definitions of advanced practice have, by their nature, tended

to remain broad in scope. The rationale for this strategy appears to be the belief that in so doing, they facilitate creativity and innovation in advanced clinical practice positions (Mirr, 1993). As already noted, the UKCC's (1994b) initial attempt at a definition of an advanced practitioner can be seen to follow this tenet when it stated that the advanced nurse practitioner will:

> "... be concerned with adjusting the boundaries for the development of future practice, pioneering and developing new roles responsive to changing needs and, with advancing clinical practice, research and education to enrich professional practice as a whole". (p5).

The use of the terms "adjusting the boundaries", "pioneering and developing new roles" and "to enrich professional practice as a whole", all indicate a lack of specificity to the definition, and at the same time place the responsibility on individual practitioners to be creative in developing their practice.

Another UK writer offers a personal view of what he believes to be the definition of advanced nurse practitioners. He states they should be:

> "Specially prepared nurses who are working in roles which demand a lot of nursing experience, education at master's degree level, and nursing skills that contribute to meeting the complex needs of vulnerable people and the need to be continuously questioning the fundamentals and boundaries of nursing". (Castledine, 1996, p288).

The definition is augmented by a list of seven categories which are proposed should form the criteria, roles and functions of advanced nurse practitioners in the UK. The categories can be seen to serve the purpose of adding a degree of specificity to an otherwise general definition. The key criteria listed for the advanced practitioner are that they should be: an autonomous practitioner; experienced and knowledgeable; a researcher and evaluator of care; expert in health and nursing assessment; expert

in case management; a consultant, educator and leader; and respected and recognised by others in the profession. This list tends to focus on a series of roles that advanced practitioners are expected to perform whilst at the same time elaborating on some of the attributes required of an advanced practitioner. However, with the exception of mentioning health and nursing assessment, the criteria stops short of identifying specific nursing practices. This approach to defining the concept of advanced practice in terms of a series of roles appears to be commonplace in the literature (see: Sparacino & Cooper, 1990; Pickler & Reyna, 1996).

Some definitions of advanced practice do not, however, limit themselves to conveying the concept of advanced practice as simply a series of roles. One of the most comprehensive and recent definitions of advanced practice is offered by the American Nurses' Association Congress of Nursing Practice, which states that:

> "Nurses in advanced clinical nursing practice have a graduate degree in nursing. They conduct comprehensive health assessments and demonstrate a high level of autonomy and expert skill in the diagnosis and treatment of complex responses of individuals, families and communities to actual or potential health problems. They formulate clinical decisions to manage acute and chronic illness and promote wellness. Nurses in advanced clinical practice integrate education, research, management, leadership and consultation into their clinical role. They function in collegial relationships with nursing peers, physicians, professionals, and others who influence the health environment". (McLoughlin, 1992. p23).

This definition identifies several features which are viewed as being nursing-focused (Mirr, 1993) and essential characteristics of advanced practice and advanced practitioners. These include:

♦ Graduate education.

♦ Expert and skilled clinicians, with the ability to not only care for, but to

diagnose and treat complex conditions.

♦ Autonomous practitioners, with the ability to formulate clinical decisions based on their clinical judgement.

♦ A health, as well as disease focus to the care they provide in their clinical role.

♦ The integration of the sub-roles of educator, researcher, manager, leader, and consultant into an eclectic clinical role.

♦ Ability to function in multidisciplinary and collegiate relationships with other professionals in the health care environment.

Whilst some may consider this definition and its characteristics to be comprehensive in nature, critics may claim it to be somewhat Utopian and concede that only in exceptional circumstances would a nurse be able to fulfil all of these requirements to maximum effect. The problems inherent in attempting to define such a complex phenomenon as advanced practice in isolation have led to a number of definitions, especially from the USA, to describe advanced practice in relation to specific practice models such as nurse practitioners and clinical nurse specialists. These models, along with others, are explored in detail later in the chapter.

To date, most definitions of advanced practice and advanced practitioners have focused on either the roles advanced practitioners undertake, or the tasks they perform. Whilst a number acknowledge that the level of academic preparation expected to become and advanced practitioner is at the Master's degree level, they fail to elaborate on the cognitive characteristics required to become a competent practitioner. Smith (1996), however, tends to emphasise the cognitive attributes above others when she states that:

"The advanced practice nurse in the Australian context is an independent nurse practitioner who uses expert problem solving skills that are a result of complex reasoning, critical thinking, and analysis to form clinical judgements. Hence, nursing practice is less likely to be a task behaviour, and practice is embedded in theory and research. The advanced practice nurse's activities are not limited to the physical and psychosocial aspects of an individual's care but ... incorporate education, research, and the contribution to health policy formulation". (Smith, 1996, p552).

In this definition, complex reasoning and problem solving skills are tied not only into patient care activities but into other activities as diverse as education and health policy formulation. Smith (1996) goes on to argue that viewing nursing practice in terms of task behaviour is unhelpful when trying to conceptualize the complexity of advanced practice. Davies and Hughes (1995) too consider that attempts to deconstruct the advanced practice role into its component parts is unhelpful. They assert that the essence of advanced nursing practice is more a "way of thinking" or a "world view based on knowledge", rather than a simply a series of roles. In the UK, Manley (1996) lends her support to the argument that the complexity of advanced practice cannot be developed or even recognised from a behaviourally-based checklist of standards. The UKCC echoed this sentiment when they arrived at a similar conclusion following the consultation exercise regarding the definition of advanced practice. They claimed that there was:

"...widespread agreement that advanced practice was not about tasks but a broader concept of nursing, midwifery and health visiting and particularly about advancing the practice of others. It was felt that a checklist of standards would conflict with the dynamic and autonomous nature of the concept of advancing practice". (UKCC, 1997b)

The definition of the concept of advanced practice is clearly equivocal. A number the definitions do share, either explicitly or implicitly, certain characteristics which appear

to be central to the notion of advanced practice. These can be summarised as comprising:

♦ Graduate education and preparation.

♦ Possession of expert clinical and cognitive skills.

♦ An expert clinician, who is both knowledgeable and experienced.

♦ Independence and autonomy in the organization of clinical practice.

♦ Role eclecticism; including the sub-roles of, clinician, educator, researcher, administrator, innovator, and consultant.

♦ Ability to function in collegiate relationships with other health care providers.

♦ A world view of advanced nursing practice which guides thinking.

Which, if any, of these characteristics take precedence, or how they are incorporated into the delivery of nursing care, depends upon the model of advanced practice adopted.

Arriving at a globally accepted definition of advanced practice then is clearly polemical, if not impossible, as any such statement would primarily serve to rigidify the concept and could potentially inhibit innovation. In the absence of such a definition, it appears logical that the notion of advanced practice is best understood and debated in terms of the series of personal and practice characteristics and attributes demonstrated by advanced practitioners.

2.3 ATTRIBUTES AND CHARACTERISTICS OF ADVANCED PRACTITIONERS

Whilst the attributes and characteristics of advanced practitioners have been alluded to in the previous discussion they generally receive little attention in the literature

(Patterson & Haddad, 1992). An overview of the limited literature highlights a number of desirable characteristics and attributes in the cognitive, affective and behavioural domains of the individual, as well as emphasising the importance of the personal and professional experience of the practitioner.

2.3.1 LEADERSHIP.

Spross and Baggerly (1989) reviewed and critiqued a number of conceptual models and frameworks of clinical nurse specialist practice and believe one of the essential attributes of the advanced practitioner to be that of effective leadership. This is not surprising as the concept of leadership is common to a number of models and definitions of advanced practice (Holt, 1984; McLoughlin, 1992; Ackerman et al, 1996; Pickler & Reyna, 1996; Manley, 1997). Patterson & Haddad (1992) emphasise that one of the properties of leadership is that it exists on more than one plane. At the higher level, they see advanced practitioners as a "major force" in moving the nursing profession forward as a whole, whereas at a lower level (but of equal importance), they see advanced practitioners being able to demonstrate the use of theory-based practice to other nurses. The latter is seen as a way establishing ANPs as clinically based leaders (Sutton & Smith, 1995). This interpretation of leadership appears to have been used by the UKCC (1994c) as one way of differentiating between specialist and advanced practice. In the case of the specialist practitioner, the UKCC anticipate that leadership will focus predominantly on clinical practice and in particular, the monitoring and improvement of standards of care at a local level. Advanced practice on the other hand, is said to be concerned with not only advancing clinical practice, but enriching professional practice as a whole, i.e. at a

higher level. Therefore, there appears to be a considerable degree of consensus that one of the essential attributes of an advanced practitioner is that of leadership.

2.3.2 CLINICAL JUDGEMENT AND DECISION MAKING

The second attribute to receive attention in the literature relates to the concept of clinical judgement and decision making. Expertise in decision making is perceived to be one of the distinctive attributes of the advanced practitioner (Snyder & Yen, 1995). Whilst the terms clinical judgement and decision making are sometimes used interchangeably, they can in fact be viewed as distinct entities. Clinical judgement concerns the ability to make distinctions between different conditions and situations, whereas decision making is the process of arriving at an appropriate course of action based upon one's clinical judgement. In this way, it is acknowledged that one informs the other and that in the case of advanced practitioners, autonomous decision making is validated by advanced clinical judgment (Joynes, 1996).

Spross and Baggerly (1989) describe decision making as a complex intellectual process which others have argued is influenced by the two essential factors of knowledge and experience (Watson, 1994). Clinical judgement and decision making are consequently seen to be reliant upon:

> "...the interaction and integration of graduate education in nursing practice [providing the knowledge] and years of clinical experience" (Spross & Baggerly, 1989, p20).

It is believed that this combination enables advanced practitioners to exercise clinical judgement at an advanced level (Snyder & Yen, 1995). Interestingly, the UKCC's (1994a) expectation of the specialist practitioner, not only the advanced practitioner,

25

is to possess the ability to make clinical judgements at a higher level, although the educational preparation required for such is only considered to be necessary at the first degree level. The absence of studies comparing the clinical judgement of advanced (USA & UK) and specialist (UK only) practitioners prevents the qualitative differences between the two groups being elicited.

2.3.3 PERSONAL QUALITIES

Unlike decision making and leadership, which to some degree can be considered to be observable behaviours and learned attributes, the affective characteristics inherent in the individual can neither be easily learned or observed. Yet these attributes are seen to be of importance in distinguishing advanced practitioners from other nurses. Patterson and Haddad (1992) list a number of such attributes including, being a risk taker and willing to 'bend' the rules (Sutton & Smith, 1995); being a visionary to utilise and guide nursing research; having an inquiring mind to participate in research, and being flexible and open to new ideas. In addition, it has been suggested that advanced practitioners value the uncertainty generated in practice situations, by identifying it as an opportunity for growth and further development (Sutton & Smith, 1995). Whether each of these attributes is present in all advanced practitioners is difficult to confirm.

2.3.4 COGNITION AND KNOWLEDGE BASE

O'Rourke (1989) emphasises the cognitive attributes of advanced practitioners which are implicit in some of the characteristics previously discussed. She suggests that advanced practitioners have the capacity to self-direct; modify theory to practice

implementation; re-perceive knowledge and/or re-arrange it to develop new theory; transfer knowledge; and introduce new learning. For some, these attributes characterize the notion of critical reflection (Sutton & Smith, 1995), along with competence in critical thinking and analysis, and are considered to be essential characteristics of advanced nursing practice (Davies & Hughes, 1995). It is attributes such as these which underpin the belief in the importance of graduate education, which is seen to provide a comprehensive knowledge base for advanced practitioners in their practice (Calkin, 1984; King et al, 1996). A highly developed knowledge base and the cognitive capacity of deliberate reasoning, combined with intuition and experience enables advanced practitioners to perceive situations in new ways and to develop their clinical practice accordingly (Calkin, 1984; Joynes, 1996).

Arguably, many of these personal characteristics and attributes are present to some degree in the majority of nurses, yet not all nurses are perceived to be, or perceive themselves to be, advanced practitioners. Patterson & Haddad (1992) account for this difference when they argue:

> "While countless numbers of nurses may be well developed in one or more of these attributes, it is not until all are present in combination that the nurse may be clearly identified as one who is practicing at an advanced level; who is continuously growing and developing professionally; and who is leading and contributing to the growth and improvement of nursing" (p19).

The attributes and characteristics of the practitioner clearly underpin the concept of advance practice, regardless of the operational or conceptual model adopted, or the environment in which practice occurs. Arguably, such attributes are as important as

27

the roles which advanced practitioners are expected to perform, or the skills they possess, however, they are far more difficult to observe, measure or quantify. Consequently, the literature tends to be dominated by the roles and functions advanced practitioners perform, with the result that various operational and conceptual models have evolved over recent years.

2.4 MODELS OF ADVANCED PRACTICE

A variety of roles have been developed within the nursing profession, all of which claim to be forms of advanced practice (Patterson & Haddad, 1992). The practice model adopted by a practitioner is determined by a multiplicity of factors, including: the nature of the clinical environment; the needs of the patient/client group; deployment and organizational goals; the preparation of the advanced practitioner; local and national regulations governing nursing practice; and, not least of all the philosophy of the individual practitioner. This results in variations in the way in which advanced roles are operationalized (Russell & Hezel, 1994) with the consequence that a number of differences both within and between categories of advanced practitioners are evident (Patterson & Haddad, 1992).

Traditionally, advanced practitioners have been differentiated by the roles and functions they perform, and the setting in which practice takes place (Pickler & Reyna, 1996). In the USA, the term 'advanced practice' describes four categories of practitioner (Uckan et al 1994); Nurse Practitioners (NP); Clinical Nurse Specialists (CNS): Certified Registered Nurse Anaesthetists; and Certified Nurse Midwives (Mirr, 1993; Bachus, 1995). In the context of this review, these are referred to as

operational models[1]. In addition to the operational models, a number of *conceptual* models of advanced practice have been posited in an attempt to explain the unique characteristics of advanced nursing practice. These models are abstractions and attempt to locate the construct of advanced practice into conceptual frameworks. *Conceptual* models of advanced practice are discussed later in the chapter (see 2.5).

2.4.1 OPERATIONAL MODELS OF ADVANCED PRACTICE

2.4.1.1 THE NURSE PRACTITIONER MODEL

The nurse practitioner role is considered to have developed as a result of a collaborative venture between nurses and physicians responding to changes in the US health care delivery system and a maldistribution of providers in the late 1960s (Fenton & Brykczynski, 1993). The main role was perceived to be one of a provider of patient care (Ford & Silver, 1967) with nurse practitioners being traditionally employed in primary or ambulatory care settings in the USA (Mirr, 1993). Educational programmes to prepare nurses to become nurse practitioners took a life course focus, as opposed to a disease or discipline focus. Consequently, nurses were prepared as either paediatric nurse practitioners, adult nurse practitioners, family nurse practitioners and more recently, gerontological nurse practitioners.

The delivery of health care has, however, changed rapidly in recent years (Watts *et al*, 1996) and has resulted in the movement of nurse practitioners into acute care settings (Keane *et al*, 1994). Amongst the reasons cited for the shift toward acute

---

[1]The review will not include literature pertaining to Certified Registered Nurse Anaesthetists or Certified Nurse Midwives, as both these unique roles are peripheral to the focus of this thesis.

care nurse practitioners is the:

"... response to social and financial pressures, anticipated residency shortages, and an anticipated decrease in existing barriers to practice" (Keane et al, 1994, p232).

Arguably, a number of these factors are reflected in the UK health care system and account, at least in part, for the movement toward the expansion of nurses' roles and responsibilities in this country.

The demand for nurse practitioners was such that a proliferation of certificate level and continuing education programmes were developed (NONPF, 1990). A particular problem with these courses was that they varied both in level and duration (Kitzman, 1989). However, the number of non-degree courses has been on the decrease in recent years, and correspondingly, the number of Master's degree courses on the increase (NONPF, 1990).

The nurse practitioner role has traditionally had a uni-dimensional focus, primarily concerned with the direct delivery of patient care (Kitzman, 1989). Practice has been identified as including; physical and psychosocial assessment; history taking; physical examination; ordering and interpreting diagnostic investigations; and developing and implementing therapeutic interventions in collaboration with other health care providers (Ford, 1979). Nurse practitioners are generally afforded prescriptive privileges in the USA, although there is considerable variation to the limitations of prescriptive authority from state to state (Pearson, 1995).

To summarise:

> "Nurse practitioners provide primary health care services to clients - individuals, families, and groups - emphasizing the promotion of health and the prevention of disease. They manage actual and potential health problems, which include common diseases and human response to disease. Consultation and referral occur as needed..." (American Nurses' Association, 1987, p2).

The nurse practitioner is increasingly prepared at the Master's degree level and is perceived to possess advanced clinical skills and reasoning, as well as being afforded prescriptive privileges.

2.4.1.2 NURSE PRACTITIONER MODEL IN THE UK.

The ability to make comparisons between nurse practitioners in the UK and those in the USA is limited. The UKCC (1997a) consider that the majority of nurse practitioner graduates in the UK fulfil the requirements for the specialist level of practice, as opposed to advanced practice. This is due in part to the notion that the nurse practitioner role is considered to consist of nurses taking on technical or medically related tasks and procedures (Castledine, 1994). The UKCC's decision is also likely to be influenced by the level of academic preparation of nurse practitioners, which has been shown to be inconsistent in terms of both academic level and duration. This is illustrated by the preparation to become a nurse practitioner ranging from a few study days (Howie, 1992; Jones 1994), to a four month training programme (Burgoyne, 1992), and in one instance, a 2 year part-time diploma programme (Simon, 1992). To meet the criteria for advanced practitioners laid down by the UKCC, the level of academic preparation would be expected to be at least Master's degree level, which the above clearly fail to achieve.

Further variance in the standard of preparation and orientation of nurse practitioner practice can be explained by the way in which the development of such posts have tended to be in response to local initiatives, as opposed to a national strategy or training programme. As a result, nurse practitioners are deployed sporadically throughout all levels of the health care system and work in a variety of contexts, including; in primary care with General Practitioners (Stilwell et al, 1987); in accident and emergency departments (Howie, 1992; Burgoyne 1992; Jones, 1994) and in nurse practitioner led clinics (Hill, 1992). Whilst the nurse practitioner undertakes activities and possess skills not performed by other nurses, their scope and sphere of practice is limited when compared to many of their US counterparts. The one exception to this rule appears to be in the emergence of advanced neonatal nurse practitioners ,whose role appears to be similar to that of their counterparts in the USA (Doherty, 1996; Dillon & George, 1997).

Whilst variations in the context and practices of nurse practitioners inevitably exist in the USA, there remains a general consensus with regard to the expectations of the level of preparation and clinical practice. In addition, in the USA each state has its own regulatory procedure and strict credentialing system determining the scope of practice of advanced practice nurses (Pearson, 1995). A similar framework is not in existence in the UK and consequently, there is a huge variation in the preparation and practice of nurse practitioners. Work is currently being conducted to identify and map the competencies and parameters of the nurse practitioner role (Cameron, 1998; Roberts-Davis et al, 1998) so that a clearer picture of nursing development in this area can be assessed.

2.4.2 THE CLINICAL NURSE SPECIALIST MODEL

The development of the CNS role is said to be largely attributed to the rapid progress made in medical technology in 1960's and the subsequent need for specialised and complex nursing care (Menard, 1987). The development of CNS practice has therefore taken place predominantly within hospital settings (Mirr, 1993). The primary purpose of the CNS role was seen as being to improve patient care (Crabtree, 1979; Holt, 1984). The title of "clinical nurse specialist" in the UK however, was not in common usage until the late 1980's (Manley, 1997) and even then roles were notably different in their orientation, scope and preparation (Manley, 1993). As in the USA, the development of the CNS role in the UK has been linked to the technological explosion in health care and has resulted in a plethora of different titles. In most cases, specialisation appears to reflect an associated medical discipline (Pickersgill, 1995) as opposed to a life course focus, such as, clinical nurse specialist in epilepsy or, clinical nurse specialist in diabetes. Whereas in the USA the CNS is acknowledged as an advanced practitioner, the UKCC consider the majority of their UK counterparts to be practising at a specialist rather than advanced level of practice (UKCC, 1997a).

In the USA, only clinical nurse specialists are *required* to possess a Master's degree in order to practice (American Nurses' Association, 1986). In the UK, whilst some CNSs possess Master's degrees, the usual route to clinical nurse specialist practice has been via the accumulation of knowledge and experience over an extended period of time. There are no university programmes specifically designed to prepare clinical nurse specialists and consequently, there is widespread variance in the level

of type of preparation in the UK (Woods, 1997a).

The CNS role is widely acknowledged as being multidimensional and multifaceted (Kitzman, 1989).

> "The clinical nurse specialist ... is an expert in clinical practice, an educator, a consultant, a researcher, and administrator..." (American Nurses' Association, 1986, p2).

However, while providing some direct care, the CNS spends more time in consultation, education and administration (Kitzman, 1989) and less on research (Cooper & Sparacino, 1990), despite expert practice being originally conceived as the pivotal role (Keane *et al*, 1994). In stark contrast to nurse practitioners, clinical nurse specialists have generally been denied prescriptive authority privileges in the majority of states in the USA. Wolf (1990) asserts that over time the CNS role has been diverted from its original purpose, i.e. that of providing specialised nursing care and, that administrators have deployed their expertise in order to meet broader institutional needs. Furthermore, Hamric (1989) asserts that some nurses use the title of CNS as a mark of educational or clinical prestige, rather than a title that describes their role function.

To summarise, the clinical nurse specialist model of practice has a wider scope of practice, in terms of education, consultation, research, administration and policy development, as well as the delivery of direct patient care. CNSs generally practice in secondary and tertiary care settings in the USA, whilst in the UK, some practice in primary care. The CNS must be prepared at the Master's degree level in the USA, but not so in the UK. CNSs work in collaborative relationships with other health care

workers and administrators, but are not afforded the prescriptive privileges given to nurse practitioners.

2.4.3 THE ECLECTIC MODEL: CLINICAL NURSE SPECIALIST / NURSE PRACTITIONER

The clinical nurse specialist and nurse practitioner roles were conceived to meet different aims and objectives, yet in recent years there has been increasing debate in USA regarding the merits of merging the two roles into one advanced practice role (Page & Arena, 1994). The premise underpinning this idea is that the uniqueness of each role has blurred over time (Pickler & Reyna, 1996). Disagreements with regard to the direction, desirability and feasibility of such a merger are commonplace (Hanson & Martin, 1990). Whilst the two roles have claims to distinct functions, it is also claimed that many of their facets can be effectively interfaced (Ditzenberger *et al*, 1995). Mirr (1993) argues, however, that the evolution of these two roles should not be considered as one moving into the setting of the other:

> "...but, rather, an advanced practice role that uses multiple practice models and a variety of settings" (pp599-600).

It has been suggested that as roles begin to merge, practitioners will be known as Advanced Practice Nurses (Monicken, 1995) and evidence exists to suggest that this change in nomenclature has already begun to take place (Uckan *et al*, 1994).

Unsurprisingly, as the eclectic model clearly acknowledges its origins in both the nurse practitioner and clinical nurse specialist movements, the trend for programmes of education to prepare such practitioners is at the graduate level (Hunsberger *et al*, 1992). The development of Acute Care Nurse Practitioners (ACNP) can be viewed

35

as an eclectic model of practice, incorporating both roles. Ackerman *et al* (1996)

consider:

> "The acute care NP is a clinician who combines the clinical skills of the NP
> with the systems acumen, educational commitment, and leadership ability of
> the CNS". (Ackerman *et al*, 1996, p69).

Ackerman *et al* (1996) describe the model as consisting of five domains of practice;

direct, comprehensive care; support of systems; education; research; and publication

and professional leadership. The first domain, direct, comprehensive care, is closely

allied to the primary function of the nurse practitioner, whereas the latter four

domains can be considered to be akin to the traditional CNS role. Ackerman *et al*

(1996) go on to mention that individual practitioner circumstances will determine

differing degrees of emphasis on each domain. Thus, it can be argued that there is

a strong likelihood that a number of ACNPs will act in *either* primarily a NP role, with

emphasis on the first domain, or in a CNS role, with emphasis on the latter four

domains. Cognisant of this fact, Ackerman *et al* (1996) state that to maximize the

role to its full potential requires involvement in all the domains.

That this represents an eclectic model is questionable, as it appears the nurse will

be acting in one advanced practice role or the other at separate points in time.

Rather than representing role eclecticism, this model appears to represent role

'dualism'.

In Canada, there is once again evidence that attempts have been made to develop

an eclectic model of advanced practice in the acute care setting. Hunsberger *et al*

(1992) conducted a survey of 655 health care professionals in the speciality of

neonatology in Canada and the USA to help them determine the role components and educational requirements for the advanced practitioner in neonatal care. The results of the survey indicated that four domains of practice were (once again) identified as clinical practice, education, research, and administration. All of these domains are present in the CNS model of practice, however, of notable difference is that Hunsberger *et al* (1992) cite that the majority of time is given to the clinical practice domain, varying between 70-75% depending on the individual interests of the institution. On the basis of their findings they adopted a designation of "clinical nurse specialist/neonatal practitioner" on the assertion that the title reflected the merger of the two existing roles. Interestingly, this title has been singled out by the Department of Health in Ontario, Canada, as adding to the confusion surrounding the titling of advanced practitioners (Ministry of Health, Ontario, 1994).

Ditzenberger *et al* (1995) also describe how the CNS and NP roles were merged into an eclectic model, once again in the neonatal care setting in the USA. In this eclectic model, the original intent was to allot equal time (2 month rotations) to the *distinct* roles of CNS *and* the neonatal NP. The stated aim of the neonatal nurse practitioner role was to provide direct patient care and clinical management of neonates in conjunction with medical staff, as well as covering for junior medical staff during nights, evenings and weekends. The alternating two month period was intended to involve the practitioner in the CNS role which included:

> "...a variety of functions related to clinical practice, education, administration, consultation and research." (Ditzenberger *et al*, 1995, p47).

The authors claim that despite the bi-monthly allocation into each role, that the:

"reality is that the NNP-CNS practice has evolved into a melding of the two roles" (p51).

A melding of the two roles seems unlikely, however, if, as the authors suggest, the activities of the practitioner are dichotomised to such an extent.

2.4.4 NURSE CONSULTANT MODEL

The use of the term consultant in the title of advanced nurse practitioners is used more extensively outside of the USA, such as in the UK and Australia (Wright *et al*, 1991; Wright, 1994; Mills, 1996; Smith, 1996; Manley, 1997). The nurse consultant appears to be predominantly employed in secondary or tertiary care settings. As with other advanced practice roles, the expectation is for the practitioner to be prepared to the Master's degree level (Pearson, 1983; Benner, 1984; Wright *et al*, 1991; Manley, 1997).

Wright *et al* (1991), describes the Consultant role in the context of elderly care in the UK as comprising four sub-roles: management/administration; research; education; and practice. Whilst the latter three sub-roles, relate directly to the American CNS model, the role of manager/administrator is slightly different. Wright *et al* (1991) suggests that such a role is necessary to be able to use:

> "...a variety of creative ways of getting around the bureaucracy to meet the needs of nurses, patients and families" (p33).

Wright (1994) attempts to explain the uniqueness of the consultant nurse by defining what he calls their *modus operandi* in terms of the nature of the consultations they perform. He emphasises the concept of consultancy in terms of a "person providing

38

professional advice". However, he goes on to suggest that in two types of consultation, patient-centred and education-centred, that the consultant may actively engage in providing direct patient care or participate in the teaching and development of an educational programme. The notion of the consultant taking a caseload and delivering direct care has, however, been challenged by Kohnke (1978), who asserts that consultant nurses delivering direct care reduce their effectiveness by limiting the number of nurses they can work with in a consultancy capacity. In his argument, Wright (1994) draws on the analogy of management consultants and marketing consultants in describing the concept of consultancy and applying it to a nursing context. It seems unlikely however, that a management or marketing-consultant would actively engage in the fundamental activities of the organization about which they were asked to consult, as is suggested by Wright (1994). The key difference appears to be that the nurse consultant may be a full-time employee of the organization, as opposed to an independent consultant, as is more likely the case in management or marketing-consultants.

Mills (1996) asserts that two key features define consultancy in relation to advanced practice:

> "First consultancy is acknowledged as a specific part of the role and second that the advanced practitioner is not only an expert in nursing practice but that he or she also has a range of other skills, for example in management and research". (p36)

In this definition, it is difficult to see how the nurse consultant differs from a CNS, whom would meet both the criteria suggested. This is confirmed further when Mills (1996) outlines the role components involved in the consultancy role to be virtually

identical to those of the CNS described elsewhere.

In the case of the nurse consultant role in Australia, Smith (1996) identifies that it bears similarities to *both* the clinical nurse specialist and nurse practitioner role reported in the northern hemisphere literature. The CNS title, already in use in Australia, appears to be employed in a different context. However, in describing the nurse consultant role it is clear that the elements of clinician, educator, researcher and consultant are, once again, all present.

When Manley (1997) described the development of an "advanced practitioner / consultant nurse" role as part of an action research project in the UK, she acknowledges using the role description of the CNS outlined by Hamric (1989) as a starting point in the absence of any other available framework. Manley (1997) states however that as a result of analysis of the action research project with which she was involved, that in addition to the four sub-roles previously identified, with which she identifies some similarities, the additional role of 'transformational leadership' was developed. This concept, described by Sashkin & Rosenbach (1993), involved the advanced practitioner/consultant nurse facilitating a cultural change in which the staff on the unit in which she worked were encouraged to become leaders. As pointed out earlier however, leadership is viewed as an essential attribute of all advanced practitioners and is not solely the prerogative of nurse consultants.

2.4.5 THE NURSE CLINICIAN MODEL

The term nurse clinician is attributed to Reiter in the 1940s (Reiter 1966) and

although the term is used less frequently than others, it has been used in a variety of contexts. Tschetter & Sorenson (1991) attempt to differentiate a nursing post they refer to as a "neonatal nurse clinician/practitioner" from other expanded roles in neonatology. They explain that the nurse clinician role involved additional post-registration education, of relatively short duration and that the title was used to differentiate between the educational level, expertise and authority to practice of the nurse clinician/practitioners and other advanced practitioners. Such was the degree of confusion surrounding the titling and certification of nurse clinician/practitioners, coupled with the move toward graduate preparation (Johnson, 1989), that in neonatology the term "neonatal nurse clinician" has been replaced by the term neonatal nurse practitioner.

The nurse clinician model can also be discussed in a UK context. The term arose out of an invitation of a UK university to tender for designing a course to prepare nurses to take on the role specified by a Regional Health Authority (Gibbon & Luker, 1995). As with other advanced practice models discussed, emphasis is placed on a Master's degree preparation for the role of nurse clinician.

Gibbon & Luker (1995) claim that the vision of their university was to produce a:

> "...'bicultural nurse clinician' who is able to work in both primary health care and hospital settings" (p165).

This is different from advanced nurse practitioners who have outpatient and in-patient roles (Uckan et al, 1994) and also differs from the other models presented, inasmuch that the post of nurse clinician does not appear to be context specific. In

doing so, the model adopts a generalist approach, as opposed to the specialisation seen in other practice models.

When considering the role specification more closely, the components of nurse clinician practice can be considered to be similar to that of the USA nurse practitioner. From the role specification outlined, rather than any operationalized evidence, emphasis is placed on: history taking; physical assessment and diagnostic assessment; planning care; referring for investigations and diagnostic tests; participation in health education activities; collaborating with other disciplines in patient management; and prescriptive privileges. All of these components are present in the NP role outlined earlier. The main difference appears to be in the context of which care takes place. In the USA, the NP role is determined by a discipline or life course focus, eg; neonatal nurse practitioners, adult nurse practitioners and so on, who work in *either* primary or secondary/tertiary care settings. The nurse clinician is said to be able to function in both settings, however, with the present demarcation between primary care trusts and hospital trusts, it is difficult to see how this role could be widely operationalized as predicted.

2.4.6 OPERATIONAL MODEL SUMMARY

Whilst there are some differences in emphasis within each practice model presented above, there are many similarities. Two operational models appear to dominate, the CNS model, with a prominent focus on the 'system' of care and care provision and, the NP model, with a prominent focus on the 'recipient' of care and care delivery. The eclectic clinical nurse specialist/nurse practitioner model, which claims equal focus

is problematic. The writers who claim this model of practice to be effective have a tendency to describe role dualism as opposed to role eclecticism. They envisage the practitioner acting in *either* a CNS type role or a nurse practitioner capacity at different times. Consequently, they appear to have in effect failed to achieve an integrative model of practice to which they appear to have originally aspired.

As for the other models of practice, arguably, the nurse consultant model shares so many similarities with the CNS model of practice that the two could be subsumed into one role. Likewise, the nurse clinician model shares so many similarities with the NP that the two accounts are virtually describing the same role. A summary of the four operational models outlined above are presented in Table 1.1

2.5 NURSING VERSUS MEDICAL MODEL OF ADVANCED PRACTICE

The discussion of models of advanced practice cannot be complete without reference to the arguments which often prevail regarding to which practice paradigm advanced practitioners belong, nursing or medicine. In the UK, this argument has been fuelled by the prospect of nurses expanding their roles into activities that were once the prerogative of doctors. The predictable result is that nurses have been accused of becoming doctor substitutes or 'mini-doctors' (Castledine, 1995; Mathieson 1996) and consequently have been considered to have their identity closely aligned with medicine rather than nursing. Recent developments, such as the role of nurse surgical assistant (Tuthill, 1995), whose explicit objective is to provide assistance to the surgeon with the aim of reducing the number of junior doctors' hours, is clearly

Table 1:1 Similarities and Differences in Four Advanced Practice Roles:

Role Title>:	Nurse Practitioner	Clinical Nurse Specialist	Nurse Consultant	Nurse Clinician (UK only)
Educational Preparation	*US*: Majority are now at Masters Degree level. *UK*: Inconsistent level and duration of preparation (See Jones, 1994; Howie, 1992).	*US*: Compulsory to hold a Masters Degree (ANA, 1986). *UK*: Widespread variance in the level and type of preparation	*US & UK*: Expectation to be prepared to at least Masters Degree level (Benner, 1984; Pearson, 1983).	*UK only*: Preparation at Masters Degree Level (Gibbon & Luker, 1995)
Practice Environment	*US*: Predominantly employed in primary care / outpatient settings. Increasing acute care emphasis (Hravnak *et al*, 1995). *UK*: Sporadically employed throughout primary and secondary care settings (Simon, 1992; Burgoyne, 1992).	*US*: Majority of CNSs employed in secondary / tertiary care settings (Sparacino, 1993). *UK*: Majority of CNSs employed in secondary / tertiary care settings, with an increasing minority in primary care	*US & UK*: Far from clear. Likely to be employed in secondary care / nursing development units, comprising a number of wards (Wright *et al*, 1991)	*UK only*: Able to work in either primary care or hospital settings. (Gibbon & Luker, 1995)
Principle Practice Focus	*US & UK*: Delivery of direct nursing care to a defined patient caseload	*US & UK*: Tendency for disease or discipline focus. Disparate & widespread, large patient population. Large portion of time involved in indirect care activities, eg education	Acts as an interface between the 'organization' and unit nursing staff. Discipline focused & unit based, eg elderly care. Delivers expert direct care & acts as change agent (Wright, 1986).	*UK only*: Delivery of direct patient care in collaboration with other health care team members, to a defined patient caseload. (Gibbon & Luker, 1995)
Practice Characteristics	*US*: Advanced practice includes; history taking, physical assessment, diagnostic assessment, prescription of investigations, treatments and drugs, and evaluation of nursing practice. *UK*: Similar, but far more limited in scope of practice	*US & UK*: Spend majority of time on education, policy formulation, and consultation. Time involved in direct care and research is limited (Cooper & Sparacino, 1990).	Wright *et al* (1991) construct the role as having four components; i) monitoring & evaluating practice, ii) education of unit staff, iii) Research, & iv) Management and administration activities	Many of the role components, such as assessment, history taking and diagnostic assessment, mirror the *US* nurse practitioner role.

foundation for such an argument.

In examining the practice of advanced practitioners, there is clearly evidence that nurses are able to undertake many of the activities, traditionally viewed within the realm of medicine, and perform them with equal competence. Both in the USA and the UK, studies have been undertaken which compare the performance and effectiveness, in particular, of nurse practitioners and doctors (Touche Ross Management Consultants, 1995; Greenhalgh & Co Ltd, 1994; United States Congress, Office of Technology Assessment, 1986; Salkever *et al*, 1982; Sox, 1979; Spitzer *et al*, 1974). It can be argued, that whilst such studies attempt to demonstrate the advanced characteristics of nurse practitioners and compare them with those of doctors, that an inevitable consequence of such studies, is to locate the concept of advanced nursing practice within a medical paradigm. Smith (1995) argues that in the USA, advanced nursing practice has been nurtured by the medical model and in the process is at risk of being defined by the medical model, in terms of:

> "...an expanded knowledge base to support diagnosis, prevention, and treatment of disease" (Smith, 1995, p2).

She argues that in so doing, advanced practice nurses define themselves as physician assistants or as a physician extension, as opposed to filling the identified gap in health care with a core of nursing practice.

The argument then, as to whether an advanced practice nurse's philosophical base stems from a medical or nursing paradigm is often a sophistry, as the real debate is founded on the medicalized tasks that such nurses are perceived to perform.

Consequently, some advanced practice nurses, in particularly nurse practitioners whose role has a uni-dimensional focus and are seen to able to perform procedures and tasks associated with medical practice, are more likely to be labelled as practising from a medical model. It is often this aspect of the role that is overemphasized (Casey, 1995). Alternatively, clinical nurse specialists, whose role has a multidimensional focus involving the patient, nursing staff *and* the organization, are more likely to be seen to be practising from a nursing model. Advanced practice nurses themselves, whether they be CNSs or NPs, would argue that they practice primarily from a nursing paradigm (Garland & Marchione, 1982; Thibodeau & Hawkins, 1994), but are able to incorporate medical tasks and procedures into their work with patients when required and where permitted.

Upon closer scrutiny, the nursing versus medical model debate, primarily revolves around two issues: the *deployment* of nurses to provide a service (or part thereof) previously provided by another health care worker, usually a doctor and the performance of procedures and tasks predominantly associated with being medical in orientation. This has led to what Thibodeau & Hawkins (1994) call "role parallelism", whereby some practitioners imitate a medical ethos and physician behaviours in order to boost their role confidence. However, Thibodeau & Hawkins (1994) concluded from their study involving 482 nurse practitioners, that:

> "...nurse practitioners...see themselves as nurses with a broader focus than that inherent in the medical paradigm" (p215).

It appears that advanced practice nurses predominantly see themselves functioning within a nursing framework (Snyder & Yen, 1995). It is argued, however, that some

practitioners fail to explain the specialist nursing knowledge they possess in relation to their field of practice in favour of emphasising the skills and knowledge they have gained from medicine (Chickadonz & Perry, 1985). It is this trait that appears to label advanced nursing practice as originating from a 'medical model'.

The real debate then has little to do with the foundation of a philosophical basis for guiding nursing practice and more to do with how clinical practice is organised, along with the additional skills that some nurses possess. The argument of advanced practitioners practising from either a nursing or medical model is therefore spurious and misleading and serves only to cloud our present understanding of advanced nursing practice (Bajnok, 1988).

2.6 CONCEPTUAL MODELS OF ADVANCED PRACTICE

The operational models of advanced practice discussed above tend to be defined by their behavioural characteristics and categorised in terms of roles, sub-roles and functions that different practitioners perform. A number of authors have attempted to conceptualise advanced practice by means other than simply describing behavioural characteristics and roles. In the early 1980s, at a time of general proliferation of nursing models and theories, a selection of practitioners and theorists devised or adapted abstract models in an attempt to capture the unique essence of the concept of advanced practice (Roy & Martinez, 1983; Holt, 1984; Calkin 1984; Russell & Hezel, 1994).

Conceptual models have been defined as a systematically constructed, scientifically

based and logically related set of concepts which identify the essential components of nursing practice together with the theoretical basis of these concepts and the values required for their use by the practitioner (Riehl & Roy, 1980). The main difference between conceptual models of advanced practice and the proliferation of nursing theories that were characteristic of the 1980s, is that the former were 'practitioner' centred whilst the latter emphasised the centrality of the 'patient'. This review will be restricted to conceptual models of advanced practice as nursing theories and models have been extensively reviewed elsewhere (see: Riehl & Roy, 1980; Aggleton & Chalmers, 1984; Fawcett, 1989; Chinn & Kramer, 1991).

Roy and Martinez's (1983) conceptual framework for clinical nurse specialist practice adapted systems theory, used in a number generic nursing models, as its basis for explaining CNS practice. Using systems theory principles of input, process, output and feedback, Roy and Martinez (1983), attempted to synthesise a framework for clinical nurse specialist practice. This cyclic feedback model was depicted as having internal and external 'inputs' to the system. Internal inputs included the education, experience, personality and socialisation of the CNS, whereas external inputs included placement in the organization, support of staff and peers, and so on. In terms of processes, the model discriminates two types of processes, regulatory and cognatory. It is in the cognitive processes that the CNS is perceived to be highly developed in terms of: processing information; clinical judgement; affective appraisal; collaboration; and accountability. The output of the system is in terms of the direct and in-direct care activities performed by the CNS and their effects on nursing practice. Self perceptions of role behaviour and formal evaluation provide feedback

48

to the system inputs and determine if adjustments to internal and external inputs need to be made.

Roy and Martinez (1983), conclude that it is cognitive processes which distinguish CNS practice from that of other nurses, in terms of their clinical judgement, collaboration and accountability. They suggest that the model can be used by the CNS to understand their practice and that the framework can be adapted and used as a framework for understanding individuals or groups of patients and staff. Like many nursing models, it has been devised as an abstraction and remains virtually untested. Its accuracy, use or benefit in explaining advanced practice at best remains questionable.

Other authors have attempted to adapt existing models of nursing on the same basis. Russell & Hezel (1994) used Neuman's Health Care Systems model as a framework for role analysis, development and enactment. They suggested that the model served to provide role clarity for the advanced practice nurse. Thus, rather than the model explaining the concept of advanced practice, it was suggested that its primary use was to help advanced practitioners analyse a particular job, with the aim of clarifying role components, anticipating problems and, developing prevention strategies. The model relied on describing advanced practice as a series of sub-roles which whilst using slightly different terminology, have all been previously identified.

The model may well prove to be of benefit to advanced practitioners, although once again there is no evidence to suggest that the model has been used or evaluated and

consequently it provides little basis for understanding the concept of advanced practice in a wider context.

Holt (1984) once again theorized a model for clinical nurse specialist practice which was based upon personal observation but remains un-tested. Whilst referring to the operational model of CNS practice in terms of the established sub-roles, she emphasized the importance of communication skills and interpersonal relationships in addition to clinical expertise. She went on to discuss the dynamic nature of the CNS role in terms of not only practice but the necessity to continue to expand clinical knowledge. The integration of these four components were seen as crucial in achieving the objective of the CNS role, namely to improve patient care. Like Roy and Martinez (1983), Holt (1984) identified the cognitive abilities of the CNS as being indicative of the level of practice in terms of their ability to connect concepts, process and determine interventions and predict outcomes. Holt's (1984) main thesis focused on the CNS as an instigator of change at the unit, speciality and institution levels with the goal of improving patient care. Key to achieving change was the CNS's ability to communicate effectively, problem solve and establish collaborative relationships at a range of organizational levels. The model identified the key concept of leadership as facilitating the CNS to influence the quality of nursing care for a large group and range of patients. The model thus attempted to explain advanced practice as an integration of roles and essential characteristics in order to achieve the primary goal of change.

Calkin's (1984) model for advanced nursing practice takes a different starting point

to those discussed above. It attempts to conceptualise the difference between advanced practitioners, general nurses, and nurses categorised as experts by virtue of their experience in practice. The model was initially devised to help administrators determine when to employ advanced practitioners. The author argues that the model can be used to explain the rationale for using advanced practitioners in a particular practice position.

The model's development and utilisation stems from a definition of nursing by the American Nurses Association (1980) in which nursing is defined as the diagnosis and treatment of human response to actual or potential health problems. Calkin (1984) asserts that nurses deal with a population of responses ranging along a continuum from the negative, to the positive, with the usual range of responses occurring between the two. She argues that these responses exist as a distribution (curve) with extreme responses at either end and the mean responses plotted in the middle third (as in a normal bell shaped distribution). She uses this population of responses to explain the levels of knowledge and skills exhibited by three groups of nurses: novice practitioners; experts-by-experience; and graduate prepared advanced practitioners. She argues that novice practitioners (illustrated in Figure 2.1) are only able to deal with a narrow range of "usual" responses of patients, as their knowledge, diagnostic and treatment skills are limited. Furthermore, she argues that in some circumstances, the knowledge level of novice nurses exceeds their skill level. The result, graphically displayed, is a wide gap between the population of responses and below, the knowledge and skill of the novice nurse. She then attempts to illustrate the same process for what she terms, expert-by-experience nurses who are acknowledged as

Figure 2.1 Population of human responses to health problems and the
relationship of the knowledge and skill level of novice nurses
(source: Calkin, 1984).

Knowledge &
Skills Needed
& Available

Population of responses

Knowledge level

Skill level

Negative
responses

Usual
responses

Positive
responses

Novice nurses
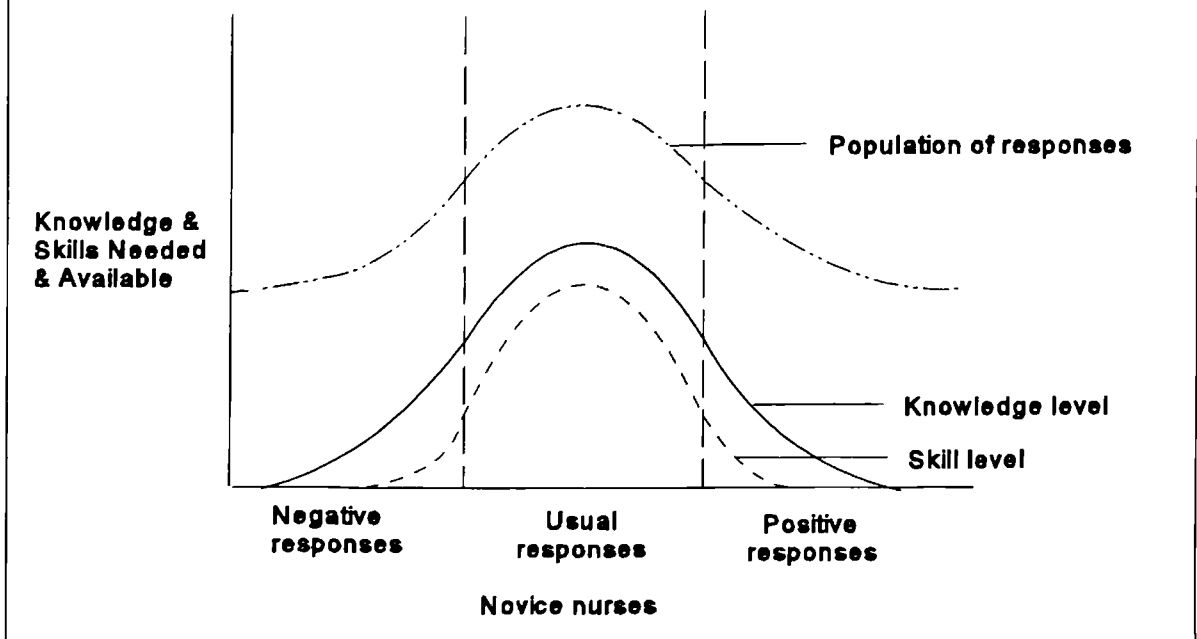
having greater and more rapid intervention skills than their colleagues. She bases this concept on the notion of Benner's (1984) expert nurse who uses intuition and experience as a basis for practice, but who may find it difficult to articulate the cognitive processes that guide their actions. The graphic display of the model in this case shows that the gap between the population of responses and the skill and knowledge level of the nurse to have narrowed considerably. However, the population of responses still exceeds the knowledge and skill level of experienced nurses. Furthermore, the skill level of the nurse is shown to exceed the knowledge level, illustrating the unarticulated processes guided by intuition in the delivery of care.

The third display of the model refers to advanced practice (Figure 2.2). In this case,

Figure 2.2 Population of human responses to health problems and the relationship of the knowledge and skill level of advanced nurse practitioners (source: Calkin, 1984).
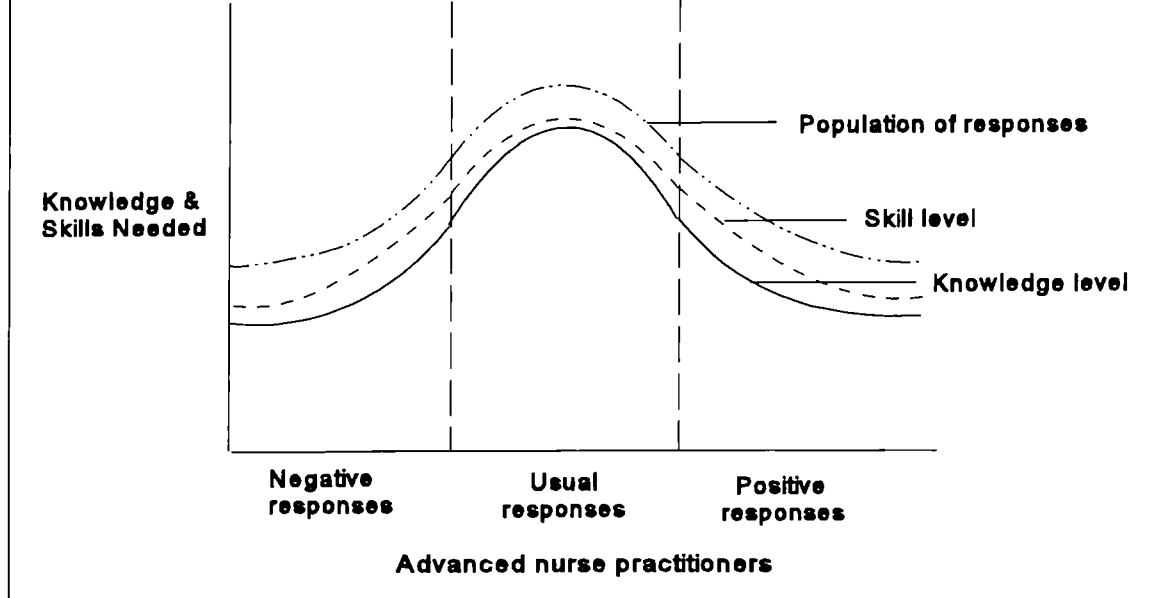
the population of responses still exceeds the nurse's knowledge and skill, but far less than other nurses. She argues that skill level still exceeds the advanced nurse practitioner's analytical and conceptual framework for providing care, and in doing so illustrates that she still values intuition and the art of nursing, as well as the science of practice. Where the population of responses are more common and frequently experienced by the advanced nurse practitioner, the level of skill and knowledge are depicted as being virtually identical. A further factor that delineates the advanced nurse practitioner from other nurses is that their level of knowledge and awareness of the extremes of population responses is greater.

The model consequently defines advanced practice as a deliberative response to a broad range of actual or potential health problems in which the advanced nurse practitioner can provide a rationale for choosing diagnostic or the treatment

processes they deliver. According to Calkin (1984), this ability is accompanied by a body of specialised knowledge and skills. Calkin (1984) asserts that the model serves as a basis for communicating about advanced nursing practice by helping advanced practitioners and administrators identify: where improvements in the care of patients can be achieved; identifying the training needs of nursing staff; identifying areas for research; advising administrators with regard to resources required meet the population of responses; and of course, articulating the essence of advanced practice.

The difference between this and other conceptual models is that no attempt is made to refer to, or describe, roles or functions of advanced practitioners, but instead advanced practice is distinguished by its degree of cognitive reasoning, knowledge base and skill competency. In so doing, the model conveys the essential differences between the various levels and types of nursing practice without confining them to a specific context or series of activities. Furthermore, the model uses the population of patient responses not only to identify direct care characteristics of advanced practice, but also as a reference point for determining the relevant indirect care activities in which advanced practitioners should be involved. Consequently, this model appears to have greater utility, although once again, reviewing the literature reveals its basic propositions have yet to be widely tested.

Benner's (1984) conceptual model of expert practice is often used in the context of attempting to explain and define advanced practice. A detailed discussion of the concept of expert practice, along with the contribution of Benner's (1984) model

follows in the chapter 3.

2.7 CONCLUSION

The literature reveals that whilst arriving at a global definition of advanced practice is problematic, the essential characteristics of the concept can be extracted from the varying interpretations of the construct which have been developed. To date, attempts at developing conceptual models of advanced practice have generally relied on the identification of a series of roles and task behaviours to explain the phenomenon. The majority of such models, perhaps with the exception of Benner (1984), remain to have their validity established.

In addition to the conceptual models of advanced practice which have been developed over recent years a number of operational models have been identified. It has been asserted in this review that, whilst various operational models exist, most could be subsumed under two principal models of advanced practice, namely the nurse practitioner or the clinical nurse specialist. Arguably, it is the personal attributes of the practitioner, rather than their title or the identification of a series of roles or behaviours, which capture the essence of advanced practice. It is not only that these attributes and characteristics are present in advanced practitioners, but that they are developed to an expert degree to allow their practice to be differentiated from that of their colleagues. The next chapter of the literature review explores the concepts of expertise and the notion of an expert practitioner.

CHAPTER THREE

LITERATURE REVIEW II: EXPERTISE AND THE CLINICAL EXPERT

CHAPTER 3: LITERATURE REVIEW - EXPERTISE AND THE CLINICAL EXPERT

3.1 INTRODUCTION

The previous chapter revealed a number of concepts associated with advanced nursing practice, including clinical expertise and the idea of the expert practitioner. Whilst these concepts have generated considerable debate and controversy in the nursing literature in recent years, the long-standing dilemma of how best to explain expert behaviour remains (Rolfe, 1997). Whilst the term 'expert' generally refers to a limited number of individuals who possess certain traits and abilities, it has been suggested that clinical expertise is an essential attribute of nurses at all levels in the organization (Radke *et al,* 1990). In this context, expertise is not intended to convey the idea that all nurses are necessarily perceived of as experts, but that the development of knowledge and skills to enable practitioners to become more clinically competent is desirable. This serves to illustrate that whilst the terms expert and expertise are commonly employed in nursing (Jasper, 1994), their usage can generate confusion. This chapter aims to examine these concepts more closely in order to disentangle their separate meanings. It will explore how, and if, the practice of advanced nurse practitioners can be differentiated from the practice of nurses perceived to be experts by virtue of their experience (Calkin, 1984).

The trend for discussing the notion of expert practitioners in a nursing context has gained popularity since the mid 1980's and has now become commonplace (Jasper, 1994). Benner's (1984) seminal work in developing a conceptual framework to identify and describe the domains and competencies of expert nursing practice and its application to practice will be discussed shortly. The arguments of those who

challenge Benner's conclusions are also considered in order to establish the merits of her theoretical framework. Finally, theoretical models from the fields of psychology and computer science are briefly reviewed in an attempt to illuminate the cognitive processes in which expert practitioners are perceived to engage.

3.2 DEFINING THE CONCEPT OF EXPERTISE

A simple dictionary definition states that expertise means "special skill, knowledge or judgement; expertness", whilst an expert is a "person who has extensive skill or knowledge in a particular field" (Collins English Dictionary, 1986). A further definition identifies that the relevant skill and / or knowledge is gained via experience (Oxford English Dictionary; 1961). These relatively straightforward definitions yield four attributes of expertise, in that an expert can be considered to be:

- skilled,

- knowledgeable,

- experienced, and

- context bound to a particular field.

When examining the nursing literature on the subject of expertise, there is a consensus that each of these attributes is used to identify the expert practitioner (Benner, 1984; Thompson et al, 1990; Benner et al, 1992; Jarvis, 1992a). However, in order for expertise to be acknowledged, the four attributes outlined above appear to rely heavily on subjective interpretation to help distinguish the characteristics of experts from non-expert practitioners. It has been suggested that this process relies on some kind of externally validated criterion (Jasper, 1994) to judge the presence of expertise.

3.3 REFINING THE ATTRIBUTES OF EXPERTISE

Jasper (1994) recognised that whilst the term expertise appears to have common meaning, it lacks a clear definition. In a small study (involving 13 nurses from various unnamed fields), utilising a strategy of concept analysis developed by Walker & Avant (1988), Jasper (1994) suggests that it is possible to recognize expert practice through various strategies. From interviews with her participants and on reviewing the literature she concluded the defining attributes of the expert to be:

1: Possession of a specialised body of knowledge or skill

2: Extensive experience in the field of practice

3: Acknowledgement by others, and

4: Highly developed levels of pattern recognition.

This list provides additional attributes to those extracted from the simple dictionary definitions at the outset. Whilst the first two can be seen to support the commonly held characteristics of expertise identified in numerous definitions, the third relates to the notion of recognition and acknowledgement of expertise, whilst the fourth is more concerned with the cognitive processes in which experts engage. This list of attributes serves as a useful conceptual framework upon which to examine the literature in an attempt to elicit the essential nature of expertise in nursing.

3.3.1 SPECIALISED BODY OF KNOWLEDGE FOR EXPERTISE

The majority of definitions recognise that an essential characteristic of the expert practitioner is a substantial knowledge base in a particular sphere of practice. In nursing, experts are seen to draw on a wide and varied body of knowledge in the delivery of their care (Robinson & Vaughan, 1992). There is a desire for the

knowledge base of experts in nursing be made explicit, yet it often appears to be indefinable (Jasper, 1994). Whether the basis of such a body of knowledge is, as suggested, acquired via the formal academic preparation at the undergraduate or post-graduate level (Fenton, 1992), or is accrued over time by exposure to clinical events and situations (Benner, 1984), or is a combination of both, remains equivocal.

It has been argued that the possession of academic qualifications is insufficient in itself to afford someone the designation of expert (Jasper, 1994). Indeed, Benner (1984) argues that knowledge is built up over years of experience in a particular clinical field and implies that formal academic qualifications are not necessarily a pre-requisite to becoming an expert. In this instance, the expert's specialised body of knowledge is believed to be primarily embedded in practice (Benner, 1984). Yet, when exploring the concept of the expert in relation to advanced practice positions, the current accepted belief, both in the UK and abroad, is that a necessary pre-requisite is academic preparation at the Master's degree level (UKCC, 1994c, Fenton, 1992). This suggests that in the eyes of professional bodies at the very least, that an expert's (i.e. advanced practitioner) specialised body of knowledge should be underpinned by theoretical knowledge. Definitions of expertise however, emphasize the *possession* of knowledge and/or skill which is not available to non-experts (Jasper, 1994), not the route by which the knowledge is acquired. This begs the question: does it make a difference if expertise is embedded in practice rather than theory?

One potential answer to this question is provided by Calkin's (1984) work. In her

model for advanced practice she explains that a disparity exists between the expertise of what she terms "experts-by-experience" and nurses who have undergone formal advanced practitioner academic programmes. The main focus of her model concerns the scope of their respective knowledge bases and analytical abilities. Whilst acknowledging that experts-by-experience possess both a comprehensive knowledge base and analytical skills, Calkin (1984) does not believe that these attributes are developed to the same extent as those of advanced nurse practitioners who have undergone formal academic preparation. She concludes that one of the main differences between the two groups is that advanced practitioners use deliberate reasoning processes to draw on their substantial theoretical knowledge base which informs their practice. Calkin's (1984) model does however, assume that the advanced practitioner has considerable clinical experience as well as an appropriate academic qualification. As such, she sees a complementarity between experience and academic qualifications in the development of expertise in nursing practice. On the basis of Calkin's (1984) model, one can conclude there are *degrees* of expertise in clinical practice influenced by the possession of specialised body of knowledge, the analytical ability of the practitioner, and the nature of the individual's clinical experiences.

Clearly, all nurses, including advanced nurse practitioners, draw on both practical and theoretical knowledge to enable them to practice (Brykczynski, 1989). Furthermore, experience is considered to be especially important in the development of clinical expertise (Schon, 1983; Benner, 1984), in that it has been argued that all learning, even theoretical abstractions, stem from experience (Jarvis, 1995). This

premise is based on the belief that the analysis of professional practice helps to generate knowledge not available by textbook approaches (McCaugherty, 1991), through a process of reflective practice (Schon, 1983).

The expert's specialised body of knowledge therefore seems to draw upon three inter-related domains of cognition, identified as propositional knowledge, practical knowledge and experiential knowledge (Heron, 1981). The latter two domains are sometimes combined and referred to as "tacit" knowledge (Polanyi, 1966). Logic would imply that it is the extent to which each of these domains is developed that defines an expert's specialised body of knowledge and thus their expertise. Unfortunately, there is little consensus to be found in the literature regarding what constitutes expert knowledge and the process through which it is acquired.

Propositional knowledge deals with theories, facts and concepts, and has been described as 'textbook' knowledge (Burnard, 1987). In the literature, this is more commonly referred to as Ryle's (1949) concept of 'knowing that'. In Calkin's (1984) discussion of the practice of experts-by-experience, it is this domain of knowledge that she perceives is least well developed and which she claims is responsible in part for the inability of some experts to be able to account for their actions.

Practical knowledge, or the concept of 'knowing how' (Ryle, 1949), is associated with the acquisition and development of skills and:

> "...is the substance of a smooth performance of a practical or interpersonal skill" (Burnard, 1987, p190).

One could legitimately argue that practical knowledge can be developed in the absence of propositional knowledge, for example, by rote learning of a particular skill. By deduction, one might conclude that practical knowledge in and of itself is a poor indicator of the presence of clinical expertise. This conclusion appears to be supported by the literature, as most writers veer away from describing expertise or experts solely in terms of a set of technical competencies or unique skills, although the possession of specialised skills is acknowledged (Jasper, 1994).

Finally, experiential knowledge is said to be:

> "...knowledge gained through direct personal encounter with a subject, person or a thing. It is the subjective and affective nature of that encounter that contributes to this sort of knowledge". (Burnard, 1987, pp190-1)

Burnard's (1987) definition explains why experiential knowledge, which he suggests is personal and idiosyncratic, is developed and utilised differently by individual nurses. It also lends weight to the prior notion of *degrees* of expertise. In some quarters, it is asserted that this kind of knowledge is most influential in the practice of experts. Benner (1984), for example, posits that it is the repeated exposure to clinical situations and events (i.e. experiential knowledge) that enables expert nurses to practice differently to novice nurses. Yet this personal knowledge, often gained via reflective practice (Schon, 1983), rests firmly at the bottom of the traditional hierarchy of what constitutes professional knowledge (Johns, 1995). Thus, whilst becoming a valued source of knowledge upon which practitioners base their decisions for taking action in the practice situation (Carr, 1989), there appears to be a tension between the drive to have advanced nurse practitioner programmes at the Master's degree level (UKCC, 1994c), where emphasis on propositional knowledge

dominates, and the valuing of the tacit knowledge domain.

The three domains of knowledge are however seen to be interrelated, with each complementing the other (Burnard, 1987) and influencing the outcome of behaviour (Figure 3.1). Cutcliffe (1997) appears to suggest that this inter-relationship between knowledge domains is responsible for the way experts:

> "... question, ...critique, and ... do not accept all things at face value, but examine, seek to understand and discover meaning in both theoretical knowledge and experiential practice-based knowledge. They value both sources of knowledge as vital, especially if the two are viewed together". (Cutcliffe, 1997, p329).

This might lead one to the conclusion that each domain of knowledge should be developed concurrently so as to add to the overall specialised body of knowledge and correspondingly increase the development of expertise. However, this argument
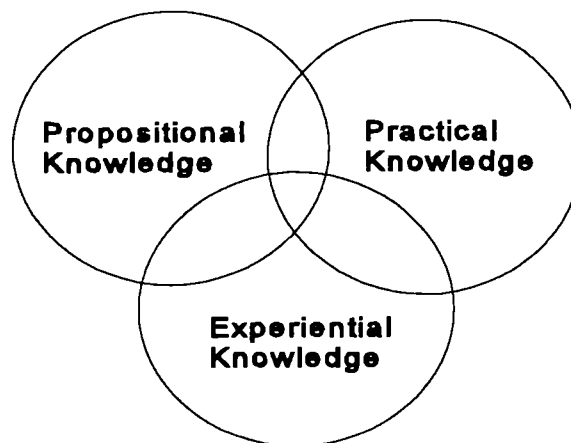
Figure 3.1 The three domains of knowledge (Source: Burnard, 1987)

presupposes that all sources of knowledge are *equally* valued. This is clearly not the

64

case. Benner's (1984) interpretation of expertise would suggest that the different knowledge domains do not necessarily need to develop to the same extent. This point of view overlooks an important issue that appears infrequently in the literature concerning expertise, namely, the currency of knowledge and the concept of evidence based practice. If expertise is embedded in experiential and practical knowledge (Benner, 1984) to the detriment of propositional knowledge, it can be argued the goal of evidence based practice in nursing may not be achieved. A small US study investigating experts management of pain illustrates this point when it was concluded:

> "Experts have practical knowledge, gained by experience, but they may not have current knowledge..." (Guyton-Simmons & Ehrmin, 1994, p43).

In this study, the experts' knowledge of pharmacologic effects of analgesic drugs was erroneous, which the researchers concluded was due to a lack of current knowledge about the agents in use. Consequently, where practice is based on primarily experiential knowledge, the danger is that behaviours may become repetitive, leading to ritualised practice, as opposed to nurses basing their practice on evidence from other knowledge domains (Jarvis, 1992b). Jarvis (1992c) suggests that practice based on practical knowledge is accepted by practitioners because it is "known to work". He concludes that the nature of practical knowledge is therefore essentially conservative, as practitioners are "loathe to change it" because of its perceived effectiveness. Applying this argument to expertise implies that the specialised body of knowledge of the expert risks becoming stagnant and un-responsive to changing needs (i.e. conservative) if the propositional knowledge domain is de-valued or ignored.

There is a more fundamental problem that appears to have dogged attempts to uncover the nature of expertise, namely, the problematic nature of measuring such a complex phenomenon. Benner (1984) was one of the first to recognise this problem when she held that expertise was contextual. Her research focused on expert knowledge embedded in practice, rather than upon the expert clinician. It would appear that an expert's specialised body of knowledge is not judged by any objective measurement, which would be difficult to define, but by the use of normative referencing by practitioners in the same sphere of practice. In other words, actors in the social setting construct the notion of expertise locally rather than through the use of any agreed criteria. This approach to identifying the presence of expertise can be found in numerous studies (Benner, 1984; Benner *et al*, 1992; Orme & Maggs, 1993; Kitson *et al*, 1993; Guyton-Simmons & Ehrmin, 1994; Butterworth & Bishop, 1995; Greenwood & King, 1995; Cutcliffe, 1997). Therefore, whilst a specialised body of knowledge is recognised as an essential attribute of the expert, there are fundamental disagreements about what constitutes specialised knowledge, as well as difficulties in measuring and defining the phenomenon. Consequently, additional criteria have been utilised to identify the presence of expertise.

3.3.2 EXTENSIVE EXPERIENCE IN THE FIELD OF PRACTICE

The second characteristic associated with expertise is considered to be extensive experience in the field of practice. This attribute identifies three separate features: longevity of service; the scope and range of experiences encountered; and specialisation in a particular field of practice. Taking the first two concepts, it would appear that it is not necessarily longevity of service that promotes expertise, but the

nature of the experience that is key (Benner, 1984; Kahneman & Tversky, 1990). In other words, it is how the experience contributes to the development of the different knowledge domains (especially the experiential domain) which appears to be important, and not necessarily how long one has practised in a particular clinical setting. However, many studies, which have relied on the selection of expert participants as part of their methodology, choose duration of experience as one of their prime inclusion criteria. Most commonly, a minimum period of 5 years clinical experience is specified as being desirable, although this figure appears to have been arrived at completely arbitrarily (Benner, 1984; Benner *et al*, 1992; Orme & Maggs, 1993; Butterworth & Bishop, 1995; Cutcliffe, 1997). There is, however, no real consensus on this point and other writers either extend the period of experience required, e.g. 8 years (Castledine, 1996) or reduce it accordingly, e.g. 18 months (Corcoran, 1986). Still others appear to recognise the uncertain and individual nature of experience by suggesting that a range of durations should be considered, e.g. 4 to 8 years experience (Greenwood & King, 1995).

The positive correlation between length of experience and the development of expertise has an appealing logic. While evidence suggests that expertise does in fact increase over time, there are additional requirements which need to be met (Fox-Young, 1995). The foundation of this argument can be found in Jasper's (1994) assertion that there is no:

> "...certain measure of what ... experience consists of, and what experience counts as valid" (p772).

One has to conclude, that it is the individual's personal characteristics and the nature

of their experience rather than the duration of that experience that is of importance.

The second feature of this attribute concerns the assertion that experience needs to be gained in a "specific field" of practice. What is unclear however, is how a specific field is defined. For example, does specific relate solely to a narrow field of specialisation, such as coronary care nursing, neonatal nursing, or oncology nursing, where the parameters to the specialised body of knowledge are well defined, or, can it relate to more generalist practitioners? In the USA, advanced practitioners include NPs who work in primary care and whose body of knowledge, by the nature of their client group, is required to be much broader than NPs in acute specialisms. Likewise, in the UK, there are Master's degree programmes aimed to prepare advanced practitioners to take on a more generic role in both primary and secondary care settings (Gibbon & Luker, 1995). These nurses are perceived to be advanced practitioners and by implication, experts in their fields, yet their knowledge base may not be developed to the same depth as expert practitioners in other specialisms. Arguably, the generalists strength is in their breadth of knowledge. Benner & Tanner's (1987) assertion that experts can only function at their highest level within their own speciality, whatever that maybe, appears a sensible way of reconciling the apparent disparity between 'depth' and 'breadth' of knowledge. The premise being, that an expert's knowledge base is not transferable to another speciality. Therefore, whilst experience and the nature of experience are widely acknowledged in the literature as being important factors in determining expertise, it has been suggested that additional criteria need to be made explicit for expertise to be recognised (English, 1993).

3.3.3 ACKNOWLEDGEMENT BY OTHERS

"Many nurses may possess a specialist knowledge base, or have practised a long time in a particular speciality, but not all nurses possessing these two features will be regarded as expert" (Jasper, 1994, p772).

This brief quotation raises the third criterion of expert practice, namely, the acknowledgement of expertise by others. Two questions in particular are raised by this issue: who identifies the expert? And, are explicit criteria used to inform such a judgement? There appear to be conflicting views in the literature as to whom is best placed to judge if a nurse has acquired expert status and, if adequate criteria exist to help those making the judgement to arrive at such a conclusion.

Benner (1984) and Benner *et al*, (1992) selected their expert participants by the use of peer and supervisor nomination. Whilst some supporters of Benner's work find this strategy quite appropriate (Darbyshire, 1994), critics claim that other stakeholders in health care, including health service managers (English, 1993) and even the patient community (Paley, 1996) are equally capable of making judgments about the expertise of nurses. Benner and her colleagues make no claims to the contrary and as such, criticisms based on the unverified assumption that they rejected these communities in favour of the professional peer group appear groundless. On reviewing Benner's work (Benner, 1984; Benner *et al*, 1992), it appears that the choice of peers to select the expert subjects was based as much on methodological pragmatism as on any other criteria.

Likewise, in a UK study of practice experts (Butterworth & Bishop, 1995), nurse executives were given the task of identifying expert practitioners. The criteria they

were given to help them identify appropriate nurses and midwives were, length of clinical experience (greater than 5 years), a grade of 'F' or above in the grading structure and lastly, the subjective judgement of the nurse advisor to nominate someone they believed to be a "skilled clinician" and expert. Whilst the authors acknowledge that the selection process was open to bias and limitation, especially with regard to the last criteria, the absence of any other suitable criteria in defining expertise becomes evident. Likewise, in an Australian study (Greenwood & King, 1995) the criteria utilised for identifying experts were similar and equally subjective. The feature these strategies have in common are attempts at objective measurements about the person, i.e. the number of years experience in a particular field, specific qualifications, a specific grade, and so on, but subjective criteria about their practice expertise and knowledge base.

Perhaps for the moment the question should change from 'what criteria are used to identify the expert?', to 'who should identify the expert?'. Jasper (1994) asserts that the label of expert should be assigned from within the nursing profession, as she believes that:

"..only similarly qualified nurses...will be able to identify the true expert"(p773), as they are more likely to understand the role (Fox-Young, 1995). This principle has been followed in a number of international studies which have required expert participants to be identified as part of their methodology (Benner, 1984; Benner *et al*, 1992 Kitson *et al*, 1993; Guyton-Simmons & Ehrmin, 1994: Butterworth & Bishop, 1995; Greenwood & King, 1995). Jasper (1994) also acknowledges the importance of recognition from outside the nursing profession for those nurses identified as

experts by their peers. Legitimising who outside the nursing profession is best placed to make judgements about the expertise of nurses, is, however, not without its problems. This point is illustrated by Cash (1995) in a critique of Benner's (1984) work, when being critical of the use of a non-nurse investigators in the research team assigned to code data relating to expert nursing practice. Cash concluded that:

> "...the determination of what constitutes expert practice is by the approval of a specific group that is empowered to do so, either by being the research team, managers, or some other legitimising groups. The concept of expertise is therefore arbitrary; it is legitimated by groups or individuals whose status is defined socially". (Cash, 1995, p532).

It is the characteristic of expertise being socially constructed by some elite, or invisible process, that has led to the desire for criterion to be developed whereby expertise can be measured and viewed objectively. English (1993) argues that an accurate description of expertise and of the criteria defining excellence are required if nurses are to strive for excellence and presumably identify when it has been achieved. This latter point appears to have merit, as in Bishop & Butterworth's (1995) study of expert nurses, one respondent is quoted as stating:

> "I'm surprised that I've been nominated as an expert, no one has bothered to tell me before". (p30).

The difficulties inherent in such an undertaking are made explicit by Fox-Young (1995) who dedicates an entire paper to outlining the multifarious factors which would require consideration. She recognises that even if appropriate standards and methods could be devised to accurately measure expertise, the interpretation of such data is fraught with difficulty. Elsewhere, it has been acknowledged that it is the tacit domain of knowledge that is at the heart of these methodological problems (Meerabeau, 1992). Consequently, whilst appearing to call for expert practice to be

objectively measured, Fox-Young's (1995) position seems to support Darbyshire's

(1994) conclusion that, attempts at objective measurement are likely to end in failure

as the complex nature and dynamics of the phenomenon do not lend themselves to,

> "...formal representational propositions which will predict or identify the
> 'criteria' of expertise" (Darbyshire, 1994, p757).

In the absence of any agreed or objective criteria, the most visible criterion by which

one is judged an expert,

> "...appear to be the practical abilities which are grounded in a knowledge
> base. As all other criteria derive from these, it is not only important to possess
> these capabilities, but it is vital that these are witnessed and labelled as
> expert by others". (Jasper, 1994, p773).

Thus, the expert nurse is one who is seen to have the "capacity to contextualize and

to 'adjust' what she knows to particular cases" (Paul & Heaslip, 1995, p40). The

visible criterion may include such things as the expert being seen to be able to

perform their craft at a higher standard than most others and to be both effective and

efficient (Thompson, *et al*, 1990). In other words, acknowledgement of expertise

appears to be by the process of normative referencing, as opposed to criterion

referencing. That is, expertise is only constructed in the social setting when it is

compared with the meaning of novice in the same setting (Edwards, 1998). The

nature of normative referencing by ones colleagues in a particular setting, has the

effect of contextualizing expertise, which is the point that Benner (1984) and her

colleagues attempt to make explicit and for which they have been derided (Cash,

1995).

Whilst the criterion for judging expertise may be vague at best, the significance of

other professional groups identifying expert practice of nurses appears to do with the

validation of nursing as a "major" profession (Jasper, 1994). Arguably, the UKCC's (1994c) expectation for advanced practitioners to be academically prepared at the Master's degree level can be seen to serve two purposes. Firstly, to provide practitioners with sound theoretical principles upon which to base their practice, but secondly, so that advanced practitioners can enhance the likelihood of being formally recognised professionally for their clinical expertise and knowledge base.

Whilst the criteria utilised to identify clinical expertise and experts are only partially made explicit in the literature, it is the cognitive processes which differentiate expert practice from non-expert practice, that have generated greatest interest both within and without nursing for a number of years. While all nurses possess practical and theoretical knowledge, the way such knowledge is put to use differs according to the degree of competency and expertise of the practitioner. It is this process that is believed to separate the expert nurse from any other. In nursing, the major stimulus of the debate on expert practice followed the publication of Benner's (1984) seminal work *From Novice to Expert.*

3.4. FROM NOVICE TO EXPERT - BENNER (1984)

Benner's (1984) framework is based on a model of skill acquisition originally developed by Dreyfus & Dreyfus (1980) in the context of chess players and pilots. In applying the model to a nursing context, Benner (1984) states that nurses pass through the same five levels of proficiency identified by Dreyfus & Dreyfus (1980) as: novice, advanced beginner, competent, proficient and expert. Benner states that,

"These different levels reflect changes in three general aspects of skilled

performance. One is a movement from reliance on abstract principles to the use of past concrete experience paradigms. The second is a change in the learner's perception of the demand situation, in which the situation is seen less and less as a compilation of equally relevant bits, and more and more as a complete whole in which only certain parts are relevant. The third is a passage from *detached* observer to *involved* performer. The performer no longer stands outside the situation but is now engaged *in* the situation". (Benner, 1984, p3 -original emphasis)

The development of skills can therefore seen to be based on incremental stages along a continuum. Critics have pointed out that as each stage merges into the next, measurement of each level is impeded (English, 1993). Benner (1984) does however provide criteria associated with each level of practice. The Novice is seen to be a nurse who has had no experience in the clinical activities they are expected to perform and relies on context-free rules to guide action and, as a result is limited in both capability and flexibility. The advanced beginner is able to demonstrate "marginally acceptable performance" as a result of experiencing and noting the meaningful situational components of practice, but still relies on rules they have been taught. The competent level of practice is typified by a nurse who has two to three years experience in the same clinical setting and has the ability to filter out the important aspects of clinical practice from those which can be ignored. In so doing, they develop mastery of skills and learn to manage a variety of situations. This level of skill is characterised by conscious, deliberate planning, in order to achieve efficiency and organization, but lacks the speed and flexibility of the proficient nurse. The proficient level of skill is where the performer perceives whole situations and is guided by maxims based on a deep understanding of that situation. The proficient nurse is able to use experience and recent events to perceive the situation, and as such, is able to anticipate typical events and modify plans in response accordingly.

The proficient nurse has a holistic understanding of the situation from experience and is able to hone in more speedily on relevant issues and aspects, without the need for laboured deliberations. Finally, expert practice is said to no longer rely on analytic principles to connect appropriate actions to a given situation.

> "The expert nurse, with an enormous background of experience, now has an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions" (Benner, 1984, p32).

Benner (1984) therefore sees the characteristic of 'intuition' as the dominating trait of the expert nurse and the one that separates them out from other levels of practitioner. The expert relies on a deep understanding of the situation, gained through experience over many years of similar situations. This has been termed tacit knowledge (Polanyi, 1958) which is embedded in clinical practice.

Benner (1984) is at pains to emphasise that in the context of expert practice (and at the other levels of competency) that experience does not simply relate to longevity of service, but to encounters with various situations which allow for the refinement of preconceived notions and theories. She goes on to argue that experts in particular still use their highly skilled analytic ability when dealing with those situations with which they have had little or no previous experience. The intuitive nature of expert practice and its relationship to critical thinking can however be problematical for nurses who may find difficulty in articulating the basis of their knowledge or actions to others. Benner (1984) puts forward the argument that in the case where clinical expertise is exhibited, the nurse draws primarily on the experiential and practical knowledge domains, as opposed to the propositional knowledge domain. It is this

aspect of her work, along with the perceived importance of the concept of intuition, that has brought most criticism.

3.4.1 CRITICISMS OF BENNER'S (1984) FRAMEWORK

Benner's (1984) framework has been utilised in a number of studies, either partially or in its entirety, to explore the concept of expertise both in advanced and non-advanced nursing roles (Fenton & Brykczynski, 1993; Greenwood & King, 1995; Maynard, 1996; Hanneman, 1996; Cutcliffe, 1997). However, it has also been criticised and questioned in the literature on a variety of grounds (English, 1993; Farrington, 1993; Cash, 1995).

One of the criticisms made of Benner's (1984) work relates to the use of the critical incident technique she adopted in her original research (Farrington, 1993). In her study, as *part* of the data collection strategy, Benner (1984) conducted paired interviews with novice nurses and nurses recognized for their expertise. Each nurse was interviewed separately and asked to reflect on patient care situations that they had had in common, i.e. critical incident technique. Farrington (1993) argues that the central theme of Benner's thesis hinges on this technique, which he suggests is fundamentally flawed. As support for his argument he cites the writing of Smith & Russell (1991), who *tentatively* claim that the critical incident technique does not appear to be a useful strategy in heightening awareness of nursing skills when used in a nurse education context. Farrington's (1993) criticism of the use of the critical incident technique appears to be based solely on the premise of its use as a teaching technique, not as a research strategy as utilised by Benner (1984). Reed (1994)

identified that as a research strategy, critical incident technique has been used in numerous studies and has been found to be a useful way of generating rich data. Furthermore, Reed (1994) viewed the use of the technique as a strength of Benner's work, whilst at the same time recognising that in some situations it has limitations. Farrington's (1993) critique of Benner (1984) is dominated by the use of the critical incident technique and what he appears to ignore is that Benner also conducted participant observation and/or additional interviews with over 60 nurses at 6 different hospitals in order to further refine and delineate the nuances of nurse performance. On what appears to be a rather superficial critique of Benner's work he makes the rather sweeping assertion that its conclusions are unbalanced and one-sided. Arguably, it is Farrington's (1993) interpretation of Benner's work that is unbalanced, ill-informed and one sided.

English (1993) also criticises Benner's approach, firstly from the point of view of using peer assessment to identify her 'expert' nurses, which he suggests presents methodological shortcomings. However, as suggested earlier, in the absence of an agreed criteria of what constitutes expertise, the practice commonly adopted in a number of studies is to use peer assessment in the identification of expert subjects.

English's (1993) second methodological criticism relates to a fundamental epistemological differences between himself and Benner. This becomes evident when English criticises Benner's assertion of intuition being a legitimate aspect of clinical decision making, which he believes:

"... is a subjective and questionable entity and hence, until empirically and

unequivocally validated, has limited applicability..." (English, 1993, p390).

English's (1993) alignment with the positivist paradigm is underlined further when he demands that some objective measurement of expertise is essential in order to generalise standards of excellence required by nurses. Thus, opposing epistemological standpoints form the basis of at least part of English's (1993) critique. This point is taken up by Darbyshire (1994) in defence of Benner (1984) when he states that:

> "English's critique is notable for its emphasis on the laudability of formal systems, rules, universally accepted definitions, measurement, objective validation, empirical testing, falsifying hypotheses and so on". (Darbyshire, 1994, p756).

Thompson *et al* (1990) however, provide a more dispassionate rationale for the difficulty in measuring expertise, when they assert that at the "heart of the problem is the inability to measure cognitive processes" (p3). They also assert that observational studies of expertise, especially in nursing, are of little use, as a great deal of nursing activity is so subtle that its nuances cannot be easily observed.

A third published critique of Benner's (1984) work is provided by Cash (1995) who focuses mainly on the notion of intuition. Like Farrington (1993), Cash (1995) also criticises Benner's (1984) use of critical incident analysis, but this time from a different theoretical perspective. Cash (1995) cites Wagner & Sternberg's (1985) criticism of this technique, whereby it is suggested that during the activity nurses select the domains perceived to be significant. It is this selectivity that Cash (1995) questions, for whilst incidents may be typical, they may not be critical. Cash (1995) takes this argument one step further by suggesting that if nurses choose the atypical

incident, then:

> "one gets further away from ... the background practices that one is trying to expose" (p531).

Consequently, Cash (1995) questions the validity of this technique as a practical means of making the nature of nursing practice explicit. The remainder of Cash's (1995) critique concentrates on the concept of intuition and its place in nursing practice. An interesting point that Cash (1995) raises concerns "epistemological power" and the relationship between intuition and the exercise of power in inter-professional relationships. Cash (1995) counters Benner's (1984) conclusion that intuition empowers expert nurses by suggesting that in nursing intuition does not give power, but needs it. The premise of this conclusion is that because:

> "The physicians have control over the clinical situation, the nurses' power is negotiated with them. Intuition, because it lacks immediate confirming evidence relies therefore for its status on the perceived epistemological power of the person having the intuition. Because nurses have relatively less power than the physicians, the status given to the nurses' intuitions will be less". (Cash, 1995, p533)

In response to this and other criticisms of her work, Benner (1996) points out that the main focus of her work was not to do with power relations. She claims that her goal in raising power as an issue was:

> "...to bring to an unequal bargaining table a cogent articulation of the intent and content of the negotiations, to clarify what the power dialogues are about". (Benner, 1996, p673)

Furthermore, she calls for further research to focus on power and status inequalities, which she hopes will be influenced by her own work. Thus, whilst Benner (1996) does not disagree that there are significant differences in the power gradients between nursing and medicine, she disputes that the notion of expertise and intuition cannot be used to redress the power imbalance.

Some of the criticisms aimed at Benner's work, such as an over-reliance on critical incident analysis and the selection of non-nurse coders, coupled with questions concerning inter-rater reliability may have some substance. These criticisms have not prevented Benner and her colleagues from further exploration of the concept of expertise (Benner *et al*, 1992) and neither has it prevented numerous studies from adopting Benner's (1984) ideas as a theoretical framework.

One of the most controversial areas in the discussion of expertise as described by Benner (1984) concerns the concept of intuition. Intuition has been described as "the absence of analysis" (Hamm, 1988). For Benner (1984) the expert nurse is one who is seen to have a perceptual awareness or an intuitive grasp of the situation with which they are dealing, enabling them to hone in on relevant issues without recourse to deliberative cognitive processes utilising context-free rules and principles. In this sense, "intuition is the active expression of tacit knowledge" (Johns, 1995, p26). Intuition frees up the mind to be more attentive and critically aware of the important issues in the care situation (Paul & Heaslip, 1995). It is this characteristic that epitomises, for Benner (1984) at least, the concept of expert practice. Benner's critics on the other hand seem to take this premise at face-value and argue that it is problematical and an over-simplification in terms of explaining the concept of expert clinical practice (English, 1993; Cash, 1995). They appear to assume that intuition lacks the intellectual processes that one would expect to associate with the concept of expertise. This view is probably reinforced by the dismissal of intuition as a significant form of knowledge from a positivistic perspective on the basis of its intangible nature (Bennett, 1987; Kikuchi, 1992). It has been suggested that intuition

and the application of experience are not in themselves indicators of expert clinical decision making and practice (Farrington, 1993). Paul & Heaslip (1995) however assert that expert nurses are knowledgeable and are able to act:

> "...intuitively by virtue of having developed, through critical thought, a deeply grounded knowledge base that can be applied in daily practice" (Paul & Heaslip, 1995, p40).

They conclude that intuition is the result of intellectual processes combining experience, knowledge, reflection, and critical thought. As such, it has been suggested that intuition is able to be developed by nurses as an essential cognitive skill (Rew, 1988) which they can learn to use more effectively and confidently (Johns, 1995). What this body of literature appears to be implicitly describing is the social learning of expertise by practitioners. In other words, it is through repeated exposure to patient episodes and situations in the social environment, that nurses 'learn' to integrate the different domains of practice and knowledge to become recognised as experts in their field. Unfortunately, there is a dearth of literature explaining the process by which expertise is acquired by practitioners.

Whilst for Benner (1984) intuition is the intangible characteristic that singles out the expert practitioner, she does not argue that non-experts are incapable of thinking in an intuitive way, although critics of her work appear have interpreted it as such (English, 1993; Cash, 1995). Schon (1983), primarily known for his writings on "reflection in action'", suggests that (non-expert) practitioners use intuitive thinking in their daily work and are often unable to state the criteria used for making clinical judgements. He makes the analogy with how individuals in everyday life act spontaneously, often in an intuitive manner, and concludes that our knowing is in our

action. He claims that practitioners do not take decisions based on what he calls, technical rationality, but instead on the basis of their experience, much in the same way that Benner (1984) describes expert practice.

There are close similarities between Benner's (1984) expert nurses and Schon's (1983) reflective practitioners and the place of 'intuitive thinking' in their performance (Farrington, 1993). However, one of the major differences between these two positions relates to the domain of tacit knowledge. In Benner's (1984) articulation of expertise, tacit knowledge remains an intangible concept practitioners find difficult to describe, whereas Schon's (1983) process of reflective practice results in aspects of tacit knowledge becoming known to practitioners (Johns, 1995). Not only is the outcome of reflection different for experts, so is the process. Robinson & Vaughan (1992) suggest that experts and non-expert practitioners reflect differently on clinical situations, in that the former bring a more critical mind of enquiry to the process. Despite these differing viewpoints, the question remains, how do experts and non-experts differ in their use of intuition? One possible solution may be found in the characteristics of the fourth attribute in Jasper's (1994) list, namely, pattern recognition and the cognitive processes that underpin it.

3.5 HIGHLY DEVELOPED LEVELS OF PATTERN RECOGNITION AND INTUITION

Pattern recognition is for Jasper (1994) what characterises the cognitive processes of the expert practitioner.

> "Crucial to this attribute is the development of 'intuitive' patterns of functioning which allow for rapid decision-making ... The mark of the expert is the capacity to think in 'wholes' due to the sophistication of the internalization of knowledge

and skills". (Jasper, 1994, p772).

In other words, it is the *internalization* of knowledge and skills, combined with the exposure to similar experiences that influence the intuitive patterns of thinking. This view is in accordance with Dreyfus & Dreyfus's (1986) model of intuitive judgement which has as two of its components, pattern recognition and similarity recognition. Whilst this interpretation bears a strong similarity to Benner's (1984) conclusions, the cognitive processes that underpin and enable the expert to function in such a way remain obscure. With the advent and development of computer science and the science of nursing informatics, computer programmers have attempted to replicate the cognitive processes used by expert practitioners to develop expert computer systems. An understanding of how these systems work sheds some light on the cognitive processes which may underpin intuitive behaviour.

3.6 EXPERT SYSTEMS

Attempts at explication of the concept of expertise, by those perceived as experts, has often proven difficult. Expert nurses commonly articulate that their clinical judgements and decision making are informed by "gut feelings", "a sense of uneasiness", or simply by "vague hunches" (Benner, 1984; Farrington, 1993). It is their inarticulateness that is problematical, but as Schon (1983) states, this is not unusual in that many practitioners make clinical judgements for which they cannot state the criteria or rules that informed their decision. This difficulty in articulating the cognitive processes underpinning clinical decisions has led to criticism. Whilst the inability of experts to accurately articulate the basis of their expertise is well documented, it has not prevented computer scientists and programmers trying to

83

develop expert computer systems which may have a wide variety of applications. One reason computer scientists have pursued this idea is to do with the recognition that the difference between novice and expert performance stems from the way information is perceived, stored and retrieved (Noyes, 1995). As computer scientists are familiar with these concepts, the development of expert systems was perhaps inevitable. Expert systems:

> "...capitalise on the large storage capacity and very fast processing times of computers by feeding them with thousands of rules and heuristics which the computer would rapidly run through until it found the one which worked best". (Rolfe, 1997, p1071).

Dreyfus & Dreyfus (1986), on whom much of Benner's (1984) work was based, conducted a critique of expert systems and concluded that the basis of their design in attempting to replicate expert behaviour was flawed. The premise of their argument is that whilst computers are able to process thousands of algorithms before arriving at the correct one, expert behaviour is spontaneous, in that the best option is chosen without time for working out all of the potential outcomes. This argument appears logical. What Dreyfus & Dreyfus (1986) appear to refute is that the *processes* that experts and expert computer systems use are similar, not that the outcome, i.e. choice of behaviour or action, is necessarily different. In this sense, expert systems of such design are of no help in furthering our understanding of the cognitive processes in which experts engage .

Computer science is however, a rapidly evolving industry and computer scientists now claim to have solved the problem of expert systems by utilising what they call "fuzzy logic". Rolfe (1997) explains that in such systems, computers are not

programmed with a set of concrete instructions which follow analytic logic. Instead

they are programmed with what he calls "fuzzy rules" which are much more

ambiguous and imprecise. To explain these fuzzy rules he provides the illustration

of where a computer might follow an instruction such as, "a bit to the right" or "a little

higher", as opposed to a precise instruction. He credits a computer scientist called

Kosko (1994) with making this breakthrough which has enabled the computer to learn

from what experts *do*, rather than relying on experts to verbalise their actions, which

often they are unable to do. The benefit of such a development is seen as being that:

> "The computer ... has access to the same accumulation of experience, the same thousands of special cases, as ... human experts. Furthermore, it generates its own fuzzy rules based on those experiences *and* is able to verbalise them". (Rolfe, 1997, p1072, original emphasis).

The actual processes and algorithms the computer uses to mimic expertise are in

effect intuitive and based upon weighing up a specific situation and taking a fuzzy

weighted average of all the available rules to help determine the appropriate course

of action (Rolfe, 1997). Fuzzy logic may help to explain the cognitive processes in

which experts engage, in context of the three knowledge domains discussed earlier.

For example, the expert nurse combines her theoretical knowledge (propositional

knowledge) with her experience of similar situations and cases (experiential

knowledge) and her personal knowledge of the situation and its demands (practical

knowledge) to "weigh up" the best course of action she should take. Priority, or the

weight assigned to each domain of knowledge, will vary according to individual

situations. In a particular situation, an expert may give low priority to the propositional

knowledge at her disposal in favour of her experiential and practical knowledge. At

other times, the reverse may be true. In this model the expert is in effect utilising

fuzzy logic as a basis for their practice. The degree of expertise or the accuracy of

conclusions and interventions will depend upon their:

> "... personal knowledge of [the]...individual case, on the volume and diversity
> of [their]...past experience and on how much scientific knowledge and theory
> [they]... have at [their]...disposal". (Rolfe, 1997, p1074).

By thinking in these terms, Rolfe (1997) suggests that experts should be better

placed to articulate the cognitive processes that guide their actions, although it could

be argued that the two things do not necessarily go together. It also provides insight

into how the cognitive processes of expert nurses differ from those of novice nurses.

In effect, this model makes clear the processes to which Benner (1984) alludes in her

discussion of intuition and expertise. It also helps to explain the *variance* in degrees

of expertise, which is possessed by the individual nurse.

3.7 COGNITIVE SCIENCE

It is not only in the realm of computer science that attempts to expose and explain the

cognitive processes of expertise have been made. Thompson *et al* (1990) suggest

that cognitive science is one of the few well developed theories that has potential for

explaining the development of expertise. Whilst a number of theories relating to

expertise, problem solving and decision making have been propounded over the past

30 years or more in the cognitive science literature (de Groot, 1966; Newell & Simon,

1972; Larkin *et al*, 1980; Chi *et al*, 1981; Anderson, 1982; Thompson *et al*, 1990),

Thompson *et al's* (1990) conceptual framework offers one of the most recent and

interesting perspectives. The premise of their argument is based on the belief that

cognition is of central importance to human function and as such is:

> "...ultimately responsible for the knowledge and skilful behaviour that is

referred to as expertise" (Thompson *et al*, 1990, p4).

Thompson *et al*, (1990) present a highly abstract and theoretical model of the way in which this neural network is responsible for distinguishing between the cognitive processes of experts and non-experts. As with other theorisations about the cognitive processes in which experts engage however, due to the physical limitations of technology and measurement, their assertions will for the foreseeable future remain at best, hypothetical and highly subjective in nature. When used to examine Benner's (1984) account of expert behaviour, network theory appears to provide one possible explanation of why the practice of experts and novices differ.

3.8 CONCLUSION

Arriving at a consensus regarding the concept of expertise and its place in nursing is not without its problems. There is general acknowledgement that Benner's (1984) seminal work in this area and its application to a nursing context has promoted considerable debate and has provided a basis upon which to examine the concept more closely. Critics of her work argue that the notion of intuition is so intangible and unscientific that its usefulness in explaining the expertise of nurses is questionable. Moreover, it appears that critics deride Benner's (1984) conclusions because of methodological limitations and her (perceived) failure to fully articulate the cognitive processes that distinguish expert practice from non-expert practice. When Benner's work is viewed within the theoretical frameworks of expert systems (Rolfe, 1997) or cognitive science (Thompson *et al*, 1990) however, she arrives at the same conclusion, only through the use of a different vocabulary and conceptual framework. It can be legitimately argued that she does over-emphasize a reliance on experiential

knowledge whilst playing down the importance of propositional knowledge (Heron, 1981), with one potential complication being that experts may not necessarily base their practice on current knowledge. The fact that experts are not always able to articulate the rationale for their actions and decisions is not necessarily an indicator that one type of knowledge prevails hierarchically or is more refined than another, simply that the cognitive processes involved are difficult to describe. As has been illustrated, it is not the possession of knowledge that designates the expert, but how that knowledge is processed and used to inform clinical practice.

A more contentious issue concerns the formal recognition of expertise and in particular, who should confer the accolade of "expert" on the individual practitioner. It has been argued that expertise needs to be recognised both from within and without the nursing profession, but the criteria for such recognition cannot be agreed. Benner (1996) acknowledges the power gradient that exists between nursing and medicine and sees the recognition of nursing expertise as being one way to ameliorate the situation. However, one of her critics (Cash, 1995) suggests that until expertise, and intuition in particular, can be located into a positivistic paradigm, that such imbalances will remain. As has been illustrated, the difficulties inherent in eliciting objective based criterion for expertise, other than the crude indicators such as length of service, grade and educational qualifications already in use, appear likely to remain.

Advanced nurse practitioners are frequently referred to in the literature as clinical experts (see Fenton & Brykczynski, 1993), however, the basis of their expertise is

either assumed by virtue of their academic qualifications, or described as a list of competencies which are context bound (Fenton & Brykczynski, 1993). Differentiating the practice of advanced practitioners from that of 'experts-by-experience' is consequently difficult, as experts appear to be classified and recognised by what they *do* and to a lesser extent what they *know*, rather than by a set of definitive characteristics. Calkin (1984) provides one explanation of how the three domains of knowledge are integrated to a greater extent by advanced practitioners than other nurses. What remains unclear from the literature is how nurses move from a position of 'expert by experience' to 'advanced practitioner' and the processes in which they engage whereby they become recognised as an expert.

Furthermore, whilst the importance of propositional knowledge is emphasised in studies of advanced practitioners, the role of intuition as described by Benner (1984) is de-emphasized. There is however an appealing logic that these two concepts are related in some way, which in turn influence how the ANP attends to the needs of the patient in their care. The abstract nature of the concept of intuition remains ambiguous and hence it becomes problematical in terms of understanding its relationships with the other domains of knowledge related to expertise. It is likely that it is for this reason that the notion of expertise is socially constructed and recognised. Furthermore, the social learning of expertise that is implicit in the prior discussion cannot be ignored, although there is an absence of literature addressing this subject explicitly. In attempting to uncover the cognitive process involved in expert action, computer and cognitive scientists have even attempted to explain the phenomenon of expertise from a different perspective (Thompson, *et al*, 1990; Rolfe, 1997). However, the actual cognitive processes which differentiate expert practice from that

of non-expert practitioners, be it by intuition (Benner, 1984), reflection (Schon, 1983), fuzzy logic (Rolfe, 1997) or organized by a neural network (Thompson *et al*, 1990) remains at best, equivocal. What perhaps becomes more important in understanding the nature of expertise and the expert practitioner is how individual engages in the transitional process (or social learning) of moving from experienced nurse to advanced (expert) practitioner. The final chapter of the literature review examines these concepts in more detail.

CHAPTER FOUR

LITERATURE REVIEW III: WORK ROLE TRANSITION

CHAPTER 4: LITERATURE REVIEW - WORK ROLE TRANSITION

4.1 INTRODUCTION

This part of the literature review is dedicated to examining the concepts of *transition* and *development,* and their relationship to the implementation of new work roles. Following a brief discussion of professional socialization[2], the central theme of transition is explored from a nursing context. A series of papers and studies that have attempted to describe the transitional process experienced by nurses entering advanced practice roles are then reviewed and have their merits assessed. The section concludes by describing and appraising Nicholson's (1984) Theory of Work Role Transitions and its application in a number of recent empirical studies.

4.2 PROFESSIONAL SOCIALIZATION

The transition into a new work role can involve many changes for an individual. These can include a re-definition of goals, a change in identity, an adjustment in informal networks, as well as a reorientation of attitudes and behavioural routines (Ashforth & Saks, 1995). Such changes are influenced not only by the demands of the new job, but equally by an individual's personal attributes, such as personality, knowledge level, communication and interpersonal skills (Topham, 1987), as well as their previous socialization experiences (Biddle & Thomas, 1979). Together, the attributes, expectations and prior experiences of an individual, along with the demands of the new work role, interact with the expectations of the organization (Topham, 1987) to set a frame of reference within which the transition takes place.

---

[2] Whilst the body of literature relating to occupational and professional socialization is considerable, due to the word limitation of this thesis, only brief consideration is given to the concept in the review.

Once in the new role, the individual adopts a strategy of role-making as part of role socialization. This is perceived to be a continuous process whose purpose is to test and validate new role behaviours (Rubin, 1988). Ultimately, this places considerable demands on the individual because:

> "...role transition denotes a change in role relationships, expectations, or abilities. Role transitions require the person to incorporate new knowledge, alter his behaviour, and thus change his definition of himself in his social context." (Meleis, 1975, p265)

In this sense, role transition may be considered analogous to the process of socialization, whose major tasks are considered to be: developing work role clarity; facilitating competence; developing realistic expectations about a job; and the development of interpersonal relationships (Adkins, 1995).

Professional socialization has been defined as the process by which a person acquires the skills, knowledge and sense of occupational identity characteristic of the profession they have chosen (Cohen, 1981). These role concepts eventually become internalised and help the individual to define their professional or organizational role (Brief *et al*, 1979; Cohen, 1981). Boyle *et al* (1996) modified Feldman's (1976) contingency theory of socialization to a nursing context and suggested that professional socialization occurs through three stages; anticipatory socialization, accommodation and role management. In each stage, personal and environmental variables interact to shape the process of professional socialization. Anticipatory socialization is said to take:

> "...place by mental rehearsing and social conditioning to the type of role enactment demanded in each social situation." (Christman, 1991, p210)

and is consequently concerned with the notion of a perceived congruence between

the individual and the role (Boyle *et al*, 1996). The accommodation phase relates to attaining congruence, whereby the nurse is preceptored and supported to learn what the profession and organization are really like and, in effect to confront the reality of the social situation. The final stage of role management is one in which there is a resolution of conflict in the socialization process.

What becomes apparent, is that professional socialization can be seen to be the result of an interactive process (Light, 1980; Hurley-Wilson, 1988) between the individual and the social structure in which the role is being expressed (Christman, 1991). In the context of advanced practice nursing, the concept has been categorised as comprising three interrelated dimensions of: professional socialization; organizational socialization; and, role socialization (Hixon, 1996).

Role socialization is considered to be of prime importance in determining the effectiveness of the advanced role and how it is operationalized (Maguire *et al*, 1995). In this respect, it has been argued that the transition from experienced nurse to advanced practitioner requires a mandatory resocialization (Sheer, 1994), whereby the individual's sense of what nursing is about is challenged (Leddy & Pepper, 1993). The term resocialization is, therefore, used to acknowledge that nurses have undergone a process of prior socialization into nursing, but are now being resocialized into a new role. This differs from Shuval's (1980) notion of post-socialization which reflects a period of practice following formal socialization, in which the outcomes of the socialization process are primarily of interest, not the resocialization process into another role.

The process of being socialized into a new work role can be both complex and variable. It is influenced by a multiplicity of factors ranging from; the attributes of the individual, the demands of the particular job, the goals and socialization processes of the organization, and, in the case of advanced practice nurses, the novelty of resocialization into a new professional framework. Consequently, the process is not without its problems, inasmuch as inadequate socialization in nursing has been associated with high turnover rates and attrition (Kramer, 1974). Central to the process of resocialization is the concept of transition.

4.3 TRANSITION AS A CENTRAL CONCEPT

The notion of transition has spawned multiple definitions and interpretations and has been identified as a central concept in nursing (Schumacher & Meleis, 1994). Schumacher & Meleis (1994) undertook a systematic review of the nursing literature and were able to identify four types of transitions: developmental; situational; health-illness; and organizational transitions. From their analysis they were able to conclude that developmental transitions focus primarily on the individual and are commonly associated with stages in the life cycle. Situational transitions are concerned with passages into various educational and professional roles. Health-illness transitions are self-evident, in that they relate to the changes experienced by individuals and their families in the context of health and illness. Finally, organizational transitions represent alterations that take place in the environment and which are seen to affect the lives of the individuals who work within an organization. The different types of transitions are not perceived to be mutually exclusive, in that they are perceived to be:

"...complex processes and multiple transitions may occur simultaneously during a given period of time". (Schumacher & Meleis, 1994, p121)

During the process of becoming an advanced nurse practitioner for example, one would expect a relationship between situational and organizational transitions.

4.3.1 UNIVERSAL PROPERTIES AND CONDITIONS OF TRANSITIONS

From their review, Schumacher & Meleis (1994) were able to synthesise a set of universal properties and conditions which relate to the concept of transition in all its forms (figure 4.1). The first property they identify is that transitions are processes that occur over time involving some kind of movement from one state to another. This is a property which is made explicit in a number of definitions of the term transition

Figure 4.1 A nursing model of transitions. (Source: adapted from Schumacher & Meleis, 1994)
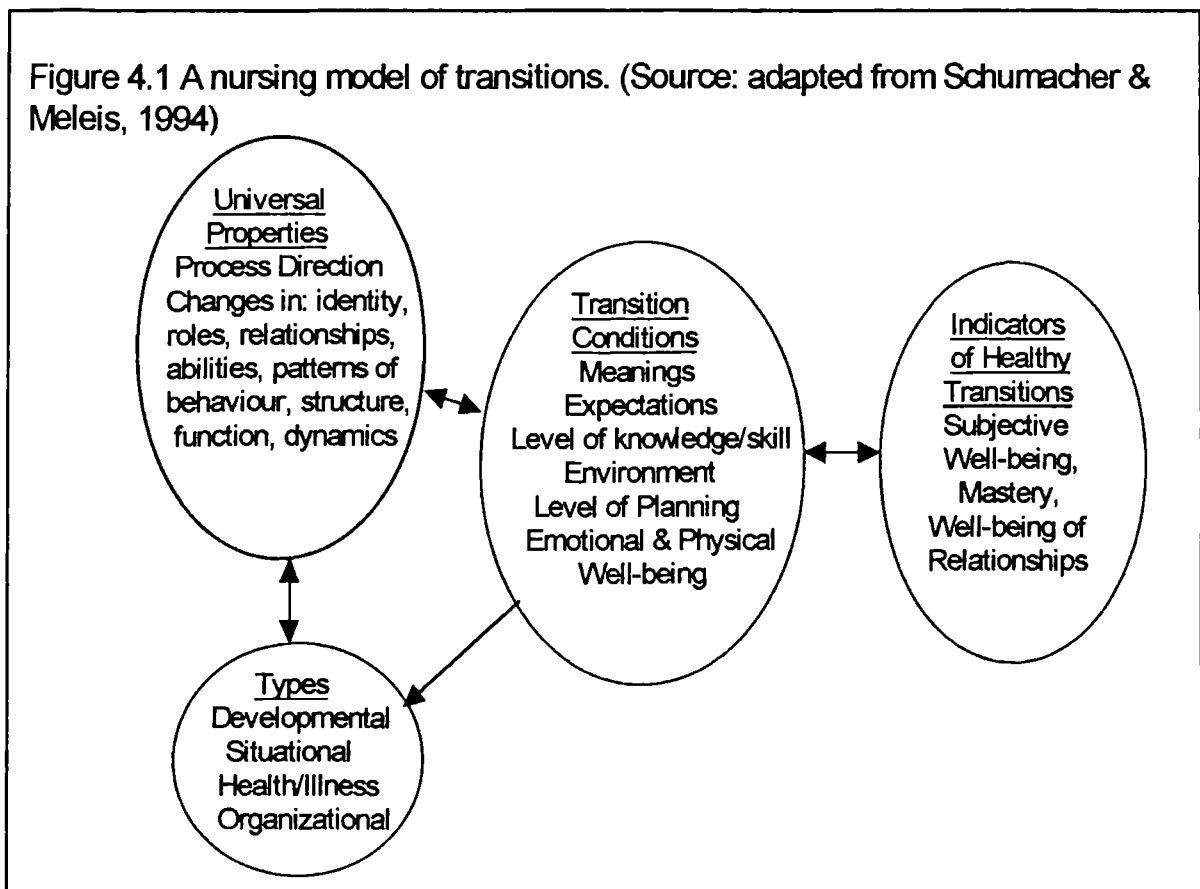
and is clearly supported in the literature (see Golan, 1981; Nicholson, 1984; Chick & Meleis, 1986). Schumacher & Meleis (1994) acknowledge that many writers have taken somewhat of a reductionist view of the transition process and have described the development and flow of transitions in terms of various stages or phases. (This is an assertion which will be seen to be borne out later in this chapter.) Schumacher & Meleis (1994) suggest that dividing the transitional process into a series of stages or phases has, however, facilitated our understanding of this phenomenon.

Schumacher & Meleis (1994) have also described a set of "transition conditions" (i.e. those factors which have a significant impact on influencing the transitional process - see figure 4.1). Each of these factors can be considered to vary in degree according to individual circumstance. Schumacher & Meleis (1994) stress that, in the literature relating to transitions in nursing, emphasis is placed on the 'process' of transition as opposed to indicating the factors which lead to a positive or negative transition. The characteristics of a positive transition have been identified as being subjective well-being (i.e. of the individual nurse in the case of transition into a new work role), role mastery and the well-being of relationships. The antithesis of these factors would indicate an unsuccessful transition.

4.4 TRANSITION TO THE ROLE OF ADVANCED PRACTITIONER.

While there is no dearth of literature on the socialization of nurses in general (Goldenberg & Iwasiw, 1993), to date, with the exception of empirical studies by Lukacs (1982), Hamric & Taylor (1989) and Hixon (1996), there has been little systematic inquiry into the work role transitions or role resocialization of advanced

practice nurses. Discussion papers and studies published over an extensive period of time focus on both the transitions of the clinical nurse specialist (Oda, 1977; Hamric & Taylor, 1989, Bass *et al*, 1993) and nurse practitioner roles (Anderson et al, 1974; Lukacs 1982; Brown & Olshansky, 1997; Roberts *et al*, 1997; Shea & Selfridge-Thomas, 1997). The majority of these papers relate to advanced practice roles in the USA, however, their findings and conclusions *may* be transferable to the UK context in the broadest sense, as:

> "...anyone entering a new and complex role experiences a process of role development before being able to function with maximum effectiveness".
> (Hamric & Taylor, 1989, p41)

The majority of studies involving clinical nurse specialists and nurse practitioners suggest that the advanced practitioner may pass through a series of stages or phases as they develop in their role. A summary of the various stages identified in models of role transition is presented in Table 4.1.

In one of the earliest theories put forward, based only on anecdotal evidence, Oda (1977) suggests that new specialists pass through three phases of role development: role identification; role transition; and role confirmation. Each of these stages is based on an elaboration of the concepts of clarification and communication, which Oda (1977) considers to be essential pre-requisites for the successful implementation of any new role. She argues that:

> "...continuous communication of role purpose and function to one's colleagues is a must" (Oda, 1977, p374)

in all three phases of role development.

The role identification phase consists of clarifying the purpose and objective of the

specific role, both for the specialist and their colleagues and in specifying *what* is to be accomplished and *how* it is to be achieved. In instances where such roles are new or unique to a practice situation, the lack of a previous role model or specific job description may prove to be problematical for the role incumbent, leading to stalling in this phase, although this is not acknowledged by Oda (1977). The basis of this assertion can be seen to be supported by a study of Community Psychiatric Nurses in the UK by Skidmore & Friend (1984a) which highlighted how nurses who found themselves in completely new roles "muddled through" by using a process of trial and error in their encounters with patients.

The second stage is identified as the role transition phase, in which the new role is implemented in order to reach mutually agreed specific goals. The ultimate aim of this phase is said to be the evolution of a specialised nursing role which meets the needs of the staff and the specific institution (Oda, 1977).

The final stage in the transition to a new role is called the role confirmation phase. In this stage, the new specialist seeks and gains reinforcement of her role definition both from colleagues and administrators. The assertion being that the specialist will be gradually accepted by colleagues who will then provide support and include the specialist in work and social activities.

Table 4.1 A comparison of staged models of transition in advanced practice nurses.

Author	1st Stage	2nd Stage	3rd Stage	4th Stage	Final Stage(s)
Anderson et al, (1974)	Identity Crisis	Developing competence	Achieving independence	Professional Intimacy	——XXX——
Oda (1977)	Identification	Transition	Confirmation	——XXX——	——XXX——
Bass et al, (1993); Shea & Selfridge-Thomas (1997)	Novice	Advanced Beginner	Competent	Proficient	Expert
Hamric & Taylor (1989)	Orientation	Frustration	Implementation	Integration	5)Frozen 6)Reorganization 7)Complacent

On examination, this framework appears to be somewhat simplistic, idealistic and aproblematical. Oda (1977) does, however, provide two examples of how nurses faced with conflicting expectations in the first two phases can devise strategies to achieve role acceptance. Oda (1977) fails to provide any indication of the expected duration of each phase, or indeed if they are sequential or run in parallel. She only states that there is some overlap and movement back and forth depending upon individual circumstances. This model relies on a unified vision of the purpose of the advanced practice role, which in many cases may be absent. Furthermore, the framework fails to seriously consider the influence of the organization and environment on the process of transition and provides only anecdotal evidence to support its claims. As such, the conclusions at which it arrives are at best questionable.

Another approach to understanding the transition to advanced practice nurse has been suggested by Bass *et al* (1993) and Shea & Selfridge-Thomas (1997). They describe the process of role acquisition from experienced clinician to novice clinical nurse specialist (i.e. in the first year of the new role) and emergency nurse practitioner respectively. Both utilise Benner's (1984) model of skill acquisition to explain the developmental stages through which the novice CNS and nurse practitioner pass before attaining expert level status. They argue that transition into the new role is a difficult process and one that provides considerable challenge in both cases. Bass *et al* (1993) provide the most detailed account of the transition process and it is theirs which will be used in this discussion from now on.

In the initial phase of role implementation, the novice seeks primarily to develop and refine their clinical and technical skills as opposed to developing competencies in the other sub-roles (Page & Arena, 1991). In the advanced beginner stage, it is suggested that the CNS starts to become familiar with the unit in which they work and is increasingly recognised and used a resource by nursing colleagues. This increased visibility in the clinical environment helps to refine the goals and responsibilities of the role in order to meet the needs of the patients and staff. Whilst being recognised as an expert clinician, other sub-roles are beginning to be developed and the CNS starts to consider the wider organizational needs and may become involved in managerial and strategic committees.

In the competent stage, the performance of the CNS is seen to be confident, effective and integrated. The sub-roles of educator, consultant and change agent are established and the foundation for development laid. At the proficient stage the neophyte CNS is characterised by the ability to anticipate both patient and staff needs based on prior experience of similar situations. Whilst developing Benner's (1984) 'intuitive-grasp', it is argued at this stage that the CNS still relies on maxims and rules to guide performance, although the nuances of clinical situations are beginning to be recognised and understood. Furthermore, at this stage all four sub-roles are developed and incorporated into daily practice and the CNS increasingly takes on a managerial role.

On reaching the expert stage the CNS exhibits a

"..deep understanding of all sub-roles [and] is able to integrate them into one

role". (Bass *et al*, 1993, p150)

At this stage the CNS is seen to have developed strong professional relationships with nursing and medical colleagues and gained their respect.

Whilst this developmental model appears logical, it is based only on the experiences of two of the authors who hold CNS positions and two who hold nurse practitioner posts. Their conclusions are not based upon any empirical or systematic study of CNSs or nurse practitioners. Consequently, it is difficult to establish how long each stage of development lasts and where one stage ends and the next commences, or whether all stages are experienced.

One of the few empirical studies exploring the role development of CNSs in the USA was conducted by Hamric & Taylor (1989), who compared the role development of a total sample of 100 inexperienced (less than 3 years in post) and experienced (more than 3 years in post) CNSs. The study utilised a survey design involving a purposely designed instrument created for the investigation to measure the conceptual areas of clinical practice, job satisfaction and the process of role development.

The results of this survey revealed:

> "...that the experience of role development is a highly variable and complex phenomenon," (Hamric & Taylor, 1989, p47)

with 7 phases of development being identified. The experience of the CNSs suggested that movement from phase to phase was fluid and highly individualised

and found to vary considerably amongst the study respondents, with some inexperienced CNSs simultaneously experiencing more that one phase. The stages of development were named orientation[3]*, frustration*, implementation*, integration, frozen, reorganization and complacent. The first three phases of development were discussed primarily in relation to inexperienced CNSs, whilst the latter were only discussed in relation to experienced CNSs. As the focus of this thesis relates to inexperienced advanced practitioners only the first three phases will be discussed in detail.

The orientation phase was experienced by all inexperienced CNSs (mean duration = 4.6 months; range 2 to 10 months) and is characterised by enthusiasm and optimism about changes the CNS will achieve in the organization. This phase was experienced to a lesser extent by CNSs who were familiar with setting in which they were taking up the new role.

The frustration phase was experienced by 95% (n=40) of CNSs in their first position. The duration of this phase ranged from 1 to 18 months and was experienced as early as the first month in post for some, whilst not being encountered by others until the second year of practice. The frustration phase is said to be:

> "... a powerful and disconcerting experience, characterised by feelings of discouragement and inadequacy as the CNS's initial assessment reveals unrealistic personal or organizational expectations, overwhelming problems, and the realization that making change is more difficult and slower than originally expected". (Hamric & Taylor, 1989, p52)

---

[3] * These phases had been previously identified by Baker (1979) and used as the basis for measures in the research instrument developed for the study.

Situational characteristics, such as lack of clear role definition, conflicting expectations with colleagues and staff resistance, were amongst the reasons cited as contributing factors to the identification of this phase. Moreover, it is likely that a high level of performance maybe an unrealistic expectation in the context of a major transition (Kane, 1992; Rice, 1988). It is noted, however, that not all CNSs experienced this phase and the authors stress that this stage in not necessarily inherent in the development of the CNS role.

The implementation phase was commonly experienced and is characterised by a re-emergence of optimism and increased confidence in practice, with a corresponding clarification of role definition and priorities. Situational factors and the experience of the CNS are seen as the key factors which influence the movement through each stage of development. Furthermore, some CNSs reported an overlap in some phases of development, whilst others who moved to positions in different organizations would go back and re-experience the earlier phases of transition, albeit for a shorter duration. Whilst this model is applied specifically to the CNS advanced role it is likely that other advanced practitioners would experience similar phases of transition.

The transition to the role of nurse practitioner has also been the subject of interest in the nursing literature. One of the earliest studies (Anderson *et al*, 1974) developed a transitional model based on the experience of students undergoing a nurse practitioner programme in the USA. The basic premise of this model is that students on the programme pass through four stages in the transition from experienced nurse to nurse practitioner. The first stage, whose onset is quite rapid following

commencement of the programme, is termed "the identity crisis". This stage is a result of a perceived conflict between the concept of being a nurse and an obsessive focus on medical skill acquisition. This stage is typified by uncertainty and an observed regression in nursing competence and confidence within the first two to three months of the programme. At this 'crisis' point the student is seen to need to progress on to the next stage of role transition.

The second phase in role development is identified as "developing clinical competence". Most students are seen to have developed baseline competence within the first three to four months of the programme. The stage at which this phase is experienced is specific to this particular programme (as are the other stages) as students spent 16-20 hours per week in supervised clinical application of the theoretical constructs encountered in the course. In alternative curricula this stage may not occur until much later, depending on the particular programme design. During this phase the validity of nursing practice is said to re-emerge for the students as their knowledge and skill base continue to develop.

The third phase of the transitional model is described as "achieving independence" and is said to commence after about five months of the programme. This stage appears to be typified by the NP student moving into areas of patient management and intervention leading to the evolution of new relationships with physicians. At this stage the authors suggest that conflicting expectations and confrontation are not atypical between the NP student and the resident physicians.

The final stage is termed "achieving professional intimacy" or reaching a level of interdependent practice. The authors suggest that most students reach this stage successfully, but not without passing through the other stages in a linear fashion. It is stated that this stage starts to become evident at around the six month point of the programme. This phase of transition signifies an agreed sharing of responsibility for the quality of patient care based on a mutual respect between nurse and physician.

There are a number of problems with this transitional model which raise questions about its conclusions. Firstly, the authors assertions are based on casual observations of the phenomenon and not upon any systematic investigation that has taken place. Furthermore, the model is specific to the particular university and course. Arguably other universities have curricula that differ in duration, content, focus, delivery, student selection and so on. It is unlikely, therefore, that these stages, if replicated at all, would be experienced at the same time or in the same sequence. Next, movement through each phase supposedly occurs in rapid succession, with only 3 months between stage 2, "developing clinical competence" and stage 4, "achieving professional intimacy". Logically, it appears to be unrealistic to expect novice nurse practitioners to achieve a level of professional interdependence when a similar stage in CNS development does not occur until after the CNS has spent greater than three years post-graduation developing her practice and establishing credibility and relationships (Hamric & Taylor, 1989). Whilst the stages of transition would appear to be appealing, the basis upon which the authors conclusions are drawn is questionable. This assertion is borne out by a study carried out by Lukacs (1982) which contradicts Anderson *et al*'s (1974) findings. In Lukacs

(1982) study 135 nurse practitioners, with a mean of 3.9 years experience, were surveyed to determine the existence, extent and nature of transitions associated with their role. The findings of the study demonstrated that 86.7% (n=117) of the sample experienced a period of transition, the average length being 5.9 months (STD=5.3 months) *post* graduation. Most of the findings from the respondents of this study would suggest that the main phase of transition experienced by nurse practitioners relate to "developing competence". Some in this group of nurse practitioners also reported experiencing the 'frustration phase' similar to neophyte CNSs (Hamric & Taylor, 1989). Therefore, for Anderson *et al* (1974) to suggest that nurse practitioner students can reach a level of independence, let alone professional inter-dependency during a short programme seems somewhat unrealistic.

It can be seen that Schumacher & Meleis's (1994) assertion that transitions are often described as a series of phases or stages is particularly true in the case of transitions into advanced practitioner roles. Whilst there is a lack of consistency in terminology relating to the stages of transition, it is evident, from the previous discussion, that several stages in role transition share similar characteristics. Essentially, what appears to be of importance are the characteristics of the stage of transition, not necessarily the terminology that is attached to individual phases. From the models and limited research presented, it can be concluded that individual circumstances, along with the attributes of the practitioner, determine the rate and stages of transition that are experienced, from which few generalisations can be made.

These transitional models appear to have three things in common:

i) a period of role development characterised by: the learning of new skills; involvement in new activities; and a change in the professional relationships with peers, managers and physicians.

ii) A recurring theme appears to be that the practitioner can (but not always) experience uncertainty, frustration, or conflict during the transitional process.

iii) The final stage in transition, which again varies in duration and nomenclature, involves attaining recognition for some degree of professional independence and autonomy, along with the refinement of skills and a clarification of role goals and objectives.

Consequently, each stage appears to be highly individualised and varies in duration and chronology.

A common factor shared by all the models reviewed in this section is a focus on the concept of transition predominantly as a process, rather than an outcome. The work of Nicholson (1984) and Nicholson & West (1987) on the other hand, whilst not involving nurses, helps to redress this balance. They have focused on the development of a Theory of Work Role Transitions which focuses on role adjustment outcomes as well as processes. The theory and its application in a number of empirical studies will now be examined.

4.5 NICHOLSON'S THEORY OF WORK-ROLE TRANSITION.

Nicholson's work develops a theory of "adjustment", which is seen to be a transition in both the behaviour and disposition of an individual when a change in employment status or a major change in job content occurs (Nicholson, 1984).

> "The central premise of the theory [is] that individual differences in the characteristics of people and the transitions they undergo mediate the relationships of change vs. stability and individual vs. situational adjustment". (Nicholson, 1984, p172).

The variables that Nicholson (1984) gives attention to in the development of his theory are: the role requirements of the new position; the motivational and psychological disposition of the individual; the individual's prior occupational socialization; and the induction-socialization process the individual experiences in the new position. These variables are related to two outcomes of adjustment, "personal development" and "role development". The former is considered to be the individual's adjustment to role transition, in which there are changes in the frame of reference, values and other identity attributes of the person. Role development on the other hand, is seen as a strategy adopted by an individual in response to role requirements of the new position in order to achieve an equilibrium in needs, abilities and identity. In this sense, role development involves the individual in initiaiting changes in certain aspects of role performance, such as, interpersonal relationships, the organization of work, tasks, objectives, role boundaries and so on. Role development is seen to vary according to situational constraints and opportunities, and the needs and expectations of the individual.

> "These two kinds of adjustment strategies can be considered to be independent, and, moreover, it should be noted that, on either dimension, developmental change can be retrograde, reactionary, or destructive." (Nicholson, 1984, p175).

110

Nicholson (1984) identifies four modes of adjustment to transitions resulting from personal and role development: replication; absorption; determination and exploration. Each mode is dimensionalized as being either high or low, resulting in the relevant mode of adjustment.

Replication represents only a minimal adjustment in either the personal or role systems of the individual and occurs as a result of low personal development and low role development. In this case, the incumbent experiences little change in identity or behaviour and makes no changes in role requirement. This outcome is typified by the individual performing virtually the same role and duties as in their previous job. Consequently, there is low personal development and low role development.

Absorption is said to be a mode of transition that is manifest when the individual gives priority to learning the requirements of the new position and assimilating the relevant skills and behaviours. Consequently, there is little in the way of adjustment to the parameters of the role itself as the person's energies are directed elsewhere. The example that Nicholson (1984) provides, to illustrate this state, is when a worker moves to a new position in which the social environment and tasks associated with the new role are in sharp contrast to their old post. This mode of adjustment is typified by high personal development but low role development.

Determination is a mode of transition that can be understood in terms that it is the direct opposite to the absorption mode of transition described above. In this transition mode the individual is able to make a significant contribution to the

111

development and parameters of the new role, but requires little or no personal

adjustment and development on their part. This is typified by high role development

but low personal development. Nicholson (1984) highlights that there are virtually no

studies that focus on this process, but expresses the idea that it is the individual who

imprints themselves on the role they have undertaken.

The final mode of transition is referred to as exploration. Nicholson (1984) describes

this mode as being:

> "...where there is simultaneous change in personal qualities and role
> parameters" (p176).

This, therefore, represents the dimensions of both high personal development and

high role development. The four modes of adjustment can be summarised thus:

> Absorption = high personal development + low role development;
> Determination = high role development + low personal development;
> Replication = both low role and personal development;
> Exploration = high role and personal development.
> (West & Rushton, 1989, p272)

The theory then adds a third dimension to the four modes of adjustment, in terms of

the affective reactions experienced by role incumbents to each mode of transition.

It is suggested that individuals can experience feelings from the positive to the

negative, with the midpoint being viewed as a neutral position. Thus, Nicholson

(1984) states, for example, that in the replication mode, positive feelings are

associated with the status quo and a sense of stability. On the other hand, negative

feelings would carry associations of restriction or being trapped in a rut with little

scope for progression. The same principle applies to the other modes of adjustment.

Arguably, this allows for individual interpretations of situations and events which help

to account for variations in the experiences of role transitions. As Nicholson (1984) states:

"... transition is above all else a process through time, and outcomes can be expected to shift from one adjustment mode to another. Individual differences in motives and affective reactions will play a major part in mediating these shifts". (p177).

Nicholson (1984) goes on to develop his theory further by identifying predictors of role adjustment. He identifies the characteristics of *novelty* and *discretion* as being central to influencing change in a work role. The latter relates to the individual's opportunity to alter the content of a particular role and the relationships with people in the work setting. Discretion is seen to influence the scope for role development. Jobs with high levels of discretion are seen to prescribe to the determination and exploration modes of adjustment, whilst roles with little or no discretion are likely to lead to replication or absorption modes.

Novelty, on the other hand, is predicted to relate to the dimension of personal development rather than role development. Nicholson (1984) defines the novelty of job demands as:

"...the degree to which the role permits the exercise of prior knowledge, practiced skills, and established habits" (p178).

That is to say that if someone enters a new role, whose function is similar to their old position, there will be low novelty and little change in skills or professional identity. In positions where novelty is high, Nicholson (1984) argues that individuals may have little opportunity to utilise familiar skills and practices, in which case there will inevitably be some personal development. He then relates the dimensions of novelty

and discretion to the modes of transition. In positions where both novelty and discretion are low, he predicts that replication will occur. Where novelty is high, but discretion is low, then absorption will be the transitional outcome mode. Likewise, where discretion is high and novelty are low, then determination with be the resulting transitional mode. In cases where both novelty and discretion are high, the resultant transitional mode will be exploration. When viewed as a matrix the predictors of novelty and discretion are related thus to the transitional outcomes

Absorption = high novelty + low discretion;
Determination = high discretion + low novelty;
Replication = both novelty + discretion are low ;
Exploration = both novelty + discretion are high.

Nicholson (1984) identifies two other predictors of work role transition which he classes as motivational orientations of the individual: the desire for control and the desire for feedback during the transition process. He treats each of these predictors in a similar fashion to novelty and discretion inasmuch as they are dimensionalized from low to high and correspondingly associated with a particular transitional mode outcome. When viewed as a matrix the predictors of desire control and desire for feedback are related thus to the transitional outcomes:

Absorption = high desire for feedback + low desire for control;
Determination = high desire for control + low desire for feedback;
Replication = both desire for control + feedback are low ;
Exploration = both desire for control + feedback are high.

Nicholson (1984) goes on to give further substance to his theory (which are not examined here) by elaborating on additional influences to the transition process, including discretionary and temporal shifts in adjustment modes.

Nicholson (1984) acknowledges that differences within individuals will be reflected

in the way they approach the challenge of role development and consequently the dimensions of discretion, novelty, desire for control and desire for feedback will vary in value and influence. He suggests the use of longitudinal studies, using standardised instrument measures, pre and post transition to validate the propositions in his theory.

Nicholson (1984) suggests that his theory can be applied to a range of transitional events with minor conceptual adjustments, ranging from retirement to geographical migrations. It therefore may be of use in explaining the transitional processes and outcome modes of becoming an advanced practitioner.

This model has obvious potential for explaining both the transition process and its outcomes and a number of recent studies have adopted the theory as a framework for empirical inquiry into various work-role transition situations, in an attempt to test its validity and reliability (West, 1987; West *et al*, 1987; West & Rushton, 1989; Black & Ashford, 1995; Ashforth & Saks, 1995). The majority of these studies adopted a longitudinal design; however, one utilised a survey design involving a stratified sample rather than a longitudinal study (West & Rushton, 1989). The results from the studies found mixed support for the theory, suggesting that whilst it has merit in many areas, further theoretical refinement and development are required.

Whilst all of these studies set out to explore Nicholson's (1984) theory and adopted similar designs, there was considerable variance in the nature and size of samples, and in the measurement instruments adopted or adapted to test the various

hypotheses propounded. Ashforth & Saks (1995) study, for example, involved 295 graduates of a business programme in Canada, who were surveyed in their final semester and at intervals of 4 months and 10 months following taking up new work positions (the timing of the measurements was completely arbitrary). The measures focused on self-reports of *discretion* and *novelty*, along with measures of the motivational orientations (i.e. desire for control and desire for feedback), prior occupational socialization, and work adjustment, using previously devised scales (with the exception of prior occupational socialization).

The results of this study revealed a number of contradictory findings to those of Nicholson (1984) and his colleagues (West *et al*, 1987; West, 1987). Firstly, Nicholson's (1984) hypothesis that novelty is positively related to personal development was supported at the 4 month stage, but only when high discretion was present, and only at the 10 month stage when there was an interaction with the motivational variables of a low desire for control or a low desire for feedback. The hypothesis that discretion is positively related to role development, was found to be supported at the 4 month stage, but at the 10 month interval the association was only present if novelty was low. The study also found Nicholson's (1984) hypothesis, relating to motivational variables as predictors of role development, was also only partially supported. Ashforth & Saks (1995) concluded that their results:

> "...suggest that personal and role adjustments following work-role transitions are a complex function of both dispositional and situational antecedents." (p170)

In other words, work-role transitions are seen to be highly sensitive and contextualized to the environment in which the individual works and to the personal

characteristics and traits on the individual. Ashforth and Saks (1995) go on to state that in their view the findings of the interactions they report can only be suggestive and are not conclusive and, thus, require further examination and theoretical development. However, they are at pains to stress the limitations of the study in terms of the nature of the sample in undergoing a common work-role transition from mundane jobs, prior to graduation, to more demanding jobs, post-graduation. They concluded this may have not provided a fair test of the theory. However, arguably the greatest flaw in this study revolves around the graduates' lack of experience in the world of work. Of the 295 students recruited into the study only 181 had had some experience of full-time employment and, of those, the mean number of years of experience was only 2.9 (STD=3.2). Consequently, many of the graduates (n=114) were taking up their first position in full-time employment, whilst many of those with prior work-experience were taking up completely new posts. In these circumstances, the transitional outcome mode most likely to occur would relate to personal development rather than role development. The study reports that personal development did occur when there was a significant interaction between the dimensions of novelty and discretion and that role development was positively related to full-time and part-time experience, suggesting that use of a graduate sample in the study was to some extent inappropriate.

Further questions can be raised regarding the measures used in the study and their sensitivity to measuring the concepts they purport to reflect. In this instance, measures devised by five different authors, along with one scale devised specifically for the study, were utilised. Whilst the number of instruments is in itself not

problematical, standardisation between instruments, in terms of their conceptual focus and the context in which they were devised, raises questions over validity. Finally, the work-role transitions studied all involved graduates taking on positions where there had been previous incumbents and against which comparisons in performance could be made. Ashforth and Saks (1995) study, therefore, only provides a limited basis, as they admit themselves, for testing the theory of work-role transitions.

Likewise, in a study involving student nurses only partial support was found for Nicholson's (1984) theory, albeit that the authors were investigating the theory's applicability to mismatches in work-role transitions (West & Rushton, 1989). This study set out to examine the consequences of a person-role 'mismatch' in which the dimensions of the role (i.e. lack of discretion) were in conflict with the personal orientation of the individual (i.e. desire for control). Nicholson's (1984) theory makes no specific predictions in relation to modes of adjustment where such circumstances exist (West & Rushton, 1989). The central focus of the study was the outcome of adjustment for someone entering a very low discretion environment (in this case nurse training was seen to be high in novelty but low in discretion in terms of its role requirements) but whose personality characteristics lean toward a high desire for control. The conflict in this case, is that a low discretion environment is associated with a low desire for control. In such circumstances it is argued that a person with a high desire for control is restricted in their opportunity to change or develop a role. West & Rushton (1989) go on to propose that when the nature of the work and the workplace an individual experiences is different to that anticipated, it is likely to

cause a negative emotional effect and:

"... any attempts to manipulate this rather rigid environment are likely to fail and result in feelings of frustration." (West & Rushton, 1989, p274).

Consequently, the study predicted that individuals who found themselves in a mismatch situation would experience high levels of stress. Furthermore, it was suggested that in the early stages of transition, such a person would choose to adhere to the culture and display a low desire for control and a high desire for feedback, as they felt pressurised to do so, even when this was contrary to their personal characteristics.

In contrast to the longitudinal design favoured in other studies this one employed a cross-sectional sampling strategy involving 145 nursing students at various stages in their training (i.e. 1-9 weeks; 4-5 months; 9-11 months; and 18 months). The data was gathered via personally administered questionnaires, with the respondents being asked to make subjective retrospective judgements of their work experiences. The potential limitations of such a design were readily acknowledged by the authors. As in the case of Ashforth & Saks (1995), this study incorporated a multiplicity of different instruments (i.e. 10) that had either been adapted or specifically devised (3) to measure the constructs of interest. One problem with this strategy is that selective items, often reduced in number, are chosen from a variety of available scales and measures and then adapted or are used in a different context from that of the original scale or measure. Arguably, this practice may serve to compromise the validity and reliability of the results reported.

The results of the study found that, in an environment of high novelty but of low discretion during training, students experienced high levels of personal change, but low levels of role change (i.e. absorption mode). Nicholson's (1984) theory predicts that in these circumstances the motivational orientations of individuals undergoing the transition would be for a high desire for feedback (associated with high novelty) and a low desire for control (associated with low discretion). The study supported this proposition inasmuch as 94% of the sample desired a lot of feedback. However, the main personality variable being tested, desire for control, which according to Nicholson's (1984) theory is positively related with an increase in discretion, was also found to be associated with high levels of personal change. Furthermore, the degree of personal change was found to be greater in those who had a high desire for control, than in those with a low desire. This finding, which is contrary to the expectations of the theory, was found to be significant even after controlling for the effects of desire for feedback. The authors explain this phenomenon by suggesting that those individuals who display a high desire for control are prevented from achieving control by the restrictive nursing environment. As a consequence they become frustrated, angry and experience work dissatisfaction (which is supported by the data).

On reviewing the study, its conclusions are questioned, not only by the methodological shortcomings noted by the authors, but the use of a sample of students with limited work experience.   As such, this study is open to the same criticism as that of Ashforth & Saks (1995), in that account of prior occupational socialization and individual experience, which are considered to be important

variables in the determination of work-role transitions (Nicholson, 1984; Adkins, 1995), are given limited consideration. The authors of the study argue that a nursing environment, especially for students, is one of low discretion and as such the theory states that prior occupational socialization will have little effect on the mode of adjustment in these circumstances. However, in this study no attempt was made to measure the construct of prior occupational socialization, so the validity of this assertion, unlike others, was not questioned. The mismatch between person and role in work-role transitions, does however raise an important point for consideration in the context of this thesis.

West *et al*, (1987) gave further consideration to Nicholson's (1984) theory when they examined transitions into newly created jobs (i.e. where there was no previous role incumbent) involving British managers. As well as examining the outcome modes of transition the study sought to explore individual motivation and responses to entering a newly created job. In deriving propositions for this group in relation to the theory it was decided that:

> "...there are no *a priori* reasons for assuming that perceived job novelty will be high for those moving into newly created jobs. While the job itself might be new to the organization, the tasks, skills and methods required for job performance may well be familiar to incumbents." (West, *et al*, 1987, p98).

However, where the job is perceived to be relatively novel to the individual and who, in addition describe themselves as having a high desire for feedback, personal change is expected as an outcome of the transition. On the other hand, job discretion is predicted to be greater as newly created jobs by definition are considered to lack precedent and to be only partially prescribed. It is suggested that:

"...to this extent the person moving into a newly created job is implicitly a role innovator" (West *et al*, 1987, p99).

Furthermore, newly created jobs are expected to be subject to variable socialization due to their unpredictability, rather than being bound by explicit socialization processes experienced by employees in established positions.

As with the other studies previously discussed, a series of propositions were derived from the theory relating to the probable modes of adjustment. In addition however, the aims of exploring socialization processes experienced by those entering newly created jobs, as well as the reasons given for seeking job moves, were identified. A two phase survey method was adopted involving an initial sample of 2304 British managers, of which 1082 comprised the follow-up sample for the second phase (i.e. fifteen months later). Two questionnaires were administered: the first gathered data including biographical variables, occupation and organization variables, job characteristics, and self-concept and role innovation; the second survey gathered follow-up data on the same variables as well as further data on work attitudes. Unlike the previous studies, the vast majority of items used to gather data on the constructs of interest appear to have been devised and tested for reliability specifically for the purpose of the study.

Amongst the results it was found that when comparing people moving into newly created jobs with those moving into existing jobs, the former reported their jobs as being more materially rewarding. As a consequence however, those people moving into newly created jobs found fewer sources of help available to them in work

adjustment. This group also reported higher job discretion and less predictability in work role characteristics. The data collected during the second phase of the study also indicated higher levels of role innovation and job discretion had been achieved over the period than other job movers. These findings support the notion that those moving into newly created jobs are likely to find increased discretion in innovating a new work role, than those movers into existing jobs.

In terms of outcomes of transitions the study's prediction, that there would be no difference in the degree of personal change reported between both groups of job movers, was supported. Also supported was the prediction that *greater* personal change would be reported in newly created jobs which were perceived as being high in novelty. Of particular interest, especially in the context of this thesis, were the findings relating to differences found between people who enter a newly created job with a new employer, or remained within the same organization. It was found that those people who remained with the same employer reported less pre-transition anxiety and less personal change as a result of their last work-role transition. They also reported less job novelty than did those moving employer. This phenomenon, however, could be accounted for in terms of the individual's familiarity with the organization and its processes, thus reducing the overall novelty experienced when moving into a new position.

One of the most recent studies to apply Nicholson's (1984) theory (Black & Ashford, 1995) suggested that the variables identified in the theory have only a moderate impact on personal change and less on role change. Whilst acknowledging that the

propositions puts forward in theory are partially supported, a number were

unsubstantiated and even found to be contrary. Black & Ashford (1995) concluded

that:

> "...two modes of adjustment may be too limited. It may be that individuals
> engage in a variety of adjustment mechanisms that extend beyond simply
> changing themselves or changing their jobs." (p433).

They go on to attack Nicholson's (1984) theory as being somewhat simplistic, stating

that the predictors, discretion and novelty, only become useful when certain

contextual conditions are present which relate to the degree suitability of the person-

job fit. A limitation (acknowledged by the authors) of the study is once again in the

nature of a restrictive and relatively small sample, in this instance, of MBA graduates.

Interestingly, this limitation can be borne out in that some of the findings from this

study contradict the results related to similar variables of another study (West, 1987)

involving a much larger non-graduate sample.

4.6 CONCLUSION

As can be seen, transition has been both a subject for considerable debate and

research interest. It has been clearly demonstrated that transition is a complex

phenomenon and one which is highly individualised and context specific. Despite

recognition as such, numerous attempts have been made to describe the central

characteristics and conditions of the transitional process and outcome and apply

them to both to the world of work and a nursing context.

The literature exploring the transition from experienced nurse to advanced

practitioner varies enormously in describing numerous phases or stages through

which practitioners may or may not pass. However, this body of literature does provide evidence of the dynamic nature of the transitional process and lends support to Schumacher & Meleis's (1994) notion of a set of universal properties and conditions of transition. The transitional process and outcome is given further theoretical substance by Nicholson's (1984) theory of work-role transition. Whilst a number of studies have questioned the validity of Nicholson's (1984) theory, the reliability of the studies themselves have been questioned (in some cases by the authors themselves) on grounds of methodological and sampling inadequacies. What, arguably, Nicholson's (1984) theory does, whilst requiring further conceptual refinement, is add to our understanding of the transitional processes and outcomes experienced by people entering new work roles. In the context of this thesis, therefore, Nicholson's (1984) theory, along with the studies specifically examining the transition of nurses into new work roles, provides a useful frame of reference for comparison and contrast. What is clear however, is that:

> "...work-role transitions constitute a period of discontinuity and flux where individuals and their roles must gravitate towards a new synchronization" (Ashforth & Saks, 1995, p157).

It is this process and its outcome that is of central interest to this thesis.

4.7 RATIONALE FOR THE STUDY

As the previous discussion has illustrated, the role of the advanced nurse practitioner, especially in the USA, has been the subject of a great deal of debate and research interest in recent years. A body of evidence has emerged which confirms that advanced practice nurses have made significant and effective contributions to health care delivery in a number of countries. The political and

professional developments now occurring in the UK have led to a situation whereby nurses are increasingly likely to be educated and trained to take on advanced practice roles. Whilst such roles have been mapped out in other countries, from a UK perspective, the concept of advanced practice remains a contemporary issue about which little is known or understood. Whilst the literature review provides an insight into the various definitions and models of advanced practice, along with the notion of expert practice, little systematic inquiry has taken place into the transitional process in which experienced nurses engage when training to become advanced nurse practitioners. The majority of writers who have attempted to describe such transitions have relied on anecdotal evidence and presented rather simplistic accounts of what in effect is a complex phenomenon. On the other hand, the limited empirical studies which have been undertaken, have, in the main, focused on the outcome of role transition in terms of *what* advanced practitioners are able to *do* when compared to other nurses or medical practitioners. Consequently, relatively little is known about *how* nurses alter their practice and identity during the *process* of role transition. Whilst advanced practice roles have become established in other countries, in the UK, there is a great deal of ambiguity concerning the entire concept of advanced nursing practice. The issue of how educational institutions and health care organizations construct the notion of advanced practice is likely to have significant implications for how practitioners are not only educated, but how they implement their roles in clinical practice. In the absence of a common frame of reference and limited evidence from international sources, both universities and trusts will need to reconcile the goals of professional development and ambition with political and organizational expediency. It is from this point of view that whilst a

number of inquiries have acknowledged the social context in which practice takes place, few have explored how advanced nursing practice is influenced or constructed from a social perspective when competing professional and political agendas prevail. In these circumstances, the importance of the social context cannot be overstated. It comes as some surprise therefore, that a number of the studies and position papers reviewed in the literature provided only a cursory reference to the influence of the social context upon role transition and the development of advanced practice. Arguably, if inquiries gave greater consideration to the social context, they could be of substantial benefit in helping to provide the answers to questions such as, why do particular roles develop in the ways they do? What are the prime factors that influence this process? Do all advanced practitioners learn the same skills, behaviours and roles, or do they vary from institution to institution? Are advanced practitioners adequately prepared, both educationally and clinically, for the job they are expected to perform? Whilst there are many questions that remain unanswered with regard to the whole concept of advanced practice in the UK, a number of these issues and problems will be addressed by this study.

CHAPTER FIVE

RESEARCH DESIGN AND METHODS

CHAPTER 5: RESEARCH DESIGN AND METHODS

5.1 INTRODUCTION

This chapter describes the research design and methods adopted for the study. It commences with a presentation of the aims of the investigation, followed by a brief outline of the philosophical, epistemological and pragmatic considerations which guided strategic and methodological choices. This is followed by a detailed account of the research strategy in which the different phases of the study are highlighted and a description of the data collection methods is provided. The chapter concludes by describing the approach used for data management and analysis.

5.2 AIMS OF THE STUDY

The general goal of the study was to investigate the experiences of a group of nurses undergoing training to prepare them for the role of advanced nurse practitioner. The study initially had five broad aims:

1: To explore if the educational and clinical preparation of advanced nurse practitioners were considered appropriate and relevant, in terms of both content and academic level, to the role anticipated to be implemented in practice.

2: To gain an understanding of the expectations of advanced practice held by ANPs and their colleagues.

3: To examine the personal and practice development of the ANP during role transition and identify the ways in which their practice and roles differed from that of their nursing colleagues.

4: To identify the ways in which the advanced nurse practitioners' role influenced the practice of professional colleagues in terms of the organization and delivery of care and, to explore if the ANP was perceived to be practising from a nursing or medical paradigm perspective.

5: To gain an understanding of the factors which facilitated and / or impeded role development and performance and how such variables exerted influence over the transitional process.

The first two aims were the predominant focus for the initial phase of the study, while the latter aims became increasingly relevant as the inquiry progressed. The aims of the study were intentionally defined in broad terms in keeping with the methodological approach adopted (see below). This strategy allowed flexibility in the research design to pursue the central themes and issues as they emerged.

5.3 METHODOLOGICAL CONSIDERATIONS

The education, training and implementation of advanced nurse practitioners into clinical practice are unique events for the nursing profession in the UK. As with other contemporary events in nursing, it has been suggested that In order to investigate such a phenomenon:

> "...it is essential that any research approach taken to investigate it should do so within its real life context and make full use of data generated from the dynamic nature of the event. It is consequently important that the research approach allows for the use of multiple sources of information so that evidence can be converged to provide a fair and accurate account of the event". (Ramprogus, 1995, pp65-6)

In so doing, consideration must be given to the participants' experience and interpretation of the situation, which can then be used as a basis for understanding the phenomenon from various perspectives (Ramprogus, 1995).

In light of these methodological considerations a qualitative approach, based within a constructivist paradigm (Lincoln & Guba, 1985; Guba & Lincoln, 1994), was adopted. Broadly speaking, constructivism, shares with other interpretive approaches to human inquiry, the goal of:

> "...understanding the complex world of the lived experience from the point of view of those who live it. ... The world of lived reality and situation-specific meanings that constitute the general object of investigation is thought to be constructed by social actors" (Schwandt, 1994, p118).

Stake (1995) holds the point of view that most modern qualitative researchers uphold the belief that knowledge is constructed by social actors from their experience, rather than being something that can be discovered. He goes onto argue that:

> "No aspects of knowledge are purely of the external world, devoid of human construction." (Stake, 1995, p100).

Guba & Lincoln (1994) hold a relativistic ontological position which assumes that these constructions are multiple, apprehendable, and on occasion conflicting social realities, which are both local and specific in nature. Moreover, they suggest that whilst the realities of different individuals often overlap with one another as they attempt to make sense of the same event or happening, at the same time each actor attaches different meanings to the phenomenon (Lincoln & Guba, 1985). That is to say, that whilst individuals may even agree on a formal definition of an entity, the construction itself is nonetheless understood differently by them. Furthermore, they point out that social constructions of reality are alterable and dynamic and may change as the social actors

become more informed and sophisticated. Consequently, Lincoln & Guba (1985) assert

that realities have to be considered as wholes and cannot be divorced and understood

in isolation from their contexts.

Social constructions or realities are often related to, and inseparable from, tangible

entities. Guba & Lincoln (1994) maintain that the meanings ascribed to or from such

tangible entities and, the process of understanding in which individuals engage,

results in a constructed reality. Schwandt (1994) however finds it difficult to reconcile

Guba & Lincoln's (1994) notion of tangible entities with that of multiple 'constructed'

realities. He states that:

> "If these tangible entities are not solely creations of the mind, then they must
> be ontologically 'real.' The distinction ... seems to be one of a difference
> between experiential reality (constructions) and ontological reality (tangible
> entities). (Schwandt, 1994, p134)

This criticism suggests that Guba & Lincoln's (1994) paradigm is in effect closely

associated with the rationalist-constructivist view as described by Stake (1995).

While principally occupying the same epistemological and ontological standpoint as

Guba & Lincoln (1994), the rationalist-constructivist view openly acknowledges the

existence of an external reality (i.e. tangible entities) which is perceived to be:

> "...capable of stimulating us in simple ways but of which we know nothing
> other than our interpretations of those stimuli." (Stake, 1995, p100).

In this way, whilst acknowledging an individual experiential constructed reality, the

belief in an external reality, corresponding suitably to our notion of it, allows two

individuals sharing the same experience to shape their realities to fit each others

(Stake, 1995). Whilst the existence of an external reality is acknowledged, of primary

interest to researchers are the relativistic social realities constructed by individuals.

Stake (1995) asserts that most qualitative researchers are relativists, however, he holds that:

> "One can believe in relativity, contextuality, and constructivism without believing that all views are of equal merit" (Stake, 1995, p103).

The point he is makes is that not all interpretations of reality are equally important and that consequently some are better than others and vary in their credibility and utility.

It is the premise of this thesis the concept of 'advanced practice' is socially constructed by actors in the social setting. As such, there are likely to be as many realities of what constitutes advanced practice as there are actors in the social environment, especially given the absence of an agreed definition of the concept in the UK. Consequently, the results of any inquiry which sets out to explore such a phenomenon are likely to be strengthened if account is taken of the multiple realities which exist and if the concept is explored from different contexts and perspectives. It is acknowledged, that whilst not all interpretations of advanced nursing practice will necessarily have equal merit, or provide convergence, it is nonetheless important to explore the construct in its social context and from a relativistic perspective.

Given these methodological considerations and the aims of the inquiry, a collective case study design (Stake, 1995) was adopted as the most appropriate research strategy. Given the aims of the inquiry, these case studies can be categorised as being both descriptive and exploratory in nature (Yin, 1989).

Case studies have acquired various definitions and usages in the literature (Woods, 1997b). A case study has been described as:

> "...an exploration of a 'bounded system' or a case (or multiple cases) over time through detailed, in depth data collection involving multiple sources of information rich in context." (Creswell, 1998, p61).

Woods and Catanzaro (1988), convey the depth of inquiry involved in case study research when they define it as an:

> "...intensive, systematic investigation of a single individual, group, community, or some other unit, typically conducted under naturalistic conditions, in which the investigator examines in-depth data related to background, current status, environmental characteristics and interactions". (Woods & Catanzaro, 1988, p553)

A further feature of case studies is that, with a few exceptions, they:

> "... are present-oriented. They examine contemporary experience rather than historic events." (Mariano, 1993)

The selection of a collective case study strategy in favour of other approaches, such as a phenomenological or ethnographic study, was based on the characteristics and features of the case study design, given the aims of the inquiry, the phenomenon being investigated and, the constructivist paradigm within which it was framed. Principally, the factors which led to this choice were:

1: Case studies are particularly relevant to investigate a phenomenon about which little is known or understood (Yin, 1989). In other words, because of their flexible nature, case studies accommodate the problem of uncertainty regarding the tentative identification of the key factors and variables (Eisenhardt, 1989) which remain to be discovered from the outset of the inquiry.

2: When the traits of an individual, organization, or event are unusual and the investigation involves the examination of multiple variables, (such as with the phenomenon of advanced nursing practice), the case study is one of the research strategies of choice (Mariano, 1993; Gilgun, 1994). Whilst the examination of multiple variables may in some ways be problematical, Yin (1981) asserts that there will always be too many potentially relevant variables to make standard experimental and survey designs appropriate for this type of investigation.

3: Case studies are particularly useful when studying a:

"...unique situation in great depth, and where one can identify cases rich in information - rich in the sense that a great deal can be learned from a few exemplars of the phenomenon in question". (Patton, 1990, p54).

In this way, the case study is the preferred way of studying contemporary events where relevant behaviours are not manipulated (Yin, 1989).

4: Qualitative approaches to research, including case studies, share the axiom that systematic inquiry must take place in the natural setting, rather than the artificially constrained environments required of some methods, such as experiments (Marshall & Rossman, 1989). In the context of advanced nursing practice, Lewis (1975) emphasised the need to study the structure of the practice setting in order to determine its effect on the process and outcome of data. The importance of empirical inquiry of the phenomenon in its social context is, therefore, paramount. As a research strategy, the case study focuses on understanding the dynamics present in the social setting (Eisenhardt, 1989).

Consequently, case studies are typified by four elements: context, boundaries, time and intensity (Mariano, 1993).

Given the purpose of the investigation, a decision to pursue a multiple, or what Stake (1995) terms a 'collective' case study design (as opposed to a 'single-case' design) involving five cases, was taken. Whilst it has been recognised there is no 'ideal' number of cases, it has been suggested that a number between 4 and 10 works well (Eisenhardt, 1989). Whilst the choice in determining the number of case studies to undertake was in part influenced by resource and pragmatic considerations associated with the investigation, it was principally guided by the theoretical replication logic for undertaking multiple case studies, discussed by Yin (1989). In this study, it was predicted that the development and implementation of advanced nursing practice would vary in different organizations and within different clinical specialisms. The design therefore utilised the principle of a 'most-different-systems' approach for conducting comparative case studies (Schultz & Kerr, 1986). Thus, in multiple-case study designs, the convergence of evidence is enhanced by asking about the same phenomenon across cases (Gilgun, 1994). That is to say, that variation and differences in cases, add depth and increase our understanding of the phenomenon of interest. In so doing, this strategy provides the opportunity for cross-case analysis, as well as within-case analysis, that would be denied by the use of a single case study design. Consequently, in this study, not only are the cases 'multiple' in number, but they occur within different clinical specialisms and across different sites. In this sense each case is used 'instrumentally' to illustrate the central issue of the study (Creswell, 1998), i.e. as opposed to a case being selected purely

for its 'intrinsic' characteristics (Stake, 1995). The collective case study strategy is, therefore, considered to be appropriate for exploring the same phenomenon, in a diversity of situations, with a number of individuals (Mariano, 1993).

A feature of the case study design is the use of multiple sources of evidence in the data collection and analysis processes (Yin, 1981). However, before data collection commences, careful consideration and explanation needs to be given to defining who or what comprise a 'case'. Deising (1971) noted that the case study design encountered particular problems in delineating the boundaries of the research entity in question. Clearly, the way a case is defined will have a major impact on the conduct and outcome of the research. Yin (1989) asserts that the definition of a "case" or "unit of analysis" should be related to the initial research question. Consequently, in this study, it was decided that each case would comprise not only the advanced practice nurse, who may be perceived of as the "key" informant, but also the people with whom he or she are considered to be either actively involved, or whom have a significant influence upon (or are affected by) either, their education and/or practice. Table 5.1 details the desirable composition of each case study.

5.3.1 STUDY FUNDING AND TIME-FRAME

The study was funded by a Regional Health Executive Research Fellowship. The duration of the Fellowship was for three years from July 1995 to June 1998. This time-frame, along with other practical considerations were influential in some of the design choices made within the context of the study (e.g. see sampling strategy below).

Table 5.1 Composition of a 'case'.

Each case study aimed to comprise:-
• The Advanced Nurse Practitioner / student - the key informant.
• Consultant Preceptor - a work based consultant whose role was anticipated to include supervision and mentorship of the ANP throughout the transitional process.
• Directorate Manager (where in post)
• Clinical Nurse Manager (where in post)
• University Pathway Coordinator - a university lecturer with responsibility for coordinating the practice and learning experiences specific to the ANPs practice discipline.
• A Junior Doctor
• A Nursing Colleague

5.3.2 SAMPLING STRATEGY

In common with other qualitative research traditions a "purposeful" or "theoretical" sampling strategy (Creswell, 1998) was adopted. Purposive sampling is not based upon the principles of probability sampling, where the aim is to obtain a representative sample, but on the selection of cases believed to be rich sources of data (Reed *et al*, 1996). In this way, the goal of theoretical sampling is to choose cases based on their likelihood of replicating or extending emergent theory (Eisenhardt, 1989).

The population for the study comprised a cohort of twenty five nurses seconded to

a one year, full-time Master's degree programme designed to prepare them as advanced nurse practitioners. The majority of study population were drawn from five main clinical specialisms:

i) Adult intensive care nursing;

ii) Accident & Emergency nursing;

iii) Neonatal nursing;

iv) Gynaecological nursing; and

v) Rehabilitation nursing.

Two factors were significant in defining the population for the study: 1) A funding constraint of the study which stipulated the research should be carried out within the funding health region. 2) That only one university within the region ran a Master's degree course specifically designed to prepare nurses based in clinical practice as advanced nurse practitioners at the time of the study.

5.3.3 ACCESS

A covering letter requesting permission for access to the cohort, along with an outline proposal of the study, were sent to the host university. Following two meetings in which the details of the study were explained and assurances given regarding confidentiality, access was granted. A letter of introduction and explanation about the study was sent to all of the students on the course, along with a short biographical questionnaire. Responses from the questionnaire yielded a sample of 16 nurses willing to be involved in the study. From this sample, five nurses, one from

each specialism, were selected to be the focus of longitudinal case studies. Whereas the *number* of cases was determined by estimating what could be realistically achieved within the resources and time-frame of the study, the selection of individual cases was based on the principles of the collective case study design and the theoretical sampling strategy described above. Each of the five individuals was selected specifically for their particular interest and relevance to the phenomenon under study (Patton, 1990). From the questionnaire information the following criteria were utilised to inform the selection process in which the individuals from five different clinical settings were chosen:

i) the clinical speciality in which the nurse worked;

ii) the part of the region in which they were employed;

iii) the prior clinical experience of the nurse; and

iv) the educational background of the nurse.

The five individuals who agreed to full access were asked to provide details of the other case study participants (i.e. Consultant Preceptor, Directorate Manager, Clinical Nurse Manager, and University Pathway Coordinator) who were to be approached. Letters of introduction and a study outline were sent to each of the case study participants and all agreed to participate in the capacity requested.

5.4 RESEARCH SCHEDULE & DATA COLLECTION METHODS

The strategies used to collect and analyse data within case studies are similar to some of the techniques used in other qualitative designs (Mariano, 1993). Within the

140

tradition of this approach, multiple methods of data collection were adopted for the study (Yin, 1989). These included, interviews, direct observation and, documentary evidence in the form of self-report role development diaries, clinical records, policies and protocols. Each data collection technique was related to specific aims of the study (see Table 5.2) and used at different phases of the research in order to provide convergence of evidence.

Table 5.2: Relationship between aims of the study and data collection methods.

Aims of the study	Method
1: To explore if the educational and clinical preparation of advanced nurse practitioners were considered appropriate and relevant, in terms of both content and academic level, to the role anticipated to be implemented in practice.	Interviews Observation
2: To gain an understanding of the expectations of advanced practice held by ANPs and their colleagues.	Interviews
3: To examine the personal and practice development of the ANP during role transition and identify the ways in which their practice and roles differed from that of their nursing colleagues.	Observation Diaries Interviews Records
4: To identify the ways in which the advanced nurse practitioners' role influenced the practice of professional colleagues in terms of the organization and delivery of care and, to explore if the ANP was perceived to be practising from a nursing or medical paradigm perspective.	Observation Diaries Interviews
5: To gain an understanding of the factors which facilitated and / or impeded role development and performance and how such variables exerted influence over the transitional process.	Interviews Observation Diaries

5.4.1 ETHICAL APPROVAL

As the research strategy involved observation of clinical practice on NHS premises and access to medical and nursing records, ethical approval was sought and granted

from the four health authorities in which the five case studies were located.

5.4.2 DATA COLLECTION

Formal data collection began in January 1996, by which time the advanced nurse practitioner students were a third of the way into the educational programme. Delays in gaining access and awaiting ethical approval meant that this was the earliest that data collection could commence, although initial contact was made with the cohort shortly after commencement of the Master's programme. Due to the time constraints placed upon the study, its longitudinal nature, and the flexible nature of the case study design (Eisenhardt, 1989), piloting of data collection procedures did not take place, with the exception of the role development diaries (see below). Discussion of the interview schedules and observation strategies did occur with research supervisors and amendments were made following their recommendations. An overview of the research schedule is provided is provided in Table 5.3.

The adaptive nature of the case study strategy provides the maximum flexibility in data collection, allowing for modification to the research schedule owing to unpredictable changes in circumstances of the case study participants and their environment. As such, case study researchers have the freedom to make adjustments during the data collection process, but as Eisenhardt points out:

> "...flexibility is not a license to be unsystematic. Rather, this flexibility is controlled opportunism in which researchers take advantage of the uniqueness of a specific case and emergence of new themes to improve resultant theory". (Eisenhardt, 1989, p539).

In order to maximise the data collected via this design, three principal methods were

adopted for this study.

Table 5.3: Research Schedule

Phase 1:	Jan - Apr '96	Interview 1: With ANP, Consultant Preceptor, Directorate Manager, Clinical Nurse Manager, University Pathway Coordinator.
Phase 2:	Jun - Sept '96	Observation 1: Clinical practice - during course
Phase 3:	Nov - Apr '97	Observation 2: Clinical practice - first 6 months post graduation of the Master's programme.
Phase 4:	Oct - Mar '97	Role Development Diaries - 6 months post course, case study ANPs plus the remaining ANPs who agreed to participate in the study.
Phase 5:	Jan - Mar '97	Interview 2: All case participants (see Table 1)
Phase 6:	Jun - Dec '97	Observation 3: Clinical practice - 9 - 15 months post graduation of the Master's programme.
Phase 7:	Nov - Jan '98	Interview 3: With ANPs, Consultant Preceptors, Nurse Managers.
Phase 8:	January 1998	Feedback & Verification: Case summaries sent to individuals for verification and feedback purposes.

5.4.3 DATA COLLECTION METHODS

5.4.3.1 INTERVIEWS

Interviews were conducted at three stages of the study (see Table 5.3), each involving select case study participants. The aim and focus of the interviews varied with each stage (see staged interview schedules below for details).

Initial contact with interview participants was made either via letter or by the ANP on the researcher's behalf. This was followed by a telephone call to confirm that the

participant was willing to be interviewed and to arrange a suitable time and venue for the interview to take place. All the participants approached agreed to the initial interview and agreed to follow-up interviews where requested. Interviews took place predominantly at the participants' place of work during their normal working hours. The exceptions to this rule were the ANPs who were interviewed at their homes, place of work, and in two instances, on university premises.

At the first interview, the aims of the study were explained and the participant was given an information sheet for reference (see Appendix No 1). The participant was invited to ask questions about the study and seek additional clarification where necessary. Most questions concerned issues of confidentiality and anonymity and were answered to the participants satisfaction. The participant then signed a consent form confirming their acceptance to take part in the study (see Appendix No 2) and their right to withdraw from the study at any time was confirmed. Consent forms were then signed by the researcher and kept securely with the relevant case study database.

The length of interviews ranged between 35 minutes and 1 hour and 15 minutes, with the mean average being approximately 45 minutes. Each interview was tape recorded for accuracy with the participants permission. Whilst the participants and focus of the interviews varied with each stage, a basic interview format was retained throughout. This involved engaging the participant in discussion about the main issues of interest. To this end interview schedules consisted of a number of general

themes which were to be discussed at each phase of the inquiry. To ensure that the issues of central concern were addressed during interviews a number of detailed open-ended questions were included in each schedule, although these primarily served to act as prompts and reminders for the researcher. The interview schedule was, therefore, used primarily to provide the general direction of the discussion, while at the same time allowing for participants to raise issues which had not necessarily been included on the schedule. Any such points that were raised during the interview were incorporated, where appropriate, into future data collection procedures.

Stage 1 interviews:

Stage 1 interviews were conducted between January - April 1996 with selected case study participants (see Table 5.3). The interviews focused on five main themes guided by the study's aims. These included: i) perceptions and role expectations of the advanced nurse practitioner; ii) the educational and clinical preparation of the advanced practitioner; iii) expectations about the impact of the advanced practitioner role on the delivery of care and upon professional colleagues; iv) factors likely to facilitate or inhibit the implementation of the advanced practitioner role; and v) the potential for role ambiguity and stress related to the new nursing role (see Appendix No 3: for interview schedule 1). Analysis of this data provided a focus for the observation schedules which were being developed, as well as providing a theoretical basis for the follow-up interviews.

Stage 2 interviews

Stage 2 interviews were conducted between January - March 1997 (i.e. at a time

when the ANPs had been in clinical practice for 4 to 6 months) with all case study

participants (see Table 5.3), with the exception of the three ANPs being observed in

clinical practice[4].

The focus for the interviews in the second stage was guided by the aims of the study

and the results of analysis of the prior interviews, observation of clinical practice, and

the role development diaries returned by this phase in the study. The themes

addressed in the interview schedule therefore included: i) the participants

understanding of the advanced practitioner role; ii) changes in the ANP and the

development of their practice; iii) the aims and objectives of the ANP and their

deployment within the organization; iv) a review of the educational preparation for

advanced practice; v) the initial impact of the role on the delivery of care and

professional colleagues; vi) identification of the factors facilitating or inhibiting the

implementation of the advanced practitioner role (see Appendix No 4 for a copy of

the interview schedule for stage 2). Once again, the questions in the schedule were

used as prompts to encourage discussion relating the issues and themes of interest.

The data analysed from these interviews, along with analysis of the data gathered

from the observation of clinical practice, the role development diaries and a review

---

[4] It was only possible to conduct observation of clinical practice at three sites. Consequently, at this
stage of the research there was considered to be little purpose in interviewing the three ANPs, as
the issues to be addressed in the interviews had previously been explored with them during
observation visits of their clinical practice.

of extant theories in the literature, provided the theoretical basis for the issues to be addressed in the final interviews.

Stage 3 Interviews

Stage 3 interviews were conducted between November 1997 and January 1998 with selected case study participants (see Table 5.3)[5]. These participants were selected because of their relevance to the issues to be explored in the final interviews and the time management and resource constraints of the study.

The focus of the interview schedule included the following themes: i) evaluation and progress of the advanced practitioner role; ii) discretion, novelty and control in the implementation of the advanced practitioner role; iii) understanding and conceptualisation of advanced practice; iv) the impact of the advanced practice role on nursing and medical practice (see Appendix No 5 for interview schedule 3).

5.4.3.2 OBSERVATION OF CLINICAL PRACTICE

Observation of clinical practice was used as a method of data collection throughout the study period. However, due to problems with access, observation visits only occurred in three of the five cases (i.e. case 1, 3, and 5). The use of published observation schedules and instruments was not adopted for the purpose of this study on the basis that: i) there were very few instruments available that measured the

---

[5] In case study 3, the Neonatal Unit, the directorate manager was unavailable for interview so the clinical nurse manager was interviewed in their place.

constructs of interest; ii) those instruments that were available were perceived to be of limited utility in the context of this study; and iii) it was the researcher's belief that such instruments would have a detrimental and limiting effect on the collection and analysis of data, as they were perceived to pre-conceptualise the phenomenon to be observed. That is not to say the observation of clinical practice was haphazard or lacked rigour. On the contrary, each stage of observation served a different purpose and became increasingly focused.

Each period of observation consisted of spending a full or partial shift accompanying the ANP as they undertook their daily activities. Whilst observing clinical practice, data collection was supplemented by having access to nursing and medical records. In this way the researcher was not only able to observe practice directly, but was also able examine pertinent documentation completed by the advanced practitioner. Furthermore, access to local policies, protocols and guidelines, which had direct bearing on the ANPs practice, was provided during observation visits.

Due to the geographical location of the study sites and unpredictable changes associated with shift work, all visits were arranged in advance with the ANP. The case study participants were given contact telephone numbers for the researcher and on several occasions rang to cancel proposed visits due to sickness, changes to shifts, or changes in work venue (i.e. to locations where prior access had not been arranged).

When undertaking observation visits, the identity of the researcher was made explicit to patients, their relatives and members of nursing and medical staff. Whilst the researcher's role was primarily as passive observer, the ANP and, on occasion their colleagues, were engaged in conversation throughout the visit about the development and implementation of the ANP role. Furthermore, in addition to the observation of practice, ANPs were sometimes accompanied on coffee and meal breaks.

The main focus for the observation visits was guided by the study's aims and the result of ongoing data analysis. The documented accounts of observation visits comprised narrative descriptions of the ANPs' clinical practice, relevant events that occurred during the visit and, the ANPs' interactions with nursing and medical colleagues. Relevant quotations and discussion excerpts were recorded verbatim at the time of their utterance so as to maximise recall. The notes from observation visits were taken contemporaneously in a small notepad and written up in full the same day, so as to maximise the accuracy and recall of data collected during the visit. Whilst the use of the notepad caused initial unease and suspicion, especially from the ANPs' nursing and medical colleagues, its continued use became familiar and accepted[6], particularly by the ANPs themselves. It is acknowledged however that initially the use of the notepad is likely to have exacerbated any alteration in behaviour that occurred due to the researcher's presence.

---

[6] Throughout the different observation stages the ANPs were questioned about their feelings of the use of the notepad for recording their activities and conversations. All stated that they had soon become familiar and used to it and did not feel threatened or particularly conscious of its continued use.

Observation Stage 1:

Stage 1 observation visits were conducted whilst the ANPs were in the second semester of their Master's programme. Earlier observation visits, whilst desirable, were not possible due to delays in access, ethical approval and scheduling of practice placements. The planning of observation visits was further complicated by the sporadic nature of clinical placements, the practice of ANPs visiting different centres to their own to gain clinical experience and, the curtailed frequency of practical placements due to the academic workload related to the course. This resulted in the schedule of observation visits detailed in Table 5.4.

Table 5.4: Schedule of stage 1 observation visits: June 1996 - Sept 1996.

Case Study	Number of Visits	Total Observation Time
1: Respiratory Medicine	4	14 hours
3: Neonatal Unit	4	13 hours 35 mins
5: Accident & Emergency	4	16 hours 05 mins
Totals	12	43 hours 40 mins

The first stage observation visits served a number of purposes. Firstly, they allowed the researcher to become familiar with the different clinical environments in which the ANPs practised. Furthermore, it allowed the case study participants and their colleagues to become familiar to the presence of the researcher in the practice setting. The first stage observations involved shadowing each ANP so as to familiarise the researcher with the nature and focus of their clinical practice, their relationships with professional colleagues and the learning requirements associated with developing their new role. At this stage, the focus for the collection of data was

150

guided primarily by the first aim of the study.

Observation Stage 2:

Stage 2 observation visits were conducted throughout the first six months in which the ANPs returned to their place of work following graduation from the Master's degree programme. The schedule of observation visits during this period is detailed in Table 5.5. Whilst the same number of visits were planned for each case, cancellation of visits due to sickness, annual leave and even the weather, meant that equity in terms of the number of visits was not achievable. Furthermore, the variance in the time spent observing practice during each visit was dictated by the working pattern of the ANP. Hence some visits were brief, e.g. 1 hour 45 minutes (case 5) whilst others were extended, e.g. 10 hours 20 mins (case 3 - night shift visit).

Table 5.5: Schedule of stage 2 observation visits: Period from Nov 1996 - Apr 1997

Case Study	Number of Visits	Total Observation Time
1: Respiratory Medicine	6	31 hours 25 mins
3: Neonatal Unit	10	50 hours 10 mins
5: Accident & Emergency	8	24 hours 25 mins
Totals	24	106 hours

Once again the ANPs were shadowed as they undertook their daily activities. The focus of data collection was guided by the analysis of the first series of interviews, the first series of observations and preliminary analysis of the role development diaries that had been returned. This guided data collection toward establishing:

i) changes occurring in the practice of the ANP and the development of their new work role; ii) the deployment of the ANP within the organization; iii) the impact and influence of the role on professional colleagues; iv) identification of the factors facilitating or inhibiting the implementation of the ANP role.

Observation Stage 3:

The third stage of observation was conducted over the period June 1997 to December 1997 at a time when the ANPs were expected to be consolidating their practice. The schedule of observation visits during this period is detailed in Table 5.6. Whilst the same number of visits were once again planned for each case, cancellation of visits due to family bereavement (case 3), extended sickness (cases 1 & 3), maternity leave (case 1) and in one instance the ANP taking up a part-time post as a university lecturer (case 5), meant that equity in terms of the number of visits was once again not possible.

Table 5.6: Schedule of stage 3 observation visits: Period from June 1997 - Dec 1997

Case Study	Number of Visits	Total Observation Time
1: Respiratory Medicine	4	19 hours 10 mins
3: Neonatal Unit	6	32 hours 55 mins
5: Accident & Emergency	4	13 hours 20 mins
Totals	14	65 hours 25 mins

As with previous observation visits, the ANPs were shadowed as they undertook their daily activities. During this phase of observation, the collection of data became

increasingly focused and refined following analysis of the previously collected empirical data and a review of extant theory in the literature. This guided data collection toward convergence with the information collected in the stage 1 and 2 observations, stage 2 and 3 interviews, and from analysis of the role development diaries. Consequently, whilst data collection was guided by similar aims to those described in stage 2 observation, the additional focus included: i) evaluation and progress of the role; and ii) discretion, novelty and control in the implementation of the ANP role.

The observation schedule for each of the three cases over the duration of the study period is detailed in Table 5.7.

Table 5.7 : Schedule of observation visits over duration of the study

Case Study	Number of Visits	Total Observation Time
1: Respiratory Medicine	15	64 hours 35 mins
3: Neonatal Unit	20	96 hours 40 mins
5: Accident & Emergency	16	53 hours 50 mins
Totals	51	215 hours 05 mins

5.4.3.3 ROLE DEVELOPMENT DIARIES

In addition to interviews and observation of clinical practice, the 16 ANPs who initially agreed to participate in the study were asked to maintain a self-report role development diary for the first six months they were in clinical practice following graduation from the Master's degree programme. The aim of the diary was to

establish how practice activities and the factors influencing the development and implementation of the advanced practice role varied across different clinical environments and health authorities. In so doing, the diaries provided additional data and enhanced the convergence of evidence collected by other means.

The diary construction and format, which was devised following analysis of the first series of interviews and observations, incorporated the key activities of advanced practice as they were perceived and anticipated by the case study participants (see Appendix 6 for the diary format). Each diary contained entries for five consecutive days in clinical practice. The layout of the diary was such that for each day the ANP was asked to enter information into different sections. In the first section, the ANPs were asked to record the activities in which they had been involved. In addition to documenting daily activities, each day the diary was completed the informant was asked to identify: i) their involvement in any activities or skills which they considered to be either 'new' or 'advanced'; ii) the factors that had helped or hindered them in their practice that day; and iii) provide general comments or an account of a ' critical incident' that for them typified their development or involvement as an advanced practitioner.

Prior to being distributed the diary was piloted with two ANPs in different clinical settings. Each was asked to complete the diary for one week along with a questionnaire pertaining to: the diary layout; the time taken to enter the information being elicited; and the potential usefulness of the diary in auditing ANP practice.

Based on the results of piloting, minor modifications were made to the layout of the diary and relevant information integrated into the instructions.

The diaries were sent out to all 16 ANPs who had originally agreed to participate in the study. The first diaries were distributed for use in October 1996 and the last in March 1997. At the end of each month, a new diary was sent to the ANPs, along with a stamped addressed envelope to encourage return of the previous months diary.

5.4.4 SUMMARY OF DATA COLLECTION STRATEGY

Data was collected from multiple and varied sources. Furthermore, whilst the data was predominantly qualitative in orientation, some quantitative data was gathered, especially via the role development diaries. This is perfectly consistent with the case study strategy as described by Yin (1989) in that the two types of data can be utilised legitimately in the same study (Strauss et al, 1964; Yin, 1989; Cresswell, 1998). In common with other qualitative approaches, case study research shares the characteristic that data collection and data analysis occur simultaneously throughout the duration of the study (Mariano, 1993; Gilgun, 1994; Miles and Huberman, 1994). The use of this strategy helped to inform and direct the focus of future data collection and analysis. In conclusion, the data set for this study was collected via the three main sources, outlined in Table 5.8.

Table 5.8: Main data sources.

Method	Number / duration	Source
Interviews	57 / --	Case study participants
Observation	51 / 215 hrs 05 mins	Case study ANPs
Diaries	52 diaries / 246 days	11 ANPs including 3 case study ANPs

5.4.5 DATA ANALYSIS

The analytical strategy adopted for this study was *based* upon the principles of Glaser & Strauss's (1967) grounded theory method, whose procedures and techniques have been further refined by Strauss & Corbin (1990). Whilst various writers suggest their own analytical strategies in the context of the case study design (Lincoln & Guba, 1985; Yin, 1989; Stake, 1995) there is a lack of consensus for the analysis of qualitative data (Creswell, 1998). While the techniques and procedures associated with grounded theory were devised for use specifically within that tradition, they share general characteristics with strategies employed in other qualitative research designs which adopt an inductive approach to data analysis. These techniques include; the generation of codes, the reduction of data, the generation and relating of categories, and the development of analytic frameworks. As such, grounded theory:

> "...provides a set of analytic techniques that can be seen as representing procedures that are consistent with, or have been assimilated into, most other approaches to qualitative research." (McLeod, 1995, p93).

Furthermore, with regard to the research strategy adopted for this study, Annells (1996) points out that it is not uncommon for the grounded theory method to be applied within the constructivist inquiry paradigm. Moreover, others confirm it to be a legitimate analytical strategy that can be used within the case study design (Eisenhardt, 1989;

Gilgun, 1994). In this sense, the grounded theory method and techniques utilised in naturalistic inquiry provide a model from which to think and work (Schatzman, 1991) and is not simply a set of procedures or techniques to be adhered to blindly.

It is evident in a study of this size and nature that the sheer volume of data collected can be problematical if management and analysis are not anticipated (Yin, 1989; Woods, 1997b). For the purpose of this study, a computer package was utilised to assist in data management and analysis. The software used, QSR NUD-IST (Non-numerical Unstructured Data Indexing Searching and Theorizing), is a powerful index based program which provides extensive coding, retrieval and searching facilities, which aids data storage, management and analysis. Cresswell, (1998) demonstrates how the program, which was designed using grounded theory analysis procedures as a template, can be put to use in five different research traditions, including both grounded theory and case studies. This package was chosen over other programs because of its strength as a powerful indexing and retrieval system and its congruence with the analytical strategy adopted for the inquiry. It is of additional benefit to studies which utilise multiple sources of evidence in data collection (as in this one) and which require a clear and well structured indexing system in order to store and follow the chain of evidence (Yin, 1989). Characteristically, this helps increase the trustworthiness and quality of a case study (Mariano, 1993).

Whilst there are obvious benefits to the use of computer programs in qualitative analysis, a number of disadvantages to their use has also been highlighted, including: the resource demands on the researcher; the potential for categories to become "fixed"

within the program; and an over reliance on the package to undertake analytical procedures (Cresswell, 1998). Whilst being cognisant of these factors, the details of data analysis procedures adopted in this study are described in detail below.

In the following discussion each stage of data collection and analysis is explained in order to demonstrate how the final set of main categories and associated sub-categories emerged and were developed.

5.5 DATA MANAGEMENT AND CODING PROCEDURES

The following section outlines the data management and coding procedures carried out in the study. Figure 5.1 illustrates a flow diagram depicting the algorithm of procedures adopted from the initial stages of data collection through to the final cross-case analysis. Each stage in turn is briefly described below.

5.5.1 DATA COLLECTION & TRANSCRIPTION

Interviews

Each of the 57 interviews conducted throughout the study was tape recorded with the participants permission. Following each interview a summary sheet was completed outlining the main points and issues raised during the contact. The summary sheets were stored with the case study data base for the purposes of quick reference. (An example of a contact summary sheet is located in Appendix No 7). Tape recordings of interviews were transcribed by the researcher, normally within two to three days of completion. When this was not possible due to other commitments, the interviews

<u>Figure 5.1 Flow diagram of data management and coding procedures</u>

1: Data collection & Transcription - tape recording and transcription of interviews + observation field notes + diaries

|

2: Familiarisation - repeated readings of interview transcripts and field notes

|

3: Importing data into NUD-IST - loading transcriptions into NUD-IST program

|

4: Open coding - Line by line coding of transcripts and observation notes

|

5: Development of categories & memos - Development of categories within the NUD-IST program + development of memos.

|

6: Revision of codes & categories - Revision and collapsing of codes and **(Axial coding)** categories following each phase of coding and analysis.

|

(Stages 1 - 6 repeated following each phase of data collection)

|

7: Arrival at final categories & sub-categories - Arriving at a final set of 5 main **(Selective coding)** categories and their associated sub-categories

|

8: Within-case analysis - the development of individual case study summaries which were then verified with each ANP and amended / corrected as necessary.

|

9: Cross-case analysis - analysis of all the case studies and the development of cross-case study propositions.

were transcribed as soon as feasibly possible. Contact summary sheets were however, completed on the day the interview took place.

Observation Field Notes

Observation field notes for each visit were recorded contemporaneously in a small note pad. Field notes consisted of three different formats: 1, descriptors of specific events in which the ANP had been involved during the visit; 2, narrative accounts of 'incidents' and 'interactions' which were the specific focus for data collection following analysis of earlier interviews, observations and role development diaries, and; 3, accounts of the interaction and conversations between the researcher and case study participants. Field notes were written up in full the same day the observation took place so as to maximise the accuracy and recall of the data collected during the visit. In addition to the transcription, each set of field notes contained biographical details of the visit including: date, time and duration; a description of the setting in which the observation took place; the bed occupancy/ patient attendance at the site; a description of staffing levels; and any other information relevant to the visit.

Role Development Diaries

As role development diaries were returned the information they contained was entered onto a diary summary sheet (see Appendix No 8). This procedure usually took place within one week of receipt of a diary. Each diary summary sheet contained biographical details about the ANP, such as place of work, number of days for which the diary was completed (out of a possible 5) and the month to which it related. A

summary of the data contained within each part of the diary was then entered into the relevant section of the diary summary sheet. This process facilitated easier analysis and comparison of the information contained within the 52 diaries that were returned over the duration of the study.

5.5.2 FAMILIARIZATION

Transcriptions of the interviews, observation field notes and role development diaries were re-read several times to gain familiarity with the data prior to coding procedures. In addition, throughout the duration of the study and in particular prior to observation visits and interviews, as well as following periods of coding, transcriptions and memos were re-read to sensitise the researcher to the emergent issues.

5.5.3 IMPORTING THE DATA INTO THE NUD-IST PROGRAM

In addition to the 'hard copies' of interview and observation data, transcriptions were saved as standard word processor files and imported via conventional means into the NUD-IST program. Role development diary summary sheets did not lend themselves to this process and consequently were analysed, coded and stored manually.

The NUD-IST program is organised so that all the qualitative data (e.g. interview transcripts and field notes) collected throughout duration of a study can be stored, coded and indexed in one location. The location in the program where this occurs is called a "project". In this inquiry, a project was established for each case study, plus a sixth project containing the data from all five case studies. Next, a "document" file

was created for each discrete piece of information within each project. Consequently, a document file related to either the transcript of an interview or observation field notes. Each document was given a header, detailing the biographical information about the transcript (i.e. whether it related to an interview or observation visit) so that it could easily be identified and retrieved. Each document was given a name (e.g. E_OBS_1) and stored in a specific project location. Subsequently, whenever working within the NUD-IST program all the document files contained in a particular project were displayed in a window on the computer screen called the "document explorer". Any of the documents within the explorer window could then be selected and browsed (i.e. the text of the document displayed on screen in its entirety to be read or printed out).

As the study progressed this process was repeated for each new piece of information (i.e. interview or observation transcripts) and a data set gradually built up within each project.

5.5.4 OPEN CODING

The next stage of data analysis was to begin open coding (Glaser & Strauss, 1967). This was performed by carrying out line-by-line analysis of each "document" and tagging segments of text that related to a particular idea or concept. The selected text was then coded at a "node"[7] within the project. Each node was given a short title, a definition giving details of the concept to which it related and a "node

---

7 A node can either contain coded text, or other nodes, which themselves contain text.

address". A number of nodes also contained memos, which were written to reflect current thinking about the project as it developed. Essentially, each node contained a number of text units which were coded for a particular concept or idea, along with references to the documents from which they originated.

Once a node had been created, it was located into an index system for each project. Each index system contained a different numbers of nodes, at which varying amounts of coding from the relevant documents and storage of developing ideas as memos, took place. The development of an index system involved arranging nodes hierarchically in an "index tree". In this way nodes (i.e. concepts) began to be related to each other and categories developed. Appendix No 9 illustrates part of an index tree within one project. Once nodes had been created they were revised (where necessary), moved, copied or even deleted from the index system as analysis progressed and conceptual understanding of the data increased.

5.5.5 DEVELOPMENT OF CATEGORIES AND MEMOS.

As codes (i.e. nodes) were developed and revised through a process of "constant comparison" (Glaser & Strauss, 1967), a series of categories emerged from the data. Initially, five main categories were developed in each project and given working titles. Each main category in turn had a number of sub-categories. Likewise, each sub-category (i.e a 'node') either contained coded text units or additional nodes where data had been coded and stored. This led to a comprehensive, if somewhat complex index system, which was exemplified in one case study by the development at one

stage of over 400 nodes and codes. In order to keep track of developing issues and themes emerging from the data analysis, a series of memos were written and stored within the index system. However, more complex and lengthy memos were written and stored separately.

5.5.6 REVISION OF CODES AND CATEGORIES - (AXIAL CODING)

Following the development of codes, categories and an index system within each case study, axial coding (Glaser & Strauss, 1967) began to take place. Axial coding involved revising, condensing, collapsing and on occasion discarding codes and categories in order to arrive at an index system which reflected the issues of interest and relevance to the purpose of the study. In this way, codes and categories were related in new and different ways in order to arrive at a storyline that reflected the central issues of relevance. Whilst this process was carried out during each phase of the study, axial coding became more intense and sophisticated as the study progressed and conceptual awareness increased. The use of the NUD-IST program's sophisticated search and retrieval tools, along with the ability to search for themes and cross-reference categories and codes within the index-system facilitated this process enormously. Furthermore, the data display features of the program which allowed the index system and individual categories to "visualised" in various ways was fundamental in helping to arrive at a final list of categories and their associated sub-categories. Toward the end of this phase of analysis the original five main categories had been increased to seven, whilst the overall number of categories and codes had effectively been halved during the revision process.

5.5.7 ARRIVING AT THE FINAL SET OF CATEGORIES AND SUB-CATEGORIES

Following final data collection and analysis and through a process of selective coding based upon Glaser & Strauss's (1967) grounded theory techniques, a final set of categories, along with their associated sub-categories, was developed. The main categories were the same in each of the five case studies, as were the majority of the sub-categories. Where individual cases varied, the codes within each of the sub-categories were developed to reflect the individuality of case study findings. Appendix 10 lists the final five main categories and the common sub-categories[8] which had been developed by the end of the study.

5.5.8 WITHIN-CASE ANALYSIS

Following arrival at a final set of categories and sub-categories which had been generated in the NUD-IST program for each project (i.e. within-case analysis), the data analysed manually from role development diaries (completed by three of the case study ANPs) was integrated into the final case study summary. Each case study summary was then sent to the relevant ANP ahead of the final interview and was used as a basis of discussion to verify the conclusions arrived at following analysis of the data. Following the verification interviews, minor modifications and corrections were made before arriving at a final within-case summary.

5.5.9 CROSS-CASE ANALYSIS

The final stage of analysis consisted of undertaking a cross-case analysis of the five

---

[8] Appendix 10 includes the main categories and common sub-categories only. It does not include individual codes within each of the main or sub-category, as these vary from case to case and would be too numerous to list.

studies, as well as utilising the data collected via role development diaries. This process involved the development of case study propositions, which were located within each of the main categories. The data for each case study was then reviewed to establish if the propositions that had been developed were supported or refuted. Where there was a lack of evidence or refutable data, propositions were either revised or discarded. The revised set of propositions were then subjected to the same process until a final set of propositions were developed which were supported by the vast majority of the data. The propositions were then used as the basis for developing the theoretical arguments discussed in the final chapters of the thesis. The final list of propositions is located in Appendix 11.

The results of this detailed and extensive analytical procedure will be now be presented and discussed.

CHAPTER SIX

DATA ANALYSIS AND INTERPRETATION

CHAPTER 6: DATA ANALYSIS AND INTERPRETATION

6.1 INTRODUCTION

The longitudinal nature of the study, along with the use of multiple methods and sources of data collection, generated a data set of considerable size and volume. The use of multiple case studies and the integrative nature in which the data from various sources was collected, managed and analysed, meant that careful consideration was given to the way in which the data from this study is presented.

Within the tradition of case study research, data is often presented in its narrative form by making use of detailed descriptions and a chronology of events so as to illustrate the complexity, density and richness of the individual "case" (Creswell, 1998). The use in this study of five cases prohibits the presentation of the data in this manner, primarily because of the limitations on available space. The second possibility which was considered regarding presentation of the data was to use one or two exemplar case studies as a basis for discussion and analysis. This strategy however, is fraught with problems of selectivity and to some extent runs contrary to the rationale for the selection of *multiple* cases studies as the method of choice. The problem of how best to represent the data, which Denzin & Lincoln (1994) refer to as the "crisis of representation", was further complicated by the completion of role development diaries by study participants outside of the five main case studies. The substantial data contained within the role development diaries in itself merits separate discussion. Consequently, following deliberation, a decision was taken to present the data in two sections. The first part of the data analysis involves a thematic presentation of all the case study data, whereas the second presents an

analysis of the role development diaries (including those completed by the advanced nurse practitioners involved in the case studies). The chapter concludes with a summary of the evidence from both sources.

The case study data presented below are, therefore, in the form of a "grand" case study narrative in which the major themes and categories that emerged following collection and analysis of the data are used as a framework in which to discuss the similarities and differences observed between different cases. Yin (1989) refers to this approach to data presentation as "cross-case analysis", which he views as perfectly in keeping with the multiple case study designs. Whilst acknowledging that this strategy inevitably dilutes the density of the "individual" case, the benefit of being able to examine and compare the nuances between cases, which would otherwise not have been apparent, is compensatory and is in keeping with the rationale of the chosen study design. This approach to data analysis and presentation has been adopted so as to present the data in a logical order and to allow the "chain of evidence" to be followed, albeit a chain of considerable length and diversity. Individual case study summaries, which were used for verification purposes with individual ANPs, are located in Appendix 12 and provide a narrative and more in-depth account of individual cases. When read in conjunction with the following discussion, the case study summaries help to locate the data presented into specific contexts and in doing so provide a greater degree of individual richness and density.

6.2 CASE STUDY DATA PRESENTATION AND ANALYSIS

The following presentation and analysis primarily utilises data collected via interviews

and observations with the participants in each of the five case studies. Modification to the data collection procedure was necessary in two of the case studies, i.e. i) gynaecology and ii) adult intensive care. In both cases, observation of clinical practice was not possible. In the first case, gynaecology, the gender of the researcher and the sensitive nature of the ANP's practice meant that approval for direct observation of clinical practice was withdrawn. In the second case, adult intensive care, organizational re-structuring and uncertainty over the future of the unit led to temporary postponement and delay in the implementation of the ANP role. Consequently, additional interviews with both ANPs were substituted for each planned observation period. Furthermore, telephone contact was maintained with both ANPs for regular updating purposes and was utilised as a further data collection technique.

The planned use of follow-up interviews as part of the data collection strategy with selected case study participants was also subject to amendment. Of those case study participants interviewed at stage 1, follow-up interviews in stage 2 were not possible in eight instances (see Table 6.1)

In order to enable the following discussion to be located into specific organizational contexts, the final composition of each "case", along with the demographic characteristics of each case study site, are presented in Appendix No 13. The sample characteristics and biographical details of the five case study advanced nurse practitioners are presented in Table 6.2 below for immediate reference purposes. It will be noted that all are female, of varying ages and years of nursing experience,

Table 6.1 Case study participants from stage 1 unavailable for follow-up interview

Case Study	Participant(s)	Reason unavailable for follow-up interview
1: Resp Med	Consultant	No contact with ANP - change in organization
2: ITU	Consultant , Clinical nurse manager, Pathway coordinator.	Consultant took up post at another hospital (not replaced). Manager left the NHS - new manager agreed to be interviewed in their place. Pathway coordinator on extended maternity leave.
3: NNU	Pathway Coordinator	Pathway coordinator left host university and took up post in another institution.
4:Gynaecology	Pathway Coordinator, Directorate manager.	Pathway coordinator unavailable for follow-up interview despite multiple attempts to contact. Directorate manager on maternity leave.
5: A&E	Pathway coordinator	Pathway coordinator left host university and took up post in another institution.

working in different clinical fields and having differing educational backgrounds. Despite this variance, each was considered by their senior nursing and medical managers, along with members of the host university, to be suitably experienced, skilled and motivated, to not only undertake the Master's degree programme to prepare them as advanced practitioners, but to implement the role upon their return

Table 6.2 Biographical details of the five case study ANPs.

	Case 1	Case 2	Case 3	Case 4	Case 5
Clinical Specialism	Respiratory Medicine	Intensive Care (adult)	Neonatology	Gynaecology	Accident & Emergency
Gender	Female	Female	Female	Female	Female
Age	35	35	38	31	45
Nursing experience	10.5 years - 7 years*	10.5 years- 9.75 years*	13.5 years - 11 years*	10 years - 2 years*	6.5 years - 5.5 years*
First degree	No	Yes	No	No	Yes

* = Number of years spent practising in current speciality - out of total years qualified.

to the practice setting.

The five 'main' categories that are utilised as a basis for the presentation and analysis of the data were developed over the duration of the study, using grounded theory analytical procedures and the NUD-IST computer program (as detailed in the previous chapter). The categories are entitled:

(i)   entering the transitional process and gaining legitimacy;

(ii)   personal development and managing the transition;

(iii)   intervening conditions in the transitional process;

(iv)   role development and practice innovation; and

(v)   establishing a new nursing identity.

The complete list of categories and the associated sub-categories that were generated and refined following data analysis are located in Appendix 10. It should be noted that some of the data presented below relate to more than one category, however, for the sake of exposition they have been discussed discretely under the most appropriate categorical heading.

6.2.1 ENTERING THE TRANSITIONAL PROCESS AND GAINING LEGITIMACY.

Entering the transitional process concerns the stage at which the key case study participants[9] were approached by their managers and nominated to undertake the

---

[9] From this point on the key case study participants will be referred to as ANPs for the sake of clarity and consistency, although it is acknowledged that at this time they had not adopted the formal title. Case study 'participants' refers collectively to all the members that comprise a specific case.

regionally funded Master's degree programme. This course was unique in the region in that it had been specifically designed for the purpose of preparing nurses to become advanced nurse practitioners. Each ANP accepted the opportunity to apply for the Master's programme, acknowledging that it provided them both with the opportunity for personal development and career progression.

On entering the transitional process the ANPs presented a common altruistic rationale for wishing to undergo a change in role.

> "I believe that what we're aiming to do, far be it from a mini-doctor, is to give a better service to ladies who present..." (Case 4)

> "On my ward I want to fight for their [patients] plight and improve the services given to respiratory patients." (Case 1)

> "... it really benefits the babies because we've got a group of people who ... will become very skilled... and cause the babies a lot less trauma." (Case 3)

As the study progressed, two other motivational factors emerged as being of increasing importance to the case study participants. The first, which became apparent shortly after the study commenced, was that undertaking the Master's degree programme was viewed as a way of ANPs gaining legitimacy for the new advanced practitioner role in which they were about to engage. Legitimacy as a concept, had different interpretations amongst the case study ANPs. For example, in cases 1 and 4, it was associated with validating some clinical practices in which the ANPs had frequently engaged prior to entry into the transitional process. The ANP in case study 1 stated that her reasons for undertaking the course were to:

> "...basically give me the academic skills that I need...and also I think to

legitimise some of my practice, like drug prescription[10]...."

In this context, formal preparation for the role of advanced practitioner served to legitimate the practices that some study participants, including doctors and managers, believed nurses had been performing at an *advanced* level for some time. As a Consultant gynaecologist observed:

> "... there's been a long history of those [ANPs] in the national health service ...basically doing the advanced nurse practitioner jobs, but not called advanced nurse practitioners".

This idea was supported in one case (case 1), where the ANP repeatedly suggested that in many ways she was acting in an *advanced* capacity prior to entering the transitional process. This was a view that appeared to be shared not only by her clinical colleagues, but by her manager and university pathway coordinator.

> "She had the knowledge, she'd done a lot of things before, but she's now got the stamp of approval, she's done it." (Hospital manager)

> "She already was advancing practice I think in her own way, long before she came to the course." (University pathway coordinator)

Clearly then, the notion of the pre-existence of advanced practitioners in other than name, is one possibility that needs to be considered.

On the other hand, in those cases where the ANPs had not been performing in an advanced capacity prior to entering the transitional process, undertaking Master's degree preparation was seen as a way of achieving legitimacy, at least academically, for the role in which they were being prepared. One ANP expressed this sentiment

---

[10] Drug prescription should only be performed by medical practitioners in this setting. Whilst pilot studies relating to nurse prescribing have been conducted in primary care settings, at the time of this research, drug prescription by hospital based nurses is generally considered to be inappropriate and of questionable legality.

when she suggested:

"I think it's important so that people know that there is a difference, because you can call yourself a specialist nurse or an advanced nurse and have no proof of that...certainly having that recognisable qualification is important." (Case 4)

The concept of legitimation therefore appeared to be an important factor for the ANPs in this study, whatever the prior status of their level of practice.

The second motivational factor for entering the transitional process, which was not confirmed until much later, was related to achieving *recognition* as an advanced practitioner and establishing a new nursing identity. These issues will be addressed later in the chapter (see section 6.2.5).

The first stages of data collection, which took place whilst the ANPs were undertaking the Master's degree course, sought to explore how the educational preparation influenced both their personal and practice development. Analysis of the data collected during and following that period suggested that, contrary to their own and others expectations, the course had had only negligible impact on practice development. The most frequently cited reason given for the failure of practice to progress appeared to be based on the belief by all the ANPs that:

"... the focus has been too much on doing a traditional Master's ...with emphasis on the *academic* rather than in relation to practice". (ANP: Case 2)

On reflection, the perceived academic emphasis of the programme was not surprising given that the academic requirements for the Master's degree qualification had to be achieved in one full-time calender year. As a result, it was not uncommon for ANPs

to cancel planned clinical activities in order to spend their time meeting the academic workload of the course. The net consequence of the ANPs' strategy to meet the immediate short-term requirements of the programme, was that the relative time available for practice development was extremely limited. This observation was corroborated by the ANPs' managers who also had expected to "see" clinical development. As one manager observed:

> "... I mean they've got their Masters in Health Studies...But I don't think it prepared them. I don't think it prepared them at all for what they're doing now. I think that... there was just not enough clinical practice for them". (Case 3)

The extent to which ANPs focused on meeting the academic demands of the programme, at the cost of practice development, was exemplified by one ANP when she returned to her place of work following the course and commented that she had to "start from scratch" to develop the clinical skills that were required for her to perform her new role.

When the ANPs were asked to reflect on the Master's degree programme most found it was not what they had anticipated. Whilst the workload associated with the course was considered to be "heavy", especially given its brevity, on the whole most considered the standard of the programme to be at a lower academic level than other Master's degrees.

> "And because some of the things seem to have been de-valued ... it makes you wonder is it really Masters level, or are you just going to come out with a degree that's not really a Master's degree at all?". (ANP: Case 3)

This assertion is difficult to substantiate however, as the ANPs prior experience of higher education was mixed and limited at most, to first degree level (see Table 6.2). The main dissatisfaction with the course was the recurrent theme amongst all the

ANPs that it had not met with their expectations of providing them with opportunities to develop practice in new and different ways, or to acquire new clinical skills. A number of the ANPs reflected their criticism of this fact on the clinical credibility of some the course lecturers when they suggested:

> "....a lot of them have been in just education for ages ... they haven't got a realism about nursing....they haven't got that realism about practice, we're the experts when it comes to practice." (ANP: Case 1)

> "And I think my concern is whether the course will prepare me adequately for this role, because I don't know really if the academics really understand this role. They're doing what they think is right, but they're not in touch with reality." (ANP: Case 2).

Clearly, there was an expectation on the part of the ANPs and others, that the course would equip them with the skills and competencies to perform at an advanced clinical level. However, there appears to have been a mis-match between the expectations of the ANPs and those of university staff with regard to the *purpose* of Master's degree preparation. In the case of the latter, the goal of preparation was identified as being oriented toward the development of cognitive skills and facilitating the learners (i.e. ANPs) to become "independent" practitioners, with added academic credibility. As one university lecturer put it, undertaking the Master's degree was about:

> "... the process of realising that they were capable of being their own master of learning.".

Consequently, it became increasingly apparent that there was tension between the university and practitioners (both nursing and medical) regarding both the process and outcome of the educational preparation. This was even reflected in a number of ANPs assertions that arriving at understanding and clarification of the concept of

177

advanced practice was associated more with contact with fellow students on the course and work based nursing and medical colleagues, than through the formal educational process itself.

> "I'm clearer about what advanced practice is from doing the course...but to be honest I've found 'Jane' [another 'ANP' in the hospital] more useful if I want to know anything about advanced practice and my colleagues on the course have been very supportive..." (ANP: Case 1)

University lecturers identified a different reason for students' problems in translating the concepts encountered in the course into clinical practice. The course coordinator stated:

> "I think the difficulty lies in the quality of the students. They may be very good at what they do in practice, but they have great difficulty coming on a course, an academic course, realising that they are the ones that translate theory into practice... Very few of them came from what I call a normal academic background as a nurse. ..."

There are other equally plausible reasons for the tension experienced between the ANPs and staff at the university, these include: the newness of the course[11]; the general ambiguity within the wider domain of nursing regarding the concept of advanced practice; and the differing expectations of practitioners, managers and academics with regard to the purpose and goal of the programme. As one nurse manager observed at an early stage in the study:

> "It's too confused at the moment, I think the whole concept of advanced nurse practitioners, specialist nurses is too confused. There is still not a clear guide from the governing body on this, and that just makes it even more confused. Everybody is ploughing their own furrow." (Case 5)

Despite reservations regarding the level, appropriateness, and goals of the educational programme, the possession of a Master's degree qualification was seen

---

[11] This was the first course of its kind the university had developed and was running.

to be of significance in providing the ANPs with academic credibility with their nursing

and medical colleagues. This point was reinforced by one ANP when she stated:

"...the course has given me a higher level of education, but how much better than an ordinary Master's in many ways it was? I have to try and pretend it was to give myself some credibility, but I don't think it was a good course to prepare you for the role." (Case 4).

6.2.2 PERSONAL DEVELOPMENT AND MANAGING THE TRANSITION.

All ANPs were successful in completing the Master's programme and returned to

their work places and took up their posts. It was at around this time that it was

recognised that undertaking the Master's course had also had a detrimental effect

on a number of the ANPs and their practice. The main criticism was related to the

full-time nature of course which had necessitated a protracted absence from the work

place and led to problems of re-integration. Whether this problem would have

occurred had the Master's degree programme been part-time is difficult to establish.

Nonetheless, a number of the ANPs appeared to experience a "loss of belonging"

from the work place during the Master's programme and find difficulty in re-

integration following their return.

"I thought the course was really ... in some ways was detrimental...I feel bad going back on the ward at the moment. I feel like I'm interfering...I feel like it's not my ward anymore. I hate it.".(ANP: Case 1)

This factor was also observed by nurse managers, as one noted:

"I think the other thing about it was, taking people out for a year has a significant impact on them as a practitioner, but also on the area that they come back to. Things don't stay the same, and there have been changes in nursing staff during the time they were away that was significant." (Case 5).

The sense of detachment experienced by ANPs varied in duration and intensity. In

one case the feeling persisted for over twelve months, with the ANP acknowledging

that re-integration into the work place had been problematical and prolonged.

> "I mean after being out for a year, I spent the first months back putting everything right, because it had just gone wrong...It really is only now [15 months post-course] that I actually feel that I've got my ward back. I'd say it's taken a year to feel like I've really got my ward back again." (Case 1)

The problems with re-integration were later identified to be due to two main factors, the novelty of the new role and a mis-match between the ANPs' expectations of their role and those of their nursing and medical colleagues. The influence of these variables became increasingly apparent as most ANPs appeared to experience difficulties in managing their role transition.

Following the ANPs return to the practice setting some nursing and managerial colleagues noted a number of personal "changes" in the ANPs. The changes which were identified most frequently related to cognitive and affective attributes, as opposed to changes in clinical practice and competencies per se. This would seem to support earlier observations that only negligible practice development had occurred during the educational programme. The changes of particular note concerned perceived increases in the ANPs' knowledge base, confidence and assertiveness.

> "Well I think her knowledge base is different, on things like physiology. She's got an incredible amount of knowledge..." (Nursing colleague: Case 2)

> "... the course has given her that confidence and the ability to move those skills forward and be autonomous". (Nurse manager: Case 4)

> "I think she's come back as probably more assertive than she was before she went off". (Nurse manager: Case 5)

This would appear to indicate that the university's philosophy of equipping the practitioner, not with clinical skills, but with the acumen, knowledge and attributes to

independently identify and meet their learning needs appears as though it may have been at least partly met.

As the study progressed it became increasingly apparent that the personality traits and characteristics of the individual ANPs were having some influence on how role transition was managed. While some of the case study ANPs appeared proactive, confident and out-going (i.e. cases 1,2, & 5), others initially appeared to lack confidence and remained relatively passive in managing their transition (i.e. cases 3 & 4). One way in which the types of personality were manifest appeared to be in relation to the concept of "risk-taking". That is to say that the way in which ANPs were prepared to engage in risk-taking behaviours provided some insight into how the role transition was managed. In this respect, those ANPs who were proactive in managing the transition demonstrated a self-awareness of the risk-taking behaviours in which they were prepared to engage, as the following quotations illustrate:

> "... a lot of what I am doing hasn't got a protocol...so if I was sort of up in court I wouldn't have a leg to stand on... I mean, I fly by the seat of my pants ... with a lot of what I do ..." (ANP: Case 1).

> "... we are bending the rules and people are starting IV fluids and altering rates and so on. I think my manager knows that it happens and she isn't very happy. But because we've got not cover after 9pm and no middle grade doctors it tends to happen." (ANP: Case 2)

> "... when it comes to the point of me making that decision, and I think, "I haven't missed anything here?", it does put you really in a vulnerable position when you're actually questioning your own knowledge and skills". (ANP: Case 5)

Those ANPs who were more passive in managing the transition had a propensity not to be prepared to engage in risk-taking behaviours. They suggested:

> "... I know that I will be doing nothing that I'm not trained to do. ... So, I wont

181

ever put myself at risk, because I'm too sensible for that". (ANP: Case 4).

"... I don't do anything outside the boundaries as they exist at the moment or outside the clinical protocols or anything that I can put my hand on my heart and say I know exactly what I'm doing here I'll contact somebody ... I've never been one to throw caution to the wind. I err on the side of caution all the time." (ANP: Case 3)

Subsequently however, it was discovered that it was not only the personal characteristics of the ANP that contributed to the occurrence of risk-taking behaviour, but also the nature of the clinical environment in which they are employed. For example, In case study 1, the ANP worked in a community hospital, with only on-call GP medical cover after 5.00pm and at weekends, in such an instance the likelihood of the ANP (and other nurses) engaging in risk-taking behaviours appears to increase as one of the ANPs colleagues pointed out:

"... I think especially in a community hospital, lots of us actually do sort of give things that officially we're not really supposed to..."

This same combination of precipitant situational circumstances and the individual risk-taking traits of the ANP were present in at least one other case (Case 2). This tentatively suggests that the need to engage in risk-taking behaviours, because of situational circumstances, may provide insight into the motivation for why some ANPs needed to legitimise certain aspects of their practice.

As the study progressed it became increasingly evident that a variety factors, other than personal attributes, were also exerting influence over how the transitional process was being managed.

6.2.3 INTERVENING CONDITIONS IN THE TRANSITIONAL PROCESS.

The assertion that, in some cases, ANPs were seen to be acting as advanced practitioners prior to undertaking the Master's programme, may suggest that the concept of advanced practice was widely understood and agreed amongst the case study participants. Analysis of the data however, points to the contrary. At all sites, there appeared to be a lack of consensus regarding the concept of advanced practice. The ambiguity surrounding the concept was made explicit by the majority of case study participants, as the following few examples illustrate:

> "....I think... perhaps their role is, ... not very well defined. So nobody is quite sure what it is that their role does involve exactly." (Nursing colleague: Case 5)

> "...it is difficult because the senior nurses see the role as one thing and the doctors as something else, and we see it something in between".(ANP: Case 3)

> "I don't know what advanced practice is. It's all very confusing. I think the skills are really ' specialist' level, not advanced." (ANP: Case 2)

> "I have to say there was a lot of confusion about the term in my opinion" (Hospital manager: Case 1)

Given the apparent ambiguity, it became evident that differing personnel had not only varying perceptions of the concept of advanced practice, but also different priorities from what they expected of the ANP role. Whilst some expectations were shared between all the case study participants, others were not. Consequently, the proposed parameters and orientation of the ANP role appeared initially to become somewhat idealised and almost de-contextualized from the everyday limitations of the clinical environment in which the ANPs worked. Subsequently, instead of defining the role parameters in the context of what could be achieved - given available

resources, the nature of the clinical environment, organizational goals and so on - role parameters were initially defined as a set of highly idealised behaviours and outcomes. The following example from one case study is typical of the others and demonstrates the notion of a highly Utopian view of the ANP role.

> "I would expect her to be running her own clinics for pulmonary patients..working alongside a consultant" (Hospital manager)

> "This is what advanced practice is - the management, the education, and the clinical practice". (ANP)

> "I could see her as ward based, but with a lot more of a peripatetic role being able to, if there was a crisis, move from the ward she was based on into another ward. To work with them if there was a specific problem highlighted". (Hospital manager)

> "...I think they [medical staff] can't wait. Our doctor ... said 'oh, you'll be able to do some of my admissions'." (ANP)

> "I think she should be on the ward and community largely. Clinics are the role of the respiratory nurse specialist" (Consultant Preceptor)

As a result, a mis-match in the expectations and priorities of differing personnel became obvious. Whilst there were both multiple and varied expectations of all the ANPs involved in the case studies in terms of the desirability of certain role behaviours, paradoxically, nursing and medical staff initially placed the onus of responsibility for defining the new work role with the ANP themselves. Arguably, the most likely reason why this occurred was to do with the ambiguity and uncertainty regarding the role of the advanced practitioner during the early stages of the transitional process. Interestingly, when the ANPs returned to work following graduation from the Master's degree programme they had little discretion to determine the parameters and scope of role development as either they desired, or as other stakeholders had originally indicated. The reason for this appeared to be

linked to the nature of the prevailing intervening conditions that existed in the various practice settings. For some (i.e. the ANP in case 1), the intervening conditions were predominantly inhibitory. In this case, the ANP found herself undertaking her old role as the ward sister, full-time, and had little time to develop her new role. The main factor which led to this situation was identified as being insufficient resources (both financial and physical) to allow the ANP to be relieved from her ward manager duties. As her hospital manager iterated:

> "Her primary role in the hospital was as a ward sister. And nothing has altered that. We don't have anybody else to do that...".

In other cases (i.e. case study 2, 4, & 5), the intervening conditions led to the ANPs being required to undertake their old role for at least *part* of the time The prime reason given for deployment in this way was linked, once again, to the availability of resources. As one hospital manager pointed out:

> "Resource wise we would fund them in the sense for 50% of their time being spent in advancing practice, and the other 50% would have to be as they used to be as a G' grade. That would have to be covered. ..." (Case 2)

However, in the one case, where additional financial resources had been secured (i.e. case 3), the ANP was deployed in a supernumerary capacity in her new role on a full-time basis.

This raises a number of issues regarding the nature of intervening conditions that influence the transitional process of developing a new work role. From the case study data, there consequently appeared to be two, inter-related factors, influencing the progress of role development. Firstly, the resources available, and secondly, the way in which ANPs were deployed within the organization.

The lack of resources were manifest in a number of ways during observation visits and ranged from: staffing shortages; sickness; the necessity for the ANP to undertake standard nursing and administrative duties; and a lack of time to spend developing practice and role innovation. The importance of the way in which ANPs were deployed within the organization and the relationship in facilitating or inhibiting role development and practice innovation were openly acknowledged.

> "They haven't made me supernumerary because there are no resources, so I've had no time where I can spend just in advanced nursing practice...I've no option." (ANP: Case 1)

> "The agreement we came to was that there was no way we could fund them the full.. time off, being supernumerary...we agreed it should be 50% service, 50% ANP, which was time for them to develop..." (Manager: Case 5)

> "The deficit in [the ANP's]... role at the moment is that she's not dedicated to doing her role in a full-time way. So when she's released from the ward, I have to pay an extra nurse to do that shift..." (Manager, Case 4).

The availability of resources and deployment strategies clearly accounted for how long ANPs could spend in developing their new role and practice innovation. However, not only did this influence the *rate* of practice development, but intervening conditions also dictated the *scope* of the ANPs' practice and the degree of discretion they were afforded to adjust practice boundaries. The data from the study clearly indicate that "key" stakeholders, such as senior medical staff and senior nurse managers, exerted considerable influence on how the ANP role was enacted. Following the early rhetoric concerning the idealised way in which the role was conceptualised, most ANPs were set a series of tasks or goals which they were expected to accomplish in their new role. The opportunity for them to move outside of those parameters appeared to be extremely limited. Thus for example, the ANP in

case 3 was expected to act primarily as a replacement for junior medical staff involving the provision of direct clinical care to neonates. Thus, the ANP's consultant was explicit in his expectations of her new role when he stated:

> "... for the first six months they should concentrate mainly on the clinical side, so that they got into the job... I suggested that they should spend 80% of their time on clinical matters."

However, whilst it may appear that this was a temporary suggestion, the consultant, with the assistance of the unit's nurse managers, was able to maintain control over the way in which the ANP role was developed. The ANP's exasperation with this situation was made clear when she pointed out:

> "...they felt it should be 90% clinical duties and 10% of the time for all the other things. And we don't see it like that at all. We want to do a lot of other things, we're not just here as replacements for junior doctors - if it's going to be like that, I'd rather not bother thank you very much."

Similarly, all the other case study ANPs found their role being dictated to the same degree. However, not all were directed in a medical replacement capacity. The ANP in case 5 was given a primarily educational remit for her new role. Subsequently, this was identified as the main reason why she failed to develop her clinical skills to any noticeable degree and was only able to influence patient care indirectly. As was openly acknowledged:

> "We want her to take a lead on education and I think she should control the allocation of study time." (Nurse manager)

> "...for me I see my role as very much in-directly affecting practice than directly." (ANP)

Likewise, the ANP in case 2 conceded that it was her nurse manager who determined that the new role should have a mainly teaching and indirect orientation. When asked why her role was developing in such a way, she replied:

"Because the boss wants it to be a teaching role...".

Consequently, it appears that the way in which the ANP was deployed was linked to the availability of resources. More importantly however, it appears to be the desires of "key" stakeholders within the organization, who moderate the degree of discretion that the incumbent has in determining role boundaries and role components when attempting to implement a new work role. As a result, ANPs seem to have little or no discretion in determining the scope and focus of their new work role.

A further intervening condition identified as having an influence on the transitional process concerned the change in relationships between the ANPs and their professional colleagues. Following a one year absence from the work place, ANPs were required to "re-negotiate" relationships upon their return to work. It appeared that relationships with managers proved most problematic. Changes in the management structure (in two cases) and the mismatch in role expectations led to a deterioration in relationships between some ANPs and their superiors. In one case, this led the ANP to accuse her managers of "lacking" vision and having little idea of her new role.

> "...I could do so much and be so beneficial for the hospital. And I think that's what they [hospital managers] don't understand, they can't see it. They haven't got the vision! " (ANP: Case 1)

> "... we feel we haven't been supported particularly well, I've got to say, by our nurse managers...we've felt a bit let down by them so far". (ANP case 3)

The importance of managerial intervention in facilitating or constraining role development was identified at the outset of the study by one ANP's consultant preceptor, when he suggested:

"It all depends who is in charge. If the wrong person's in charge then the trust will constrain it. If the right person's in charge, with imagination, some idea of the future, then it won't be constrained" (Case 1)

The relationship between manager and ANP appeared to be an important factor in determining the nature and pace of the work role transition. However, in some cases (Cases 2 & 4), the re-negotiation of relationships between ANP and manager proceeded amicably.

It was not only the relationship between ANP and manager that was of interest, but relationships with other professional colleagues. The data suggests that the ANPs relationship with their immediate nursing colleagues was dependent, to some extent, on the way in which the new role was implemented and upon the way in which the ANP was deployed. For the majority of ANPs who were not deployed in a full-time supernumerary capacity, the fact that they had to resume their old roles as traditional sisters meant that when acting in that capacity, they were treated in a similar fashion to other nurses. At such times the ANPs perceptions were that they were viewed with little difference by the majority of the nursing staff with whom they worked. Typical comments from the ANPs colleagues support this point of view, as one replied when asked if the ANP treated any differently to other nursing staff:

"...No I don't think so. Not at all...." (Nursing colleague: case 4).

Despite the perceived minimal change in relationships with their nursing peers when undertaking a traditional nursing role, when ANPs were afforded time to spend in practice development, they appeared to experience a 'change in status'. When this occurred, ANPs were both perceived and treated differently from other nursing staff.

Interestingly, this was manifest most overtly in the way in which ANPs experienced 'conflict' with their nursing colleagues, concerning both the philosophy and practice orientation of their new role. From a philosophical standpoint, some ANPs were seen by a few of their colleagues to be "selling out" traditional nursing values. As one nurse manager noted:

> "...it quite difficult when they came back because they seemed to have no impact into nursing. Because the medical supervisors had them looking at almost, training them as they would a junior intensivist...nurses resented that a lot. What's that to do with nursing?"

In another case, an ANP recounted a situation where she had to defend herself against an outburst from a nursing colleague:

> "...she said she saw us as a doctor, which I strongly disagreed with. She said well you work with the doctors, you socialise with the doctors, you have lunch with the doctors. Does anybody know what you are doing! It's all secretive behind closed doors!'." (Case 3)

When the new role did not involve the ANP in acting in a medical 'replacement' capacity, conflict was associated with the impact of the new role on senior managers. In such cases, conflict appeared to be associated with the perceived threat the ANP posed to managers' existing roles. However, once the ANPs had become established in their new roles, the incidence of conflict with nursing colleagues and nursing managers receded.

The study also sought to establish how the development of the ANP role would influence relationships with medical colleagues. In all cases, the ANPs acknowledged that they had both the respect and support of senior medical colleagues prior to entering the transitional process as the following examples indicate:.

190

"She's always had a very good relationship, always with the Consultants, and I think that because of her knowledge even before she did her ANP course, I think she's always been respected for that..." (Hospital manager, Case 1)

"... the medical staff at the hospital are super.... I have very little trouble with them....I get on very well with the Consultants, they respect my opinions and vice-versa." (ANP: Case 2)

That ANPs had that support was in some ways not surprising as consultants were required to give an undertaking to act as preceptors to the ANPs both during and following the Master's degree programme. The support of consultants may also be attributed to having their own interests served by the implementation of the ANP role. This assertion seems to be strongly supported in those cases where the ANP role was overtly directed toward 'replacing' the practice of medical practitioners (e.g. case 3 & 4). The following example from one ANP serves to illustrate this point when she suggested that:

"...at the moment we're just sucked purely into doing the clinical work and haven't had opportunity to develop any other bits of the role we want to develop. Mind you the consultants don't like the idea of the new rota... they want us to be clinical all of the time..." (Case 3).

In this instance there was clearly a consultant agenda driving the direction of the role transition in which the ANP was engaged. In those cases where the ANP role had little direct impact on the delivery of what could be termed "medical care", consultant staff appeared to be less influential in affecting the outcome of role transition.

It was not only the relationships with senior medical staff that were seen to change however, in some cases (case 1, 3, & 4), there were noticeable alterations in the status of relationships with junior medical staff. For example, in case 1, despite the ANP's role development being stifled by the presence of impedient intervening

conditions, she experienced a significant change in relationship with the staff grade doctor with whom she worked. The magnitude of the change in the relationship was emphasised by the ANP when she stated:

> "...I probably work alongside with Dr X [middle grade doctor] and the consultants, more than any other member, even the nurses. I know that sounds daft. If people say who do you work the closest with, I would say Dr X. I'm not saying that I'm the same, but I'm saying that is who I probably discuss patients with the most."

Whilst in this case, the change in relationship was predominantly positive, in another (i.e. case 3) the development of the ANP role led to a mixed reaction. The problem identified in this case related to two issues, firstly the perceived "competition" between the ANP and junior doctors for opportunities to learn and acquire new skills, and secondly, the junior doctors' perceptions and expectations of the ANP role. The ANP was cognisant of the former when she suggested:

> "The SHOs who are on GP rotation appear to be more accepting us than the career paediatricians who are aggrieved at having to compete for opportunities with us to develop their skills...". (Case 3)

The second problem related to the SHOs' perception that the ANP was performing an identical role that of their own, despite a contrary expectation that the ANP would simply be undertaking some additional tasks. One junior doctor verbalised his expectations in observing that:

> "... in terms of neonatal advanced nurse practitioners, they'd be able to do things like intubate, put lines in, sort a baby out and do advanced roles that an ordinary nurse wouldn't do, but the term would still imply to me that they would still be nurses. That's what they're called. But, the role that they've been playing here and that I've seen them playing, really is more of an SHO role".

In this case, the occasional conflicts which occurred between the ANP and junior medical staff appeared to be primarily related to both the mis-match in expectations and the perceived competition concerning skill acquisition. In other cases,

relationships with junior medical staff, on the whole, were perceived to be positive. Moreover, in the case where conflict did occur, the incidence receded as junior medical staff became familiar with the ANP role.

That most ANPs experienced some change in relationships with medical staff of all grades is supported in the data. Interestingly however, it could be suggested that the change in relationships may have been the outcome of a deliberate strategy in which ANPs attempted to consolidate their new position within the organization. This was made explicit during one observation visit when an ANP stated:

> "I think what nurses need to do is ... strengthen the relationships with doctors, not as handmaidens, but so they can understand more what we are about". (ANP: Case 1).

Whilst this was only commented on by one ANP, the change in relationships that were observed between ANPs and their consultants certainly appear to support this point of view. On the other hand, another explanation for the change in relationship with medical staff, may be that the latter themselves see the development of ANP role as a positive attribute in meeting their own needs as suggested earlier.

Overall, the ANPs acknowledged that following initial uncertainty, they experienced a "general" feeling of support in their endeavour to develop advanced practice from all staff groups within the work place. Whilst support for the development of the ANP role was perceived to be an important variable in the transitional process, in and of itself it did not appear to guarantee progress in role development. Despite a clear strengthening of relationships between the ANPs and their medical colleagues throughout the period of the study, ANPs struggled to make changes to the

parameters of their new role.

An important feature of re-negotiating relationships with professional colleagues and in gaining legitimation for the new role concerned establishing clinical credibility. This concept varied according to the way in which the new role was being developed. In cases where the ANP was primarily involved in delivering patient care, clinical credibility was chiefly associated with gaining competence in psychomotor skills, procedures and tasks. In such cases, the standard of practice was compared with that of medical practitioners, as few, if any other nurses were performing the same role or skills. On the other hand, in the case of the ANP (i.e. case 1) who perceived herself to be acting in an advanced capacity before undertaking the Master's degree course, she considered that her clinical credibility had already been established with her colleagues.

The issue of credibility was perceived differently in cases where the ANP role did not involve the delivery of direct patient care. In these situations, credibility in maintaining traditional nursing skills was seen to be of prime importance. As one manager noted:

> "... the views of all the senior nurses is ... that for them to maintain their roles as ANPs they've got to be seen clinically out there doing the job. They've got to be clinically credible". (Nurse manager: Case 5).

'Clinical' credibility in this context was primarily associated with 'general' nursing care activities (as opposed to any 'advanced' activities) and the need for the ANP to act as a role model to other nursing staff whilst engaged in practice.

194

The credibility of all the ANPs was also enhanced by possession of the Master's degree qualification, as was recognised by both nurse managers and consultant medical staff.

> "...it [MSc] enhances [her] credibility when she comes to put forward a proposal, and it's gaining the respect of medical colleagues that are a bit medically minded" (Hospital manager, case 1).

> "... I can see some advantages because of the sort of mystique and the aura of having a degree after your name because the place being what it is and the nursing establish being what it is and people, you've got to have a degree nowadays... " (Consultant, Case 3)

The data suggest that whilst ANPs measure role development by the degree of practice innovation and the alteration of practice boundaries, there is an implicit recognition for the need for the ANPs' identity and role to remain rooted within a nursing paradigm. It appears that it is for this reason that importance is attached to acting as a role model to their nursing colleagues. Arguably, this premise is based on the assumption that the goal of advancing nursing practice is to develop and enhance the delivery of nursing care, as opposed to becoming a substitute for junior medical staff or expanding practice into marginal areas. Interestingly, the evidence in at least two of the case studies suggested that the ANP role was being developed in such a way. The data concerning how individual roles were developed will now be presented.

6.2.4 ROLE DEVELOPMENT AND PRACTICE INNOVATION

Analysis of the data suggested that the prevailing intervening conditions determined not only the orientation of role development, but its rate. One of the questions the study wished to address was to identify the ways in which the practice of the

advanced practitioner differed from that of their nursing colleagues. Analysis revealed that there were five major areas of difference that distinguished the practice of the ANP:

(i) the development of new clinical skills, such as patient assessment, technical procedures and competencies;

(ii) cognitive abilities, such as decision making and an increase in knowledge base;

(iii) the focus of the activities in which the ANP was involved;

(iv) increased practice independence and autonomy; and

(v) the context in which practice took place.

(i) The development of new clinical skills

As the study progressed, it became apparent that the ANPs' "advanced activities" (as they referred to them) were oriented toward either the delivery of direct patient care or were concerned with staff development and leading change within the practice setting. In cases 1,3 and 4, the former dominated, whilst in cases 2 and 5, the latter orientation was evident. The Utopian view of an eclectic role (incorporating both orientations) which had prevailed amongst many of the study participants at the outset of the inquiry, failed to emerge.

For those ANPs whose role was predominantly oriented toward the delivery of direct patient care, the acquisition of new clinical skills took priority in the early stages of role development. This was emphasised by one clinical manger who identified:

> "...they had that year in university they...gained very little clinical experience. ... when they were coming back....they thought they were going to be involved in lots of other areas [but] one of the priorities for us on the unit was

consolidation of the clinical skills". (Case 3)

The ANPs initially took every opportunity to gain experience in procedures and skills in which they were expected to become competent. Equally, time was spent developing competence in activities such as patient assessment, arriving at provisional diagnoses, interpreting diagnostic investigations, and planning patient treatments and management. These characteristics distinguished the practice of ANPs from that of their nursing colleagues, who were predominantly involved in delivering a more traditional nursing service.

For those ANPs whose role transition was oriented toward staff development and leading change, the acquisition of new skills and competencies was related to those activities required to deliver a new organizational and teaching role. Thus, gaining competence in developing practice protocols or teaching materials was seen as more appropriate than learning new psychomotor skills or medical procedures. In these cases, initial attempts to acquire additional clinical skills, such as intubation, receded as the orientation of the role became established and ANPs acknowledged that they would be unable to develop a "clinical" role.

(ii) Cognitive abilities

Whilst cognitive development was associated with the acquisition of "propositional" knowledge gained from undertaking the Master's degree programme, the cognitive changes associated with role development predominantly concerned the development of "practical knowledge", along with some affective change.

For ANPs whose role was directed toward the delivery of direct care, the development of practical knowledge was evidenced over the duration of the study. The change in cognitive abilities was apparent in a number of ways, including: reduction in the supervision of clinical practice; decreasing reference to theoretical materials; increased speed in skill performance and technical procedures; and the application of skills and theoretical principles to an increasing range of patient episodes and situations. Increased cognitive ability appeared to accompanied by affective changes, such as increases in confidence and assertiveness, even in those cases (e.g. case 3) where the traits of the individual revealed an initial reticence in these domains. As one such ANP reflected:

"... I think I am making more decisions now. I feeling more confident and, what's the word, less timid about putting my view forward". (ANP: Case 3).

For those ANPs whose practice was of the opposite orientation, the change in cognitive ability was associated with achieving a greater breadth of knowledge. In these cases, increased "practical knowledge" corresponded to the nature of role acquisition. Consequently, ANPs were seen to gain "knowledge of the system" in order to allow them to perform more effectively. Likewise, affective changes, such as increased assertiveness and confidence, accompanied cognitive and role development. These changes were frequently commented upon by case study participants.

"... I have seen a change in her sort of working relationships with people and in the way she deals with a problem....she's much more organised in her approach to problems and problem solving. ..." (Nurse manager: Case 5).

Cognitive abilities were also associated with knowledge of the practice discipline and

ANPs whose role was oriented toward staff development were still viewed as being knowledgeable about clinical issues. The following quotation illustrates the way in which cognitive and affective changes are perceived to be consolidated as role transition develops and ANPs' come to be recognised by their peers.

> "... I would say that she is more confident now, especially when she is able to argue the issues with the medics. I think she does that more confidently ..." (Nursing colleague: Case 2).

(iii) The focus of the ANPs' activities.

The third area in which the ANP role differs from that of nursing colleagues concerns the focus of activity and associated changes in patterns of behaviour. One feature that appears to characterise this transition is a shift in practice priorities. This was evident in a number different ways according to whether role orientation was primarily concerned with the delivery of a service to patients, or in meeting the wider needs of nurses within the organization. In the case of the former, the shift in focus concerned a move from delivering traditional nursing interventions, to one of medical assessment and patient management. While the traditional "caring" role was incorporated into the ANPs' practice, in these circumstances it appeared to be relegated to secondary status. For example, one ANP (case 4), when acting in her "advanced capacity", conducted a clinic in which she assessed, treated, and managed patients within a prescribed range of conditions. Undoubtably, part of her role reflected a traditional nursing emphasis as the ANP herself points out:

> "...I do believe as a nurse I can give them a little bit more just from a counselling, advice and sympathy side of things".

However, she demonstrated a significant change in her pattern of behaviour as a

result of the shift in practice focus. Likewise, the advanced activities in which the ANP in case 1 was involved concerned the delivery of a pulmonary rehabilitation programme for both in-patients and outpatients. Once again, this required a shift in practice focus. The most significant shift in practice focus however was observed in case 3 where the ANP assumed a role virtually identical to that of a junior doctor in the neonatal unit. This was illustrated by the way in which the ANP shadowed junior medical staff and worked under the supervision of the registrar on the unit upon her immediate return from the Master's programme. Priority was given to gaining experience in various clinical activities such as: the examination of babies; attendance at the resuscitation neonates in the labour ward; as well as gaining practice in invasive procedures such as umbilical arterial catheter (UAC) insertion, cannulation and lumbar puncture. Consequently, the majority of the activities in which the ANP engaged were both new and novel to the role she was performing. It was not simply the acquisition of clinical skills that signified a change in focus (as a number of other nurses on the unit were competent in a limited number of 'enhanced' skills, such as cannulation), but the way in which the focus of her practice mirrored that of junior medical practitioners. In this sense, not only were the activities of the ANP similar, but the way in which her working day was organised was identical to that of junior medical staff on the unit.

ANPs whose role orientation was toward the system of care similarly altered the focus of their activity. On this occasion, the shift in focus concerned the organizational aspects of their role, such as: involvement in protocol and policy development; assessment for the need to initiate change in the practice environment;

and acting as consultant or teacher to colleagues. In this way, their daily patterns of behaviour differed significantly (when they were perceived to be acting in their 'advanced' role) from that of their nursing colleagues.

(iv) Increased practice independence and autonomy

One of the most overt aspects of the ANPs' role development and practice innovation concerned changes in practice independence and autonomy. 'Within' the role they were asked to perform, ANPs were afforded varying degrees of practice independence and given greater autonomy in decision making. The extent of these changes were clearly apparent to the ANPs nursing and medical colleagues:

> "That's the basic difference...she doesn't have to go and ask a doctor....She can check heart and lungs, she can take the blood, she can do everything, she doesn't need to go and ask a doctor". (Nurse manager: Case 4)

> "...[that] has definitely changed, she is much more autonomous in what she does than she used to be." (Consultant: case 5)

Corresponding to changes in practice independence and autonomy, ANPs were afforded certain 'privileges' which were not available to other nurses. When the role involved the delivery of direct care, these included such things as: ordering expensive investigations (independently); altering treatment regimens; admitting patients without medical approval; and in one instance (case 3) moderate prescription privileges via protocol. Consequently, the data revealed that whilst the ANPs had very little discretion to adjust the boundaries and scope of their new role, they were afforded a higher degree of discretion and practice independence "within" the context of care delivery.

Likewise for those ANPs who had a primarily organizational role, increased independence was associated with privileges such as: freedom of time management; the autonomy to amend protocols and educational programmes as considered necessary; and the freedom of access to resources and personnel. In this respect, increased autonomy and independence can be considered to be a common feature of role development, regardless of role orientation.

(v) Altered practice context.

The final feature that distinguished the practice of ANPs in the way in which their role was implemented concerned an adjustment (sometimes temporary), in practice context. In two cases (case 1 and 4), "advanced" practice was regularly conducted away from their clinical base, in an out-patient clinic. For another (case 3), part of her role required attendance at emergency deliveries in the labour ward suite, conducting baby checks on post natal wards, and accompanying babies on transport to other hospitals. Whilst the change of context in itself, is not a highly significant issue, it is a further way in which the ANP role developed to be different from that of the 'traditional' nursing role. Even in those cases where the ANP was not primarily involved in directly delivering care, the context of practice still changed. On these occasions ANPs disengaged from the clinical area to the non-clinical environment of the classroom or administrative offices. The notion of ANPs changing the context in this way was not always met with approval. One junior doctor stated his dissatisfaction with the ANP disengaging from the practice setting when he commented:

"... since she started to be an advanced nurse practitioner we didn't see her

in the ITU. Most of the time she is outside or in the room doing papers or preparing for things. So actually it takes her away from the ITU and again it takes her away from being in contact with the patient. And I think that the most important thing is to be in contact with the patient..." (Case 2).

Role development then can be seen to be associated with a number of different concepts, ranging from not only the roles ANPs perform, but the nature of skill acquisition and cognitive development, to the context of care and the prime focus of activity. Each of these characteristics appeared to influence the way in which the ANPs new identity was perceived.

6.2.5 ESTABLISHING A NEW NURSING IDENTITY

It became evident as the study progressed that throughout the period of transition ANPs sought to establish a "new" identity and gain recognition for developing their practice and role. Recognition appeared to be a fundamental concept in establishing this new nursing identity and was sought at different levels within and outside the organization.

The establishment of a 'new' nursing identity was signalled when the title of 'advanced nurse practitioner' was formally adopted by all the case study ANPs on return from the Master's degree programme. The use of the ANP title on correspondence to other health care workers, when on the telephone, or when meeting visiting nursing and medical staff, identified that the ANPs had a different identity to other nurses. Interestingly, most did not use the title when they introduced themselves to patients, presumably because it would have had little relevance to them.

The need for recognition was made explicit by one ANP when she stated:

> "... there's the things of seeing your practical outcomes with your patients, but I think the recognition for it, for instance...being invited to speak at the British Thoracic Society meeting. You know, like being recognised by all disciplines ..." (Case 1)

The ways in which the ANPs were both afforded and sought recognition varied in nature and degree between cases. For example, recognition of ANPs as independent practitioners was afforded by consultant physicians and GPs by way of patient referrals and the delegation for patient management (i.e. case 1, 3 and 4). In one case (case 1) however, this was a practice that occurred prior to the ANP undertaking the Master's degree. For others, it was a totally new experience and one which singled them out from their nursing colleagues.

The perceived change in status led ANPs to believe that their standing within the organization altered when they entered their new role. As a consequence, most ANPs considered that they were treated differently to other members of nursing staff.

> "It feels different putting my name and qualifications on letters and things. I think I am treated differently because of it." (ANP: Case 1).

The change in attitude toward the ANP was noted by one ANP's consultant preceptor who stated:

> "I think there is a different attitude to her now amongst her colleagues on the wards. There's no doubt about that...I think there is a different attitude, there is no question about that and there is also an attitude within the junior doctors, they know who is boss ...". (Consultant: Case 4)

While an alteration to the ANPs identity occurred as a consequence of role transition, it was interesting to note how some ANPs considered that their change in status was capitalised upon by the organization for its own ends. The following quotations

illustrate this point.

> "They're just using me as a trophy. Someone to pick off the shelf, and say, look we've got an advanced practitioner...". (ANP: Case 5).

> "...you really felt like you were the pet poodle being taken out when big-wigs came around in the hospital to be shown off, rather than it was taken seriously sometimes. Those hospital trusts are very concerned with image..It was like I was taken out of the cupboard and dusted..." (ANP: Case 2)

This would suggest that the development of the ANP role, at least by some organizations, was used as a ploy to influence potential purchasers, although was clearly one to which ANPs objected. Recognition as a concept in this context can be seen almost as a reciprocal arrangement between the ANP and the organization.

Recognition however was not afforded from all quarters. As a result of four of the five ANPs resuming their old role and responsibilities as ward/unit sisters on a part-time basis, a number of their nursing colleagues viewed them in much the same way as before the transition took place.:

> "They don't treat me any differently...I don't think the girls on the ward really appreciate the significance of the achievement, but it's made me feel different...." (ANP: Case 1).

In contrast, the nursing staff in the one case where the ANP was deployed on a separate contract and in a supernumerary status acknowledged the need for the ANP to be seen as "different" and separate from other nurses. One experienced sister suggested:

> "... they've got to be seen as somebody different, because they are, and it's for their own recognition as well." (Case 3).

In the same case, the ANP's consultant preceptor was also cognisant of the need to establish a unique identity which he saw as being neither totally allied to nursing or

totally allied to medicine:

> "I think that from the nursing side of it they've not got to be seen as nurses, they've got to be seen as practitioners. They've not got to be seen as doctors particularly I think they need to get their own identity and I've been very keen on that and also that they're funded separately somehow or other, otherwise you get pulls from various vested interests about that."

The need for the ANP in this case to relinquish her "traditional" nursing identity was reinforced by one of the other consultant staff on the unit. In one incident for example:

> 'A health care support worker approached the ANP to deal with a telephone query from the pharmacy department (that could have been dealt with by any of the nursing staff). The Consultant who was present said, "That's a nursing role, not an ANP role, you've got to learn to say no to that type of thing".

The way in which the ANP role had developed in this case inevitably led to comparisons being made between the new role and that of other nurses and junior medical staff. In this case, the ANP's nursing colleagues appeared to respond to her in a similar capacity as they would to junior medical member of staff. The reason why they appeared to do so, was because they perceived the ANP role to be closely allied to medicine. As both the clinical nurse manager and directorate manager observed:

> "I think that nurses see them now as SHO's. I know they do. I would say if you ask people, they would see them." (Clinical nurse manager)

> "... I think that the [nursing] staff feel that they [ANPs] are just doing a medical role. I think they are fitting into the medical team system very well. I think the job is to get the nursing side sorted." (Directorate manager)

This was confirmed when a junior doctor compared his role with that of the ANP and concluded,

> "...the role that I see them in on here, is that of an SHO really. The only difference being that they don't do the same hours and so their rota is

different."

In addition to recognition from professional colleagues and peers, the data reveal that ANPs expected financial recognition from the organization. However, due to alleged fiscal restraints placed on most trusts within the study [with the exception of one case (Case 3)], none of the ANPs received a grade increase upon graduation from the Master's course. Whilst most ANPs clearly anticipated receiving additional financial remuneration for their efforts, managers were explicit that such assurances had not been made.

> "They see it that I've passed this so I should get more money, but that certainly wasn't any agreement at the start, and it may not necessarily be appropriate now." (Directorate manager: Case 5)

One year post qualification, one trust had made a grade increase (Case 4), one ANP (case 5) had changed her job title, taking up a lecturer-practitioner post (which co-incidently involved a grade increase), one ANP had sought employment in a different capacity at another hospital (case 2) and one ANP (case 1) had not received any pay award. The one ANP who received an increase in salary upon her return from the Master's programme (case 3), did so only because the organization had managed to secure additional resources. Failure to be afforded financial recognition was used as a reason by some ANPs to either threaten or actively seek alternative employment (i.e. cases 1, 2, and 5).

> "... I mean they haven't given me the 'H' grade that I wanted, and if they expect me to do the job without providing the resources, well then I leave and get another job somewhere else. I'm sorry but that's the way it is". (ANP: Case 1).

Perhaps one of the most significant indicators of the emergence of a new identity,

particularly for those ANPs whose practice orientation was directed toward the delivery of direct care, related to a change in "clinical status". This is apparent when practice boundaries between the nursing-medical interface overlap and the ANPs competence is no longer measured in terms of their "nursing" ability, but is compared to the practice of medical practitioners. The following quotations illustrate this argument.

> "So what I'm hoping is that, cos the GPs, some are alright, but to be honest I could do a better job myself...what I want to do is, with respiratory patients is to be able to...assess them myself and prescribe something myself...without a GP." (ANP: Case 1)

> "I wasn't very happy with the new SHO even though she's done neonates before. I had to keep telling her to do things properly. She didn't extend the neck properly, she wasn't doing cardiac massage properly, so I thought we better have a registrar here....".(ANP: Case 3).

The comparison of the ANPs knowledge and ability with that of medical practitioners was also made by senior medical staff.

> "...She's already telling the staff grade doctor, who has much less intelligence than she has, how to fulfil his role there. The nurse practitioner will guide junior medical staff..." (Consultant: Case 1).

Arguably, by affording ANPs such clinical status, along with the trend for comparison of their role in some circumstances with medical practitioners, as opposed to nursing colleagues, a change in identity appears inevitable. However, all the case study ANPs expressed a determination to maintain an identity within a nursing paradigm. Initially, all were quick to espouse the importance and values of "nursing care", as the following quotations illustrate.

> "...when I went into the course I was thinking, I bet I'm the only person on the course that thinks nursing is all about bed bathing and shit shovelling and

basic nursing care. It's all the other things as well, yes. All the flashy stuff, but we shouldn't lose what we actually do, which is the caring aspect of nursing." (ANP: Case 1).

"The reduction of junior doctors hours is the issue that underpins all this, but, the nursing aspect is by far and above the most important thing...becoming a doctor, if that's what it is all about, then I'd say goodbye to that now, nursing is where I want to be." (ANP: Case 4)

At this stage, ANPs appeared to be acting as "gate-keepers" for the protection of nursing values at a time of attempting to develop practice into new areas. However, a paradox arose when the ANPs discussed the concept of advancing their practice. In most cases, the presence of impedient intervening conditions was identified as a cause of delay in role development. These conditions often resulted in the ANPs primarily engaging in the very activities which they perceived as being fundamental to advanced practice (i.e. basic nursing practices). Consequently, whilst ANPs espoused the virtues of traditional nursing practices, engagement in such practices was seen as a barrier to role development. This suggests that ANPs experienced a tension between preserving traditional nursing values and practices, and gaining professional recognition and acknowledgement as an advanced nurse practitioner.

While some ANPs and their managers expressed their concerns that the ANPs' identity should remain rooted within a nursing paradigm, paradoxically, most case study participants commonly compared the attributes and benefits of the ANP role to those of a junior doctor. It is possible that simply by comparing the role of the ANP with that of a junior doctor, that the new role becomes fixed within a common and familiar frame of reference which is medically focused, as opposed to being identified as a nursing role with its own referent criteria.

Enactment of the new role led most ANPs to experience a conflict between preserving their traditional nursing values and developing a new professional identity. The dissonance regarding ANP identity appeared to be experienced regardless of role orientation. As one ANP's nursing colleague noted:

> "Maybe it's just getting used to different cultures and they've been caught in the middle of the two cultures ... nursing and medical. And maybe that's what's very strange for them because it's been something that's been inbred in them for years and then all of a sudden they are crossing the line, maybe that's why it's been so hard at times." (Case 3).

The transient loss of role identity experienced at a time of attempting to establish a new nursing role was summed up by the ANP's clinical nurse manager:

> "...I feel that they don't feel they're with nursing and they don't think they're with doctors, they're sort of in the middle".

Establishing a new identity can be seen to be problematic and contingent upon a multiplicity of factors and intervening conditions. Consequently, it appears that at a time of reconstructing nursing practice, it is issues surrounding the professional identity of the ANP that are more difficult to reconcile than the acquisition of the skills and roles the practitioner is required to perform.

6.2.6 CASE STUDY DATA SUMMARY

The preceding discussion has attempted to convey the main issues that arose from the case study data. It is acknowledged that limitations of space and the volume of data, created difficulties in presenting the results in all their richness. Moreover, it is recognised that not all of these issues were experienced to the same degree across all of the case studies. That not all themes were present to the same degree in each case does not negate or lessen the importance of the data, but merely serves to

illustrate the complexity and uniqueness of the concepts of role transition and advanced practice.

The relationship between the five main categories that were developed following data collection are hopefully evident, even though they have been discussed separately. When the five main categories are viewed as a whole, they help to develop an understanding of the dynamic process of role transition from experienced nurse to advanced practitioner. However, as discussed in the previous chapter, data was also collected through the use of role development diaries. This data will now be presented and discussed, and will expand upon the analysis presented above.

CHAPTER SEVEN

ANALYSIS AND PRESENTATION - ROLE DEVELOPMENT DIARIES

CHAPTER 7: ANALYSIS AND PRESENTATION - ROLE DEVELOPMENT DIARIES

7.1 INTRODUCTION

As part of the research design a role development diary was developed and used as an additional method of data collection within the study. Whereas an integrative approach to data analysis and presentation was adopted within individual case studies the results from the role development diaries are presented separately. The rationale for this decision is based on the fact that the diaries were completed by ANPs other than those involved in the five case studies. Where case study ANPs completed role development diaries (n=3), findings were integrated into the overall case study analysis presented earlier as well as being represented here. (A copy of the role development diary can be found in Appendix 6).

It is acknowledged at the outset of this chapter that the accuracy and reliability of the data collected via the role development diaries can be called into question. Firstly, the sample size is small (n=11) and in a number of instances diaries were returned with missing or clearly inaccurate entries. The nature of the inaccuracies were related primarily to the information ANPs were asked to submit regarding specific timings and incidence of patient episodes. ANPs were asked to enter interval data (i.e. times and frequencies) into the initial sections of the diaries and written accounts into other sections. For the purpose of analysis and presentation the interval data were converted into ordinal measures in order to accommodate the variance in the ways in which the diaries were both completed and returned. The information entered into the open sections of the diary were treated differently as will become evident as the discussion progresses.

7.2 PRESENTATION AND ANALYSIS OF RESULTS

At the outset of the study sixteen ANPs agreed to complete role development diaries for one week, in each of the first six months they were in practice, following graduation from the Master's degree programme (i.e. October 1996 - March 1997). In September 1996 diaries were sent to each participant, along with instructions for their use and stamped addressed envelopes for their return. At that time replies were received from two of the participants to state that they had withdrawn from the programme prior to its completion and were no longer able to be involved in the study. Of the remaining fourteen ANPs, three, including two involved in case studies (i.e. case study 3, Neonatal Unit and case study 5, A&E) failed to complete or return any diaries. The remainder of the participants (n=11) completed and returned between two and six diaries.

For the purpose of data analysis and discussion the clinical areas in which the ANPs were employed were divided according to patient dependency into the following two groups:

1: 'High' patient dependency on medical, nursing and instrumental intervention; including neonatal units (NNU) and adult intensive care units (ITU).

2: 'Acute' patient dependency on medical, nursing and instrumental intervention; including accident and emergency department (A&E); gynaecology (Gynae); respiratory medicine (Resp med); ear, nose and throat department (ENT); and community psychiatry (Psy).

This strategy was adopted to allow comparison of the data and to explore if the

advanced practice role was enacted differently in areas of high and acute patient dependency. Figure 7.1 details the distribution of ANPs by patient dependency, practice environment and the number of diaries completed.

Figure 7.1 Distribution of ANPs and number of diaries completed () - [maximum = 6].

High dependency:

NNU	n=3	(5+6+6=17)
ITU	n=3	(4+2+6*=12)

Acute dependency:

Resp med*	n=1 (5)	Comm Psy	n=1 (2)
ENT	n=1 (6)	A&E	n=1 (6)
Gynae*	n=1 (4)		

* Diaries completed by case study ANPs.

The number of diaries completed by the ANPs varied and ranged from two (n=2) to six (n=5). The reason for failure to complete diaries as requested was not established. The completed diaries yielded entries for a total of 246 days (High Dependency n=132; Acute Dependency n=114). Due to inconsistencies in the number and frequency with which diaries were returned it was not possible to carry out meaningful comparison between the two groups on a month-by-month basis. Therefore, the results presented below are the aggregated mean averages from individual ANP diaries and the respective patient dependency groupings.

7.2.1 ACTIVITY ANALYSIS

The first series of results concern an analysis of the activities in which ANPs were

involved. Tables 7.1 and 7.2 display the rank order in terms of the amount of time

ANPs in each group were engaged in different domains of practice over the six month

period. (Rank 1 = Most time spent in the domain, rank 4 = least time spent in the

domain).

Table 7.1 Rank order of time spent in different domains of practice - High dependency grouping.

Domain of practice	NNU1	NNU2	NNU3	ITU1	ITU2	ITU3	Agg Rank
Direct care with patients	1	1	2	1	1	1	1
Administration / managerial	2	3	1	2	2	2	2
Education / counselling	3	4	3	3	3	4	3
Other	4	2	4	4	4	3	4

Table 7.2 : Rank order of Time spent in different domains of practice - Acute dependency grouping.

Domain of practice	A&E	Resp	Psy	Gyn	ENT	Agg Rank
Direct care with patients	2	2	3	1	1	2
Administration / managerial	1	1	1	2	2	1
Education / counselling	3	3	2	4	3	3
Other	4	4	4	3	4	4

In comparing the two groups it appears that overall the ANPs, with one or two

exceptions, engaged in similar working patterns in terms of the amount of time spent

in the different practice domains. Five out of six ANPs in the high dependency group

ranked the time they spent in direct care with patients highest. In the acute

dependency settings, the top ranking activity was related to administration and

management. The data were subjected to cross tabular bi-variate analysis to

establish if any associations could be identified between the domains of practice and

the level of patient dependency. The results revealed that there was a relatively strong association between the level of patient dependency and the amount of time ANPs spent in the delivery direct patient care activities (gamma = 0.8) as well as the amount of time they spent in administration/managerial domain activities (gamma = -0.8). This finding is in some ways unremarkable as one might expect nurses in high dependency units to spent more time in direct patient care activities than their counterparts in lower dependency settings. Likewise, the result that ANPs in acute dependency settings have greater managerial and administrative responsibilities may have been anticipated on a similar basis. On the other hand, as the role of advanced practitioner is new, such assumptions remained to be confirmed.

When examining the other domains, education/counselling and patient dependency were only moderately associated (gamma = -0.5), whilst the "other" domain showed a relatively weak association (gamma = -0.4). This suggests that the nature of patient dependency is only of minimal influence in these domains of practice.

In addition to establishing the overall amount of time spent within the general domains of practice the diaries also sought to elicit information pertaining to the specific activities in which ANPs engaged. In the direct care domain, ANPs were asked to identify the specific nature of their practice during a number of patient contact episodes (up to a maximum of 10) for each day the diary was completed. Due to the unique characteristics of the various practice environments in which the ANPs worked, the number of patient contact episodes was expected to vary both across

and within patient dependency groupings. The variance in the number of diaries completed and returned in each group also accounted for some of the difference observed in the recorded number of patient episodes. Tables 7.3 and 7.4 display the rank order of frequency in which ANPs in each dependency grouping engaged in different clinical activities during patient contact episodes.

Table 7. 3 Frequency (rank order) of activities during patient contact episodes within the direct patient care domain - high dependency

Associated activities	NNU1	NNU2	NNU3	ITU1	ITU2	ITU3	Rank
Nursing / medical histories	5	6	1	1	7	6	4
Physical Examinations	6	1	2	2	1	3	1
Diagnostic investigations	1	3	3	6	2	4	2
'Standard' interventions	3	2	5	3	4	2	2
'Advanced' Interventions	2	7	4	4	3	7	5
Teaching / advice given	7	4	6	7	5	5	7
Counselling given	4	5	7	4	6	1	5

Table 7.4 Frequency of activities during patient contact episodes within the direct patient care domain - acute dependency

Associated activities	A&E	Resp	Psy	Gyn	ENT	Rank
Nursing / medical histories	1	5	1	1	7	2
Physical Examinations	1	4	6	2	4	4
Diagnostic investigations	1	6	6	7	6	7
'Standard' interventions	6	1	2	5	4	5
'Advanced' interventions	7	7	4	6	1	6
Teaching / advice given	1	3	5	3	3	2
Counselling given	1	2	3	4	2	1

These results reveal some interesting differences once again both between and within the two groupings. Firstly, the total number of patient contact episodes varied considerably as anticipated, with the high dependency grouping reporting fewer contacts. This result was somewhat exaggerated however by the number of patient contact episodes reported by the ANPs in A&E and ENT in the acute dependency grouping. The reason these ANPs reported high numbers of patient contact episodes is most likely due to the nature of their respective clinical environments, which are characterized by a large throughput of patients.

It is interesting to note the overall difference in distribution and ranking of the domain activities reported by the two groups. In the high dependency grouping, the top 3 activities in terms of frequency (i.e. 1=Physical exam; 2^{*12}= Diagnostic investigations & 2^* =Standard nursing interventions) were all related to establishing either a diagnosis or the status of the patients' condition/response to treatment , as well as meeting patients physical needs. In the acute dependency grouping, the top 3 activities in terms of frequency (i.e. 1=counselling; 2^*=nursing histories; & 2^*= teaching and giving advice) were all related to meeting patients physical *and* psychological care needs, with correspondingly less emphasis on assessment and diagnosis. This tentatively suggests that the focus of activity within the direct patient care domain is contingent upon the dependency of the patients within the clinical context and the prioritisation of need. For example, in high dependency settings priority is given to establishing diagnoses and ascertaining the response to treatment

---

[12] *= tied ranking.

in order to deliver effective interventions which stabilise the patient's condition. In the acute care group however, diagnostic investigations were ranked 7th and last. On the other hand, teaching and giving advice ranked highly in the acute care group but were ranked 7th and last in the high dependency group. This illustrates that the needs of the patients, and hence the practice of the ANP, are influenced by the level of patient dependency.

The data were then examined to establish if there was any correlation between the time spent in activities the ANPs perceived to be advanced and those activities acknowledged as being standard nursing interventions. The results of the analysis revealed only a very weak association (gamma = 0.2) between the two variables, suggesting that the level of patient dependency in itself is not an indicator of whether practitioners engage in activities which they perceived to be either advanced or standard.

The data presented thus far illustrates that there was considerable variance concerning the nature of activities undertaken in patient contact episodes. This variance could be an artefact of the way in which the data were collected or could suggest that it is not only the dependency of patients that determine practice activities, but other factors within the environment.

The second domain of practice for which data was collected concerned administration and management activities. The aim of collecting information for this

domain was once again to establish if there were any differences in the nature of activities between the two groupings. Tables 7.5 and 7.6 show the amount of time in rank order, in which the ANPs in each group engaged in administrative and managerial activities.

Table 7.5 Time spent in activities within the administration and management domain of practice - high dependency.

Associated activities	NNU1	NNU2	NNU3	ITU1	ITU2	ITU3	Rank
Ward rounds / meetings	1	2	3	1	3	2	1
Records - Reviewing/completing	3	4	2	2	2	4	3
General administration	2	3	1	3	1	3	2
Protocol development/review	4	1	5	4	5	1	4
Practice development activities	5	5	4	5	4	5	5

Table 7.6 Time spent in activities within the administration and management domain of practice - acute dependency.

Associated activities	A&E	Resp	Psy	Gyn	ENT	Rank
Ward rounds / meetings	2	2	1	4	5	3
Records - Reviewing/completing	1	4	4	1	2	2
General administration	3	1	2	2	2	1
Protocol development/review	5	5	5	5	4	5
Practice development activities	4	3	3	3	1	3

In both groups, the ANPs spent approximately one third of their time during the first six months of practice undertaking activities within this domain. The overall ranking of time involved in general administrative activities, record keeping, ward rounds and meetings, were generally similar. The variables of particular interest in this category were related to practice and protocol development, as these activities are commonly

associated with the concept of advanced nursing practice in the literature. In both groups, the least amount of time was spent in protocol and practice development activities. In the high dependency group more time was dedicated to protocol development than practice development activities, with two ANPs (NNU#2 & ITU#3) identifying they spent most time in this activity. In the acute dependency group the reverse was evident with only one ANP (ENT) ranking practice development highly. Examining practice and protocol development in relation to patient dependency reveals a strong association (protocol development: gamma =0.8; practice development: gamma =-1). This suggests that activities associated with practice development and organizational change are more likely to occur in acute dependency settings, whilst protocol development is more likely to occur in high dependency settings than acute care. One reason for explaining the difference in emphasis could be that in the high dependency group, practice protocols take on more significance in terms of the ANPs increased involvement in activities such as invasive procedures and patient management. As a number of these procedures are new, the development of protocols are of importance in terms of facilitating the ANP to become involved in such activities. Furthermore, the lack of involvement in practice development activities in the high dependency group suggests that the ANPs energies are initially directed toward gaining competence and practising new procedures and skills. In the acute dependency the reverse appears happen with more time being spent in practice development in the wider context with less emphasis on protocol development. A likely reason for this phenomenon is that in acute dependency areas technical procedures and skills may take on a lower priority. This conclusion may be questionable however as examination of the results obtained

within each group once again reveal some cases of extreme variance in the amount of time spent in each activity within dependency groups, which may to some extent effectively skew the aggregated data.

The third domain of practice for which data was collected concerned the education and counselling activities in which the ANP engaged. The aim of collecting data in this domain was to establish if there were any differences in the nature of activities between the two groupings in terms of a specific orientation toward nursing or medical staff. Tables 7.7 and 7.8 illustrate the rank order of the amount of time and type of educational and counselling activities in which ANPs engaged.

Overall, the average amount of time spent in this domain of activity was similar between the high dependency group (12%) and the acute dependency group (15%). When comparing different activities it is noticeable that within both groups teaching and advising/trouble-shooting is oriented primarily toward nursing staff, suggesting that at least part of the ANP role, albeit limited, is aimed indirectly toward improving the knowledge base and standards of nursing care in the clinical setting.

The ANPs in the acute dependency group appear to carry out more counselling and health education with colleagues and patients relatives than in the high dependency group. This was confirmed when the data were subjected to cross tabular correlation revealing a very strong association between the nature of patient dependency and these activities (teaching: gamma = -0.9; counselling: gamma = -0.8). The reason for this result is uncertain. It may have been expected that as areas of high patient

Table 7.7 Time spent in activities within the education and counselling domain of practice - high dependency.

Associated activities	NNU1	NNU2	NNU3	ITU1	ITU2	ITU3	Rank
Teaching Nurses / midwives	1	3	1	1	1	1	1
Advising/troubleshooting - nurses	2	2	6	2	2	2	2
Counselling/health education	3	6	2	3	2	3	3
Teaching medical staff	7	1	3	5	2	4	4
Advising/troubleshooting - medical staff	6	4	6	4	5	4	5
Case/seminar presentations	4	5	5	5	6	7	6
Other	5	7	4	5	6	6	7

Table 7.8 Time spent in activities within the education and counselling domain of practice - acute dependency.

Associated activities	A&E	Resp	Psy	Gyn	ENT	Rank
Teaching Nurses / midwives	2	3	1	2	2	1
Advising/troubleshooting - nurses	3	1	3	3	3	3
Counselling/health education	1	4	3	1	1	1
Teaching medical staff	5	6	3	3	5	5
Advising/troubleshooting - medical staff	4	2	3	3	4	4
Case/seminar presentations	6	5	2	3	6	5

dependency are perceived to be more stressful than acute dependency settings that the reverse would have occurred. This difference may however once again be an artefact of the way in which the data was collected.

Teaching medical staff was found to be more prevalent in the high dependency

grouping than the acute dependency group, although the association was weak (gamma =0.3). Of the remaining activities, an emphasis on trouble-shooting and advising medical staff on specific issues appears to have occurred more frequently in the acute dependency grouping (gamma =-1). This finding is somewhat contrary to that which may have been expected given that teaching medical staff was more frequently engaged in the high dependency setting. These findings, whilst remaining inconclusive, do suggest that the number and type of medical staff present in the clinical area may influence the way in which the ANP role is enacted.

In addition to undertaking a general activity analysis of the ANPs during their first six months of practice, the data collected also sought to elicit the nature of the activities the ANP perceived to be either new or advanced[13]. To this end, each day the diary was completed the ANPs were asked to identify, in their own words, any activity in which they had been involved (either by observing, participating under supervision, or undertaking independently) which they perceived to be either advanced or new to their practice. This yielded a total of 131 separate items reported by both groups[14]. The items were collated and following analysis were sorted into 7 separate categories in which each could be discretely located. The categories that were constructed included: 1, invasive procedures and technical skills; 2, patient assessment and management; 3, research and audit activities; 4, change of context

---

[13] 'Advanced' in this context relates to activities and skills which ANPs perceive to be carried out at a higher level of practice than other nursing staff in the clinical setting.

[4] Activities repeatedly reported by an ANP or identically matching an activity reported by another ANP were treated as one item.

or practice focus; 5, teaching and supervising; 6, initiating changes in the environment; and 7, consultancy and counselling.

Definitions for each category were developed in order to clarify the concept and assist in the location of items. For example, the definition developed for the category patient assessment and management stated:

"This category relates to statements which suggest the practitioner has become involved in developing skills associated with the clinical management of a patient. These include nursing/medical assessment, patient management decisions and treatment evaluation, as well as statements which reflect involvement in ordering/interpreting diagnostic investigations and determining therapeutic interventions"

Examples of some of the items located in this category taken from the diaries as verbatim statements include, "physical examination and assessment", "adjusting ventilation following blood gases", "discharge examination" and "changing drug regime".

The reliability of the interpretation and categorization of this data was checked with two experienced nurses - one employed in education and one employed in practice. The nurses were given an instruction sheet along with the category definitions and asked to locate each item into the appropriate class and to identify any items or categories which were ambiguous in nature. This procedure yielded a 93% rate of agreement from the nurse in practice and 88% rate of agreement from the nurse in education. Following discussion with both nurses over the disputed items, agreement was reached and a small number of revisions made to the categories. Tables 7.9 and 7.10 illustrate the frequency of activities identified as being either new or

advanced for each dependency grouping in their respective rank order.

Table 7.9 Frequency of 'new' or 'advanced' activities identified as being developed within the first six months of practice - high dependency.

New /advanced practices	NNU1	NNU2	NNU3	ITU1	ITU2	ITU3	Rank
Invasive procedures & technical skills	X	1	2	1	1	X	2
Patient assessment and management	X	2	1	1	1	1	1
Research & audit	X	X	X	X	4	1	3
Change of context / practice focus	X	3	4	X	X	X	6
Teaching and supervising	X	3	3	X	4	X	5
Initiating change in the environment	X	X	X	X	3	X	4
Consultancy and counselling	X	X	X	X	X	X	X

('X' indicates that the ANP failed to identify new or advanced activities in the relevant category)

Table 7.10 Frequency of 'new' or 'advanced' activities identified as being developed within the first six months of practice - acute / low dependency.

New / advanced practices	A&E	Resp	Psy	Gyn	ENT	Rank
Invasive procedures & technical skills	1	2	X	1	3	2
Patient assessment and management	2	1	2	1	2	1
Research & audit	2	X	2	X	4	5
Change of context / practice focus	X	X	2	X	X	3
Teaching and supervising others	X	2	1	3	4	4
Initiating change in the environment	2	4	X	3	4	7
Consultancy and counselling	X	5	X	3	1	6

('X' indicates that the ANP failed to identify new or advanced activities in the relevant category)

Analysis of these results reveal a number of interesting features. In both groups patient assessment and management, along with the development of competence in invasive procedures and technical skills, ranked most highly. Whilst this may have

227

been anticipated in the high patient dependency environment given earlier findings, a similar result in the acute dependency grouping was a little more surprising. The evidence would indicate that these two aspects of practice were singled out as a priority for the development of new skills and were considered to be areas in which the scope of the ANPs practice was expected to evolve. This result may, however, be an artifact of the educational programme and clinical training regimen, in which the orientation of the ANP role was initially expected to be predominantly toward the delivery of direct patient care. Subsequently, in those cases where the orientation of the ANP role was toward enhancing the system of care delivery, emphasis on gaining competency in these clinical skills is likely to have decreased.

The development of new or advanced activities in the remaining categories were less frequently identified. Once again it is possible to interpret this evidence from a number of perspectives. Firstly, it may be argued that activities within the remaining categories were not identified as frequently because they were not perceived to be particularly new or advanced. Whereas learning a new technical skill or determining a particular therapeutic intervention a patient should receive are easily distinguishable as new behaviours, undertaking teaching or supervision may not have been perceived as a new role, even though there may have been significant changes or developments in the way the ANP performed this activity. Consequently, ANPs may not have reported developments in some categories as they were not overtly perceived to be different from those of other nurses. An alternative interpretation of the data is that once again priority, especially during in the early

stages of role development, was given to achieving technical competence in new skills and activities which were oriented toward direct patient care. Hence, minimal mention was given to activities such as audit, research or practice development, however, these activities may increasingly become the focus of attention at a later time in the role transition.

7.2.2 TIME SERIES ANALYSIS

The activity data obtained from the diaries was then subjected to time series analysis to establish if any noticeable change occurred in the different practice domains or activities during the six months the diaries spanned. This presented some methodological problems in that the number and frequency with which diaries were returned was inconsistent. In order to make a meaningful comparison between the two groups only the diaries completed for all six months (i.e. high dependency n=3, acute dependency n=2) were subjected to this type of analysis.

The first procedure adopted was to compare the time spent in each domain of practice for each month a diary was completed. The results of this analysis revealed that there was no discernable pattern in the data to suggest a shift either toward more or less involvement in any particular domain of activity.

The second procedure adopted was to rank order the individual activities within each practice domain and establish if there was any shift in the nature of individual practice. The direct care domain activities of practice were the first to be compared

Figure 7.2 Time Series Analysis NNU2:
Standard interventions vs Advanced Interventions
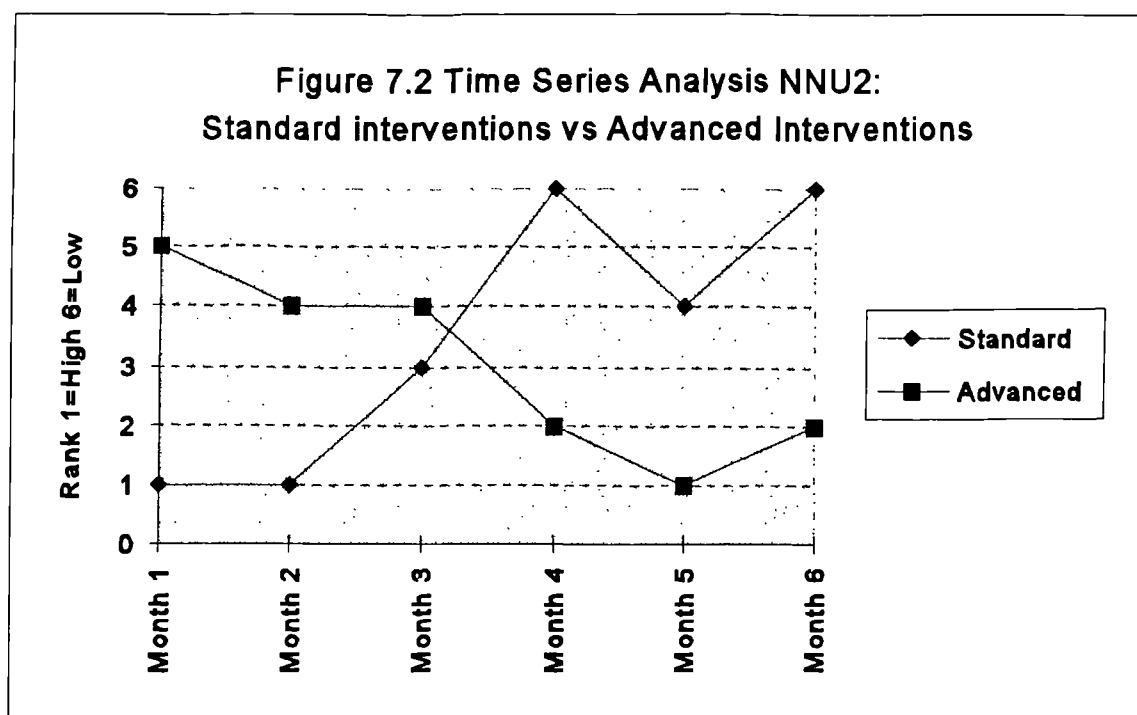
to see if there was any noticeable change in the frequency with which activities were undertaken. The analysis revealed a shift of practice emphasis in one case only, NNU#2. The frequency with which this ANP engaged in standard nursing interventions and activities which were considered to be advanced, revealed an inverse relationship over the time the data was collected (Figure 7.2). Whereas one might expect to see such a change when a new work role is being developed, this

phenomenon was not observed with any of the other ANPs whose diaries were subjected to analysis. On the contrary, in the majority of cases patterns of activity in the direct care domain can be considered to have been irregular. This is illustrated nowhere better than in distribution of time spent in activities which the ANPs considered to be advanced (Figure 7.3). As can be seen, the ANP ITU#3 spent only minimal amounts of her time in advanced activities over the duration the data was collected. On the other hand, the ANP in A&E undertook advanced activities in the

majority of her patient contacts. Alternatively, the ANPs NNU#3 and ENT showed

Figure 7.3 Time series analysis for activities considered advanced
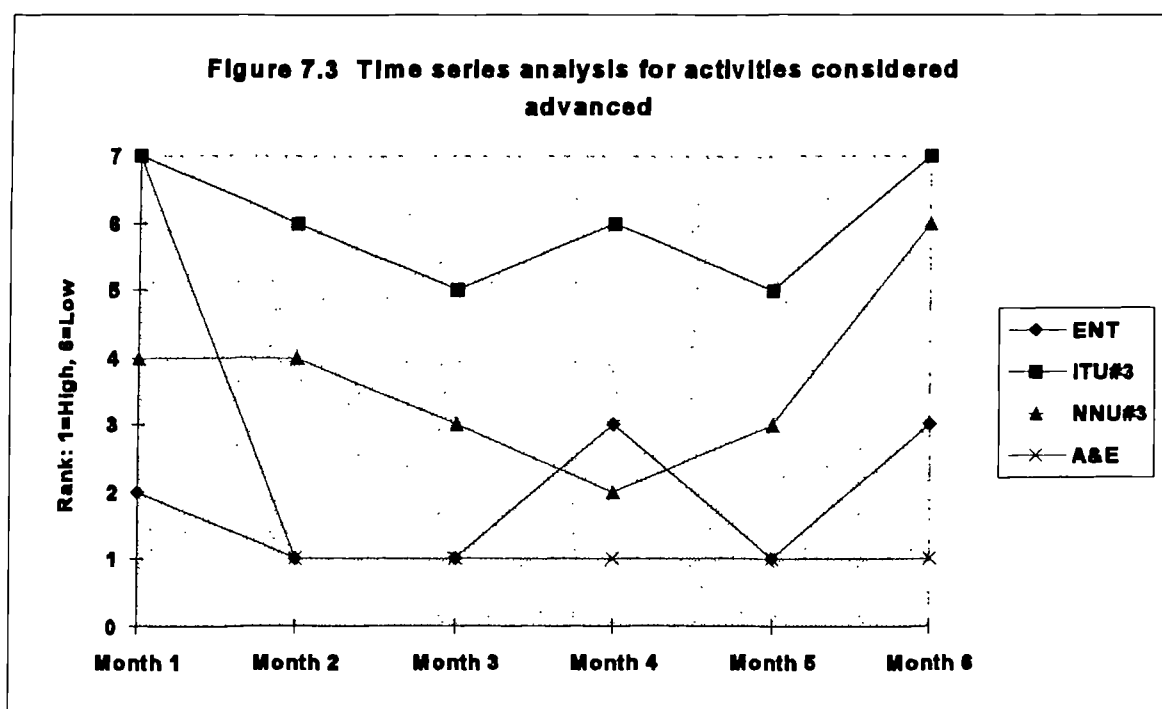
shifting patterns of activity in this practice domain. Consequently, with the exception

of case NNU#2, there is insufficient evidence to suggest that ANPs spend increased

amounts of time involved in advanced activities at the expense of other activities

during the first six months of practice.

The activities of interest in the administration and management domain concerned

protocol development and organizational change, which, as the literature indicates,

are features of some advanced practice roles. When conducting a time series

analysis there was once again no discernable pattern of increased activity in either

domain in the five cases examined. Likewise, in the education and counselling

domain of practice there was no evidence to suggest any change in patterns of

behaviour.

Overall, the result of time series analysis in those cases selected, revealed little evidence of any major shift in practice activity. This could indicate that given the novelty of their new role, the first six months ANPs engage in practice is a time of role exploration and as a result the patterns of behaviour in different domains of practice were irregular. Alternatively, the absence of any discernable overall change in patterns of behaviour, when considered in conjunction with other data, could equally be an indicator of how organizational and environmental factors exert influence on the process of role transition. At best, the results of time series analysis remain inconclusive.

7.2.3 FACILITATORS AND BARRIERS TO PRACTICE DEVELOPMENT

In addition to eliciting information regarding practice activities, the diaries were also used to gather data pertaining to the factors the ANP identified as being of help or hindrance to their development during the first six months of their role transition. Each day the diary was completed the ANP was asked to identify any factor they had encountered during the day that had acted to either facilitate or inhibit their role development. Once all the diaries were collated, the factors identified were sorted and grouped by the individual concepts to which they related. Across both dependency groupings, a total of 17 separate factors were identified as being facilitative of the implementation of the advanced practitioner role, compared to the identification of 23 inhibiting factors. Whilst the majority of factors were experienced by both groups, the frequency with which they were identified varied greatly. This does not necessarily suggest that the most frequently cited factors were the most

important, but it does indicate that they were experienced more commonly and thus warrant attention.

Figures 7.4 and 7.5 illustrate the most commonly identified (i.e mentioned on three or more occasions) facilitating and inhibiting factors. As the majority of factors were experienced by both groups the results are presented as an overall aggregate. An

---

Figure 7.4 Frequency of factors identified as facilitating role implementation

Facilitating factors

Support, encouragement and recognition by medical staff (f=29)

Support, encouragement and recognition by nursing staff (f=16)

Increasing confidence to practice independently (f=11)

Availability of time to practice skills & develop role (f=10)

Deployment in a supernumerary status (f=8)

Negotiating the scope of practice of the new role (f=7)

Support and encouragement of managers (f=6)

Good communication and teamwork with medical staff (f=6)

Good staffing levels (f=3)*

Changes in working pattern and practice location (f=3)**

Identified in high dependency only

**Identified in acute dependency only*

---

indication is made next to the relevant entry where the occurrence of a factor was specific to one dependency grouping.

7.2.4 FACILITATING FACTORS

When considering the facilitating factors that were identified most frequently, the majority of the data can be viewed in terms of three of the categories developed from the analysis of the individual case study data:-

- Transitional relationships

- Organizational governance and the clinical context

- Establishing a new nursing identity

<div style="border:1px solid black; padding:1em;">

Figure 7.5 Frequency of inhibiting factors to role implementation

Inhibiting Factors

Being required to undertake their 'old role' during the transition (f=33)

Lack of time and physical resources (f=16)

Lack of understanding of the ANPs abilities and role (f=11)

Poor levels of nursing staff within the environment (f=9)

Resistance to the concept of ANPs from medical staff (f=7)

Absence of practice protocols, e.g. prescribing (f=5)

Declining motivation (f=4)**

Resistance to ANP role from nursing colleagues (f=4)

Working with inexperienced medical staff (f=3)

Medical supervision - i.e. needing to have medical notes countersigned (f=3)*

Identified in high dependency only

**Identified in acute dependency only*

</div>

7.2.4.1 Transitional relationships

Examining the data, the concept that was most frequently cited as facilitating role development was support. Both instrumental and emotional support were mentioned

as being of benefit to the ANP in attempting to implement their new role. However, of particular interest is that in both dependency groupings, support not only featured prominently, but it was support from medical staff that was most frequently cited. This raises the question: why was the support of medical staff cited so frequently? It is possible to conjecture a number of reasons, with some being more plausible than others. For example, medical staff may perceive the development of the ANP role to be in their own interests in terms of: helping the reduction of junior doctor hours; ensuring protected teaching time for medical staff; or partly as a solution for staffing and rotational problems. However, some of the medical staff interviewed in the case studies acknowledged that having an ANP in post had already brought benefits to the service they provided and hence could provide a further reason why medical staff gave their support. Arguably, a more convincing rationale for why the support of medical staff was cited so frequently is that it is an indication of the changing nature of nursing practice, in which the ANP may be required to cross the traditional boundaries between nursing and medicine. This is not only in terms of skills and procedures, but also in terms of patient assessment, diagnosis and management. As such skills have traditionally been the remit of medicine, it is hardly surprising that ANPs rely on the support and help of doctors as they attempt to develop their own skill base in this area.

It was not only the support of doctors but that of nursing staff and managers that was also cited frequently. It appears that support from nurses and managers however is important for different reasons. Whereas the support of medical staff is associated with practice and skill development, support from nursing staff appears to be

associated with facilitating time and resources to enable the ANP to develop their practice. In this context, instrumental support appears to be of greater importance, whereas emotional, as well as instrumental support appears to be sought from medical staff.

7.2.4.2 ORGANIZATIONAL GOVERNANCE AND THE CLINICAL CONTEXT

The second series of factors fit into the category of organizational governance and the clinical context. These factors relate to the environmental context in which practice takes place and particularly to the deployment of the ANP within the service.

- Deployment

Four of the eleven participants who completed diaries in the study were deployed in their new capacity on a full-time basis (i.e. they were not included in the nursing establishment). Of the remainder, six were deployed in their new role on a variable part-time basis, with one ANP (case study 1) having no dedicated time for role development. As a result, the majority of ANPs were included, at least partly, within their respective nursing establishments. The nature of this type of deployment meant that the ANPs were required to undertake their old role for at least part of the time. Being deployed in a supernumerary capacity (i.e. outside of the nursing establishment) was cited on 8 occasions as being an important factor in helping with role transition. The reasons for this are apparent in terms of allowing the ANP the time (another factor identified as facilitating the ANP role f=10) and scope to develop desired aspects of clinical practice.

- The clinical Context

As will become apparent in the following section, the nature of factors within the working environment play an important part in determining not only how the advanced practice role is developed but also how workplace characteristics affect the transitional process. The only factors cited as being of help in implementing the ANP role in terms of the clinical context were good staffing levels and changes in work pattern and the practice location, which were identified by different dependency groupings. Sufficient staffing resources appears to be associated with deployment of the ANP on a supernumerary basis, in that the latter often depends on the former. A change in work pattern or practice location (such as out-patient clinics) suggests that the constraints of the clinical context may not be as dominant.

7.2.4.3 ESTABLISHING A NEW NURSING IDENTITY

The final group of facilitating factors relate to the concept of establishing a new nursing identity. This category includes involvement in negotiating role parameters, gaining recognition and the increasing confidence of the ANP to practice independently. These factors appear to be not only facilitative, but may be viewed as key motivating factors for the progress of the ANP role. In addition, these factors are arguably associated with the development of a new nursing identity in that specific recognition as a resource by nursing colleagues and the acknowledgement of trust in the ANPs ability to perform new activities by medical staff help distinguish the ANPs' identity.

7.2.5 INHIBITING FACTORS

As with the facilitating factors, the overall inhibiting factors that were identified from the data can be viewed in terms of the same three distinct categories and therefore may be seen as opposing poles on the same continuum:-

• Transitional relationships

• Organizational governance and the clinical context

• Establishing a new nursing identity

7.2.5.1 TRANSITIONAL RELATIONSHIPS

Whilst support featured prominently in the list of factors identified as helping ANPs implement their role, at the opposite end of the continuum, resistance to the role did not feature as highly. It is interesting to note however, that as well as experiencing support from medical staff some ANPs also experienced resistance and resentment from medical colleagues, albeit far less frequently (f=7). However, in a minority of cases, resistance from nursing colleagues (f=4) was also cited in the diary data. One reason specified for resentment from junior medical staff appears to revolve around the issue of competing with ANPs to practice and develop new skills during their rotation. The fact that this factor is predominantly cited as occurring in the high dependency grouping may be indicative of the nature of some of the new skills nurses are developing in this type of clinical setting.

The reasons given for resistance to the role from nursing colleagues appear to revolve around issues of perceived professional jealousy, or a fundamental

disagreement with the concept of advanced nurse practitioners. This data lends additional support to the notion of ANPs establishing a new or different nursing identity that is seen to depart from the stereotypical nursing image.

7.2.5.2 ORGANIZATIONAL GOVERNANCE AND THE CLINICAL CONTEXT

It is issues related to the clinical context and organizational governance that are the most frequently cited inhibiting factors to the implementation and development of the advanced practice role.

• Deployment

The most frequently cited inhibiting factor by the ANPs, in each dependency grouping, was identified as being expected to develop the new work role whilst being included in the nursing numbers and being required to fulfil the responsibilities of their old job (f = 33). This was the single most frequently cited factor in either the inhibiting or facilitative categories. Having to undertake an old role appears to lead to the ANP experiencing a conflict of interests between, on the one hand, attempting to develop and establish their new role, whilst on the other hand, having to meet the needs of the nursing service and the responsibilities of their old role. This phenomenon occurred in a number of cases despite reassurances that upon their return to the practice area following graduation from the Master's programme the ANP would be deployed in a supernumerary capacity.

• The Clinical Context

In terms of the clinical context, a number of factors were identified as inhibiting the

development of the advanced practice role. These included poor staffing levels (often due to sickness), a lack of resources and, the absence of practice protocols. It appears that it was the poor levels of staffing and lack of resources that contributed to the necessity for the ANP to be included in the nursing establishment. This resulted in role development being delayed and planned activities and learning experiences being abandoned.

The chief complaint with regard to a lack of resources was also related to staffing issues and concerned the availability of time. A number of ANPs maintained that they had too many other commitments with the result that development of their new role was inhibited. Interestingly, the lack of available time was primarily identified by those cases who were required to undertake their old role on either a part or full-time basis. A lack of physical resources was exemplified by one ANP who stated that part of her new role involved independently running a clinic for her client group in the outpatients department. On more than one occasion a room within the department was not made available for her use with the result that she unable to perform her new role. Consequently, the nature of the clinical context and the availability of resources were seen to exert considerable influence over the pace and nature of role transition.

7.2.5.3 ESTABLISHING A NEW NURSING IDENTITY

The challenges of establishing a new professional identity as an advanced nurse practitioner were not without their problems. As well as dealing with the re-negotiation of professional relationships, a problem that was highlighted on a number

of occasions concerned the lack of understanding and clarification of the ANP role and its goals (f=11). Ambiguity concerning the concept of advanced practice appeared to be one reason that conflict was experienced with some professional colleagues. Furthermore, failure to arrive at a mutually agreed set of goals and objectives for the new role may also account for the decline in motivation experienced by some ANPs.

The need to establish practice independence as part of the new role and with it a new professional identity was evident in the identification of two of the inhibiting factors cited. Firstly, the need for ANPs to work under the close supervision of medical staff in some cases (f=3) was seen as an inhibiting factor. This may have been viewed by some ANPs as signalling practice dependence on medicine. However, a more likely reason for the supervision, such as the counter-signing of medical records, was as a safety precaution, especially in the initial phases of role development prior to the ANP gaining competence and confidence. The second inhibiting factor identified in this category concerned the ANPs having to work with junior and/or inexperienced medical staff (f=3). This once again suggests that in establishing a new identity, especially in the absence of a nursing role model, ANPs compare their competence and level of practice with that of medical practitioners as opposed to fellow nurses. In this instance, the presence of inexperienced medical staff was seen to inhibit role development as the junior medical staff were not perceived to be able to teach the ANPs new skills or procedures.

The overall impact of inhibiting factors can be seen to influence both the motivation of the ANP and role development during the transitional process. One ANP commented in her final diary that the:

> "Past 6 months felt unsupported/unstructured. Preceptor left and change of management and no acting sister led to 'Jack of all trades' service [which led] ANP to run departments and oversee others trying to act up. At the same time expected to make changes in practice development and enhance skills and learning, latter taking 'back burner 90% of time'. Motivation has been hammered.."

Consequently, the rate and progress of role development appears to be influenced considerably by both organizational governance and unanticipated factors in the clinical context.

7.2.6 CONCLUSION

The role development diaries were used as an additional method of data collection in order to provide a convergence of evidence with data collected by other means. Whilst the diaries were only completed by three of the five case study ANPs, analysis of the diaries completed by the ANPs outside of the case studies provided an additional dimension to the overall study. Much of the evidence gained from the diaries converges with data collected by other methods and substantially adds to the overall conceptual understanding of the dynamic nature of role transition. It is acknowledged however, that there are obvious limitations to the use of such instruments for data collection, such as compliance, accuracy of entries, and the representativeness of the events that are reflected during the period of completion. However, the focus of the study was toward the transitional process of becoming an advanced practitioner and in this way the information extracted from the role

development diaries further enriches the overall body of evidence.

7.3 SUMMARY OF EVIDENCE

The evidence suggests that the study participants understanding of the concept of advanced nursing practice varied considerably throughout the transitional process and was subject to interpretation as a set of idealised behaviours and activities. In the reality of the clinical context the development of the new nursing role was primarily oriented toward either direct patient care or the system of care delivery, which in itself was dependant upon prevailing intervening conditions within the environment. The intervening conditions which exerted greatest influence on the determination of the parameters of role transition and, consequently upon the outcome of the transition, were related to organizational governance and the status of transitional relationships within the clinical context. Furthermore, the orientation of role development, along with the rate and scope of practice innovation were also contingent upon the nature of the clinical environment, the degree of novelty and discretion associated with the new role, and the availability of resources.

The evidence strongly suggests that the ANPs responsible for reconstructing nursing practice discovered their academic preparation to be inadequate for the purpose of developing their new role in clinical practice. Whilst personal development, academic credibility and legitimacy for role development were associated with the academic preparation, practice development was deemed to be negligible.

The evidence also indicates that during the process of reconstructing nursing practice ANPs sought to establish a new nursing identity and to gain recognition and status for their new role. In so doing ANPs experienced conflicts with their professional colleagues and during the transitional process suffered a loss of their nursing identity to varying degrees. Furthermore, whilst claiming that the reconstruction of practice remained within a nursing paradigm, ANPs whose role orientation was toward the delivery of direct patient care associated advances in clinical practice with the acquisition and competence of skills and privileges normally possessed by medical practitioners. On the other hand, those whose role orientation was toward the system of care delivery struggled to articulate the essence of advanced nursing practice in the context of their new role. Consequently, whilst ANPs reconstructed their clinical practice utilising an eclectic combination of knowledge and skills borrowed from other disciplines, the development of a unique body of nursing knowledge was not evident. Furthermore, Benner's (1984) notion of intuition and its part in explaining expert behaviour also failed to emerge as a significant factor for the ANPs involved in role transition at this stage. The most likely reason for this relates to the 'novice' status which most of the nurses found themselves in as ANPs and the accompanying need to spend a considerable amount of time in developing new skills and roles.

Finally the use of the term 'advanced nurse practitioner' appears to have generated: a considerable amount of confusion and ambiguity, a degree of inter and intra professional rivalry and, appears to have relegated, intentionally or otherwise, traditional nursing skills, knowledge and values to a secondary status. It must be

remembered however, that this data needs to be viewed in the context of the

relatively early stages of role transition and the emergence of a new clinical role. The

major findings from this study will now be explored more fully.

CHAPTER EIGHT

DISCUSSION I: RECONSTRUCTING NURSING.

CHAPTER 8 - DISCUSSION

8.1 INTRODUCTION

Drawing on the evidence presented in chapters 6 and 7, this chapter develops theoretical arguments in relation to the three central and interrelated concepts which develop an understanding of the process and outcomes of the role transition in which advanced nurse practitioners engage. The chapter begins with a presentation of a brief summary of the central themes to emerge from the findings of the study. This is followed by an introduction and explanation of the key construct, "reconstruction", and the development of a conceptual model which illustrates the process of role transition. Chapter 9 examines the contingent nature and idealism of practice reconstruction. It is argued that it is because the concept of advanced practice is socially constructed and locally determined that reconstruction need to be understood within the social context and the contingent conditions it imposes on the transitional process. The final discussion chapter examines the end stages of practice reconstruction that had been achieved by completion of the study. It was concluded that three different operational outcomes of role transition can be observed regardless of the way in which practice is reconstructed. This final chapter ends with a concluding argument in support of the thesis that advanced nurse practitioners seek to establish a new professional identity as a way of attempting to claim professional power and to escape some of the constraints and submissiveness associated with a traditional nursing identity. The thesis ends with consideration of the implications of the findings of this study for practice and future research.

8.1.1 KEY THEMES TO EMERGE FROM THE STUDY

The three key themes which emerged from the findings of this study were:

(i) That while the nature of role transition varies in different clinical settings, the process of reconstruction in which practitioners engaged can be understood in terms of changes that take place to seven personal and practice domains. The way in which these domains are reconstructed is dependent upon the orientation of role transition.

(ii) Regardless of clinical setting or practice orientation, the process, rate and parameters of reconstruction are determined by, and contingent upon, locally imposed conditions. The major conditions which affect role transition are: organizational governance; the nature of the clinical environment; the traits and abilities of the individual; the degree of novelty and discretion pertaining to the reconstruction of nursing practice; and the influence of transitional relationships in the practice setting.

(iii) The process of reconstructing a new nursing role results in one of three outcomes [adapted from Nicholson's (1984) theory of work role transition], depending on the nature and influence of the dominant contingent conditions in the practice setting. These operational outcomes have been classified as: practice replication; practice fragmentation; and practice innovation. In addition to the operational outcomes of practice reconstruction, role transition involves the initial stages in the development of a new professional identity whose purpose can be seen

to be one of recognition, empowerment and escapism.

These three themes can be seen to have a relationship with one another which can be illustrated by the use of a conceptual model (Figure 8.0). The model indicates an iterative cycle which is intended to demonstrate that the process of reconstruction is dynamic in nature, with changes to any of the variables being possible. So for example, if the nature of conditions change significantly within the practice environment, there is likely to be equal impact on both the process and outcome of role transition. In this example changes in contingent conditions could be either favourable or detrimental to the advanced practitioner and hence her practice and its corresponding outcomes would be influenced accordingly.

The following chapters examine the relationships between these three domains, and seeks to provide a comprehensive account of the process and outcome of role transition from experienced nurse to advanced practitioner.
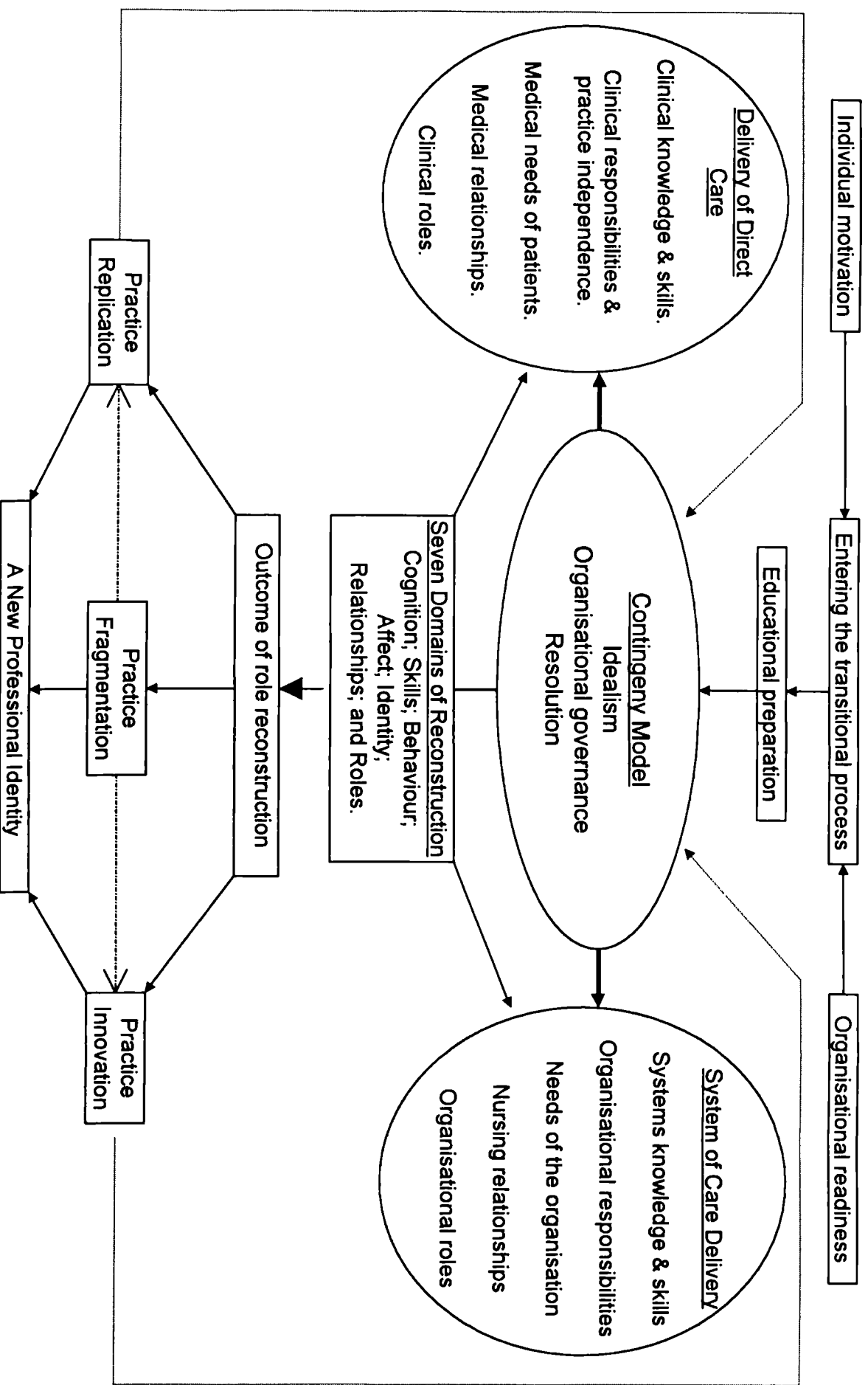
Figure 8.0 A model of practice reconstruction

8.2 RECONSTRUCTING NURSING

8.2.1 INTRODUCTION

Nurses have an established tradition of "extending" and "expanding" their practice and skills in a variety of ways. Recently, the trend for role expansion has shown an increase in both magnitude and momentum, with a recent Department of Health project mapping out over 800 new roles[15] amongst nurses and professions allied to medicine in acute care settings alone (Cameron, 1998). Moreover, it is becoming increasingly common for nurses who undertake role extension to assume a different job title as an indication that they have undergone additional training, such as in the case of "emergency nurse practitioners", "enhanced role nurses" and so on. It becomes apparent, however, that in the majority of such cases that nurses have simply incorporated selected additional tasks or skills, with minimal training, into an established nursing role. One example of this phenomenon is in the case of emergency nurse practitioners, where nurses are taught to assess and treat minor injuries and in the process learn a limited number of additional skills, such as suturing. When nurses have taken up new posts which have involved a more radical change in roles and responsibilities, such as in the case of "surgical assistants", then arguably the role incumbent is no longer involved in the practice of "nursing", but acts as a technician who is directly accountable to a medical practitioner. In this instance, the post-holder assumes an identity similar to that of a physician assistant who, as

---

[15] New roles in this context were defined by post holders either undertaking activities beyond the accepted scope of practice for a specific professional group, or undertaking completely new work roles.

a practitioner, is not required to have a nursing background. The absence of the term "nurse" from such job titles serves to reinforce the argument that when nurses take up posts such as these, which many consider represent career advancement, the roles in themselves do little to signify any progress or development of the practice of nursing.

The educational preparation and implementation of advanced nurse practitioners who were the subject of this study therefore represents a major shift in nursing strategy. In this instance, practitioners were required to undertake a Master's degree course whose purpose was to provide them with the foundation and skills from which they were expected to advance nursing practice. Advance in this context is related to the expectation that ANPs would break established nursing boundaries and forge new roles and relationships, rather than simply accept delegated tasks from other disciplines as they have done so in the past. This chapter examines the concept of reconstruction as a process in which practitioners can be seen to engage in during the transition between roles.

8.2.2 THE PROCESS OF RECONSTRUCTION.

Studies of role transition in nursing provide little insight or help in understanding the concept of reconstruction as it applies to advanced nurse practitioners in the UK. This is because whilst transitions have been identified as a central concept in nursing (Schumacher & Meleis, 1994) those inquiries that have investigated changes in

educational and professional work roles have done so from a position of movement between established roles, such as from student to staff nurse, in which the transition is considered to be both planned and deliberate (see: Talarczyk & Millbrandt, 1988; Jairath *et al*, 1991; Alex & McFarlane, 1992) . Moreover, the studies that have examined the transition of nurses into advanced practitioner roles, such as clinical nurse specialist and nurse practitioner (Anderson et al, 1974; Oda 1977; Lukacs 1982; Hamric & Taylor, 1989; Bass *et al*, 1993; Shea & Selfridge-Thomas, 1997; Brown & Olshansky, 1997; Roberts *et al*, 1997) are predominantly North American in origin and relate to movement between roles which have been established for some time. In these circumstances, the validity of drawing comparisons between the findings of this study and those cited above is highly questionable given that, in addition to situational differences, the majority explain the process of transition in terms of a series phases or stages through which role incumbents pass at various points in time.

In one of the relatively few studies in the UK to explore specialist and advanced nursing practice, Roberts-Davies *et al* (1998) developed a 'typology of innovative nursing roles' from the nursing literature. They developed a number of different 'domains' to identify the characteristics which:

> "...reflect the **main** orientation or emphasis within a given role..." (Roberts-Davies *et al*, 1998, p37 - original emphasis).

This study, along with its American counterparts, appears to have had little concern

with the process of *how* nurses reconstruct their practice as advanced practitioners, instead appearing to be pre-occupied with attempting to generate criteria by which specialist and advanced practice can be differentiated. Hence the taxonomy of domains that was generated was based on: the psychomotor skills performed by the practitioner (i.e. the skill/task specific domain); the various roles in which practitioners engaged (i.e. role specific domain); the characteristics of the patient population (i.e. the condition specific domain); the practice discipline (i.e. area specific domain); and other generic areas relating to client groups and the context of care delivery. Consequently, it appears from examining the literature that no previous studies have conceptualised *how* practice is reconstructed when developing a "new"[16] nursing role. This thesis therefore adopts a unique position in attempting to understand and explain the phenomenon of reconstruction and its relationship to the contingent conditions which determine both the process (i.e. the *how*) and the outcome (i.e. the *what*) of role transition.

The idea of reconstruction is central to this thesis. The evidence from this study reveals that in the transition from experienced nurse to advanced nurse practitioner, nurses engage in a process of reconstruction involving changes to their practice, their roles, their relationships and their identity. Moreover, practitioners undergo this transformation in the absence of a common frame of reference and without recourse

---

[16] In this context 'new' relates to the development and establishment of a nursing role which is new to an organization and where there have been no previous incumbents or role models and where practice has to be reconstructed in the absence of an established frame of reference.

to prior role models. The problems of novelty and ambiguity of practice reconstruction are exacerbated in this instance by the innovation of such roles being new to the organizations in which the practitioners are employed. This situation creates the phenomenon of multiple interpretations and meanings amongst different stakeholders regarding the roles which advanced practitioners are expected to perform, and the nature of practice reconstruction. This gives rise to the situation whereby the concept of advanced practice is socially constructed by various actors within the organization, which in turn leads to the phenomenon of an idealised notion of advanced practice. The existence of an idealised notion of advanced practice is one of the main factors that makes the process of reconstruction difficult for advanced practitioners, as will become evident in the next chapter.

It is the premise of this thesis that the concept of reconstruction provides a framework which enables the construct of advanced practice to be distinguished from other forms of role development in nursing. During the transition from experienced nurse to advanced practitioner the individual is required to re-build or re-structure the domains of: cognition; skills; behaviour; affect; identity; relationships; and the roles that comprise and inform nursing practice. Reconstruction in this sense occurs concurrently along two axes: the *personal* and the *practice*. The latter can be viewed as the outcome (or the *what*) of reconstruction, i.e. what is observable and can be seen to have changed in terms of role enactment, whilst the former involves the process (or the *how*) of reconstruction in which the individual engages on a personal

level. In terms of work role transitions these concepts have been referred to elsewhere as "personal" development and "role" development (Nicholson, 1984). These two dimensions can be considered discretely or in conjunction with one another. When viewed in relationship with one another, role development should not only be considered to be dependent upon personal development, but also upon the nature of contingent conditions in the clinical setting. If these conditions could be controlled for, then role development would become the dependent variable whilst personal development would be categorised as the independent variable. It is the philosophical position of this study however, that to understand the concept of reconstruction and advanced practice, one needs to fully examine the context within which role transition takes place. The classification of the variables personal and role development in this sense then serves to be of only theoretical significance.

Paradoxically, what is not evident from the literature is any suggestion that the process of reconstruction involves the practitioner in initially engaging in an act of "deconstruction" within each of the seven domains identified above. This thesis holds the position that this process is necessary in order for the practitioner to accommodate the changes required within each domain, which in turn allow practice to develop. In this sense, deconstruction is not a destructive process in that cognition, skills, roles and so on are not jettisoned or rejected. Rather, through the practitioner engaging in deliberation and reflection, elements within each domain are selected and modified within the parameters of the new role with the goal of

maximising performance. The example of patient assessment can be used to illustrate the premise of this argument.

Prior to role transition all the ANPs involved in this study were experienced nurses who were considered to be competent in performing "nursing" assessments of the patients in their care. "Nursing" in this context is generally perceived to be primarily concerned with the process of caring (van Maanen, 1990; Graham, 1991; Salussolia, 1997) in which the nurse takes on a series of therapeutic roles which are seen to be largely independent from medicine and the professions allied to medicine. Following role transition however, a number of ANPs in this study found themselves in the position that as part of their new role they were required to not only undertake a nursing assessment, but a full physical assessment, along with a medical history. In turn this required that ANPs became competent in the use of new equipment and developed new skills such as auscultation and palpation. Furthermore, it also demanded they refine not only their knowledge base, but cognitive skills such as decision making. The process of moving toward a new level of practice competence can be seen to have involved the ANPs in deconstructing their notion of patient assessment in order to accommodate the new concepts and skills to which they had been exposed. At the same time ANPs engaged in a process whereby they reconstructed the concept of patient assessment by assimilating the new knowledge and competencies they have acquired into their existing cognitive and skill domains. Thus, reconstruction in this context can be seen to involve the integration of new

257

concepts and skills into an existing framework of understanding. In this sense

deconstruction and reconstruction are not processes that occur in strict sequence or

instantaneously, rather, they are gradual in nature involving the parallel development

of specific domains in an iterative cycle.

The evidence from the study supports the notion that ANPs engage in the

deconstruction-reconstruction cycle in each of the seven domains identified

according to the orientation of their transition and the specific requirements of the

new role. That is to say that different domains are deconstructed and reconstructed

at different times, at different rates and by differing degrees according to the

demands of role transition and the individual's previous experience. The cycle is at

its most active at the outset of role transition and decreases in intensity as the

incumbents practice becomes established in their new role. That is to say that there

is an inverse relationship between reconstruction and deconstruction over the

Figure 8.1 The inverse relationship between deconstruction & reconstruction
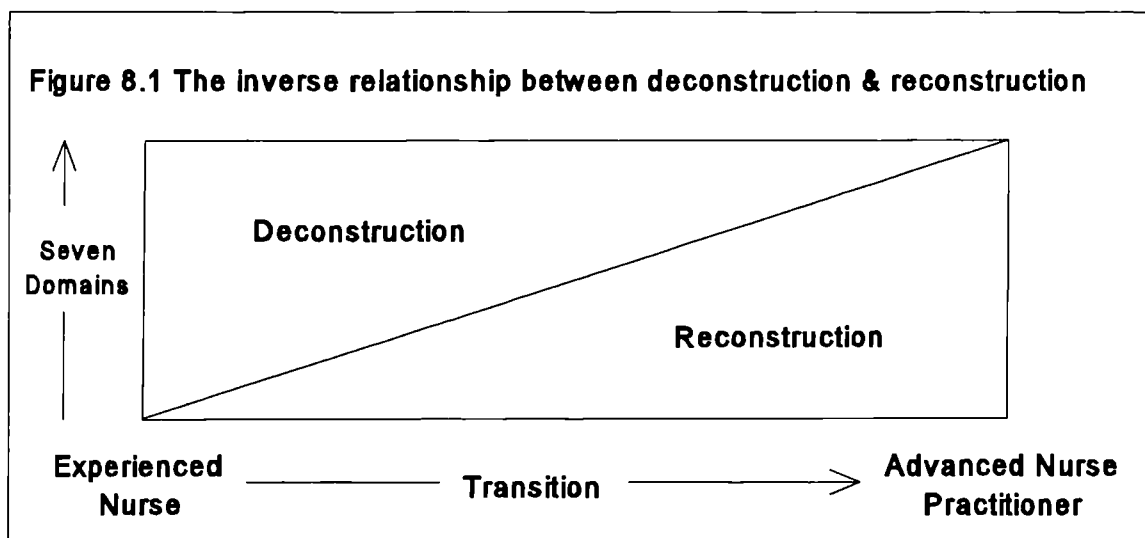
duration of the transition (Figure 8.1). This is a concept that has been implicit in the

findings of other studies, but is one which has failed to be articulated. For example,

Roberts *et al*, (1997) observed in a sample of nurse practitioners students in the USA

that as they progressed in their education and practice they:

> "...experienced a reemergence of their nursing knowledge and skills and
> began to combine them with the new knowledge they had acquired..."
> (Roberts *et al*, 1997, p68)

In other words, what they were describing was a manifestation of the deconstruction-

reconstruction cycle as conceptualised in this thesis.

It is legitimate to question at this point whether any nurse who undertakes to add new

dimensions to their work role engages in the same cycle of deconstruction and

reconstruction? In other words, what makes the situation of advanced practitioners

different to that of any other nurse involved in role innovation? In answering these

questions, the evidence from this study indicates that the concept of reconstruction

as it applies to advanced practitioners is clearly different to that of nurses who simply

extend their role by taking on additional clinical skills and responsibilities. In the case

of the latter, nurses 'added' a skill or activity to their practice portfolio, but did not

deconstruct any of the seven domains identified above to any significant degree. For

example, if a nurse in A&E learns to suture minor wounds (i.e. she takes on an

additional skill), whilst this involves minor modifications to her skill and cognitive

domains, she undergoes little or no change overall in her roles, behaviours, identity,

relationships and so on. Consequently, for the most part her role and duties remain

unaffected. In this sense the deconstruction-reconstruction cycle is not apparent as all the nurse is doing is learning a new skill. Likewise, the cycle is equally inappropriate to describe those cases where nurses radically change their role when taking up positions such as "surgical assistant". As suggested earlier, one could argue that the incumbent is no longer practising nursing but acting as technician and hence the notion of reconstructing nursing can be no longer seen to apply. The fundamental difference here between ANPs and nurses such as these, is that to act as technician does not appear to involve the cycle of deconstruction and reconstruction. Whilst the "surgical assistant" learns new skills and knowledge and assumes a different identity, her previous skills, knowledge, roles and identity are simply replaced or exchanged for new ones as the post demands. In other words, there is little opportunity for the nurse to integrate her existing knowledge and skills into the performance of her new work role. Consequently, the deconstruction-reconstruction cycle as discussed in this thesis can be used as a method to identify nurses who undergo transition to a significantly different nursing work role from those who simply extend their skills or enter positions which are predominantly technical in nature.

8.2.3 THE SEVEN DOMAINS OF RECONSTRUCTION.

A number of studies have adopted the use of different 'domains' to explain the concept of advanced practice (Fenton, 1985; Brykczynski, 1989; Bass *et* al, 1993; Ackerman *et al*, 1996; Watts *et al*, 1996). Most of these studies acknowledge

Benner's (1984) seminal work in identifying the seven domains of nursing practice which they have taken and adapted in varying degrees for their own purposes. What each of these inquiries have in common, along with others, is a tendency to describe advanced practice in terms of a series of roles characterised by behavioural objectives. So for example, Ackerman *et al* (1996) list five domains relating to acute care nurse practitioners: direct comprehensive care; support of systems; research; education; publication and professional leadership. Each domain in turn has a relevant set of behavioural indicators. The same approach is evident in the other studies mentioned above and although in these previous studies the domains may have different names, they nonetheless conceptualise advanced practice as a series of roles with behavioural objectives, such as the helping role and the teaching-coaching function to name but two. Whilst these studies illustrate the outcome (i.e. the *what*) of advanced practice in the USA in terms of a series of roles, they tend to conceptualise the transitional process (or the *how*) by using Benner's (1984) novice-to-expert framework. This framework is however generally misrepresented in that it is used to describe a series of stages through which the practitioner passes at different points in time. It does little to explain the "*how*" or the "*why*" of practice reconstruction, instead conforming to norm of identifying "*what*" a practitioner is able to achieve at the novice stage, the advanced beginner stage and so on.

This thesis takes a different approach in explaining the transitional process (i.e. the *how* of becoming an advanced practitioner) by conceptualising the phenomenon as

involving a cycle of deconstruction and reconstruction in seven individual domains (i.e. cognition; skills; behaviour; affect; identity; relationships and roles). While a set of behavioural indicators could be attached to a number of these domains, for others they would be difficult to construct, for example in the case of the 'affect' and 'identity' domains. Moreover, it is argued that in the context of the evidence from this study that any such set of behavioural objectives would need to be defined with reference to the contingent nature of reconstruction.

Schumacher & Meleis (1994) have identified similar concepts to those of the seven domains identified above which they refer to as "universal properties". They argue that a set of universal properties are common to most types of transition that individuals go through in life and help to differentiate transition, in all its forms, from non-transitional change. Schumacher & Meleis (1994) however fail to identify a change in the affective domain as a property of transition and likewise appear to amalgamate the skills and cognition domains into the property of abilities. Whilst the domains identified above are not new concepts in themselves and have been discussed in varying combinations elsewhere, the relationships of the "seven domains of reconstruction" as they relate to the development of a new nursing role have not been addressed by the nursing literature.

When examining the evidence from this study the process of reconstructing nursing can be seen ultimately to involve the advanced practitioner in changing the direction

or major focus of their practice in one of two ways. That is to say that the new role either involves the practitioner primarily adopting the position of "clinician", involving the delivery of direct patient care, *or* that of what can be termed "orchestrator", primarily concerned with enhancing the system of care delivery within the wider organization. The first of the two directions concerns the reconstruction of practice with the principal aim of the practitioner becoming increasingly involved in clinical activities directed toward assessment, diagnosis, treatment and management of patients, with a range of acute or chronic conditions pertaining to their specific practice discipline. The second direction of transition concerns a reconstruction of practice which is principally oriented toward enhancing the system of care delivery. In other words, practice is reconstructed so as to allow the practitioner to become primarily involved in activities which enhance the organization and delivery of nursing care at both a ward/unit and organizational level. In the case of the latter the ANP can be considered to indirectly influence the delivery of patient care. The evidence from this study does suggest that ANPs may sporadically spend minimal amounts of time involved activities characteristic of the opposing orientation of role transition, but overall, the direction of reconstruction tends to dominate toward the extremes of the direct-indirect care practice continuum (figure 8.2).

Figure 8.2 The direction of practice reconstruction.
|–X*————————————————————————————————————Y*–| Delivery of Direct Care   System of Care Delivery
X = Location of cases 1,3 & 4 on the direct-indirect care continuum.   Y = Location of cases 2 & 5 on the direct-indirect care continuum.
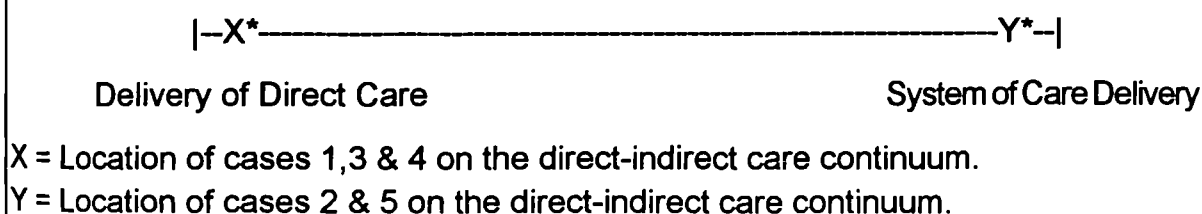
Subsequently, it can be asserted that it is the orientation, or focus of the new work role which dictates to what extent each of the seven domains need to be deconstructed, and in turn determines the way in which each domain is required to be reconstructed. Figure 8.3 provides a summary of the way in which the seven domains were reconstructed according to the orientation of role transition. It should be observed that this diagram illustrates the way in which each of the seven domains is *reconstructed* (as opposed to deconstructed which is implicit from the figure) according to practice orientation. The affective domain, which includes concepts such as attitudes and values, will be used as a further example to explain the concepts illustrated in figure 8.3.

The nursing literature is replete with accounts of how patient care has been "medicalized" by doctors who are accused of having a reductionist approach to patient management. The typical view held by nurses is one of the medical profession relating to patients by way of their symptoms or medical condition, e.g. the "kidney in bed 3" phenomenon. Nursing on the other hand in recent years has purportedly rejected this approach in favour of "holism" and "individualism", characterised by the perception of nurses relating to patients as people, e.g. the "person in bed 3" approach. Each of these strategies has an associated value system characterised respectively by the concepts of 'cure' and 'care'. When advanced practitioners are involved in role transition which is oriented toward the delivery of direct patient care, they engage in the deconstruction of their attitudes

Figure 8.3 The seven domains of reconstruction

```
                            ┌─────────────┐
            ┌───────────────┤ Orientation ├───────────────┐
            ▼               └─────────────┘               ▼
  ┌───────────────────────┐              ┌───────────────────────┐
  │ Delivery of direct care│              │ System of care delivery│
  └───────────────────────┘              └───────────────────────┘
```

| Clinical and specialised | ◄── Cognition ──► | Systems and generalised |

| Clinical skills | ◄── Skills ──► | Organisational skills |

| Clinical responsibilities and practice independence | ◄── Behaviour ──► | Organisational responsibilities |

| Medical needs of the patient | ◄── Affect ──► | Needs of the organisation |

| 'Advanced' practitioner | ◄── Identity ──► | 'Advanced' practitioner |

| Medical predominance | ◄── Relationships ──► | Nursing predominance |

| Clinical roles | ◄── Roles ──► | Organisational roles |

and value system in order to accommodate the roles, skills and activities that their new position demands. In this case a number of the practices in which they are expected to become competent are more commonly associated with the medicalization of patient care. What is 'reconstructed' then is an affective domain that still regards the concepts of "holism" and "individualism" as central, but increasingly becomes accepting of the medical needs of the patient and the need to treat the symptoms, as well as the person. Likewise, when the direction of role

transition is toward enhancing the system of care delivery, the values of the practitioner in terms of seeing herself and her immediate priorities uppermost, are reconstructed so as to acknowledge and react to the needs of the organizational system within which she works. Hence, whereas in the past the practitioner would be quick to blame the "system", she now acknowledges and recognises its bureaucratic idiosyncrasies and may even make excuses for it.

This deconstruction-reconstruction cycle is repeated within each of the domains that are illustrated in figure 8.3. It can be seen that each domain can be conceptualised as having polarised extremes and that it is the orientation of practice reconstruction that accounts for a practitioners' position along each continuum. So for example, in terms of cognition, the advanced practitioner undergoing transition as a clinician develops clinical knowledge and reasoning, which are highly specialised and applied to patient care. For ANPs with the opposing orientation, their knowledge base and reasoning expand to become more generalised and are applied to the various systems that influence care. Similarly, in the domain of relationships, ANPs deconstruct their prior relationships in order to form new ones which are necessary for role enactment. Thus, when the direction of role transition is toward the delivery of direct care, the ANP reconstructs her relationships predominantly with physicians, whereas for the ANP with an opposing orientation the reconstruction of her relationships is with her nursing colleagues. The only exception to this rule of dichotomy is with the domain of "identity" in which ANPs occupy the same position

266

on the continuum. The reasons why this phenomenon is observed will be discussed in the final chapter.

What this model illustrates then is not only *how* practice is reconstructed, but how reconstruction is manifest within each domain (i.e. the *what*). In addition, it also explains *why* each domain is reconstructed in a specific way according to the orientation of role transition. In arriving at the study's conclusions concerning the outcome of role transition (which is discussed fully in the final chapter) each of the seven domains of reconstruction were considered to have a set of properties. These properties relate to the concepts of direction; rate; degree; and context. By utilising certain of these domain properties one is able to establish not only in what ways practice has been reconstructed, but how quickly, and to what extent. Taken together, they give an indication of whether the practitioner has achieved an advanced stage of practice in comparison to other nurses within the clinical setting, or has only made minor modifications to their role.

The first of the four properties concerns direction and is obviously related to the overall orientation of role transition that has already been discussed elsewhere. Consequently, this property requires no further elaboration. The second property, rate, concerns the pace of reconstruction within each domain and in this respect is closely associated with the nature of the contingent conditions within the practice setting. Subsequently, if conditions are favourable, the pace of reconstruction can

be sustained at a constant rate. If on the other hand, contingent conditions are volatile and disabling, then the pace of reconstruction becomes sporadic with the overall rate of progress being delayed.

The concept of degree relates to the magnitude of change within each domain. So for example, where there are only small degrees of change within each domain one could conclude that reconstruction has either not occurred or at best has been conservative. Correspondingly, the greater the degree of change within each domain the more radical the role transition and the more noticeable the change in nursing practice. The final property, context, locates dimensional changes in each domain to the demands of the local environment. In turn this has implications for the transferability of the ANPs' roles and skills to other practice settings. The evidence from this study indicates that for advanced practitioners in acute care settings the more extensively they engage in practice reconstruction the more context specific it becomes. The influence of the practice specialism, the orientation of role transition, the level of patient dependency, and the contingent nature of reconstruction each dictate that the expertise the practitioner develops during role transition is highly individualised. It is for these reasons that expertise is seen to be non-transferable and is consistent with Alspach's (1984) assertion that when competency is demonstrated in relation to a specific field, setting, role or level of practice, the alteration of any of these elements undermines the competency of the practitioner. So for example, whereas nurses generally are able to move relatively freely between

different specialities during their career, if an advanced practitioner were to move to a completely different clinical speciality (which is obviously unlikely), she would, at least in the short-term, no longer be considered to be advanced in her practice. However, although ANPs are unlikely to move between disciplines, they may possibly move between practice settings within the same discipline. Dillon & George's (1997) UK study found that ANPs working in different neonatal units performed broadly the same function and skills, which demonstrates that within-discipline mobility will not necessarily be restricted. What the findings of the present study dispute however is that advanced practitioners trained in acute care settings will easily be able traverse the primary/secondary care interface in the sense to which Gibbon & Luker (1995) refer. In other words, it is difficult envisage a situation where an ANP trained in a neonatal unit could move freely between working in a community setting and then an institutional setting at an advanced level of practice. It must be stated however that Gibbon & Luker's (1995) expectations of the training and goal of advanced practitioners starts from a different premise to those in this study.

As will have been concluded, the complex nature of reconstruction, along with the concepts associated with each domain, present difficulties in terms of precise measurement. This is further compounded when one considers the present contingent nature of role transition. The purpose of this study has however been to establish an understanding of the process of role transition, identify the relevant domains involved, and then to describe the mechanism of reconstruction, as opposed

269

to generating specific measurement tools. Future research may however wish to develop and test appropriate instruments for the purpose of measuring changes in the domains that have now been identified. In the context of this study, analysis relied upon verbal and written reports, along with observation to arrive at an indication of the magnitude of reconstruction that the case study participants had achieved by the end of the study. Conceivably, it is possible for each domain described above to be considered in isolation and the degree of change along each continuum plotted, although in attempting to measure the extent of role transition it is recommended that the seven domains should be considered in relationship with one another and not be treated individually. This is because it is suggested that only when changes to each domain have been maximised within the context of the clinical setting can a level of advanced practice be considered to have been attained. In other words, a practitioner cannot be considered to have reached an advanced level, if for example, they have only maximised reconstruction of their skill base whilst exhibiting only minimal changes in the other domains. On the other hand, somebody who exhibits major changes to their cognitive abilities, skills, relationships, roles, values, behaviours and identity, clearly can be seen to have attained status of advanced practitioner when compared to their nursing peers in the same setting. It is, therefore, the overall profile of the practitioner in terms of the level of development of each of the seven domains which provides the clearest indication that a state of advanced practice has been achieved.

When the framework utilising the seven domains of reconstruction is used to examine the outcome of role transition in the wider context, the indication is that when the new role is oriented toward the delivery of direct care many of the practice characteristics of the ANP are consistent with the role of the "nurse practitioner" as described in the North American literature. Likewise, when practice reconstruction is oriented toward the system of care delivery it shares many of the similarities that are present in the practice of "clinical nurse specialists" as described in the North American literature (for example see Fenton & Brykczynski, 1993). Both of these established roles are well-founded and recognised to be advanced in nature in the international literature (Autar, 1996b).

8.2.4 ADVANCED NURSE PRACTITIONERS AND THE RECONSTRUCTION OF NURSING KNOWLEDGE

Earlier, it was argued that the UKCC saw the reconstruction of nursing via the development of advanced practitioners as a way to enhance the 'professional' status of nursing. At this stage in the early evolution of the advanced practitioner role it is worthwhile considering if the UKCC is likely to have its goal achieved. One of the prominent traits of a profession is the development of systematic theory and knowledge (Greenwood, 1957). In this sense, the generation of nursing theory has been seen largely to be born out of a professional need (McFarlane, 1976). Nursing over recent years has attempted to generate its own substantive theoretical foundation, but is generally considered to have failed in its attempt to articulate a

knowledge base which it can call unique. More recently there have been calls for nursing to abandon its search for an original body of knowledge (Nolan *et al*, 1998). Correspondingly, and by coincidence, the generation of nursing theories appears to have been in abeyance whilst nursing considers its future.

Arguably, one strategy that appears to have been adopted to meet the goal of recognition as a "major" profession is the development of advanced nurse practitioners. One of the premises of this position is the hope and anticipation that advanced practitioners will enhance the knowledge base of nursing where theoreticians have failed. The inclusion of compulsory "nursing theory" modules in advanced practitioner programme curricula in the USA (Shah *et al*, 1993; Hravnak *et al*, 1995; King & Ackerman, 1995), and the development of similar modules in this country, such as "knowledge development in nursing" (Davies, 1993), serve to illustrate that the drive for the development of a unique body of knowledge is still alive. Whilst the deconstruction-reconstruction cycle involves modification to the cognitive domain of individual practitioners, the question which arises is: in this process is a unique body of nursing knowledge synthesised?

In the initial phases of practice reconstruction which was the focus of this study there is no evidence to suggest that the theoretical development of "nursing" knowledge has occurred. The reason for this is that just as in the general domain of nursing, where theories have been "borrowed" from other disciplines such as psychology,

sociology and anthropology (Meleis, 1985), nurses engaging in role transition to become advanced practitioners appear to adopt a similar strategy. When their orientation is as clinicians, ANPs borrow theories and knowledge from areas such as medicine, biology, and physiology. Likewise, when they are directed toward the system of care delivery they borrow educational theories and theories of change. Consequently, it is the direction of the transition which determines the origin of the disciplines from which ANPs adapt and borrow theories. Thus, contrary to some expectations, the ANPs in this study have not synthesised any new nursing knowledge, but have merely reconstructed their knowledge base from the relevant disciplines to be able to inform their practice as advanced practitioners. This indicates that ANPs are in fact utilising "transdisciplinary knowledge" (Retsas, 1995) which, whilst it has historically been condemned on grounds of doing little to enhance the development of a unique body of nursing knowledge, is becoming an increasingly accepted and advocated position (Nolan *et al*, 1998).

The findings of this study therefore reveal that advanced practitioners are entering what Kidd & Morrison (1988) describe as the fifth period of knowledge in nursing. This is similar to the notion of transdisciplinary knowledge but which Kidd & Morrison (1988) refer to as "constructed knowledge". They view constructed knowledge as being based on the integration of knowledge from equally legitimate but differing origins. The UKCC themselves seemed to have moved toward acknowledging this position when they openly stated that practitioners should have an "eclectic

273

knowledge base" (UKCC, 1996, p7). The evidence from this study then clearly supports that as opposed to developing "new" nursing knowledge, practitioners draw on transdisciplinary knowledge in the pursuit of advanced practice. This in itself need not exclude nursing from eventually being recognised as a major profession as arguably, it is the way in which "constructed knowledge" is applied in the practice of nursing that will make the theoretical base of nursing unique.

8.3 CONCLUSION

In summary, whilst the role of advanced nurse practitioner is new to the UK, the findings from this study suggest that through deliberate strategy or otherwise, practice reconstruction in its broadest sense follows one of two directions. When viewed in terms of outcome, the models of practice are similar to the advanced practice roles of clinical nurse specialist and nurse practitioner frequently outlined in the North American literature. The reconstruction of nursing in this thesis has been conceptualised as a process involving the practitioner in a cycle of deconstruction and reconstruction in seven personal and practice domains. Each of these domains have properties of direction, rate, degree and context which can be used to help to differentiate progress in role transition as an advanced practitioner from that of a nurse involved in extending her role through the acquisition of limited additional skills. It has been cautioned however that the highly contingent nature of the transitional process, the polarisation between various role orientations and the varying ways in which advanced practice is socially constructed suggest that arriving

at a universal list of behavioural competencies is fraught with difficulties and inappropriate.

The next chapter takes up the contextual nature of reconstruction which was found to be reactive, retrospective and highly contingent in character. It will be shown that multiple interpretations of the concept of advanced practice result in position whereby the transitional process is idealised by each of the actors in practice setting. Furthermore, it will be illustrated that the way in which practice was reconstructed in this study runs contrary to the UKCC's current idealised concept of advanced practice.

CHAPTER NINE

DISCUSSION II: THE CONTINGENT NATURE OF RECONSTRUCTION

CHAPTER 9: DISCUSSION - THE CONTINGENT NATURE OF RECONSTRUCTION

9.1 INTRODUCTION

The previous chapters have indicated that the reconstruction of nursing and the transitional process in which advanced practitioners engage is influenced by a multiplicity of factors. The way in which these factors interact with ANP role transition will be addressed in this chapter. It will be argued that it is the ambiguous nature of the concept of advanced practice is at least partly responsible for actors in the social setting arriving at multiple and often conflicting interpretations of the same construct. It is suggested that interpretations of advanced practice held by dominant stakeholders within the organization shape both the conditions and the context in which the ANP role transition is managed. Consequently, it will be demonstrated that, contrary to the idealised expectations about advanced practice that prevailed at the outset of the transition process, the way in which these nurses reconstructed their roles and practice was primarily a contingent process. It is clear from the evidence of this study that it is the contingent nature of reconstruction that accounts for individual advanced practitioners developing their role in different ways. The notion that role transition may be experienced as contingent upon different factors within an organization is clearly not new. The idea shares a number of conceptual similarities with role theory and with theories of socialization that assert that any transitional process is influenced by past experiences, education and the current working environment (Hupcey, 1994). Where this thesis is unique however is in examining the transition into a role which is new and novel to both the individual and the

277

institution.

The central issue of this chapter concerns the idea of contingency. The interpretation of the concept of contingency that is addressed below should not be confused with the "contingency theory of management" which has been applied to health service administration and managers (Strasser, 1983; Loveridge, 1988). Strasser (1983) states that:

> "The contingency theory of management in its most basic form assumes that there is no single best way to manage. Instead, effective management is a function of the manager's ability to select from a menu of strategies the most appropriate strategy for the situation he or she confronts." (Strasser, 1983, p16).

The concept of contingency is used here principally to convey a sense that the process and outcome of reconstruction in which advanced practitioners engage is volatile, vulnerable and ultimately controlled by the external demands in the social environment. The chapter will explore how "key" stakeholders within the organization control both the orientation and extent of reconstruction by limiting the discretion of advanced practitioners expected to become leaders in innovatory practice. A three stage model of contingency is proposed which explains how ANPs move from a position of "idealism" to one of role acceptance and implementation over the duration of the transition. It should be noted at the outset, that the model represents the early stages in role transition and that in the future further stages are likely to be identified.

9.2 STAGE 1: THE IDEALISM OF RECONSTRUCTION

Schumacher & Meleis (1994) identified that all transitional processes have direction in terms of their flow or development from one state to another. It has already been established that in the case of the transition from experienced nurse to advanced nurse practitioner this direction can take one of two routes: that of "clinician" delivering direct care, or that of "orchestrator" enhancing the system of care delivery. What is not clear is why a group of practitioners who undergo a generic educational programme should end up implementing the concept of advanced practice in such polarised ways. This question is considered problematic because the same phenomenon is not apparent in other nurses who undergo further specialised training, for example district nurses, ITU trained nurses, coronary care nurses, or community psychiatric nurses. In each of these cases the roles and responsibilities which nurses adopt following training can be seen to have similar parameters, content and outcomes. Moreover, as such roles have become established they have acquired common interpretations and shared understanding amongst actors in the social environment.

The first reason why ANPs may implement their roles in clearly divergent ways relates to the novelty and ambiguity of the concept of advanced practice. Given that there are no uniformly agreed definitions of advanced practice as it applies to health care in the UK, multiple interpretations and realities evolve amongst different actors in the practice setting. This fact alone makes defining and agreeing the parameters

of reconstruction between advanced practitioners and others in the social context extremely difficult. While the evidence from this study clearly indicates that the transition from experienced nurse to advanced practitioner has direction, how that direction is determined is contingent upon how the concept of advanced practice is socially constructed, which itself is neither a straightforward or simple process.

The evidence collected from all the case study participants at the outset of this inquiry indicated that in *each* case the parameters of role reconstruction, including the intended direction, were initially idealised as a set of optimal behaviours encompassing a broad range and scope of clinical and organizational activities. The direction of transition was anticipated as being omni-directional, with what appeared to be the expectation of producing an "eclectic" practitioner able to meet a variety of practice and organizational demands. The findings which were confirmed at the conclusion of the study however, indicated that contrary to initial expectations, the orientation of practice reconstruction in *all* cases had become 'uni-directional. In other words, the orientation of practice reconstruction took one of the two directions previously identified, regardless of how the scope and boundaries of the new role were initially conceptualised and constructed. This experience was associated with a sense of conflict and frustration for the ANPs in this study. Previous research has shown that conflict between the practitioner and the institution in terms of the expectations of role enactment are not uncommon (see: van Maanen & Schein, 1979; Topham, 1987). In this inquiry, it was the ANPs themselves, in addition to other

members of the institution, who idealised the parameters of reconstruction at the outset of transitional process. ANPs initially constructed a theoretical model of advanced practice which in itself was idealistic and largely failed to take cognisance of the constraints and contingent nature of the practice environment. The way in which other actors in the organization socially constructed the role of the advanced practitioner however, was ultimately found to diverse considerably from the ANPs' own interpretation of their role. One likely reason why this situation arose may be related to the way in which ANPs had their expectations of the new role artificially inflated by their employers as an enticement to undertake the Master's degree course. As a phenomenon this is not new. As Louis (1980) points out, over 25 years ago research into work on unrealistic expectations revealed that organizational recruiting practices often relied on this strategy. An equally plausible explanation for the idealised stance that ANPs adopted is related to their prior position as expert nurses within their practice discipline. As such, they had an established frame of reference upon which to base assumptions regarding proposed developments in general nursing practice. Consequently, as practitioners they were in a position whereby they could easily distinguish the realistic from the unrealistic proposal. When they entered the transitional process to reconstruct their practice however they found themselves in a position where they had moved from a status as "expert" to one of "novice". In this context, the findings of this study are consistent with the idea that:

> "...novices bring with them different backgrounds, faulty perceptions of the jobs to be performed within the setting, including their own, and perhaps

values and ends that are at odds with those of the working membership." (Van Maanen & Schein, 1979, p211).

However, in some cases this idealised concept of advanced practice was apparently held, at least initially, not only by ANPs but also by other stakeholders in the organization. The parameters of reconstruction tended to be framed in terms of a vision of an ultimate set of goals to be achieved at some distant point in the future. Frequently in the early stages of transition, the roles and duties the ANP was required to perform were in stark contrast to the apparently agreed ideal vision of advanced practice they shared with other stakeholders. Thus it can be seen that the novice in circumstances such as these has their initial expectations reinforced by the organization as opposed to their being immediately at odds with institutional expectations as would be implied by Van Maanen & Schein (1979).

What remains to be answered then is the question of whether the ANP role was idealised merely as a result of its novelty and the propensity for both the institution and the practitioner to "sell" the innovation to one another? Or, were there other reasons for the parameters of the advanced practitioner role being idealised? In attempting to understand why this phenomenon occurs Louis (1980) asserts that "transitioners" (i.e. those undergoing a career transition) generate expectations to replace voids in first hand knowledge with best guesses of what might be. However, the findings from this study suggest that it is not only the "transitioners" themselves, but those closely involved in the transitional process who generated expectations on

a "best guess" basis. This would appear to suggest that both the novelty of the role and the absence of a common frame of reference combined to force actors in this social environment to initially make best guesses of what the role of an advanced practitioner should involve. Kenner & Lott (1990) claim that in circumstances such as these, (i.e. where there is the absence of a prior frame of reference) the expectations for a new transition, whatever it may involve, may be unrealistic and vague. The vague, unrealistic and differing expectations of the concept of advanced practice that were generated in this study had the consequence of resulting in the development of a significant degree of role ambiguity. There was a lack of clarity regarding: role objectives; the scope of practice; individual responsibilities; and the expected outcomes of practice reconstruction amongst the various stakeholders. It has been observed elsewhere that roles are expected to be ambiguous when they are new to an organization or profession, or require coordination between different professions or occupational groups (Rapson, 1982). However, the expectations expressed by participants in this study were not just vague and ambiguous, but were also generally overly optimistic of what was likely to be achieved given the circumstances in which the transition was taking place.

A further explanation then that could account for why such an idealistic notion of the function of advanced practitioners emerged, is that the concept of advanced practice had been openly debated in the public domain. One only has to turn to recent publications of the UKCC to notice that their interpretation of the concept of

advanced practice could be characterised as similarly Utopian. They frequently

expressed the belief that the advanced practitioner was somebody who should have:

"... an eclectic knowledge base [and]...are expected to be grounded in practice but to have research, education and consultancy functions as well" (UKCC, 1996, p7).

In addition, they espoused expectations for advanced practitioners to have: a high

level of professional leadership; to be an expert resource for management, education

and supervision; and to have increased political and professional influence in respect

of nursing and health services (UKCC, 1996). Clearly, such an interpretation of

advanced practice can be viewed as being idealistic in the sense that it is highly

unlikely that any one practitioner could fulfil such an expansive role to the full

potential the UKCC propose. The fact that this idealised image of the advanced

practitioner had been reported extensively in the nursing press, especially given the

absence of any other easily accessible source of reference, is likely to be a major

contributory factor to the Utopian view of advanced practice that prevailed amongst

the case study participants in this inquiry. The assertion that the UKCC's vision of

an advanced practitioner is overly optimistic is easily evidenced if one uses their own

criteria as a measure which against to estimate the progress of development of the

ANPs in this study. The results discussed in earlier chapters would indicate that none

of the case study participants attained advanced practice status as defined by the

UKCC. All these nurses however considered themselves to have reconstructed, or

attempted to reconstruct their practice, so that they are now performing different roles

and functions, arguably at a higher level, than their nursing colleagues. When the

UKCC's criteria are used in this sense their idealised notion of advanced practice is clearly unhelpful to practitioners and institutions alike.

In contrast, the findings from this study suggest that ANPs would meet the notion of 'advanced practice' as defined by the American Nursing Association, which states that:

> "The term advanced practice nursing refers to nurses who have acquired the knowledge base and practice experiences to prepare them for specialization, expansion, and advancement in *selected practice roles*. Specialization is concentrating or *delimiting one's focus to part* of the whole field of nursing. Expansion is *acquiring new practice skills*. Advancement involves both specialization and expansion and is characterized by a new integration of theories and skills. Graduate education in nursing is required for advancement". (Barnard *et al*, 1994, p12, emphasis added).

This definition of advanced practice is clearly conditional, recognising that practitioners can only realistically advance in "selected roles" in part of the "whole field of nursing". The problem then appears to be that the UKCC have either failed or chosen not to recognise the contingent nature of practice reconstruction. Consequently, they are unrealistic about what ANPs are able to achieve in their anticipation of an omni-directional focus to the reconstruction of practice, at least in the early stages of role transition. In this sense, the notion expressed by Roberts-Davies *et al*, (1998) that advanced practice is "a point at which you never arrive"(p38) appears to be clearly insightful.

If advanced practice is indeed a point at which a practitioner can never arrive then

what is the purpose of ANPs, other stakeholders and the UKCC idealising the concept of advanced practice to such a degree? The evidence from this inquiry would suggest that the way in which advanced practice is idealised has less to do with general goals of the UKCC and more to do with being considered a solution for the immediate needs of the institution. Organizations appear to have taken the concept of advanced practice and used it as a means for their own local ends. Consequently, expectations of advanced practitioners that are generated by actors in the social setting are characterised by immediacy and short-termism. So for example: the senior medical staff may view the ANP as someone to substitute for junior doctors (i.e. they have a politically driven motive); the nurse manager may view the ANP as someone who can lead staff development and change (i.e. they have an organization driven motive); for the directorate manager the ANP is identified as being the prime candidate to undertake research (i.e. they have a professionally driven motive); on the other hand the educationalist sees the ANP as a teaching resource (i.e. they have an educationally driven motive); whilst the practitioner themselves may recognise elements of each position or have additional ideas of their own (i.e. they have personal and career motives). It is these differing perspectives of the aim and purpose of advanced practitioners which lay the foundation for the idealisation of the concept. Ultimately, it is these competing expectations which generate conflict during the transitional process. During the idealism stage however, most ANPs experienced a sense of enthusiasm and anticipation regarding their forthcoming role, mainly because it was viewed as an unknown quantity.

It is clearly apparent then that the idealism of reconstruction has little to do with maximising the development of nursing as a profession or in the potential of advancing nurses per se. What becomes evident is a manifestation of the reactive and retrospective status of reconstruction which is driven primarily by a variety of personal, organizational, and political agendas. Consequently, the idealism stage is not as first appears a result of some shared Utopian view of advanced practitioners and the nursing profession, but is a product of the actualisation of competing institutional and personal itineraries. So for example, some aspects of the organizational agenda can be seen to have been driven by national health policies such as the reduction of junior doctors hours (NHS Management Executive, 1991) and changes in medical specialist training (Working Group on Specialist Medical Training [Calman Report], 1993). Subsequently, these policies were used by some senior medical staff to define the parameters of role transition. In other cases locally determined priorities, driven primarily by the need to improve or expand services dictated how the parameters of practice reconstruction were defined. In this way the structural organization of the health care system can be seen ultimately to govern the reconstruction of practice as opposed to a professional agenda driven by nursing itself.

The evidence from this study indicates that ANPs spend the first year (i.e. whilst undertaking academic preparation) and the initial months following graduation in the idealism of reconstruction stage where the parameters of reconstruction appear to

be under continual review. It is only upon their return to practice that other stakeholders within the organization begin to exert influence over the direction, discretion and content of role transition.

9.3 STAGE 2: ORGANIZATIONAL GOVERNANCE

Following the initial period of idealism ANPs entered a period of negotiation with managerial and medical staff where the goals and parameters of the advanced practitioner role become established within the physical and financial constraints of the clinical setting. It is at this point in time that the contingent nature of reconstruction begins to fully emerge and the process of organizational governance is imposed. Subsequently, it is at this stage, that the individual experiences the "reality shock" (Hughes, 1958) that their initial expectations regarding the work role transition are unlikely to be met. It is at this stage that the idealism of advanced practice as initially held by the ANP (and the UKCC) is challenged by the institution. Moreover, at this time the reason underpinning the ANP's apparent drive for gaining legitimacy begins to emerge.

9.3.1 GAINING LEGITIMACY.

A distinction between nurses who, in a traditional sense have extended their roles and advanced practitioners, is the expectation for the latter to possess a minimum qualification of a Master's degree (UKCC, 1994c). It can be concluded from the findings of this inquiry however that educational preparation to Master's degree level

is not simply associated with the provision of pre-requisite knowledge and skills to be able to demonstrate an advanced level of practice. All the advanced practitioners involved in this study identified that their Master's degree qualification was also considered to be essential in contributing to their academic credibility and legitimacy with nursing and medical colleagues. The question this raises is: why is legitimacy viewed with such importance? After all, the ANPs in this study were experienced practitioners and each was considered to have the clinical respect of their nursing and medical colleagues *prior* to entering the transitional process. Moreover, in a number of cases, the study participants had undergone further clinical skills training and were deemed competent in performing a range of activities and tasks that had previously been the prerogative of medicine or other disciplines. In other words, they had already extended their role in the traditional sense and gained credibility in performing selected additional skills and tasks. Consequently, preparation at Master's degree level seems a highly elaborate and unlikely course of action if one of its primary purposes is to simply afford practitioners with the legitimacy to undertake additional activities and roles. The precedence in most trusts continues to be for such training to be conducted locally in order to meet a specific organizational need or training requirement.

One probable answer to the question of why ANPs seek legitimacy then lies in the broader political agenda of the UKCC and its almost obsessive drive to have nursing shake off its image as a "minor" profession (Retsas, 1995). If viewed from this

perspective, educating an elite group of practitioners at Master's degree level could be seen as one way of enhancing the status of nursing in the wider health care domain. This is an issue that will be returned to in the final chapter where it will be dealt with more fully.

Leaving aside the professional status of nursing, it is the premise of this thesis that the primary purpose of gaining legitimacy, via preparation at Master's degree level, is that it can be considered to be a means by which advanced practitioners can pro-actively reconstruct their practice in new and novel ways. In this sense, legitimacy is not concerned with validating the acquisition of tasks and skills delegated by other disciplines, neither is it concerned with verifying the practice of advanced practitioners in terms of their effectiveness. Legitimacy in this context is primarily concerned with endowing practitioners with the authority and status to propel them into a unique position whereby it is they who are able to determine practice development requirements and lead role transition. This assertion shares some similarity to the notion expressed elsewhere in the literature that Masters' degree programmes are desirable to legitimate professional leadership in nursing (Lava, 1994). Where the position of this thesis diverges however, is in the assertion that legitimacy for the ANPs in this study was primarily associated with practical application in the immediate environment and is not concerned with leadership in the wider political sense to which Lava (1994) refers. Furthermore, this interpretation of legitimacy also departs from the view commonly held in the nursing literature that

Master's degrees are deemed to have benefits associated with specialization and increased ability to practice autonomously (see: Watson & Wells, 1987). While these phenomena were observed in the ANPs in this study, they are not related to the concept of legitimacy as advocated here. Although specialization and autonomy maybe characteristic of advanced practice, they can equally apply to roles that arise from delegation by other disciplines.

Taking this argument to its logical conclusion it can be asserted that by locating legitimacy within the framework of higher education, advanced practitioners and the UKCC hope that nurses will become more empowered and independent in leading role transition and developing practice in the mainstream[17]. To this end the actual content of the Master's programme almost becomes of secondary consideration in gaining legitimacy. In other words, it is the academic standard associated with advanced practice that becomes the benchmark for attaining legitimacy, rather than the actual ability of the practitioner to fulfil the role requirements. Likewise, legitimacy from a professional or clinical sense also becomes of secondary importance, as credibility is sustained by the selection of ANP candidates who are viewed by their peers to be suitable and experienced clinicians prior to entering the transitional process.

---

[17] In the past, nursing's control over major practice initiatives has been restricted to Nursing Development Units (for example see: Pearson, 1983). "Mainstream practice" in the context of this thesis refers clinical settings other than NDU's.

Academic legitimacy then can be seen to empower advanced practitioners by providing them with a "safeguard" during the process of role transition. This was manifest in that while ANPs were challenged about their new role, the basis of such disputes concerned either a fundamental opposition to the concept of advanced practice, or were related to fears of role encroachment by ANPs into the work of their colleagues. None of the ANPs were challenged about their competence or adequacy to perform as advanced practitioners, neither were they challenged about their management of the role transition. That is to say that ANPs enjoyed a degree of protection by the legitimacy that they had been afforded by undergoing Master's degree preparation.

This notion of legitimacy however also proved problematical for some ANPs, as they were faced with the dilemma that they did not consider that the course they had undertaken had adequately prepared them for the role they were expected to implement. As such, a number of ANPs experienced the "imposter phenomenon" (Clance, 1985) whereby they were in fear of being discovered to have not developed their knowledge and skill base to the extent that they believed their colleagues to have anticipated. This phenomenon has been observed elsewhere in the study of early role transition of advanced practice nurses (Brown & Olshansky, 1997), although the authors did suggest that the experience could more readily be associated with what they term "transient identity confusion". This concept, along with a discussion of the identity advanced nurse practitioners assumed in this study will

292

be addressed in the final chapter.

Given then that the primary purpose for gaining legitimacy was to maximise the probability of practitioners achieving independence in the management of their role transition, it will be shown in this chapter that this is a position that failed to emerge. Furthermore, it will be demonstrated that the main reason for the failure of nurses to take charge of their role transition was that they were still considered to be marginal stakeholders within the health care organization. Hence, while undoubtably achieving legitimacy with their peers and workplace colleagues to perform as advanced practitioners, ANPs were only able to exert minimal influence over the direction of the reconstruction of nursing practice within the wider organization. In this sense, the transition from experienced nurse to advanced practitioner can be considered to be highly contingent in nature.

9.3.2 IMPOSING ORGANIZATIONAL GOVERNANCE

Through the imposition of organizational governance, reconstruction can be seen to become principally reactive and retrospective in nature. Thus, whilst some ANPs engaged in activities that met with *part* of their idealised notion of advanced practice prior to entering the transitional process, it is asserted here that such practices simply coincided with the goals of the organization and had little to do with the aim of gaining legitimacy. This position differs considerably from the education and implementation of advanced practice roles in other countries, such as the USA and

Australia. In those countries universities and health care organizations have established a common understanding and agreement of the purpose of differing advanced practice roles. As a result, when an advanced practitioner engages in role transition there is congruence between the expectations of the individual and those of the employer. To the contrary, in this inquiry it was discovered that despite practitioners engaging in a generic educational programme with shared aims and goals, once they re-entered the organization the process of reconstruction became ultimately dependent upon the nature of the prevailing contingent conditions within the institution. That is to say that there was no common pattern of role enactment as might have been seen in other specialist roles and consequently transitions were seen to vary considerably between organizations, clinical settings, and the expectations of ANPs and their employers.

In the context of this thesis, the purpose of organizational governance was at first thought to be one of apparent mediation, but ultimately was perceived to be one of control over the way in which the advanced practice role was implemented in the clinical setting. The direction of role transition bore a close relationship to the priorities which key stakeholders (other than the ANP) identified as being of importance and appropriate for delegation to ANPs. In this way, the findings from this study are partly in concert with Topham's (1987) assertion that:

> "It is the institutional members that *enforce* the role expectations of the [advanced practitioner]. Thus, role behaviours of the [ANP] come from an interaction of individual and *organizational* role expectations". (Topham, 1987,

294

p82, emphasis added).

Arguably however, while the expectations of the practitioner and the organization interact, it is the individual's expectations that become of secondary importance to those of the dominant stakeholders. In health care institutions, the dominant stakeholders can be considered first and foremost to be medical practitioners (Bates, 1990) along with managers.

Central then to the concept of organizational governance are the positions various stakeholders assume, along with their scope of influence, in the management of role transition. With respect to this phenomenon, two distinct groups of stakeholders were identified by this study, "key" stakeholders (i.e. the ANP, managers and senior medical staff) and "marginal" stakeholders (i.e. the ANPs' nursing colleagues, junior medical staff, PAMs, and patients). In context of the concept of organizational governance it was found that organizational expectations are primarily enforced by managerial and senior medical stakeholders. This finding is similar to other studies which have discovered a conflict between key stakeholders concerning agreement over the focus of the ANP role (Zammuto *et al*, 1979; Hayden *et al*, 1982). The implications of these findings are that at this time ANPs remain in a subordinate position within the organizational hierarchy. A similar discovery was identified in a study by Lurie (1981) where she found that nurse practitioners in the USA remained subordinate to their physician colleagues despite changes to their role which allowed for increases in such factors as clinical autonomy. Thus, whilst in stage one, ANPs

are considered to be one of the key stakeholders in the transitional process, in that they were expected to define the parameters of reconstruction, in the second stage they become similar in status to marginal stakeholders. As a consequence ANPs find themselves challenging the organization's agenda for their role orientation regardless of how their development in that new role is progressing. A sustained professional-bureaucratic conflict characterizes progress through this stage. This same phenomenon has been observed amongst staff nurses entering new health care settings (Ahmadi *et al*, 1987) and thus it is probable that 'organizational governance' as a state is experienced by anyone who finds their professional values in conflict with those of the bureaucracy in which they are employed. A further characteristic of the professional-bureaucratic conflict is that at this stage job satisfaction is found to decrease inversely to the degree of conflict experienced. Once again this is consistent with the literature examining the socialization of nurses into other roles (see: Gardner, 1992; Boyle *et al*, 1996)

Organizational governance can be viewed as the means by which role parameters for advanced practice are operationalized by the institution. Accordingly, the concept is congruent with the implementation of 'innovations' by organizations in general whereby,

> "...the organization integrates or places the innovation in perspective within the framework of its continuing operations". (Zammuto *et al*, 1979, p99).

It is proposed that in this context "continuing operations" is defined as the

actualisation of an organization's agenda in order to achieve its goals. It is in effect the organization's pragmatic stance towards its own needs that takes the idealised concept of advanced practice, selects appropriate elements which serves its purpose and disregards elements for which it has no immediate need. In other words, once key actors within the organization have identified the elements that can be delegated to the ANP, they integrate the innovation within the framework of the institutional agenda while being cognisant of the available resources. Consequently, the process of organizational governance creates the situational variables that dominate the parameters within which practice is expected to be reconstructed. In this way, the structure and situational demands of the practice setting become powerful socializing agents of the new work role (Lurie, 1981; Christman, 1991) and not the idealised notion of advanced practice that prevailed in stage one. Consequently, the limits and boundaries of the ANP's scope of practice in this situation are determined locally, rather than conforming to any nationally agreed (or idealised) practice standards or criteria. In other words, the nature of the clinical environment, the availability of resources, and the institutional agenda sanction the extent of the ANP's practice. Consequently, while multiple interpretations of advanced practice are socially constructed, ultimately it is the organizational agenda and the availability of resources which act to limit the extent of role transition. Such structural and organizational characteristics have been recognised as being crucial to the successful integration of advanced practitioners into their practice setting (Sullivan et al, 1978; Ventura, 1988). In this sense it was recognised nearly twenty years ago

297

in the USA that the availability of resources, rather than the nature of the practice setting, was likely to be linked with the *rate* of implementation of advanced practice nurses (Zammuto *et al*, 1979). The evidence from this study clearly supports that this holds true in the UK today.

One further feature of organizational governance is the development of what can be termed transitional relationships. Whilst the nature of these relationships vary according to the orientation of role transition, initially they serve to provide support and facilitate the reconstruction of practice. The evidence from this study however indicates that they also act on another level to temper or extend the scope of role development according to the dominant organizational agenda. In other words, the use of such tactics as joint accountability along with reconstruction of new professional relationships can be seen as strategies for maintaining organizational governance which ultimately serve to reinforce the subordinate status of advanced practitioners. This phenomenon is illustrated nowhere more clearly than in the scope of discretion ANPs are afforded in their practice.

Nicholson (1984), in his theory of work role transitions, predicted that discretion along with work role novelty, were the key variables that had a direct bearing on the outcome of adjustment to a change in role. He stated that the degree of discretion afforded an individual, i.e. the role incumbent's opportunity to alter the components, parameters and relationships of the job, was positively related to the outcome of work

298

role transition. He suggested that jobs with low discretion (combined with low novelty) resulted in "replication" whereby there was little change in role or personal development, whereas the mode of adjustment when discretion was high (combined with high novelty) led to what he termed "exploration", whereby there was considerable role and personal development. Although Nicholson (1984) did regard discretion as a "multidimensional construct", the evidence from this study reveals that his interpretation of the concept requires further refinement. It is suggested here that when discretion relates to an institutional context which is traditionally bound by hierarchical bureaucracies, the concept of discretion needs to be considered in different terms. In this study, discretion could be seen to exist in two different dimensions: "within-role" discretion and "organizational" discretion. Within-role discretion relates to the amount of discretion (and autonomy) an individual has *within* the parameters of a given role. On the other hand, organizational discretion can be considered as a means to exert influence over the parameters of role transition. In this study there is clearly evidence to suggest that an ANP role is contingent upon organizational discretion and it is this which in turn governs the nature and degree of within-role discretion. The parameters of role transition are determined from a perspective of organizational governance, with ANPs having varying degrees of discretion within the scope of their day-to-day practice. Utilising Nicholson's (1984) interpretation of discretion to examine the data from this inquiry could suggest that the ANPs had a high degree of discretion and were thereby free to develop and reconstruct their practice as they desired. However, as has been discussed earlier,

organizational governance sanctions the level of discretion afforded to the individual

practitioner so that while it is possible for the practitioner to have a relatively high

level of discretion within their role, at the same time they can have a low level of

discretion to alter the parameters of that role. Consequently, the construct of

discretion, as discussed by Nicholson (1984), needs to be defined and considered

in both contexts or, to be considered differently in low-discretion environments such

as nursing (West & Rushton, 1989). The evidence from this study suggests that

within-role discretion undoubtably facilitates role development, but the extent of

practice reconstruction remains dependent upon how the parameters of role

transition are determined, which ANPs have only low to moderate discretion in

helping to define.

The nature of organizational governance indicates then that the innovation of the

ANP is targeted and controlled by the organization, at least initially, to perform

specific functions. This phase can be considered to be the stage whereby the

institution mandates how the advanced practitioner role will evolve and to what ends

it serves. In this sense, organizational governance is a continuous state in the same

way in which role socialization can be viewed as a continuous process (Rubin, 1988).

For the purpose of this discussion however, organizational governance can be seen

to exert most influence when ANPs test the parameters of their role and discretion

against the system during the first year they engage in practice on a full-time basis.

Consequently, this period is characterised not only by changes in the seven

domains of reconstruction, but a continuing cycle of exploration and challenge between the ANP and other stakeholders in the institution.

9.4 STAGE 3: RESOLUTION

The third stage that ANPs experience as a result of the contingent nature of reconstruction has been termed resolution. Resolution in this context does not necessarily signal arrival at a point of mutuality between the ANP and the organization, but reluctant acquiescence and acceptance on the part of the advanced practitioner. Chronologically, this stage was found to emerge toward the end of the second year of implementation. It was at this point that ANPs acknowledged the limitations to role enactment imposed via organizational governance which up until this stage they had frequently challenged. Arrival at this phase then indicates the passage from idealism, through the exploration, challenges and conflicts characterized as responses to organizational governance, and final acknowledgement and acceptance that idealised goals are unattainable and that control is maintained by the institution. It is at this time that other stakeholders also come to accept the ANP in the performance of their role. In other words, ANPs come to accept the contingent conditions as they are apply to their own situation and acknowledge the limits of their development at this specific point in time. The extent to which reconstruction has been realized does not appear to be an indicator that this phase has been reached. The evidence from this study shows instead that a range of outcomes related to role transition, from minimal adjustment to extensive changes,

had been achieved by the time this stage was entered by ANPs. The most likely interpretation of this phenomenon is that challenging organizational governance is time limited, whereby ANPs reach a point where they consider further challenge to the "system" to be futile.

Paradoxically, the resolution phase, whilst signalling acquiescence on the part of the ANP can also be considered to be the stage when the ANPs (in most cases) become most effective. In other words, not only have the ANPs become more skilled in the roles and responsibilities their new post demands but they have ceased to challenge the "system", choosing instead to work within the limitations imposed through organizational governance. In this sense, as was pointed out by Van Maanen & Schein (1979) the influence of the organization peaks during the passage between roles (i.e. at the organizational governance stage) whereas the point at which the individual has greatest impact on the organization peaks well after the movement between roles (i.e. at the resolution phase of reconstruction).

The resolution stage is also characterised by the re-emergence of the ANP as a "key" stakeholder in that whilst they have acquiesced to reconstruct their practice within the limiting contingent conditions, they begin further re-negotiations of the parameters of their role with the other key stakeholders. On this occasion however not only do they acknowledge the nature of contingent conditions within the organization, but frame their ideas and suggestions within the constraints imposed

upon them.

The contingent nature of reconstruction can be conceptualised as a three stage model which helps to provide a chronological overlay of the transitional process (Figure 9.1). As is indicated in the figure, the model can be seen as linear with the ANP experiencing each stage fully, before moving onto the next in sequence. The model is not intended to portray the socialization experience of ANPs, but to explain how both the process of reconstruction (discussed in the previous chapter) and the outcome of role transition (discussed in the next chapter) occur differently between practice settings.

Figure 9.1 Three stage model of contingency

Stage 1	Stage 2	Stage 3
Idealism ———▶	Organisational Governance ———▶	Resolution
Related characteristics	Related characteristics	Related characteristics
Emerges throughout 1st year & Master's degree. Multiple constructions of advanced practice. Omni-directional focus. Enthusiasm. ANP+ Managers + Snr Medics = key stakeholders	Emerges throughout 2nd year - post-graduation. Organisational constructs of advanced practice applied to institutional agenda . Uni-directional focus. Conflicts & Challenge. Managers + Snr Medics = key stakeholders.	Emerges toward end of 2nd year onwards. Contingent nature of practice acknowledged. Uni-directional focus. Acceptance & acquiescence. ANP + Managers + Snr Medics = key stakeholders

Whilst this model serves to illustrate the contingent nature of reconstruction it shares some similarities with theoretical frameworks developed elsewhere that have been generated to explain the transitional process in which advanced practitioners and other nurses engage (Hamric & Taylor, 1989; Page & Arena, 1991; Bass *et al*, 1993; Boyle *et al*, 1996) along with theories of socialization (Merton, 1957; Feldman, 1976; Wanous, 1977: 1992; Van Maanen & Schein, 1979; Jones, 1986). The main difference between those frameworks which attempt to conceptualise the transition of nurses into advanced practitioner roles and the model of contingency described above, concerns how reconstruction is conceptualised. Whilst these staged models portray role transition as a series of phases such as orientation, frustration, and implementation (Hamric & Taylor, 1989) their main focus is in attempting to theorize the "content" of role transition. That is to say that they attempt to explain the way in which practice is reconstructed as a process in terms of a series of stages. What is asserted in this thesis is that the way in which some of these models propose practice is reconstructed have intertwined stages of transition with stages of contingency. As a result, they tend to confuse the two concepts. As an example, the second stage in the Hamric & Taylor (1989) model was identified as the frustration phase and was experienced by 95% of CNSs in their first position. The frustration phase is said to be:

> "...a powerful and disconcerting experience, characterised by feelings of discouragement and inadequacy as the CNS's initial assessment reveals unrealistic personal or organizational expectations, overwhelming problems, and the realization that making change is more difficult and slower than originally expected". (Hamric & Taylor, 1989, p52)

304

Situational characteristics, such as lack of clear role definition, conflicting expectations with colleagues and staff resistance were amongst the reasons cited as contributing factors to the identification of this phase. Clearly, this stage bears similarity to stage two of the contingency model outlined above, but is in this case intended to describe the way in which practice is reconstructed. This example serves to illustrate the point that the definition of the frustration phase has little to do with explaining the content of role development and more to do with revealing how manifestations of organizational governance result in frustration for practitioners. Whilst this example is the most extreme case of confusion between the contingency of role transition and the content of reconstruction, there is evidence of a similar tendency for other models to discuss these clearly discrete concepts interchangeably.

Likewise, the three stage model of contingency shares similarities with various theoretical frameworks which have been developed to explain the process of organizational socialization (for example see: Feldman's three-stage contingency theory of socialization [Feldman, 1976]; Buchanan's three-stage early career model [Buchanan, 1974]; Schein's three-stage socialization model [Schein, 1978]). Once again there are problems of comparison here as a number of these models relate to newly hired employees. Moreover, the model of contingency described above is not intended to represent a theoretical framework of socialization. Undoubtably however, the model of contingency does have a number of characteristics in common with

theories of socialization and therefore some discussion is merited.

The first stage of the model, idealism, is analogous to the "anticipatory socialization" stage expressed in a number of models in which unrealistic expectations are identified (Merton, 1957; Feldman, 1976; Wanous, 1977;1992). However, as discussed above the reasons why expectations are idealised in this study are specific to advanced practitioners and concern the ambiguity of the concept of advanced practice and the UKCC's desire to promote nursing. Generalizing the idealism stage to the role transitions encountered in other fields may clearly be inappropriate. Likewise, the second stage, organizational governance, has a number of commonalities with the encounter or accommodation stage of the socialization process which is responsible for shaping the individual's long-term orientation to their work role (Louis, 1980). It is at this stage, as it was in this study, that the individual experiences the "reality shock" (Hughes, 1958) that their initial expectations regarding the work role transition are unlikely to be met. Furthermore, it was at this stage in the transition of ANPs that the idea of socialization being used as a "control mechanism" to maintain the status quo in the organization (Etzioni, 1964) was at its most intense. The third stage of the model, resolution, shares features in common with the adaptation stage of the socialization process which is seen to be an end state (Louis, 1980) where an individual adapts to the organization, its rules, customs and expectations. In this sense there is role acceptance and implementation on the part of the ANP, however, the rules and customs of the organization were already

known to the ANP and so it is on this point that "resolution" and the "adaptation" stages vary. It has however been established that regardless of prior socialization experiences that each major role change involves socialization to the new role, even if the change in roles is within the same organization (Van Maanen & Schein, 1979; Louis, 1980). In this sense the practitioners in this inquiry can be considered to have undergone a process of "resocialization". What the model of contingency indicates is that while prior socialization into the organization in someways eases role transition, ANPs:

> "... may be unprepared for the attitudinal changes inherent in the [new] role...[and] may find that behaviours and attitudes useful in earlier nursing roles do not lend themselves to autonomous practice and equal relationships with other health professionals" (Lukacs, 1982, p21)

In circumstances such as these, it is likely that personality traits and characteristics of the individual play an important part in mediating and adapting to the resocialization process. Interestingly, and contrary to expectations, the evidence from this study revealed that those ANPs who perceived themselves to be "risk-takers" or who were readily prepared to challenge other key stakeholders during the organizational governance phase, did not necessarily progress more rapidly during the transitional process. On the other hand, those ANPs who initially lacked confidence and were less prepared to openly challenge key stakeholders progressed in their role more readily, although not always in ways they desired. Consequently, while the findings of this study dispute assertions that personal characteristics such as a lack of assertiveness or confidence necessarily inhibit role development

(Hayden *et al*, 1982), they do indicate that the management of role transition is generally problematic regardless of personality traits.

Given the novelty of the role of advanced practitioner, it is suggested that the ambiguity of the ANP identity and multiple interpretations of the concept of advanced practice result in uncertainty in terms of the way in which the ANP is expected to be socialised into their new role. Consequently, theories of socialization which relate to the entry stages to an established work role may be inappropriate to apply to the case of advanced practitioners who were the subject of this study. That ANPs undergo role socialization is not in dispute, merely that the combination of factors which have been discussed make it a highly individualised and contingent experience.

9.5 CONCLUSION

Just as contingency theory recognises that there are many possible means to attain a given end (Strasser, 1983), the contingent nature of the reconstruction of nursing indicates that there are many situational variables that influence the process and outcome of role transition. The findings from this study indicate that the most powerful factors influencing the transitional process of ANPs are exerted by a process of organizational governance. It is the contingent nature of reconstruction imposed by the institution that dominates the resocialization process of moving from an experienced nurse to advanced practitioner, regardless of the effect of individual

or job variables. This is somewhat contrary to the view expressed elsewhere in the literature that the outcome of work role transition is equally influenced by individual, job and organizational variables (Black & Ashford, 1995).

At this point it is worth considering the future and contemplating whether the reconstruction of nursing will continue to remain reactive in nature, or whether the position will change. Brown & Olshansky (1997) suggest that the nature of the changing environment can present problems to new nurse practitioners who are vulnerable during their transition. However, in this study it was not only the nature of the environment but the problem of novelty and differing interpretations of the concept of advanced practice which made ANPs vulnerable. Whilst the concept of advanced practice remains ambiguous in the UK, retrospective and reactive reconstruction is likely to continue. On the other hand, with increasing numbers of courses and graduates, along with empirical studies such as this, greater clarification and consistency in interpretation of the role may emerge. For the time being, however, the evidence from this study indicates that multiple reconstructions of practice take place, resulting in discrepancies in the rate of transition, practice orientation, skill and knowledge base, outcomes and so on. That advanced practitioners share a common theoretical grounding appears to have little impact on these factors. Furthermore, that reconstruction is reactive in itself is not totally unexpected and need not necessarily be perceived as a negative consequence, as role transition in this sense can be viewed as being responsive to local need and

conditions. This does make role transition difficult and problematical for the practitioners as the expectations upon them are considerable and not always in accordance with their own. In addition, the reactive status of reconstruction also creates problems for nursing's governing body, the UKCC, in terms of its need to arrive at a list of common competencies that can be used to distinguish the advanced practitioner from a specialist practitioner or experienced nurse. The findings from this study indicate that reconstruction can be considered to be a relatively unique experience for each individual within each organization and one that is not easily generalised. The three stage model of contingency serves to explain the variance in both the process and outcome of the role transition of advanced practitioners. While the concepts it addresses have been discussed elsewhere, the way in which the model is presented illustrates a sequence of events which help to locate the concept of reconstruction in the context of the individual's social environment.

CHAPTER TEN

DISCUSSION III: THE OUTCOMES OF RECONSTRUCTION.

CHAPTER 10. DISCUSSION - THE OUTCOMES OF RECONSTRUCTION

10.1 INTRODUCTION

The final chapter of this thesis examines the outcomes of practice reconstruction. The following discussion takes account of not only the early stage in the evolution of the ANP role in the UK, but also the limitations associated with the brevity of this study. The following exposition explores the study's findings regarding the outcomes of role transition, as well as considering the future impact of the continuing development of the advanced nurse practitioner role. To date, the discussion has illustrated the different ways in which practice is reconstructed when the orientation of role transition is focused toward either the delivery of direct care, or the system of care delivery. Furthermore, a model of contingency has been presented to illustrate how the process and outcome of role transition are influenced by a variety of factors in the social setting. The following argument develops a simple classification of role transition outcomes and demonstrates their relationship to the contingent conditions outlined in the previous chapter. It will be contested that the outcomes of practice reconstruction can be considered to exist on two conceptual levels. The first, which has been termed the "operational outcome", relates to a concept of practice reconstruction which to a large extent is observable in the roles, behaviours, skills and relationships of the advanced practitioner. The second, and arguably more subtle outcome, concerns the beginnings of a change in professional identity associated with the role transition from experienced nurse to advanced nurse practitioner. The chapter concludes by addressing the implications for the

establishment of a new professional identity for both practitioners and the nursing profession as a whole.

10.2 OPERATIONAL OUTCOMES.

10.2.1 THEORETICAL FRAMEWORK

In arriving at a set of operational outcomes, Nicholson's (1984) theory of work role transitions was utilised as an initial theoretical framework against which to judge the outcome of practice reconstruction. Whilst Nicholson's (1984) theory was posited over a decade ago, it has been utilised in a number of recent studies to explore the phenomenon of work role transition (see: Black & Ashford, 1995; Glen & Waddington, 1998). The results of these, and other studies have found varying degrees of support for the theory and whilst some suggest modifications to the framework, the fundamental propositions of the theory have not been significantly challenged. The use of this theoretical framework in discussing the operational outcomes of role transition for the ANPs in this study, is therefore, considered appropriate. Before discussing the operational outcomes of role transition identified in this thesis however, it is necessary to briefly revisit the principal elements of Nicholoson's (1984) theory.

Nicholson (1984) proposed that there were four modes of adjustment to the transition into a new work role: replication; absorption; determination; and exploration. He suggested that when personal and role development were measured using the key

313

variables: discretion; novelty; desire for feedback; and desire for control, the outcome of any work role transition could be located into one of four adjustment modes. While specific measurement scales and instruments were not used in this study, the general concepts of personal and role development, along with the key variables as identified and dimensionalised by Nicholson (1984), were used as a theoretical framework in which to examine the results of data analysis. As Nicholson's (1984) theory was extensively evaluated in the literature review, the matrix illustrating the different modes of adjustment along with their associated dimensional properties is provided in Table 10.1 as a reminder.

Table 10.1 Nicholson's (1984) theory of work role transition - modes of adjustment and the relationship of the key variables dimensionalised at low and high extremes.

Key variables -> Adjustment mode	Role Development	Personal Development	Novelty / Feedback	Discretion / Control
Replication	Low	Low	Low	Low
Absorption	Low	High	High	Low
Determination	High	Low	Low	High
Exploration	High	High	High	High

Following comparison of Nicholson's (1984) modes of adjustment with the outcomes of role transition that were observed in this study, it was decided that some adaptation was required in order to accommodate the data. This took the form of reducing Nicholson's (1984) four modes of adjustment to three and re-naming two so that they more accurately reflected the findings of the study. This procedure required a revision of the relationships between the four key variables (see Table 10.1) and the adapted modes of adjustment developed following analysis of the data. The

314

necessity to perform these operations was borne out of the uniqueness of the work role transition undertaken by advanced practitioners and the need to take account of the contingent nature of practice reconstruction, to which Nicholson (1984) appears to have given only cursory consideration.

10.2.2 ARRIVING AT OPERATIONAL OUTCOMES

Following analysis and consideration of the data, three operational outcomes of practice reconstruction were eventually developed: practice replication; practice fragmentation; and practice innovation. The relationship of these outcomes with those identified by Nicholson (1984) is illustrated in Table 10.2.

Table 10.2 Development of operational outcomes of practice reconstruction from Nicholson's (1984) four modes of work role transition adjustment.

Nicholson's (1984) modes of adjustment		Corresponding modified operational outcome
Replication	——>	Practice Replication
Absorption	——>	Practice
Determination	——>	Fragmentation
Exploration	——>	Practice Innovation

When Nicholson's (1984) theory was first developed, it was intended for use as a "grand" theory to enable prediction of the outcome of work role transitions in a wide variety and types of organizations. The desire to refine and adapt the theory for the purpose of this study was based on the wish to apply an appropriate theoretical

framework and its principles to the phenomenon of increasing numbers of nurses undergoing work role transitions. In addition, the need to develop a conceptual framework in which account could be taken of the unique characteristics and organizational structures in which nurses are employed became equally apparent. In this context, it was considered that the contingent nature of practice reconstruction and its impact on the outcome role transitions was insufficiently developed by Nicholson (1984). However, it was felt that the basic principles underlying his theory could be suitably adapted for the purpose of this study. This thesis then serves to develop and apply Nicholson's (1984) conceptual framework to a specific occupational group, whilst at the same time seeking to make the theory more robust.

10.3 OPERATIONAL OUTCOME CRITERIA

The three outcomes of practice reconstruction are explained below along with the criteria which were utilised in their generation. Moreover, the relationship between Nicholson's (1984) modes of adjustment and those developed in the context of this study will be illustrated. In addition, the association between the key variables: role development; personal development; novelty; and discretion, and the adapted outcome modes of adjustment will be discussed.

10.3.1 PRACTICE REPLICATION.

The first operational outcome of practice reconstruction to be addressed relates to the concept of "practice replication". This outcome shares many conceptual

similarities with Nicholson's (1984) idea of replication as one potential mode of adjustment in work role transition. He describes replication as:

"... those transitions that generate minimal adjustment to personal or role systems. The new incumbent makes few adjustments in ... her role identity or behaviour to fit into the new role and makes no changes in role requirements. The person performs in much the same manner as in previous jobs and also in much the same manner as previous occupants." (Nicholson, 1984, pp175-76).

Replication in this case can be seen to be characterised by low degrees of personal and role development. Consequently, the individual also encounters low levels of novelty and discretion (see Table 10.1) and hence minimal changes in work role occur. The evidence from this study indicates however, that Nicholson's (1984) propositions fail to fully take into account the contingent nature of work role transition and movement into a role which in itself is both new to the incumbent and the organization. The four key variables identified by Nicholson (1984) can however be developed further to fully explain the concept of practice replication.

Nicholson (1984) argues that when (practice) replication occurs, personal development is low. He argues that there is little personal change in identity, abilities, skills, values or frame of reference. While this may be accurate for individuals moving between established jobs, the evidence from this study suggests the contrary where the role is new to an organization and the individual. In the case of ANPs, undergoing transition required formal academic preparation at the Master's degree level, inevitably resulting in some degree of personal development. In the one case

where practice replication was the outcome, the ANP experienced a change in identity, values and frame of reference. Moreover, while there were only minimal changes in her psychomotor and clinical skills, cognitive development was acknowledged to have taken place. Consequently, in contrast to Nicholson's (1984) theory, it is argued that in this set of circumstances, personal development can be seen to occur. Thus, low personal development may be identified as a key variable by Nicholson (1984) to explain the replication mode of adjustment to a new work role, but in the context of this study the evidence indicates a contrary point of view.

On the other hand, Nicholson's (1984) articulation of the concept of role development and its association with the corresponding modes of adjustment is more consistent with the findings of this study. Nicholson (1984) argued that replication results when there is little change to the parameters or requirements of the work role and the person performs in much the same manner as in previous jobs. The evidence from this inquiry clearly indicates that the ANP performed in much the same way following preparation for the new role as she did prior to entering the transitional process (i.e. practice was replicated). Consequently, role development in the sense of:

> "...changes in task objectives, methods, materials, scheduling, and interpersonal relationships integral to role performance" (Nicholson, 1984, p175),

can be considered to have been low. The main reason for this phenomenon occurring appears to have been due to the inhibiting nature of the contingent conditions which prevailed in the organization at the time of practice reconstruction.

Nicholson (1984) acknowledges that:

"Role development varies according to the constraints and opportunities of the role and the needs and expectations of the person." (Nicholson, 1984, p175)

However, he appears to underestimate the influence that contingent conditions may exert on the transitional process.

The next variable to consider in the discussion of the outcomes of role transition is the concept of novelty. According to Nicholson's (1984) theory, novelty is associated with the degree to which prior knowledge, skills, and activities can be utilised in the performance of the new work role. Low levels of novelty are associated with the concept of replication, in that the individual primarily utilises existing knowledge and skills in the performance of the new work role. In the context of this study, practice replication conforms to this notion, as one ANP acknowledged:

"... it's [work role] not really that new at all. Some bits are, but a lot of it is what I was already doing before". (case 1).

The fact that the ANP was experiencing low levels of novelty in this case was primarily due to the contingent conditions which were preventing her from developing new and novel practices. When utilising novelty as a predictor variable, it is suggested that one needs to be cognisant of the nature and influence of contingent conditions.

The final key variable to consider in relation to practice replication is Nicholson's (1984) concept of discretion. As discussed in the previous chapter, this concept

needs to be considered as a multi-dimensional construct, which in this thesis has been identified as comprising "organizational" as well as "within-role" discretion. The degree of discretion afforded the individual when practice replication is the resultant outcome of transition, varies along each dimension. The individual can have high levels of within-role discretion, but low levels of discretion to move outside of the parameters of the new work role as it had been constructed under the aegis of organizational governance. Discretion can therefore be more readily utilised as a predictor variable when measured in conjunction with the degree of "role" development experienced by an individual.

The relationship between Nicholson's (1984) four key variables and the outcome of role transition classified as practice replication, is illustrated in Table 10.3.

Table 10.3 Relationship between Practice Replication and key variables.

Outcome / Variable>	Role Dev	Personal Dev	Novelty	Ind discretion-Organization
Practice Replication	Low	Moderate	Low	Mod/High < - > Low

In the context of this study, this outcome would suggest that the transition from experienced nurse to advanced nurse practitioner has to a large degree failed to succeed. This conclusion is based on the evidence which reveals that little of what the ANP role involves, in terms of activities, roles, responsibilities and so on, can be considered to be different from the way in which the ANP was practising prior to entering the transitional process.

10.3.2 PRACTICE INNOVATION

The outcome of role transition at the opposite end of the continuum from practice replication, has been termed "practice innovation". Practice innovation has been used to replace Nicholson's (1984) corresponding mode of adjustment which he referred to as "exploration". The change in terminology identifies the concept as one that is more commonly used and understood within practice based disciplines. For Nicholson (1984), exploration is the mode of adjustment that relates to simultaneous changes in role parameters and personal qualities affecting the outcome of work role transition. In the context of this thesis, practice innovation is defined as the reconstruction of practice, requiring the development of: new skills, activities and roles; a change in practice parameters; increased practice independence and autonomy; and changes in personal qualities. Utilising the four variables associated with work role transitions it is possible to illustrate the essential differences between practice innovation and the outcome of practice replication discussed earlier.

The first variable, role development, is the single most important indicator that practice innovation has occurred. Moreover, the more extensive the degree of role development the more radical the nature of practice innovation. When the transition involves the practitioner undertaking largely new and novel practices that have either traditionally been the prerogative of other disciplines, or are new and unique to nursing, then practice innovation can be seen to occur. By its very nature, role development in this context, which involves a considerable change in cognitive skills,

practice activities and parameters, leads to a high degree of personal development. This is not only because the ANP develops and learns new skills and information, but is also associated with a change in practice values. Sometimes however, this new set of values may be dissonant with the ANP's existing nursing values, dependent upon the nature of the role transition. In other words, the effect of contingent conditions, particularly during the organizational governance stage, may result in the practitioner developing her role in radically new ways, which, may be at odds with her own values of how the advanced practice role should be developed.

The third variable, novelty, is also by the nature of practice innovation experienced to a high degree, primarily for the reasons explained above. Likewise, with regard to the final variable discretion, when the outcome of role transition is practice innovation, ANPs experience a substantial change in the amount of discretion that they are afforded within their role (when compared to other nurses or measured against their old role). Yet again however, the ANP can experience little discretion to move outside of the prescribed parameters of practice reconstruction. Consequently, just as with practice replication, organizational governance can be seen to regulate the degree of organizational discretion the ANP is afforded. As discussed in the previous chapter, it is the contingent conditions within the practice setting which to a large degree determine if circumstances are either detrimental or favourable for practice innovation to occur.

The relationship between Nicholson's (1984) four key variables and practice innovation is illustrated in Table 10.4.

Table 10.4 Relationship between Practice Innovation and key variables.

Outcome / Variable	Role Dev	Personal Dev	Novelty	Ind discretion-Organization
Practice Innovation	High	High	High	High - Low

10.3.3 PRACTICE FRAGMENTATION.

The third possible outcome of role transition is termed "practice fragmentation". This outcome replaces two of Nicholson's (1984) modes of adjustment, namely, "absorption" and "determination". Neither absorption or determination are considered to be applicable to work role transitions which involve the development of a role which is both new to the individual and the organization.

Nicholson (1984) describes absorption to be the outcome of a transition in which the individual is not required to modify the parameters of the new role, but instead bears the burden of learning the skills, knowledge and behaviours required to perform in the role. However, in the case of advanced nursing practice, the role itself is new and has no established parameters in a general sense, as such, it is not possible at this stage in time for absorption to be a possible outcome.

Determination on the other hand, is epitomised as being the opposite to the absorption mode of adjustment. The incumbent of the new job is seen to possess the knowledge, skills, and abilities to be able to perform in the new role. Thus, whilst the

323

individual is relatively unaffected by the transition, they are able to adjust the parameters of the role. As nurses in the UK have only extended their roles by taking on additional tasks in the past, few, if any, are in a position at this time to have acquired all of the skills, knowledge and abilities to meet Nicholson's (1984) concept of determination. So, whilst these two modes of adjustment *will* be applicable in the future (i.e. when advanced practice roles have become established and the cadre of advanced practitioners have increased in number and competence), in the context of the current stage of development of advanced practice roles in the UK, where practice is undergoing an initial period of reconstruction, neither outcome is appropriate or likely. The evidence from this study indicates however, that a third outcome of role transition is evident and which lies between the extremes of practice replication and practice innovation, namely, "practice fragmentation".

Practice fragmentation occurs as a direct result of the pressures exerted by the contingent conditions in an organization. Those factors of particular relevance are: organizational governance; deployment; and resource availability. Practice fragmentation refers to those cases where ANPs attempt to develop and implement a new role on a part-time basis. In such cases, ANPs experience both practice innovation when acting in an "advanced" capacity and practice replication when undertaking their "traditional" nursing duties. The demands and requirements of the organization are central in leading to this situation, which in turn, can be seen to retard the rate of practice reconstruction.

Where practice fragmentation occurs, role development can be classified at best as moderate, in terms of both rate and scope. This is because whilst the ANP is performing new activities which require the use of new skills, behaviours and knowledge, the rate of role development and practice competency are retarded due to the requirement of having to perform in a traditional nursing capacity for part of the time. Just as there are varying degrees of role development, there are corresponding degrees of personal development. As Nicholson (1984) himself observed, a certain amount of personal development is an inevitable consequence of role development. The evidence from this study indicates that those factors associated with personal development were seen to increase in parallel with role development. Consequently, some ANPs reported high levels of personal development whilst others reported moderate levels of personal development.

Likewise, the variable novelty, corresponded to the amount of time in which the study participants were involved in developing the advanced practitioner role, along with its scope and orientation. The final variable, discretion, remains constant in this mode of adjustment, as it is in the other two. Thus, when practice fragmentation is the outcome of role transition, ANPs once again experience moderate to high degrees of discretion within their role when acting in an advanced capacity, but low levels of discretion to alter the parameters of their practice.

The relationship between Nicholson's (1984) four key variables and the practice

325

fragmentation outcome of role transition are illustrated in Table 10.5.

Table 10.5 Relationship between Practice fragmentation and key variables.

Outcome / Variable>	Role Dev	Personal Dev	Novelty	Ind discretion / Organization
Practice fragmentation	Moderate	Mod<—>High	Moderate	Mod<—>High / Low

Practice fragmentation therefore, can be seen to comprise elements of both practice replication and practice innovation. In this sense, advanced practice can be perceived of as both a contingent and transient state, with the ANP moving toward opposite extremes of the practice continuum as conditions encountered within the organization dictate (Figure 10.1).

Figure 10.1 The transient nature of advanced practice associated with the outcome of practice fragmentation.

Contingent conditions

| Practice | Practice | Practice |
| Replication | Fragmentation | Innovation |
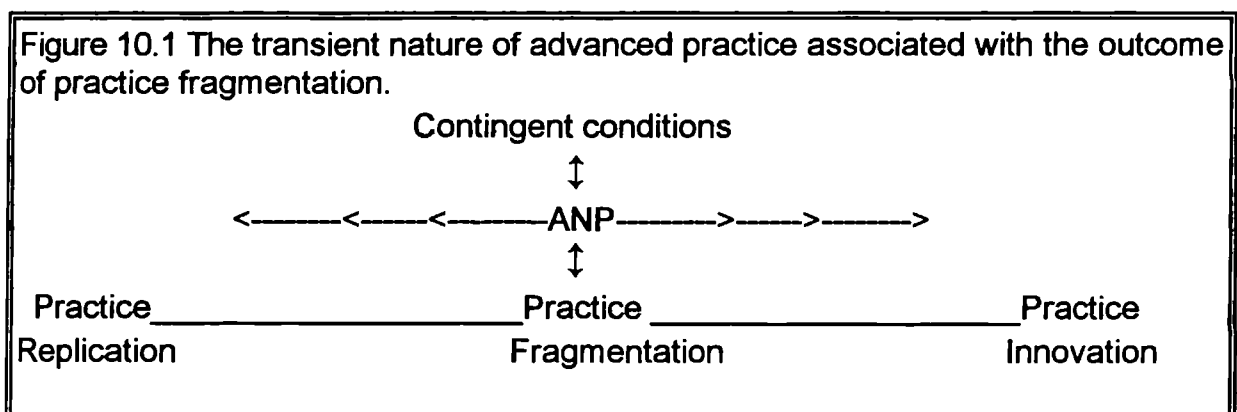
10.3.4 OPERATIONAL OUTCOMES OF PRACTICE RECONSTRUCTION - SUMMARY

It is now possible to construct a simple classification system (Table 10.6) to illustrate the relationship between the outcomes of practice reconstruction and Nicholson's (1984) key variables. It is also possible to account for the nature and effect of the contingent conditions ANPs encountered during the process of practice

326

reconstruction, on the outcome of transition. Whilst Nicholson's (1984) theoretical

framework provided an initial basis for discussion of the data, it was necessary to

adapt his model to provide a more coherent and conceptually congruent framework

in which account could be taken of the transition into work roles which are both new

to the individual and the organization.

Table 10.6 Matrix illustrating the relationships between the outcome of practice reconstruction and selected variables allowing for the effect of contingent conditions for each case study ANP.

Outcome mode>	Practice Replication	Practice Fragmentation	Practice Innovation
Case study No.	1	2, 4 & 5	3
Role Dev.	Low	Moderate	High
Personal Dev.	Moderate	Mod<—>High	High
Novelty	Low	Moderate	High
Discretion / Org*	Mod <—> High/Low	Mod<—>High / Low	High / Low
Contingent Cond.	Impedient tendency	Compromise tendency	Liberating tendency

* Org = organizational discretion

As can be seen in Table 10.6, contingent conditions exert two effects on the nature

of practice reconstruction; impedance or facilitation. When both tendencies are

present within the same environment, the result is compromise and practice

fragmentation.

It is possible, that as organizational and contingent conditions are dynamic in

character, that in the future ANPs may move between the three outcomes of role

transition. Thus, whilst the three outcomes of practice reconstruction remained

stable for the duration of this study, changing contingent conditions in the future may

lead to ANPs experiencing different outcomes at different times. This conclusion is

in keeping with Nicholson's (1984) assertion that:

> "... transition is above all else a process through time, and outcomes can be
> expected to shift from one adjustment mode to another. Individual differences
> in motives and affective reactions will play a major part in mediating these
> shifts". (p177).

In this sense advanced practice is likely to be a potentially transient state.

10.4 OUTCOMES OF ROLE TRANSITION IN STUDIES OF ADVANCED NURSE PRACTITIONERS

The operational outcomes described above vary considerably, in conceptual terms,

from those identified in other studies of transition in advanced nurse practitioners.

The main point of departure of this thesis, can be seen in terms of the identification

of three possible outcomes of role transition. Most studies which have explored role

transition in advanced practitioners demonstrate a tendency to suggest that only a

single outcome occurs following a linear transitional process (Anderson *et al*, 1974;

Oda, 1977; Hamric & Taylor, 1989; Brown & Olshansky, 1997). Hamric & Taylor

(1989), in a study of clinical nurse specialists, identify this stage as

"implementation". In a much earlier study, Anderson *et al*, (1974) proposed that

nurse practitioners achieved a unified state of "professional intimacy" at completion

of their training. Likewise, Oda (1977) suggests all specialist nurses achieve a state

of "role confirmation" on conclusion of role transition. More recently, Brown &

Olshansky (1997) studied the transitional process experienced by primary care nurse

practitioners in the USA and concluded that over time they arrive at a stage which is termed "broadening the perspective". According to the authors, this was a stage where practitioners ultimately became effective within the system. None of these studies identify that alternative outcomes are possible, only that the relevant outcome varies in terms of when it is achieved. Once again however, these studies originate in North America and therefore it is possible that cultural, educational and health care system differences account for the variance between their findings and those of this inquiry. An alternative explanation of why different outcomes were identified in this study could be related to an artifact of the duration of the study period. That is to say, that arrival at a point of "practice innovation" had not been identified in all cases because data collection ceased before the ANPs had the opportunity to successfully complete their transition.

Other studies (Bass *et* al, 1993; Shea & Selfridge-Thomas, 1997) have adopted Benner's (1984) theoretical framework of novice to expert to explain the outcome of transition. The inconsistent way in which these criteria have been applied however, creates problems in their application to the findings of this inquiry. The use of Benner's (1984) framework is further complicated because of the possibility of applying its criteria to individual *roles* an advanced practitioner performs. So for example, one ANP could be a *competent* clinician, a *novice* researcher, and *proficient* in an educational role. It is asserted here, that fragmentation of Benner's (1984) criteria to such a degree, is of only limited utility in understanding the concept

of advanced practice. Consequently, Benner's (1984) criteria were rejected as being appropriate to explain the outcome of role transition of ANPs in the UK at this time.

The operational outcomes identified by this inquiry can be seen to provide specificity to the result of role transition, rather than conforming, as other studies do, to conceptualising the outcome of practice reconstruction as a single, unified state. It is acknowledged however, that these outcomes may be indicative of the current stage in development of the ANP role in the UK, or are possibly artefacts of the duration of the study period. Nonetheless, they provide clarity to both why and how the result of reconstruction occurred as it did for the ANPs who were the subject of this study.

10.5 ESTABLISHING A NEW PROFESSIONAL IDENTITY.

In addition to the operational outcomes of practice reconstruction, the evidence from the study indicates that as a further outcome of role transition, ANPs expressly sought to gain recognition for their practice development. This can be considered to be the first stage in the establishment of a new and different professional identity. It has previously been recognised that individuals can undergo a radical change in personal identity following movement into a new work role or situation (Van Maanen & Schein, 1979). However, in the context of this study, the ANPs' desire to change their identity has implications for the professional basis of nursing and thus goes beyond the simple change in personal identity that appears to accompany any

transition (Schumacher & Meleis, 1994).

It is asserted here that, regardless of the operational outcome of role transition, the ANPs' determination to seek recognition and to establish a new identity remains constant. In other words, whether the outcome of practice reconstruction was replication, fragmentation or innovation, the ANP still sought to have their new professional identity acknowledged and recognised by others. Interestingly, at one level, the ANPs motives for seeking recognition appeared to differ according to the operational outcome of role transition that was achieved.

In the one case where practice replication was the outcome, the reason for seeking recognition and a change in identity appeared to be closely related to the concept of "legitimacy". That is to say that, if practice replication is simply identified using Nicholson's (1984) key variables and criteria, account fails to be taken of the possibility that the individual's performance *prior* to entering the transitional process was equivalent to that of an advanced practitioner. Thus, when utilising Nicholson's (1984) theory, cognisance needs to be taken of the existing practice orientation and competence of the practitioner prior to role transition. In this inquiry, the outcome of role transition in one case (i.e. case 1) demonstrated only minimal changes in role development and met all the criteria for practice replication. On conclusion of the study however, the practice of this ANP was considered to be at an advanced level when compared to other nurses, albeit on a sporadic and infrequent basis. In this case, the personal motivation for undergoing the transition to become an advanced

practitioner was to a large extent aimed at achieving legitimation for her existing practice activities. It was concluded that achieving legitimation primarily served the purpose of gaining formal recognition, with the aim of being clearly identified as an advanced nurse practitioner. As a result of gaining recognition, the ANP was seen to be not only different in terms of her capabilities, skills and practice activities, but to have a changed status and identity within the organization.

When practice fragmentation was the outcome of reconstruction, ANPs in effect had a dual identity. When they were performing in their old role as part of the nursing establishment, their identity was that of a member of the nursing team. When they were deployed in an advanced capacity however, ANPs assumed a different identity, to which was attached a variety of practice or managerial privileges. During this time, ANPs asserted their authority in their new role in different ways, depending upon the orientation of practice reconstruction. As a result, they were treated differently by, and acted differently toward, their nursing and medical colleagues. Consequently, they too achieved a different status within the organization, albeit on a temporary and shifting basis. Whilst this phenomenon may be an artefact of the way in which new roles and duties were being performed, an equally likely explanation is that ANPs maximised the change in their identity, in order to consolidate their position in the organizational hierarchy.

The notion of establishing a new professional identity is given further substance in

the case where practice innovation was sustained as the outcome of role transition. In this instance, the orientation of practice reconstruction, which resulted in the ANP largely acting as a replacement for medical practitioners, led to her professional status and identity being viewed as similar to that of a junior doctor. That is not to say that the ANP associated her change in identity purely on the basis of assuming responsibility for some medical tasks and roles. On the contrary, the ANP demonstrated frustration at being identified as a doctor replacement. The cause of her frustration appeared to primarily stem from the desire to establish her own unique professional identity. Arguably, she saw this as a means by which she could move away from acting as a doctor replacement and develop her role in a way considered more appropriate. Hence, the purpose of establishing a new professional identity in this case appears to have been aimed toward enabling and empowering the ANP to become more autonomous. In doing so, she hoped to gain recognition and have greater control over the contingent conditions influencing her role transition. Ackerman *et al* (1996) viewed empowerment as central to advanced practice which they suggest is:

> "...consistent with a flattened organizational structure, where the administrative hierarchy is replaced by shared governance." (Ackerman *et al*, 1996, p72).

In other words, empowerment is necessary to challenge the locus of control within the organization.

Therefore, regardless of the outcome of practice reconstruction, it can be seen that

by intent or otherwise, ANPs tacitly seek to be recognised as practitioners with a unique professional identity. In the process of striving for a new professional identity however, ANPs appeared to experience a loss in belonging and personal identity during the transition period. This phenomenon is similar to that discovered in a study of neonatal ANPs in the UK (Dillon & George, 1997) whereby practitioners experienced a sense of isolation and felt that their professional identity was neither with the nursing profession, nor within the medical profession with whom they worked. This time of uncertain professional identity has been identified as a period where new advanced practitioners are susceptible to role challenge from nursing and medical colleagues (Sullivan *et al*, 1978). Maguire *et al* (1995) suggest that where practitioners experience a disparity in their nursing identity, it affects not only how they practice, but how they are perceived by other disciplines. The data supports this assertion in that, in all cases the ANPs were challenged by both nursing and medical colleagues about the scope, purpose, authority of their role, along with the ambiguous nature of their identity. At the time the challenge was at its most intense (i.e. during the first 6-9 months in clinical practice post graduation) those ANPs for whom the likely outcome of practice was either practice replication or practice fragmentation sought to apply for new positions[18]. That this was as a direct result of role challenge or because of their ambiguous identity, was inconclusive. The main

---

[18] Of the four case study ANPs to which this relates: one considered application and made informal inquiries for another position; one applied for a position in another organization but was unsuccessful following interview; one eventually was successful in securing full-time employment in a senior managerial capacity at another hospital; and the fourth combined her post with a part-time lecturer-practitioner position within the same organization.

reason given for seeking alternative employment by most ANPs was related to being unable to implement the new role as desired, due to the intervention of various contingent conditions. This is entirely consistent with advanced practitioners in other countries who cite an inability to use their practitioner skills in the practice setting as the main reason for changing jobs (Lynaugh *et al*, 1985).

In the process of seeking to establish themselves as practitioners with a unique identity, ANPs appeared to experience a conflict in their own "nursing" identity. This was most noticeable in those for whom the outcome of transition was either practice replication or fragmentation. The origin of their personal conflict was *identified* as being disenchantment with the traditional nursing roles in which they were required to engage during the transition. This led to a paradox whereby, whilst ANPs espoused the virtues of nursing and its underpinning philosophy, each sought to distance themselves from that traditional identity, in order to be recognised in their new capacity. That is not to suggest that ANPs intentionally devalued nursing or their nursing colleagues, merely that in the context of their own development, they associated themselves with a different identity. In so doing, most appeared to suppress their nursing identity in favour of seeking recognition as advanced practitioners. The notion of practitioners submerging their "nursing" identity is not new. Studies have found that *during* educational preparation for advanced practice, nurses have experienced a temporary loss of identity and skills, as a consequence of having to learn new skills and theory, more commonly associated with the practice

335

of medicine (Anderson *et al*, 1974; Roberts *et al*, 1997). However, whilst this was partly true of the nurses in this study, the apparent desire to develop a new identity continued following the educational preparation for the advanced practitioner role. A more logical explanation for this phenomenon becomes apparent when examining the assertion that a nurse's identity:

> "... appears to be influenced by certain factors such as education, philosophy, socialization, professional relationships, and the nature of clinical practice" (Maguire *et al*, 1995, p54)

If this is held to be true, that ANPs seek to establish a new identity is unsurprising. For in examining each of these elements it can be seen that: ANPs undergo separate education; develop a new philosophy of how their role should be ideally enacted; undergo role socialization that results in altered professional relationships; and, in some cases, experience substantial changes in boundaries and components of clinical practice. Moreover, these changes occur regardless of the orientation of the ANP role being directed toward the delivery of direct care or the system of care delivery. In other words, all the factors which influenced the development of the ANPs' traditional nursing identity were subjected to re-definition during their educational preparation and the subsequent reconstruction of practice. These assertions are supported by the findings of a relatively recent US study of neonatal nurse practitioners (Beal *et al*, 1996) which concluded that, advanced practitioners had only a very weak nursing identity due to the way in which the role had been enacted, but also, because of the role socialization processes in which practitioners engaged. Once again, the data is supportive of this notion in that in some cases the

institutional philosophy, which was conveyed through organizational governance, reinforced the idea that ANPs should no longer consider themselves to be nurses in a traditional sense.

Arguably however, the development of a new identity is most apparent through the status afforded the practitioner whilst they are involved in clinical practice. For the ANP whose practice is oriented toward the delivery of direct care, this is manifest by empowerment of the practitioner to make vital clinical decisions concerning patient management. That is, ANPs have greater authority and practice independence, allowing them to achieve some degree of role autonomy and discretion. It is these characteristics which are considered to be the hallmarks of professional practice (McKay, 1997). On the other hand, when role transition is oriented toward the system of care delivery, the development of a new nursing identity is embedded less in the acquisition of clinical skills and privileges, and more in the focus of the activities in which the ANP is involved. Some authors suggest that enhancing the clinical status of advanced practice nurses, by allowing them opportunities for professional growth and personal satisfaction, enhances practice development and increases the effectiveness of advanced practitioners (Ventura, 1988). In the context of this discussion however, enhancing clinical status has been seen as a factor which has enabled ANPs to take a step toward establishing a new professional identity.

In addition to being afforded varying degrees of clinical status however, the ANPs

actively sought ways in which they could be recognised as having a different nursing identity. The most obvious strategy was to adopt the formal title of "advanced nurse practitioner", which, whilst not being used during contacts with patients, was frequently used to signal a different professional identity in communication and correspondence with colleagues. In some cases, ANPs also disseminated the development of their role through professional forums. In this way, not only did they highlight the existence of their role, but took the opportunity to emphasise the difference in their practice and their identity. A legitimate question that this raises is: were these strategies simply concerned with developing personal egos or was there a more fundamental reason underlying the development of a new identity?

Arguably, the answer to this question lies in the concepts of "escapism" and "gaining professional power". The evidence clearly indicates that in all cases, contingent conditions, dominated by organizational governance, exerted influence over the process and outcome of practice reconstruction. Furthermore, whilst ANPs experience increased degrees of practice independence and autonomy, the locus of control for role development remained with physicians and nurse administrators. In some ways therefore, advanced practitioners can be seen to have simply given up one subservient role, for another with a different title. However, there were elements to the role transition which suggested that these practitioners were seeking to escape the shibboleths that have held nursing back in the past. The development of their knowledge, skill and practice base, divorced their professional identity from that of

338

traditional nurses and allowed them to experience greater practice independence and achieve recognition. In fact, recognition was fundamental to the establishment of a new nursing identity and was achieved in a number of ways. Professional recognition, afforded at a national level, is evident through the acknowledgement of advanced practitioners within the clinical nursing structure. At a local level however, there were a number of other ways in which recognition was acknowledged, such as: a perceived change of status within the organization; a change in work title; altered relationships and working practices with professional colleagues; and not least of all, increased prestige for the organization. In achieving such recognition, ANPs have the potential to become seen as experts and specialists who can be called upon for advice and support, not only from nursing staff, but also medical practitioners. The development of a new professional identity for advanced nurse practitioners then is analogous with Skidmore & Friend's (1984b) research about the specialisation of community psychiatric nurses. Skidmore & Friend (1984b) attest that practitioners who can be seen to have specialised have:

> "... developed a special knowledge which excludes intrusion; it gives the practitioner security in that [s]he has developed knowledge others do not have; status, in that [s]he is often consulted by others and escapism in that, because [s]he holds this power of knowledge, [s]he can develop [her] role to suit [her]self." (Skidmore & Friend, 1984b, p203).

Thus, by escaping a traditional nursing identity, advanced practitioners may be in a stronger position to develop their own practice and power base in health care delivery. When examining the development of nurse practitioners who work in primary care settings in the USA, this can be seen to have been achieved to a large

degree. In the context of the UK, the establishment of a separate, yet associated professional identity, would also serve the purposes of the UKCC in trying to achieve professional recognition and status for nursing.

There are therefore, both practical and political benefits to ANPs developing a new professional identity. That this was deliberate strategy on the part of the UKCC appears unlikely, rather, it was contrivance of circumstance and opportunity. The circumstances which acted as a catalyst to the development of the advanced practice role, such as the reduction in junior doctors hours has arguably allowed the UKCC to seize the opportunity to drive home its own political agenda of the professionalisation and the empowerment of nursing. By embarking on the development of Master's prepared practitioners, whose identity remains rooted within a nursing paradigm, yet whose practice is divorced from that of the traditional nurse, the UKCC appears to be utilising its opportunity to affect a change in the status of nursing. The danger inherent in such a strategy, is that nurses who develop a unique identity will be dissociated from the practice of nursing. The evidence from this study reveals that already ANPs are having their identity associated with that of physicians rather than nurses. Furthermore, in some cases, whilst ANPs espouse the virtues and values of nursing, when they are required to engage in traditional nursing behaviours they appear to de-value those experiences by bemoaning the lost opportunities to develop their new role. The potential outcome of attempting to attain a new professional identity, is that advanced practitioners could break away from the mainstream of nursing and develop their own professional practice sociation. Whilst this would arguably provide advanced practitioners with more power to control

the development of their role, it could also serve to further fragment nursing and hence do little to establish nursing as a major professional discipline.

Finally, the evidence from this study indicates that despite seeking to change their professional identity, ANPs as yet have been unable to influence the fundamental structures of the organization in which they work, to allow them freedom in role development. Lurie (1981) discovered the same phenomenon following a study of nurse practitioners working in institutional settings in the USA. She discovered that despite support from peers, physicians and supervisors, advanced practice nurses were unable to influence the institution in adjusting the boundaries of practice to be more congruent with their own expectations. It remains to be seen if ANPs in the UK will in the future be able to exert influence over their professional development and succeed in creating a professional identity which is congruent with their new found ideals and those of the UKCC.

CHAPTER ELEVEN

CONCLUSION, IMPLICATIONS AND FUTURE RESEARCH AGENDA.

CHAPTER 11. CONCLUSION, IMPLICATIONS AND FUTURE RESEARCH AGENDA.

This thesis has proposed that the transition from experienced nurse to advanced nurse practitioner involves a cycle of deconstruction and reconstruction within seven distinct personal and practice domains. It has been shown that this transitional process entails a journey that is highly subjective and often problematic in nature. It was discovered that from the outset, the individual's motivation for undergoing role transition and the organization's readiness to embrace the concept of advanced practice, were in a state of disequilibrium. It has been established that from an initial stage of idealism, where ANPs and key stakeholders promote the concept of advanced practice to be something that is ultimately unachievable, practitioners experience the reality shock of attempting to construct a role within an environment of competing agendas and constraints, imposed through the process of organizational governance. It has been suggested that practice reconstruction then, is contingent in nature upon key stakeholders within the organization and a variety of factors experienced within individual practice settings. It is asserted here that it is as a direct result of the influence of these contingent conditions that leads to practice reconstruction taking one of two fundamental directions. The first, primarily involved the ANP acting as a clinician in the delivery of direct patient care, whilst the second saw the ANP enacting a role whose prime purpose served to enhance the system of care delivery. The idealised eclectic role to which some individuals in the organization and to which the UKCC originally aspired, failed to emerge as an outcome of the reconstruction of nursing at this time.

Regardless of the direction of role orientation, the outcome of the transitional process

was observed to be characterised by one of three states: practice replication; practice fragmentation; and practice innovation. Whilst individual ANPs strove to achieve the latter, contingent conditions within the practice setting acted to mediate and sanction practice development.

The transitional process was also seen to involve the ANPs in attempting to gain recognition and status within the organization, with the aim of escaping from what in effect was fundamentally still a subservient role. In order to achieve this goal, the ANPs embarked upon trying to establish their own unique professional identity within the practice setting. In so doing, it is conjectured that the development of a new identity was ultimately seen as a means to empower advanced nurse practitioners to have greater independence and influence over the matters of health care delivery within the institutions within which they worked. It is proposed that this strategy indirectly served the purpose of the UKCC in progressing its own agenda to have nursing achieve greater professional status and independence. Whilst the latter still appears to be some way off, a change in status and identity would allow ANPs to escape from the constraints associated with a traditional nursing identity and stamp their own unique individuality and authority on the practice of nursing.

The results of this study serve to illustrate that attempts to arrive at a conclusive definition of the concept of advanced practice is fraught with difficulty. The highly individual and context bound notion of advanced practice, which is socially constructed

by actors in the social setting, suggests that striving to arrive at a global definition of advanced practice is an erroneous endeavour. The evidence from this study indicates that any definition which could be universally applied would be either too specific so as to be exclusionary, or too general to be meaningful. This thesis, does therefore, not attempt to offer a conclusive definition of the concept of advanced practice. Instead, it is suggested that the use of a practitioner profile, where change in each of the seven domains of reconstruction could be demonstrated would serve as a more useful and meaningful indicator of the attainment of an advanced level of nursing practice.

The results of this inquiry have a number of implications for practitioners, educators and policy makers alike. In particular, all parties need to be aware not only of the contingent nature of practice reconstruction, but the dichotomised nature of role orientation. Consequently, it is suggested that *prior* to employing advanced practitioners appropriate educational requirements, person specifications, and resource implications for development of the ANP role need to be considered thoroughly. Institutions also need to consider the location of the practitioner in the organizational hierarchy and develop appropriate role objectives that are realistic and framed within the constraints of the practice discipline. To allow for integration of the ANP into the clinical environment, careful though needs to be given to the adequate dissemination of the purpose of the new role to nursing and medical colleagues. At a policy level, the results of this study suggest that if an advanced level of practice is to be officially recognised and pursued as an avenue of professional development for nurses, criteria need to be established that are cognisant of the contingent nature and individuality of practice reconstruction.

The seven domains of reconstruction identified by this study could provide a basis for a general framework of this nature.

A number of issues have been identified by this inquiry which can be taken forward as a future research agenda in exploring the concept of advanced nursing practice. Firstly, having identified the seven domains of reconstruction, the development of measurement instruments to help establish the degree of change in each personal and practice domain during the transitional process could be considered. Another question that remains to be answered is: is there any relationship between the dichotomous nature of role orientation and the way in which the seven domains are reconstructed? In terms of health care economics, outcome indicators could be identified that would help determine the effectiveness and efficiency of the advanced practitioner role. As this study has identified a dichotomous role orientation, different outcome measures could be developed accordingly. Thus, outcomes such as patient satisfaction, length of stay, re-admission rates, auditing of clinical records, patient management protocols and the cost effectiveness of interventions, are just some examples of the type of outcomes which could be used to evaluate the ANP role. For those ANPs whose role is directed toward the system of care delivery, audit tools would need to measure the impact of the ANP role on professional colleagues and service delivery. Arguably, of these evaluative research approaches, the latter by its nature is likely to prove most challenging. Future studies may also wish to examine the relationship between organizational governance and role effectiveness. Furthermore, studies need not necessarily be confined to secondary or tertiary care settings and could be expanded to examine the ANP role in

primary care. In addition, comparative studies could be conducted between nurses undertaking innovative roles who are not educated to Master's degree level and those who are, to establish if there is any significant relationship between practice performance and educational preparation.

That further research is required is obviously without question as there is a need to continue to increase our understanding of the concept of advanced practice and the role of the advanced nurse practitioner. This thesis has provided a theoretical and practical platform from which to proceed, whilst acknowledging the limitations of the multiple case study design utilised in this inquiry. Any future research agenda needs to be cognisant of not only methodological problems, but the political and professional agendas which underpin the emergence of advanced practice as a present day phenomenon. This thesis has provided an initial step in understanding the complex nature of role transition and the reconstruction of nursing.

REFERENCES

Ackerman M. H., Norsen L., Martin B., Wiedrich J., & Kitzman H. J. (1996)
Development of a Model of Advanced Practice *American Journal of Critical Care* Vol 5, No 1, pp68- 73.

Adkins C. L. (1995) Previous work experience and organizational socialization: a longitudinal examination. *Academy of Management Journal* Vol 38, No 3, pp839-862.

Aggleton P. J. & Chalmers H. A. (1984) Models and theories 1: defining the terms. *Nursing Times* Vol 80, pp24-28

Ahmadi K. S., Speedling E. J. & Kuhn-Weissman G. (1987) The newly hired hospital staff nurses, professionalism, satisfaction and alienation. *International Journal of Nursing Studies* Vol 24, No 2, pp107-121.

Alex M.R. & MacFarlane M.E. (1992) The transition process: Joint responsibility of nurse educators and employers. *Canadian Journal of Nursing Administration* Vol 5, No 4, pp23-26.

Alspach J. A. G. (1984) Designing a competency-based orientation for critical care nurses. *Heart & Lung* Vol, 13, pp655-662.

American Nurses' Association. (1980) *Nursing: A social policy statement* Publication No. NP-63 35M. American Nurses' Association, Kansas.

American Nurses' Association. (1986) *The role of the clinical nurse specialist.* Publication No. NP-70 2M. American Nurses' Association, Kansas.

American Nurses' Association. (1987) *Standards of practice for the primary health care nurse practitioner.* Publication No. NP-70 2M. American Nurses' Association, Kansas.

Anderson E. M., Leonard B. J. & Yates J. A. (1974) Epigenesis of the Nurse Practitioner Role. *American Journal of Nursing* Vol 74, No 10, pp1812-1816.

Anderson J. (1982) Acquisition of problem solving skill. *Psychological Review* Vol 89, pp369-406.

Annells M. (1996) Grounded Theory Method: Philosophical Perspectives, Paradigm of Inquiry, and Postmodernism. *Qualitative Health Research.* Vol 6, No 3, pp379-393.

Ashforth B. E. & Saks A. M.(1995) Work-role transitions: A longitudinal examination of the Nicholson model. *Journal of Occupational and Organizational Psychology* Vol 68, pp157-175.

Autar R. (1996a) The Scope of Professional Practice in specialist practice. *British Journal of Nursing* Vol 5, No 16, pp984-990.

Autar R. (1996b) Role of the nurse teacher in advanced nursing practice. *British Journal of Nursing* Vol 5, No 5, pp298-301.

Bachus K. (1995) Advanced Registered Nurse Practitioners: Preparation, roles and practice settings. *The Kansas Nurse* Vol 70, No 9, pp 3-4.

Bajnok I. (1988) Specialization meets entry to practice. *The Canadian Nurse* Vol 84, No 6, pp23-24.

Baker V. (1979) Retrospective explorations in role development. In: *The Clinical Nurse Specialist and Improvement of Nursing Practice.* (Padilla G. V. ed) Nursing Resources, Wakefield, MA. pp56-63.

Barnard K., Cronenwatt L. R., Doughty S. E., Hall B., Harkness G. A., Koithan M. S., Lamendola F. P., Pokorny B. E. & Walker M. K. (1994) *Nursing: A social policy statement, 1994 revision.* American Nurses Association, Washington D.C.

Barrett G. (1995) To extend or not to extend - that is the question: A postal survey of opinions of nursing and medical staff regarding extended roles. *Journal of Neonatal Nursing* Vol 1, No 3, pp9 -13.

Bass M., Rabbett P. M. & Siskind M. M. (1993) Novice CNS and Role Aquisition *Clinical Nurse Specialist* Vol 7, No 3, pp148-152.

349

Bates B. (1990) Twelve paradoxes: a message for nurse practitioners. *Journal of the American Academy of Nurse Practitioners* Vol 2, No 4, pp136-139.

Beal J.A., Maguire D. & Carr R. (1996) Neonatal Nurse Practitioners: Identity as Advanced Practice Nurses. *Journal of Gynaecological and Neonatal Nursing* Vol 25, No 5, pp401-406.

Beales J. & Baker B. (1995) Minor injuries units: expanding the scope of accident and emergency provision. *Accident and Emergency Nursing* Vol 3, No 2, pp65-67.

Benner P. (1984) *From Novice to Expert*. Addison-Wesley, London.

Benner P. (1996) A response by P. Benner to K. Cash, "Benner and expertise in nursing: a critique". *International Journal of Nursing Studies*. Vol 33, No 6, pp669-674.

Benner P. & Tanner C. (1987) How expert nurses use intuition. *American Journal of Nursing* Vol 87, pp23-31.

Benner P., Tanner C. & Chesla C. (1992) From beginner to expert: gaining a differentiated clinical world in critical nursing care. *Advances in Nursing Science* Vol 14, pp13-28.

Bennett M. J. (1987) Research methodology in clinical diagnostic reasoning. In: *Clinical Judgement and Decision Making: The Future with Nursing Diagnosis*. (Hannah K. J., Reimer M., Mills W. C., & Letourneau S. eds) Wiley Medical, New York, pp53-57.

Biddle B. J. & Thomas E. J. (1979) *Role Theory: Concepts and research*. Robert E Krieger, Huntington, New York.

Black J. S. & Ashford S. J. (1995) Fitting In or Making Jobs Fit: Factors Affecting Mode Adjustment for New Hires. *Human Relations* Vol 48, No 4, pp421-437.

Boyle D. K., Popkess-Vawter S. & Taunton R. L. (1996) Socialization of new graduate nurses in critical care. *Heart & Lung.* Vol 25, No 2, pp141-154.

Brief A. P., Aldag R. J., Vansell M. & Melone N. (1979) Anticipatory socialization and role stress amongst registered nurses. *Journal of Health and Social Behaviour.* Vol 20, pp161-166.

Brown M. & Olshansky E. F. (1997) From Limbo to Legitimacy: A Theoretical Model of the Transition to the Primary Care Nurse Practitioner Role. *Nursing Research* Vol 46, No 1, pp46-51.

Brykczynski K. A. (1989) An interpretive study describing the clinical judgement of nurse practitioners. *Scholarly Inquiry for Nursing Practice: An International Journal.* Vol 3, No 2, pp75-104.

Buchanan B. (1974) Building organizational committment: The socialization of managers in work organizations. *Administrative Science Quarterly* Vol 19, pp533-546.

Burgess K. (1992) A dynamic role that improves the service: combining triage and nurse practitioner roles in A & E. *Professional Nurse* Vol 7, No 5, pp301-303.

Burgoyne S. (1992) Emergency nurse practitioners. *Nursing Standard* Vol 6, No 27, p12.

Burnard P. (1987) Towards an epistemological basis for experiential learning in nurse education. *Journal of Advanced Nursing* Vol 12, p189-193.

Butterworth T. & Bishop V. (1995) Identifying the characteristics of optimum practice: findings from a survey of practice experts in nursing, midwifery and health visiting. *Journal of Advanced Nursing* Vol 22, pp24-32.

Cahill H. (1996) Role definition: nurse practitioners or clinicians' assistants? *British Journal of Nursing* Vol 5, No 22, pp1382-1386.

Calkin J. D. (1984) A model for Advanced Nursing Practice *Journal of Nursing Administration.* Vol 14, No 1, pp24-30.

Cameron A. (1998) *Exploring New Roles in Practice: The methodological challenge of identifying new roles.* Conference paper, Qualitative Research in Health & Social Care, Bournemouth, 30.4.98.

Carlisle D. (1996) Crossing the line. *Nursing Times* Vol 92, No 23, pp 26-29.

Carr W. (1989) Introduction: understanding quality in teaching. In: *Quality in Teaching* (Carr, W. ed) The Falmer Press, Lewes. pp1-20.

Casey N. (1995) Editorial. *Nursing Standard* Vol 9, No 46, p3.

Cash K. (1995) Benner and expertise in nursing: a critique. *International Journal of Nursing Studies* Vol 32, No 6, pp527-534.

Castledine G. (1991) The advanced nurse practitioner: part 1. *Nursing Standard* Vol 5, No 3, pp34 - 36.

Castledine G. (1994) Specialist and Advanced Nursing and the Scope of Practice. In: *Expanding the role of the nurse:The scope of professional practice* (Hunt G. & Wainwright P. eds) Blackwell Scientific Publications, Oxford, pp101-113.

Castledine G. (1995) Will the nurse practitioner be a mini doctor or a maxi nurse? *British Journal of Nursing* Vol 4, No 16, pp938-939.

Castledine G. (1996) The role and criteria of an advanced nurse practitioner. *British Journal of Nursing* Vol 5, No 5, pp288-289.

Chi M., Feltovitch P. & Glaser R. (1981) Categorisation and representation of physics knowledge by experts and novices. *Cognitive Science* Vol 5, pp121-152.

Chick N. & Meleis A. I. (1986) Transitions: A nursing concern. In: *Nursing research methodology: Issues and implementation.* (Chinn P L. ed) Aspen, Rockville, M.D. pp237-257.

Chickadonz G. H. & Perry A. M. (1985) Clinical specialization versus generalization: Perspectives for the future. In: *Current Issues in Nursing* 2nd edn. (McCloskey J C. & Grace H K. eds) Blackwell Scientific, Boston. pp73-90.

Chinn P. L. & Kramer M. K. (1991) *Theory and Nursing; A systematic approach (3rd Ed)* Mosby, St.Louis.

Christman L. (1991) Perspectives on role socialization of nurses. *Nursing Outlook.* Vol 39, No 5, pp209-212.

Clance P. R. (1985) *The imposter phenomenon: Overcoming the fear that haunts your success.* Peachtree, Atlanta.

Cohen H. A. (1981) *The Nurse's Quest for a Professional Identity.* Addison-Wesley, Menlo Park, California.

Collins English Dictionary (1986) Collins, London.

Cooper D. M. & Sparacino P. (1990) Acquiring, implementing and evaluating the clinical nurse specialist role. In: *The Clinical Nurse Specialist: Implementation and Impact.* (Sparacino P., Cooper D. M., & Minarik P. A, eds) Appleton & Lange, Norwalk, Connecticut. pp41-75.

Corcoran S. (1986) Task complexity and nursing expertise as factors in decision making. *Nursing Research* Vol 35, pp107-112.

Crabtree M. (1979) Effective utilization of clinical nurse specialists within the organizational structure of hospital nursing services. *Nursing Administration Quarterly* Vol 4, pp1-10.

Creswell J. W. (1998) *Qualitative Inquiry and Research Design: Choosing Among Five Traditions.* Sage Publications, Thousand Oaks, California.

Cutcliffe J. R. (1997) The nature of expert psychiatric nurse practice: a grounded theory study. *Journal of Clinical Nursing* Vol 6, pp325-332.

Darbyshire P. (1994) Skilled expert practice: is it 'all in the mind'? A response to English's critique of Benner's novice to expert model. *Journal of Advanced Nursing* Vol 19, pp755-761.

Davies B. & Hughes A.M. (1995) Clarification of advanced nursing practice: charachteristics and competencies. *Clinical Nurse Specialist* Vol 9, No 3, pp156-60.

Davis B. D. (1993) An international approach to master's-level preparation for clinical nurse specialists. *Journal of Advanced Nursing* Vol 18, pp1429-1433.

de Groot A. (1966) *Thought and Choice in Chess.* Mouton, The Hague.

Deising P. (1971) *Patterns of Discovery in the Social Sciences* Aldine Publishing Company, New York.

Denzin N. K. & Lincoln Y. S. (1994) Entering the Field of Qualitative Research. In: *Handbook of Qualitative Research.* (Denzin N. K. & Lincoln Y. S. eds) Sage Publication, Thousand Oaks, California, pp1-17

Department of Health (1993a) *A Vision for the Future* . HMSO, London.

Department of Health (1993b) *The Challenges for Nursing and Midwifery in the 21st Century (The Heathrow Debate).* Depatment of Health, London.

Dillon A. & George S. (1997) Advanced neonatal nurse practitioners in the United Kingdom: where are they and what do they do? *Journal of Advanced Nursing* Vol 25, pp257-264.

Ditzenberger G. R., Collins S. D. & Banta-Wright S. A. (1995) Combining the role of clinical nurse specialist and neonatal nurse practitioner: The experience in one academic tertiary care setting. *Journal of Perinatal and Neonatal Nursing* Vol 9, No 3, pp45-52.

Doherty L. E. (1996) The Advanced Neonatal Nurse Practitioner: Room for one more? *Journal of Neonatal Nursing.* October, pp23-27.

Dreyfus H.L. & Dreyfus S. (1980) A five-stage model of the mental activities involved in directed skill acquisition. Unpublished study, University of California, Berkeley.

Dreyfus H.L. & Dreyfus S. (1986) *Mind over Machine.* Blackwell Science, Oxford.

Edwards B. (1998) A & E nurses' constructs on the nature of nursing expertise: a repertory grid technique. *Accident and Emergency Nursing* Vol 6, pp18-23.

Eisenhardt K. M. (1989) Building Theories from Case Study Research. *Academy of Management Review.* Vol 14, No 4, pp532-550.

English I. (1993) Intuition as a function of the expert nurse: a critique of Benner's novice to expert model. *Journal of Advanced Nursing* Vol 18, No 3, pp387-393.

Etzioni A. (1964) *Modern Organizations.* Prentice-Hall, Englewood Cliffs, New Jersey.

Farrington A. (1993) Intuition and expert clinical practice in nursing. *British Journal of Nursing* Vol 2, No 4, pp228-229, 231-233.

Fawcett J. (1989) *Analysis and Evaluation of Conceptual Models of Nursing (2nd Ed).* F.A. Davies, Philadelphia

Feldman D. C. (1976) A contingency thoery of socialization. *Administration Science Quarterly* Vol 21, pp 433-452.

Fenton M. V. (1985) Identifying competencies of clinical nurse specialists. *Journal of Nursing Administration* Vol 15, No 12, pp31-37.

Fenton M. V. (1992) Education for the advanced practice of clinical nurse specialists. *Oncology Nursing Forum* Vol 19, pp 16-20.

Fenton M. V. & Brykczynski K. A. (1993) Qualitative Distinctions and Similarities in the Practice of Clinical Nurse Specialists and Nurse Practitioners *Journal of Professional Nursing* Vol 9, No 6, pp313-326.

355

Ford L. C. & Silver H. K. (1967) Expanded role of the nurse in child care. *Nursing Outlook* Vol 15, pp43-45.

Ford L. C. (1979) A nurse for all settings: The nurse practitioner. *Nursing Outlook* Vol 27, No 8, pp516-521.

Fox-Young S. K. (1995) Issues in the assessment of expert nurses: purposes, standards and methods. *Nurse Education Today* Vol 15, pp96-100.

Gardner D. L. (1992) Conflict and retention of new graduate nurses. *Western Journal Nursing Research* Vol 14, pp76-85.

Garland T. N. & Marchione J. (1982) A framework for analysing the role of the nurse practitioner. *Advanced in Nursing Science* Vol 4, No 2, pp19-29.

Gibbon B. & Luker K. A. (1995) Uncharted territory: Masters preparation as a foundation for nurse clinicians. *Nurse Education Today* Vol 15, pp164-169.

Giles S. (1993) Passing the Buck *Nursing Times* Vol 89, No 28, pp42-43.

Gilgun J. F. (1994) A Case for Case Studies in Social Work Research. *Social Work* Vol 39, No 4, pp371 - 380.

Glaser B. & Strauss A. (1967) *The Discovery of Grounded Theory* Aldine de Gruyter, New York.

Glen S. & Waddington K. (1998) Role transition from staff nurse to clinical nurse specialist: a case study. *Journal of Clinical Nursing* Vol 7, pp283-290.

Golan N. (1981) *Passing through transitions* Free Press, New York.

Goldenberg D. & Iwasiw C. (1993) Professional socialisation of nursing students as an outcome of a senior clinical preceptorship experience. *Nurse Education Today* Vol 13, pp3-15.

Graham I. W. (1991) Primary nursing: accountability is the key to its mystery. *Nursing Practice* Vol 4, No 2, pp26-28.

Graham I. W. (1992) Reconstructing nursing: a coronary care perspective of the primary nurse philosophy. *Intensive and Critical Care Nursing* Vol 8, pp118-124.

Greenhalgh & Company Management Consultants (1994) *The interface between junior doctors and nurses.* Greenhalgh & Company Ltd.

Greenwood E. (1957) Attributes of a profession. *Social Work* Vol 2, No 3, pp44-5.

Greenwood J. & King M. (1995) Some surprising similarities in the clinical reasoning of 'expert' and 'novice' orthopaedic nurses: report of a study using verbal protocols and protocol analyses. *Journal of Advanced Nursing* Vol 22, pp 907-913.

Guba E. G. & Lincoln Y. S. (1994) Competing Paradigms in Qualitative Research. In: *Handbook of Qualitative Research.* (Denzin N. K. & Lincoln Y. S. eds) Sage Publication, Thousand Oaks, California, pp105-117.

Guyton-Simmons J. & Ehrmin J. T. (1994) Problem Solving in Pain Management by Expert Intensive Care Nurses. *Critical Care Nurse* October, pp37-44.

Hamm R. M. (1988) Clinical intuition and clinical analysis: expertise and the cognitive continuum. In: *Professional Judgment: A reader in clinical decision making* (Dowie J. & Elstein A. eds) Cambridge University Press, Cambridge. pp78-105.

Hamric A B. (1989) History and Overview of the CNS Role. In: *The Clinical Nurse Specialist in Theory and Practice. 2nd edition.* (Hamric A. B. & Spross J. A. eds) W. B. Saunders, Philadelphia. pp3-18.

Hamric A. B. & Taylor J. W. (1989) Role Development of the CNS. In: *The Clinical Nurse Specialist in Theory and Practice. 2nd edition.* (Hamric A. B. & Spross J. A. eds) W. B. Saunders, Philadelphia. pp41-82.

Hanneman S. (1996) Advancing Nursing Practice with a Unit-based Clinical Expert. *IMAGE: Journal of Nursing Scholarship* Vol 28, No 4, pp331-337.

Hanson C. & Martin L. L. (1990) The nurse practitioner and clinical nurse specialist: Should the roles be merged? *Journal of the American Academy of Nurse practitioners* Vol 2, No 1, pp2-9.

Hayden M. L., Davies L. R. & Clore E. R. (1982) Facilitators and inhibitors of the emergency room nurse practitioner role. *Nursing Research* Vol 31, p294.

Healy P. (1996) Confusion reigns over nurse practitioners *Nursing Standard* Vol 11, No 6, p13.

Heron J. (1981) Philosophical basis for a new paradigm. In: *Human Inquiry: A Sourcebook of New Paradigm Research.* (Reason P. & Rowan J. eds) John Wiley, Chichester.

Hill J. (1992) A nurse practitioner rheumatology clinic. *Nursing Standard* Vol 7, No 11, pp35-37.

Hixon M. E. (1996) Professional Development: Socialization in Advanced Practice Nursing. In *Advanced Practice Nursing: Changing Roles and Clinical Applications.* (Hickey J.V., Ouimette R.M. & Venegoni S. L. eds) Lippincott, Philadelphia, pp33-53.

Holmes S. (1994) Development of the cardiac surgeon assistant. *British Journal of Nursing* Vol 3, No 5, pp204-210.

Holt F. (1984) A theoretical model for clinical nurse specialist practice. *Nursing & Health Care* Vol 5, pp445-449.

Holyoake D. (1995) Advancing in Confusion *Nursing Standard* Vol 9, No5, p56.

Howie P. (1992) Development of the nurse practitioner. *Nursing Standard* Vol 6, No 27, pp10-11.

Hravnak M., Kobert S. N., Risco K. G., Baldisseri M., Hoffman L. A., Clochesy J. M., Rudy E. B. & Snyder J. V. (1995) Acute Care Nurse Practitioner Curriculum: Content and Development Process. *American Journal of Critical care* Vol 4, No 3, pp179-188.

Hughes E. C. (1958) *Men and Their Work* Free Press, Glencoe, Illinois.

Hunsberger M., Mitchell A., Blatz S., Paes B., Pinelli J., Southwell D., French S. & Soluk R. (1992) Definition of an advanced nursing practice role in the NICU: the clinical nurse specialist/neonatal practitioner. *Clinical Nurse Specialist* Vol 6, No 2, pp91-95.

Hunt G. & Wainwright P. (1994) Introduction. In: *Expanding the role of the nurse:The scope of professional practice* (Hunt G. & Wainwright P. eds) Blackwell Scientific Publications, Oxford, ppx-xvi.

Hupcey J. E. (1994) Graduate Education for Nurse Practitioners: Are Advanced Degrees Needed for Practice? *Journal of Professional Nursing* Vol 10, No 6, pp350-356.

Hurley-Wilson B. A. (1988) Socialization for Roles. In: *Role theory: Perspectives for health professionals, 2nd ed.* (Hardy M. E. & Conway M. E. eds) Appleton & Lange, Norwalk, CT. pp73-110.

Jairath N., Costello J., Wallace P. & Rudy L. (1991) The effect of preceptorship upon diploma program nursing students' transition to the professional nursing role. *Journal of Nursing Education* Vol 30, pp251-255.

Jarvis P. (1992a) Quality in practice: the role of education. *Nurse Education Today* Vol 12, pp3-10.

Jarvis P. (1992b) Reflective Practice and Nursing. *Nurse Education Today* Vol 12, pp174-181.

Jarvis P. (1992c) Theory and practice and the preparation of teachers of nursing. *Nurse Education Today.* Vol 12, pp258-265.

Jarvis P. (1995) Towards a philosophical understanding of mentoring. *Nurse Education Today* Vol 15, pp414-419.

Jasper M. A. (1994) Expert: a discussion of the implications of the concept as used in nursing. *Journal of Advanced Nursing* Vol 20, pp769-776.

Jewell D. & Turton P. (1994) What's happening to practice nursing? *British Medical Journal* Vol 308, pp735-736.

Johns C. (1995) The value of reflective practice for nursing. *Journal of Clinical Nursing* Vol 4, pp23-30.

Johnson P. J. (1989) Education for advanced practice neonatal nurse practitioners in patient management roles. *Neonatal Network* Vol 8, pp7-8.

Jones G. (1994) Accident and emergency and the nurse practitioner. In: *Expanding the role of the nurse:The scope of professional practice* (Hunt G. & Wainwright P. eds) Blackwell Scientific Publications, Oxford, pp162-181.

Jones G. R. (1986) Socialization tactics, self-efficacy, and newcomers' adjustments to organizations. *Academy of management Journal*, Vol 29, pp262-279.

Joynes J. (1996) An analysis of component parts of advanced nursing practice in relation to acute renal care in intensive care. *Intensive and Critical Care Nursing* Vol 12, pp113-119.

Kahneman D. & Tversky A. (1990) The simulation heuristic. In: *Judgement Under Uncertainty: Heuristics and Biases.* (Kahneman D., Slovac P. & Tversky A. eds) Cambridge University Press, New York. pp201-208.

Kane J. J. (1992) Allowing the novice to suceed: Transitional support in critical care. *Critical Care Nursing Quarterly* Vol 15, No 3, pp17-22.

Keane A. Richmond T. & Kaiser L. (1994) Critical Care Nurse Practitioners: Evolution of the Advanced Practice Nursing Role. *American Journal of Critical Care* Vol 3, No 3, pp232-237.

Kenner C. & Lott J. W. (1990) Parent transition after discharge from the NICU. *Neonatal Network* Vol 9, No 2, p31-37.

Kidd P. & Morrison E. F. (1988) The progression of knowledge in nursing research: a search for meaning. *Image: the journal of nursing scholarship* Vol 20, No4, pp222-224.

Kikuchi J. F. (1992) Nursing questions that science cannot answer. In: *Philosophic Inquiry in Nursing* (Kikuchi J. F. & Simmons H. eds). Sage, Newbury Park, pp26-37.

King K. B. & Ackerman M. H. (1995) An educational model for the acute care nurse practitioner. *Critical Care Nursing Clinics of North America* Vol 7, No 1, pp1-7.

King K. B., Parinello K. M. & Baggs J. G. (1996) Collaboration and Advanced Practice Nursing In: *Advanced practice nursing: changing roles and clinical applications.* (Hickey J. V., Ouimette R. M., & Venegoni S. L. eds) Lippencott, Philadelphia. pp146-162.

Kitson A., Harvey G., Hyndman S. & Yerrell P. (1993) A comparison of expert- and practitioner-derived criteria for post-operative pain management. *Journal of Advanced Nursing.* Vol 18, pp218-233.

Kitson A. (1997) Using evidence to demonstrate the value of nursing. *Nursing Standard.* Vol 11, No 28, pp34-39.

Kitzman H. J. (1989) The CNS and the nurse practitioner. In: *The Clinical Nurse Specialist in Theory and Practice. 2nd edition.* (Hamric A. B. & Spross J. A. Eds) W. B. Saunders, Philadelphia. pp379-394.

Kohnke M. (1978) *The Case for Consultation in Nursing: Designs for Professional Practice.* John Wiley, New York.

Kosko B. (1994) *Fuzzy Thinking.* Harper Collins, London.

Kramer M. (1974) *Reality shock: why nurses leave nursing.* CV Mosby, St Louis.

Larkin J., McDermott J., Simon D. & Simon H. (1980) Models of competence in solving physics problems. *Cognitive Science*. Vol 4, pp317-345.

Last T. & Self N. (1994) The expanded role of the nurse in intensive care. A national survey. In *Expanding the Role of the Nurse: The Scope of Professional Practice*. (Hunt G. & Wainwright P. Eds) Blackwell Scientific Publications, Oxford. pp114 - 131.

Lava P. A. (1994) The Self-Concepts and Motivational Orientations of Registered Nurse Master's Degree Students. *Journal of Nursing Education* Vol 33, No7, pp317-319.

Leddy S. & Pepper J. M. (1993) *Conceptual bases of professional nursing (2nd ed)*. J.B. Lippincott, Philadelphia.

Lewis J. (1975) Structural aspects of the delivery setting and nurse practitioner performance. *Nurse Practitioner* Vol 1, pp 16-20.

Light D. (1980) *Becoming Psychiatrists: The Professional Transformation of Self*. Norton, New York.

Lincoln Y. S. & Guba E. G. (1985) *Naturalistic Inquiry*. Sage Publications, Newbury Park, California.

Louis M. R. (1980) Career Transitions: Varieties and Commonalities. *The Academy of Management* Vol 5, No 3, pp329-340.

Loveridge C. E. (1988) Contingency Theory: Explaining Staff Nurse Retention. *Journal of Nursing Administration* Vol 18, No 6, p22-25.

Lukacs J. L. (1982) Factors in Nurse Practitioner Role Adjustment. *Nurse Practitioner* March, pp21,23, 50.

Lurie E. E. (1981) Nurse Practitioners: Issues in Professional Socialization. *Journal of Health and Social Behaviour*. Vol 22, pp31-48.

Lynaugh J. E., Gerrity P. L. & Hagopian G. (1985) Patterns of practice: master's prepared nurse practitioners. *Journal of Nursing Education* Vol 24, pp291-295.

MacAllister L. & Chiam M. (1995) Why do nurses agree to take on doctors' roles? *British Journal of Nursing* Vol 4, No 21, pp1238-1239.

Maguire D., Carr R. & Beal J. A. (1995) Creating a successful environment for neonatal nurse practitioners. *Journal of Perinatal and Neonatal Nursing* Vol 9, No 3, pp53-61.

Manley K. (1993) The Clinical Nurse Specialist *Surgical Nurse* Vol 6, No 3, pp21-25.

Manley K. (1996) Advanced practice is not about medicalising nursing roles *Nurs Crit Care* Vol 1, No 2 pp 56-57.

Manley K. (1997) A conceptual framework for advanced practice: an action research project operationalizing and advanced practitioner / consultant nurse role. *Journal of Clinical Nursing.* Vol 6, pp179-190.

Mariano C. (1993) Case Study: The Method. *National League for Nursing* Vol 19 No 2535 pp311-337.

Marshall C. & Rossman G. (1989) *Designing Qualitative Research* Sage Publications, London.

Mathieson A. (1996) Anger at 'mini-doctor' jibe. *Nursing Standard* Vol 10, No50, p15.

Maynard C. A. (1996) Relationship of Critical thinking Ability to professional Nursing Competence. *Journal of Nursing Education* Vol 35, No 1, pp12-18.

McCaugherty D. (1991) The use of a teaching model to promote reflection and the experiential integration of theory and practice in first year student nurses: an action research study. *Journal of Advanced Nursing* Vol 16, pp534-543.

McFarlane J. K. (1976) The role of research and the development of nursing theory. *Journal of Advanced Nursing* Vol 1, pp443-51.

McKay S. (1997) The route to true autonomous practice for midwives. *Nursing Times* Vol 93, No 46, p61-62.

McLeod J. (1995) *Doing Counselling Research.* Sage Publications, London.

McLoughlin S. (1992) Congress on nursing practice meets. *American Nurse* Vol 24, p 23

Meerabeau L. (1992) Tacit nursing knolwedge: an untapped resource or a methodological headache? *Journal of Advanced Nursing.* Vol 17, pp108-112.

Meleis A. F. (1975) Role insuffciency and role supplementation: A conceptual framework. *Nursing Research.* Vol 24, No 4, pp264-271.

Meleis A. F. (1985) *Theoretical nursing: development and progress.* J.B. Lippincott, Philadelphia.

Menard S. W. (1987) The clinical nurse specialist: Historical perspectives. In: *The Clinical Nurse Specialist* (Menard S. W. ed) John Wiley & sons, New York. pp1-7.

Merton R. (1957) *Social Theory and Social Structure.* Free Press, Glencoe, Illinois.

Miles M. B. & Huberman A. M. (1994) *Qualitative Data Analysis, 2nd ed.* Sage Publications, Thousand Oaks, California.

Mills C. (1996) The Consultant Nurse: a model for advanced practice. *Nursing Times* Vol 92, No 33, pp36-37.

Ministry of Health, Ontario (1994) *Nurse Practitioners in Ontario: A plan for their education and employment.* Ministry of Health, Ontario.

Mirr M.P. (1993) Advanced Clinical Practice: A Reconceptualized Role. *AACN* Vol 4, No 4, pp599-602.

Mitchinson S. & Goodlad S. (1996) Changes in the roles and responsibilities of nurses. *Professional Nurse.* Vol 11, No 11, pp734-736.

Monicken D. R. (1995) Consultation in Advanced Practice Nursing. In:*Advanced Practice Nursing: A Guide to Professional Development* (Snyder M. & Mirr M. P. eds) Springer Publishing Company, New York, pp183-195.

National Organization of Nurse Practitioner Faculties (NONPF) (1990) *Advanced Nursing Practice: Nurse Practitioner Guidelines: Final Report* NONPF, USA.

Newell A. & Simon H. (1972) *Human Problem Solving.* Prentice Hall, Englewood Cliffs, New Jersey.

NHS Management Executive (1991) *Junior Doctors: The New Deal.* NHS Management Executive, London.

Nicholson N. (1984) A Theory of Work Role Transitions. *Administrative Science Quarterly* Vol 29, pp172-191.

Nicholson N. & West M. A. (1987) *Managerial Job Change: Men and Women in Transition.* Cambridge University Press, Cambridge.

Nolan M., Lundh U. & Tishelman C. (1998) Nursing's knowledge base: does it have to be unique? *British Journal of Nursing* Vol 7, No 5, pp270-276.

Noyes J. (1995) An explanation of the differences between expert and novice performance in the administration of an intramuscular injection of an analgesic agent to a patient in pain. *Journal of Advanced Nursing* Vol 22, pp800-807.

Oda D. (1977) Specialized Role Development: A Three-Phase Process. *Nursing Outlook* Vol 25, No 6, pp374-377.

Orme L. & Maggs C. (1993) Decision-making in clinical practice: how do expert nurses, midwives and health visitors make decisions? *Nurse Education Today* Vol 13, pp270-276.

O'Rourke M. (1989) Generic professional behaviours: Implications for the Clinical Nurse Specialist Role. *Clinical Nurse Specialist* Vol 3, No 2, pp128-132.

Oxford English Dictionary (1961) Oxford University Press, Oxford.

Page N.E. & Arena D.M. (1991) Practical Strategies for CNC Role Implementation. *Clinical Nurse Specialist* Vol 5, No 1, pp43-48.

Page N.E. & Arena D.M. (1994) Rethinking the Merger of the Clinical Nurse Specialist and Nurse Practitioner Roles. *Image: Journal of Nursing Scholarship* Vol 26, No 4, pp315-318.

Paley J. (1996) Intuition and expertise: comments on the Benner debate. *Journal of Advanced Nursing* Vol 23, pp665-671.

Patterson C. & Haddad B. (1992) The advanced nurse practitioner: common attributes. *Canadian Journal of Nursing Administration* Vol 5, No 4, pp18-22.

Patton M.Q. (1990) *Qualitative Evaluation and Research Methods. 2nd ed.* Sage Publications, Newbury Park, California.

Paul R. W. & Heaslip P. (1995) Critical thinking and intuitive nursing practice. *Journal of Advanced Nursing* Vol 22, pp40-47.

Pearson A. (1983) *The Clinical Nursing Unit.* Heinemann, London.

Pearson L. J. (1995) Annual Update of How Each State Stands on Legislative Issues Affecting Advanced Nursing Practice. *Nurse Practitioner* Vol 20, No 1,pp13-51.

Pickersgill F. (1993) A 'New Deal' for nurses too? *Nursing Standard* Vol 7, No 35, pp21-22.

Pickersgill F. (1995) A natural extension? *Nursing Times* Vol 91, No 30, pp24-27.

Pickler R. H. & Reyna B. A. (1996) Advanced Practice Nursing in the care of the High-Risk Infant. *Journal of Perinatal and Neonatal Nursing* Vol 10, No 1, pp46-53.

Polanyi M. (1958) *Personal Knowledge: Towards a Post Critical Philosophy.* Routledge and Kegan Paul, London.

Polanyi M. (1966) *The Tacit Dimension.* Routledge and Kegan Paul, London.

Radke K., McArt E., Schmitt M., & Walker E.K. (1990) Administrative preparation of clinical nurse specialists. *Journal of Professional Nursing* Vol 6, pp221-228.

Ramprogus V. (1995) *The Deconstruction of Nursing.* Avebury, Aldershot.

Rapson M. F. (1982) Role Stress of Nurse Practitioners. *Nurse Practitioner* July-August, pp48, 50.

Reed J. (1994) Phenomenology without phenomena: a discussion of the use of phenomenology to examine expertise in long-term care of elderly patients. *Journal of Advanced Nursing* Vol 19, pp336-341.

Reed J. Proctor S. & Murray S. (1996) A sampling strategy for qualitative research. *Nurse Researcher* Vol 3, No 4, pp52-68.

Reiter F. (1966) The nurse-clinician. *American Journal of Nursing* Vol 66, No 2, pp274-280.

Retsas A. (1995) Knowledge and practice development: toward an ontology of nursing. *The Australian Journal of Advanced Nursing* Vol 12, No 2, pp20-25.

Rew L. (1988) Intuition: Concept analysis of a group of phenomenon. *Advanced in Nursing Science.* Vol 8, No 2, pp21-28.

Rice J. M. (1988) Transition from staff nurse to head nurse. A personal experience. *Nursing Management* Vol 19, No 4, p102.

Riehl J. P. & Roy C. (1980) *Conceptual Models for Nursing Practice* Appleton-Century Croft, Norwalk

Rieu S. (1994) Error and trial: the extended role dilemma. *British Journal of Nursing* Vol 3, No 4, pp168-174.

Roberts S. J., Tabloski P. & Bova C. (1997) Epigenesis of the Nurse Practitioner Role Revisited. *Journal of Nursing Education* Vol 36, No 2, pp67-73.

Roberts-Davies M., Nolan M. R., Read S. & Gilbert P. (1998) Realizing specialist and advanced nursing practice: a typology of innovative nursing roles. *Accident & Emergency Nursing* Vol 6, pp36-40.

Robinson K. & Vaughan B. (1992) *Knowledge for nursing practice.* Butterworth Heinemann, Oxford.

Rolfe G. (1997) Science, abduction and the fuzzy nurse: an exploration of expertise. *Journal of Advanced Nursing.* Vol 25, pp1070-1075.

Roy C. & Martinez C. (1983). A conceptual framework for CNS practice. In: *The Clinical Nurse Specialist in Theory and Practice.* (Hamric A. B. & Spross J. A. Eds) Grune & stratton, New York. pp3-20.

Rubin S. (1988) Expanded Role Nurse: Part 1 Role Theory Concepts. *Canadian Journal of Nursing Administration,* June pp23-27.

Russell J. & Hezel L. (1994) Role Analysis of the Advanced Practice Nurse Using the Neuman Health Care Systems Model as a Framework. *Clinical Nurse Specialist* Vol 8, No 4, pp215-220.

Ryle G. (1949) *The Concept of Mind.* Penguin, Harmondsworth.

Salkever D.S., Skinner E.A., Steinwachs D.M. & Katz H. (1982) Episode-based efficiency comparisons for physicians and nurse practitioners. *Medical Care* Vol 20, pp 143-153.

Salussolia M. (1997) Is advanced nursing practice a post or a person? *British Journal of Nursing* vol 6, no 16, pp928, 930-933.

Sashkin M. E. & Rosenbach W. E. (1993) A new leadership paradigm. In: *Contemporary Issues in Leadership* (Rosenbach W. E. & Taylor R. eds) 3rd edn. Westview Press, Colorado, pp87-108.

Schatzman L. (1991) Dimensional analysis: Notes on an alternative approach to the grounding of theory in qualitative research. In:*Social organization and social process: Essays in honor of Anselm Strauss.* (Maines D. R. ed) Aldine De Gruyter, New York, pp303-314.

Schein E. H. (1978) *Career dynamics: Matching individual and organizational needs.* Addison-Wesley, Reading, Massachusetts.

Schon D. (1983) *The Reflective Practitioner.* Temple Smith, London.

Schultz P. R. & Kerr B. J. (1986) Comparative case study as a strategy for nursing research. In: *Nursing research methodology: Issues and implementation.* (Chinn P. L. ed) Aspen, Rockville, MD, pp195-220.

Schumacher K. L. & Meleis A. I. (1994) Transitions: A Central Concept in Nursing. *Image: Journal of Nursing Scholarship.* Vol 26, No 2, pp119-127.

Schwandt T. A. (1994) Constructivist, Interpretivist Approaches to Human Inquiry. In: *Handbook of Qualitative Research.* (Denzin N. K. & Lincoln Y. S. eds) Sage Publication, Thousand Oaks, California, pp118-137.

Shah H. S., Sullivan D. T., Lattanzio J. & Bruttomesso K. M. (1993) Preparing Acute Care Nurse Practitioners at the University of Connecticut. *AACN Clinical Issues.* Vol 4, No 4, pp625-629.

Shea S. S. & Selfridge-Thomas J. (1997) The ED nurse practitioner: Pearls and pitfalls of role transition and development. *Journal of Emergency Nursing* Vol 23, No 3, pp235-237.

Sheer B. (1994) Reshaping the Nurse Practitioner Image Through Socialization. *Nurse Practitioner Forum.* Vol 5, No 4, pp215-219.

Shuval J. T. (1980) *Entering Medicine: The Dynamics of Transition.* Pergamon Press, Oxford.

Simon P. (1992) Pioneer Spirit. *Nursing Times* Vol 88, No 30, pp16-17.

Skidmore D. & Friend F. (1984a) Muddling through.*Nursing Times Community Outlook* May 9, pp179, 181.

Skidmore D. & Friend F. (1984b) Specialism or escapism? *Nursing Times Community Outlook* June 13, pp203-205.

Smith A. & Russell J. (1991) Using critical learning incidents in nurse education. *Nurse Education Today.* Vol 11, pp284-291.

Smith M. C. (1995) The Core of Advanced Practice Nursing. *Nursing Science Quarterly.* Vol 8, No 1, pp2-3.

Smith S.M.S. (1996) Independent Nurse Practitioner. *Nursing Clinics of North America* Vol 31, No 3, pp549-563.

Snyder M. & Yen M. (1995) Charachteristics of the advanced practice nurse. In: *Advanced Practice Nursing: A Guide to Professional Development* (Snyder M. & Mirr M. P. eds) Springer Publishing Company, New York, pp3-12.

Sox H. C. (1979) Quality of patient care by nurse practitioners and physician's assistants: a ten year perspective. *Annals of Internal Medicine* Vol 91, pp459-468.

Sparacino P. S. & Cooper D. M. (1990) The role components. In: *The Clinical Nurse Specialist: Implementation and Impact.* (Sparacino P., Cooper D. M. & Minarik P. A. eds) Appleton & Lange, Norwalk, Connecticut. pp11-35.

Sparacino P. S. (1993) The Advanced Practice Nurse: Is the Time Right for a Singular Title? *Clinical Nurse Specialist* Vol 7, No 1, p3.

Spitzer W.O., Sacket D.L., Sibley J.C., Roberts R.S., Jend M. & Kergin D. J. (1974) The Burlington randomised trial of the nurse practitioner. *New England Journal of Medicine* Vol 290, pp251-256.

Spross J. A. & Baggerley J. (1989) Models of advanced nursing practice. In: *The Clinical Nurse Specialist in Theory and Practice* (Hamric A. B. & Spross J. A. eds) WB Saunders, Philadelphia. pp19-40.

Stake R. E. (1995) *The Art of Case Study Research.* Sage Publications, Thousand Oaks, California.

Stilwell B., Greenfield S., Drury M. & Hull F. M. (1987) A nurse practitioner in general practice: working style and pattern of consultations. *Journal of the Royal College of General Practice* Vol 37, pp154-157.

Strasser S. (1983) The effective application of contingency theory in health settings: problems and recommended solutions. *Health Care Management Review* Winter, pp15-23.

Strauss A., Bucher R., Ehrlich D., Schatzman L. & Sabshin M. (1964) *Psychiatric ideologies and institutions.* Free Press, Glencoe, IL.

Strauss A. & Corbin J. (1990) *Basics of Qualitative Research: Grounded Theory Procedures and Techniques.* Sage Publications, Newbury Park.

Sullivan J. A., Dachelet C. Z., Sultz H. A., Henry M. & Carrol H. D. (1978) Overcoming barriers to the employment and utilization of the nurse practitioner. *American Journal of Public Health* Vol 68, pp1097-1103.

Sutton F. & Smith C. (1995) Advanced nursing practice: new ideas and new perspectives. *Journal of Advanced Nursing* Vol 21, No 6, pp1037-1043.

Talarczyk G. & Millbrandt D. (1988) A collaborative effort to facilitate role transition from student to registered nurse practitioner. *Nursing Management* Vol 19, No 2, pp 30-32.

Thibodeau J. A. & Hawkins J. W. (1994) Moving Toward a Nursing Model in Advanced Practice. *Western Journal of Nursing Research* Vol 16, No 2, pp205-218.

Thompson C., Ryan S. & Kitzman H. (1990) Expertise: the basis for expert system development. *Advances in Nursing Science* Vol 13, pp1-10.

Topham D. L. (1987) Role Theory in Relation to Roles of the Clinical Nurse
	Specialist. *Clinical Nurse Specialist* Vol 1, No 2, pp81-84.

Touche Ross Management Consultants (1995) *Evaluation of Nurse Practitioner
	Pilot Projects: Executive Summary.* Touche Ross.

Tschetter L. & Sorenson D. S. (1991) Educational preparation for the neonatal
	nurse clinician/practitioner: From past to future. *Journal of Perinatal
	and Neonatal Nursing* Vol 5, No 3, pp61-69.

Tuthill V. (1995) The training of nurse surgical assistants. *British Journal of
	Nursing* Vol 4, No 21, pp1240-1245.

Uckan E. M., Surratt N. & Troiano N. H. (1994) Critical care obstetrics: The role of
	advanced practice nursing. *Journal of Perinatal and Neonatal
	Nursing.* Vol 8, No 2, pp40-47.

United Kingdom Central Council for Nursing, Midwifery & Health Visiting. (1986)
	Project 2000. A New Preparation for Practice. UKCC, London.

United Kingdom Central Council for Nursing, Midwifery & Health Visiting. (1989)
	Exercising Accountability. UKCC, London.

United Kingdom Central Council for Nursing, Midwifery & Health Visiting. (1990) *The
	Report of the Post-Registration and Education and Practice Project.*
	UKCC, London.

United Kingdom Central Council for Nursing, Midwifery & Health Visiting. (1992a)
	Code of Professional Conduct for the Nurse, Midwife and Health Visitor.
	UKCC, London.

United Kingdom Central Council for Nursing, Midwifery & Health Visiting. (1992b)
	The Scope of Professional Practice. UKCC, London.

United Kingdom Central Council for Nursing, Midwifery & Health Visiting. (1993)
	Post-registration Education and Practice. UKCC, London.

United Kingdom Central Council for Nursing, Midwifery & Health Visiting. (1994a) *The Council's Standards for Education and Practice Following Registration.* Annex 1 to Registrar's letter 20/1994, UKCC, London.

United Kingdom Central Council for Nursing, Midwifery & Health Visiting. (1994b) *Register No 14, Spring.* UKCC, London.

United Kingdom Central Council for Nursing, Midwifery & Health Visiting. (1994c) *The Future of Professional Practice - The Council's Standards for Education and Practice Following Registration.* UKCC, London.

United Kingdom Central Council for Nursing, Midwifery & Health Visiting. (1996) *PREP - The nature of advanced practice - an interim report.* UKCC, London.

United Kingdom Central Council for Nursing, Midwifery & Health Visiting. (1997a) *Register No 19, Spring.* UKCC, London.

United Kingdom Central Council for Nursing, Midwifery & Health Visiting. (1997b) *The Council's Decision on PREP and Advanced Practice* Registrar's Letter 8/1997, UKCC, London.

United States Congress, Office of Technology Assessment (1986) *Nurse practitioners, physician Assistants and certified nurse midwives: A policy analysis.* Government Printing Office, Washington D.C..

Van Maanen H. M. Th. (1990) Nursing in transition: an analysis of the state of the art in relation to the conditions of practice and society's expectations. *Journal of Advanced Nursing* Vol 15, pp914-925.

Van Maanen J. & Schein E. (1979) Toward a theory of organizational socialization. In *Research in organizational behaviour, Vol 1.* (Staw B. ed) JAI Press, Greenwich, CT; pp209-264.

Ventura M. (1988) Assessing the effectivenss of nurse practitioners. *Nursing Times* Vol 84, No 9, pp50-1).

Wagner R. K. & Sternberger R. J. (1985) Practical intelligence in real-world pursuits: the role of tacit knowledge. *J.Person.Social Psychol.* Vol 49, No 2, pp436-458.

Walker L. & Avant K. (1988) *Strategies for Theory Construction in Nursing. 2nd edn.* Appleton and Lange, Norwalk, Connecticut.

Wanous J. P. (1977) Organization entry: Newcomers moving from outside to inside. *Psychological Bulletin* Vol 84, p601-618.

Wanous J. P. (1992) *Organizational Entry, 2nd edition*, Addison-Wesley Publishing Co, Reading Massachussetts.

Watson P. G. & Wells N. (1987) Nurses attitudes towards the advantage of master's degree preparation in nursing. *Journal of Nursing Education* Vol 26, No 2, pp63-68.

Watson S. (1994) An exploratory study into a methodology for the examination of decision making by nurses in the clinical area. *Journal of Advanced Nursing* Vol 20, No 2, pp351-360.

Watts R. J., Hanson M. J. S., Burke K. G., Gallagher S. M. & Foster D. E. (1996) The Critical Care Nurse Practitioner: An Advanced Practice Role for the Critical Care Nurse. *Dimensions in Critical Care Nursing* Vol 15, No 1, pp48-56.

West M. A. (1987) Role innovation in the world of work. *British Journal of Social Psychology* Vol 26, pp305-315.

West M. A., Nicholson N. & Rees A. (1987) Transitions into newly created jobs. *Journal of Occupational Psychology* Vol 60, pp97-113.

West M. A. & Rushton R. (1989) Mismatches in the work-role transitions. *Journal of Occupational Psychology* Vol 62, pp271-286.

Wolf G. A. (1990) Clinical Nurse Specialists: The second generation. *Journal of Nursing Administration.* Vol 20, No 5, pp236-241.

Woods L. P. (1997a) Conceptualizing advanced nursing practice: curriculum issues to consider in the educational preparation of advanced practice nurses in the UK. *Journal of Advanced Nursing* Vol 25, pp 820-828.

Woods L .P. (1997b) Designing and Conducting Case Study Research in Nursing. *NT Research* Vol 2 No 1 pp48-56.

Woods N. F. & Catanzaro M. (1988) *Nursing Research: Theory and Practice.* Mosby, St Louis.

Working Group on Specialist Medical Training (Calman Report) (1993) *Hospital Doctors: Training for the Future.* Department of Health, London.

Wright S. G. (1986) *Building and Using a Model of Nursing.* Arnold, London.

Wright S. G. (1991) Nursing Development. *Nursing Standard* Vol 5, No 38, pp52-3.

Wright S. G. Johnson M, & Purdy E. (1991) The nurse as a consultant *Nursing Standard* Vol 5, No 20, pp31-34.

Wright S. G. (1994) The nurse consultant: fact or fiction? In: *The Clinical Nurse Specialist: Issues in practice* (Humphris D. ed) MacMillan Press, London. pp84-93

Yin R. K. (1981) The case study crisis: some answers. *Administrative Science Quarterly* Vol 26, pp58-65.

Yin R. K. (1989) *Case Study Research: Design and Methods (Revised Edition)* Sage Publications, Newbury Park, California.

Zammuto R. F., Turner I. R., Miller S., Shannon I. & Christian J. (1979) Effect of clinical settings on the utilization of nurse practitioners. *Nursing Research* Vol 28, No 2, pp98-102.

APPENDICES

PARTICIPANT INFORMATION SHEET.

<u>ADVANCED NURSE PRACTITIONER STUDENT INFORMATION SHEET</u>

Project title:
* A Prospective Analysis of Factors which Contribute to the Development and Performance of Advanced Nurse Practitioners and the Impact of the Role on Professional Practice

Researcher:
* Leslie Woods, Research Fellow, Department of Applied Social Studies, Keele University.

Project Funding:
* West Midlands Health Authority, New Blood Fellowship.

Research Aims:
* To investigate the processes of educational and professional training and establish how they influence the role expectations of the Advanced Nurse Practitioner student and those of her/his nursing and medical colleagues.

* Evaluate how the Advanced Nurse Practitioner students' practice develops and how their role consequently influences the practice of professional colleagues in terms of the organization and delivery of care.

* Identify the factors which facilitate and/or impede role development and performance.

Research Design:
* Longitudinal qualitative case studies:
* Each case comprises: Advanced Nurse Practitioner Student
                                      Clinical Nurse Manager
                                        Directorate Nurse Manager
                                        Consultant / Preceptor
                                        Advanced Nurse Practitioner Course Lecturer
                                        Nursing Colleague of the ANP
                                        Junior Doctor

Data Collection Methods:
* In-depth interviews
    Each of case study participant will be interviewed twice.

* Observation of Clinical Practice and the Clinical Environment
    It will be planned to observe each student in the case study for approximately for
    4 hours on 10 - 15 occasions throughout the course and upon completion.
    At the end of each period of observation, the student will be interviewed for a
    short period to discuss the content of the observations.

    *NB Baseline observations of practice would have been desirable, however, due
    to the time-frame of the project, this will not be possible.

* Role Development Diaries
    All students on the course, willing to be involved in the study, will be asked to
    complete a role development diary for 1 week of each of the last 6 months of the
    course.

* Questionnaire
    As baseline observations of practice will not be possible, a self-report
    questionnaire pertaining to a description of the students' nursing role prior to
    commencing the course will be administered as early as possible. This will
    provide a baseline comparison with the role development diaries completed later.

Timetable:
* In-depth interviews
    The first set of interviews will take place as soon as ethical permission has
    been approved and agreed, i.e. as close to the beginning of the course as
    possible. The second set of interviews will take place following completion of the
    course.

* Observation of Clinical Practice and the Clinical Environment
    The observations will take place at 3 points. The first series of observations will
    take place as soon after ethical approval as possible, but hopefully toward the
    middle of the course, eg January '96 - March '96; the second series, toward the
    end of the course, eg July '96 - September '96; and the third series after
    completion of the course, eg January '97 - March '97.

- Role Development Diaries

    Each diary will be completed for 1 week of each of the last 6 months of the course. Approximately April '96 - September '96

- Questionnaire

    This will be administered as soon as possible after ethical approval

Appendix 2:
CONSENT FORM.

PERSONAL CONSENT TO THE CONDUCT OF A RESEARCH INVESTIGATION

STUDY TITLE:

A PROSPECTIVE ANALYSIS OF FACTORS WHICH CONTRIBUTE TO THE
DEVELOPMENT AND PERFORMANCE OF ADVANCED NURSE
PRACTITIONERS AND THE IMPACT OF THE ROLE ON PROFESSIONAL
PRACTICE

NAME OF RESEARCHER:

LESLIE WOODS, RESEARCH FELLOW

The aims and research methods of the investigation in which I have been asked to
take part have been explained to me by Mr Leslie Woods. I have read and
understood the information sheet pertaining to the study, set out overleaf.

I have had the opportunity to ask questions and to consider the answers given.

I understand that participation in the study is voluntary and that I may withdraw
from the study at any time of my own accord, and that by doing so I will not be
pressurised or coerced into continuing to participate against my will.

I hereby give freely my fully informed consent to take part in this research
investigation.

Name:..
Signature:...

Date:..

I confirm that I have explained the nature of the above investigation to the above
named:

Name:...Leslie Woods..........................Signature:..
Date:..

Appendix 3:
STAGE 1 INTERVIEW SCHEDULE

<u>Interview Schedule for Initial stage:-Nurse Practitioner Students:</u>

Question Focus: "Perceptions and Role Expectations"

Q: What do you think Advanced Nursing Practice is?

Q: What do you think your role will involve as an Advanced Nurse Practitioner in your unit?

Q: What do you think the major roles of the advanced nurse practitioner should be?

Q: How clear are you in your mind about what the role will involve?

Q: Is there a unit job specification for your role?

Q: What do you perceive to be the boundaries of your practice as an advanced practitioner: - what do you think you should or should not do?

Q: What new skills do you think you will have to develop?

Q: In what ways do you think your role will alter from the position you previously held on the unit?

Q: To whom will you be accountable to in your capacity as an advanced nurse practitioner?

Q: How do you feel about entering this new role?

Question Focus: "Educational Preparation"

Q: How are you finding the course?

Q: In what ways do you think the course prepares you to become an advanced practitioner?

Q: Do you think the course will *adequately* prepare you for the role ahead?

Q: Is the content of the course to date what you expected?

Q: Why do you think it is necessary to have an advanced practice course at the Master's Degree level, other than it is advocated by the UKCC?

Question Focus: "Impact of the Role"

Q: How do you think the delivery of nursing care will change on the unit as a result of the implementation of the advanced nurse practitioner role?

Q: How do you think the delivery of medical care will change on the unit as a result of the implementation of the advanced nurse practitioner role?

Q: Do you think the implementation of the role will result in a reduction of junior medical staff hours on the unit? If yes, how? If no, why?

Q: What impact do you think the role will have on the unit nursing staff?

Q: What impact do you think your role will have on the nurse managers?

Q: Do you think the role will have any impact on nursing policy formulation within the unit?

Q: What impact do you think the role will have on the medical staff, including the consultants?

Q: What impact do you think the role will have on patients?

Q: Do you think the role will have an impact on any other health care provider groups, for example physios, OTs, GPs etc ?

Question Focus: "Barriers and Facilitators of Advanced Practice"

Q: What factors do you think will help you in implementing the role of advanced nurse practitioner in your unit?

Q: Are there any factors that you think will be a barrier to you implementing the role of advanced nurse practitioner on your unit?

Q: How much support do you think you will require, and from whom?

Q: What kind of influence have your peers on the course had on the process of becoming an advanced practitioner?

Q: What kind of response do you think you will receive from your nursing colleagues as you try to implement this new role?

Q: How do you feel about being preceptored by the consultant?

Question Focus: "Role Stress / Ambiguity"

Q: Do you consider there to be any difference in your expectations of the role and those of the nurses on the unit?

Q: Do you consider there to be any difference in your expectations of the role and those of the nurse administrator/manager over the directorate?

Q: Do you consider there to be any difference in your expectations of the role and those of the consultants on the unit?

Q: Do you consider there to be any difference in your expectations of the role and those of the junior medical staff on the unit?

Q: Do you consider there to be any difference in your expectations of the role and those of your peers and teachers on the advanced nurse practitioner course?

Q: Are there any areas of role conflict which you think may arise in the future? If so, why?

Appendix 4:
STAGE 2 INTERVIEW SCHEDULE

<u>Interview Schedule for second stage:-Case study participants other than ANPs</u>

Question Focus: "Perceptions of how the role is developing".

Q: In the first interview, I asked the question "what does advanced nursing practice mean in your particular specialism?" - I am interested in how your views have moved on since then, now that you have an ANP in post, in terms of what do you now see the main role of the ANP to be?

Q: What changes have you seen in the ANP's *practice, if any,* following the Master's Course?

Q: What changes have you seen in the ANP as a person since she came back in the role of an ANP following the Master's course?

Q: What in your view separates the ANP role from that of an experienced sister as it is being implemented on the unit?

Q: Was there a particular rational to deploy the ANP in the way you have in this department? And if so, what was it? (Manager/consultant only)

Q: One of the things expected of ANPs is to take a bigger role in clinical assessment and decision making, treatment initiation and so on. Do you think that the ANP is developing her skills in this area, the way the role is working out in the unit?

Q: Looking at the balance between direct care and indirect care activities, do you think the ANP's time should be mainly focused toward teaching and facilitating the development of the other nursing staff and raising the standard of practice throughout the unit, or should she be used more as an expert practitioner in her own right and spend the majority of time involved in direct care activities and developing advanced clinical skills?

Q: Are too many pressures being put on the ANP to try and do everything?

Q: Looking back at the ANPs formal preparation, what are your feelings about the Masters course?

Q: Do you think you have a clearer understanding of what 'advanced practice' is, since the ANP has been in post, or has your view merely been confirmed?
Question Focus: "Impact / effect of the ANP role on the delivery of nursing care and on professional practice (nursing/medical/pams)".

Q: How do you feel the ANP is fitting into system?

Q: Have you noticed any changes in the behaviour of the nursing staff on the unit as a result of the implementation of the advanced nurse practitioner role? Is the ANP treated any differently?

Q: Has there been any change in the way nursing care is delivered or organised that can be attributed to having an ANP in post?

Q: How do you think the medical staff have reacted to the introduction of the advanced practitioner role?

Q: Does the ANP have a greater collaborative relationship with her medical colleagues do you think?

Q: Is the ANP more readily involved in decision making / clinical judgements about patients than previously, or has to all intents and purposes her practice remained the same?

Question Focus: "Barriers and facilitators of advanced practice".

Q: Do you think that there are any factors on the unit that are being a barrier to the implementation of the advanced practitioner role as desired?

Q: Likewise, are there any factors that are helping the implementation of the advanced practitioner on the unit?

Q: How do you intend to evaluate the ANP role? What will you be measuring / evaluating? (Manager/Consultant only)

Q: When would you expect to start seeing 'results' of the ANP being in post?

Q: What would you expect the benefits to be? And have you started noticing any difference at this stage?

Q: Have your expectations been met in terms of what you anticipated the ANP would have accomplished at this relatively early stage in their development?

Q: Now you have an ANP in post - do you think the advanced practitioner role as it is developing is appropriate for your unit?

Appendix 5:
STAGE 3 INTERVIEW SCHEDULE

<u>Interview Schedule for final stage:- Questions for consultants</u>

Question Focus: "General considerations and rationale"

Q: What are your general feelings and thoughts about the whole notion of advanced nurse practitioners now that there has been one (or more) in the clinical area for over 12 months?

Q: What have been the major challenges in implementing the ANP role in this area?

Q: What have been the prime determinants for the role developing in the way it has?

Q: Do you see the main thrust of the ANP role being directed toward the delivery of patient care and improved patient outcomes? Or, is it directed toward the 'organization & staff 'so as to have a more indirect benefit on patient outcomes? Why so?

Question Focus: "Nicholson's theory"

Q: How much control and input have you had in determining how the ANP role develops?

Q: How much feedback do you or your colleagues give to the ANP about their performance or development of the role?

Q: How much discretion does the ANP have in deciding how the role should be developed?

Q: In order to fulfil the requirements of the role, do you think that the ANP has had to learn a lot of new skills and knowledge? Or were they already in possession of the knowledge and skills previously, in which case only a few aspects of the new role are novel to them?

Question Focus: "Evaluation of the ANP role"

Q: What are the benefits from having an ANP?

Q: Are there any down-sides to having an ANP?

Q: What makes the ANP and their practice different from that of other nurses?

Q: Do you think ANPs are always acting in an 'advanced' capacity, or do they move in and out of the role as required?

Q: Do you consider the ANP to be an autonomous practitioner?

Q: Does the ANP have any specific privileges in their clinical practice, which are not afforded to other nurses, such as prescribing, admission privileges etc?

Q: Are there any formal plans to evaluate the ANP role at this time? If so, what criteria are you considering using?

Question Focus: "Impact of the ANP role"

Q: One of the things I am interested in, is to establish if the presence of an ANP has had any impact on the clinical practice of medical staff or the way they work. In this unit, do you think the ANP has had any impact on medical staff? And if so, in what way?

Q: Are professional relationships between the medical staff and (*name*) different as a result of her being an ANP, or are they the same as before?

Q: Does the opinion of the ANP carry more weight, than would previously have been the case before they took on the role?

Q: Do you think that the ANP is recognised for her clinical expertise, and as a result now has different status?

Q: In what ways do you think the ANP has developed over the past 12 months, in terms of their knowledge, skills and personal attributes?

Q: Has their clinical expertise and clinical judgement & decision making increased or improved?

Q: Have you any thoughts you would like to add regarding the ANP role?

ROLE DEVELOPMENT DIARY - (size adjusted for illustration purposes)

Introduction

The aim of this role development diary is for you to record your clinical practice and experiences over a specified period of time. The purpose of this exercise is to build up a picture of how your clinical practice develops as you progress in practice. In addition, it will ask you to specify the factors that you think are influencing your practice development both positively and negatively. These factors may for example originate within the clinical environment you are working in, or from outside it, elsewhere. You can be reassured that everything that you enter into the role development diary will be kept confidential.

Your role development diary, along with those of your colleagues who have agreed to participate in the research project, will provide important data about the components of advanced nursing practice, along with the factors influencing the development of that practice.

It is likely, that *you* will also find the diary useful in terms of how it asks you to reflect on your practice and seeing for yourself how your practice changes over time. If you wish, once the role development diaries have been collected and photocopied for the purposes of data analysis, they can be returned to you for your personal use. They should provide quite a lot of evidence about your practice that you may find useful in the future!

Over the page are a number of questions about how to use the diary. Whilst the format will be unfamiliar to you at the outset, I am sure that very quickly you will be able to complete it the minimal amount of time. Whilst it may look a large document, you will not complete everything on every page. I have merely tried to anticipate every eventuality!

As a guide, when piloting the Role Development Diary, an average days entries took 30 minutes, (and that was with the format being new and unfamiliar).

Once again I would like to express my appreciation for your cooperation with this project. Without you, it would not be possible!

Questions about the use of the role development diary

You are asked to complete the diary for **five** consecutive, clinically based days in **each** of the following months; October, November, December, January, February and March. This will provide data on a total of 30 clinically based days.

Which five days in a month should I record?

Selection of which five days you choose to record in your diary in any particular month is left to you. Thus, in October you may record the last five clinically based days of the month and in November you may choose five days in the middle of the month. Alternatively, you may choose the third or fourth week in each month to record your practice. The decision is left totally to you.

Exactly what is meant by five *consecutive* days?

Five consecutive days refers only to the days you spend in clinical practice, and **excludes** study days and days off. For example, if in October your pattern of work is, Monday and Tuesday based in the clinical area, Wednesday a study day, Thursday and Friday spent back in the clinical area, and Saturday and Sunday are days off, then the five consecutive clinically based days you are asked to record would be Monday, Tuesday, Thursday and Friday of the first week and Monday of the following week i.e. only those days spent in clinical practice.

What if I do not spend a *full* day in clinical practice - can this count as one of the consecutive days?

Yes is the answer. On each day you are asked to indicate how long you spent in the clinical area. It does not matter if this time varies in length.

What if I spend one of the five consecutive days working in a clinic or out-patient dept/different area - would this count?

Ideally, for the sake of continuity and consistency, it would be better if your role development diary reflects experiences that will be a regular feature of your practice. For example, if you are likely to run a regular clinic session as part of your practice, then this certainly should be one of the five days. However, providing you are spending the

placement day undertaking activities related to your role, and not say, just observing (in which case treat it as another study day), then I can see no reason why this cannot be included as one of the days.

When is the best time for me to record my practice and experiences in the diary?
Ideally, you should complete the diary at the end of, or shortly after, each day of clinical practice. This has benefit that you will be able to accurately recall and record events and incidents that have happened on that particular day. If you leave it until the end of the five day period before making your entries, you are likely to be less accurate and even forget certain things, in which case the data will not be a true reflection of your practice development. The benefit for *you*, is that if you complete the diary on a daily basis, its format will become more familiar to you and it will take *less* time to complete, than if you are trying to make five days worth of entries in one go!

What if I "officially" only act as an advanced practitioner for part of the time, and the remainder of my time is "officially" spent undertaking my 'old' role?
This information is also of interest to me if the situation occurs. Please complete the entries in both instances as you would if you were "officially" acting in an advanced capacity. This will reveal if and how your role differs when acting in different capacities. In addition, it may show that you are actually involved in advanced activities, despite "officially" undertaking your 'old' role. If this situation does occur, please indicate so on the *General Comments* page for the relevant days entry.

Instructions for using the role development diary
The role development diary is split into five sections, one section for each day.
Each section (or day) has 9 pages dedicated to the following headings:-
* Direct Patient Care Activities
* Administration and Management Activities
* Education and Counselling Activities (Not directly involving the patients)
* Other Activities that you have been involved in today
* Your Practice and Educational Development
* Factors that have Helped or Hindered You in Your Practice Today
* General comments / Critical Incident (Optional)

The first four pages use a tick box or one word answer format, whilst the next five pages use a short answer and tick box format. In this way, I hope it will take a minimal amount of time to record what will be quite a lot of useful and interesting information. So whilst the diary may *look* a little long, I hope once you are familiar with the format, it will not take too long to complete. In addition, there may be days when one or more pages of the diary are not relevant, in which event **please write N/a** on the top of that page. (In this case it will take even less time to complete!!!).

If you are unsure where to record a particular event or experience, please enter it in the place you think most relevant, or on a separate sheet. The key factor is that you record it somewhere!

When you have completed the diary for the period of five days, please return it to me in the envelope provided.

If, you have any suggestions that would make the diary easier to use for you, (without loosing any of the information asked for) please let me know how, and I will do my best to adapt it for you for subsequent completion. Thank you once again for your assistance and cooperation

DAY 1: ACTIVITY ANALYSIS

NAME: _____ DATE: _____ WORKPLACE: _____

TIME SPENT IN DESIGNATED CLINICAL AREA: _____ HRS _____ MINS: TIME SPENT IN CLINICS / OPD / OTHER*: _____ HRS _____ MINS

(* Delete as necessary. Specify 'other' _____)

DIRECT PATIENT CARE ACTIVITIES

(*i.e. any activity involving the patient directly including; assessment, examination, investigations, nursing care, treatments, teaching /advice, counselling, etc.*)

State the number of patients directly cared for during the shift: [   ]

State number of patients directly cared for in your 'usual workplace' [   ] State the number of patients (if appropriate) seen in clinics/OPD/other [   ]

How much time out of the shift approximately, did you spend involved in direct care activities (see below) _____ HRS _____ MINS (Approx)

Which of the following activities did you undertake with the patients in your care (Complete for a MAXIMUM of 10 patients only). Please tick as many boxes as are relevant.

Tick the column marked S* if the activity you undertook was directly supervised, in person, by your designated preceptor/supervisor

ACTIVITY CARRIED OUT WITH PATIENT(S) (Page 1 of 2)	patient 1	S*	patient 2	S*	patient 3	S*	patient 4	S*	patient 5	S*
a: Nursing and Social History ONLY										
B: Full Medical, Nursing and Social History										
C: Physical Examination and/or Assessment										
D: Diagnostic Procedures and/or Investigations										
E: Standard Nursing Interventions; eg; dressings, hygiene and so on										
F: Interventions you consider to be 'advanced'/New for you										
G: Teaching / Advising										
H: Counselling / Comforting / Giving Information										
I: Other: (Please specify)										

DAY 1: ACTIVITY ANALYSIS

ADMINISTRATION AND MANAGEMENT ACTIVITIES

These activities would include for example, completing patients records, participating in ward rounds and unit meetings, using/answering the telephone, etc.

Which of the following administration and/or management activities were you involved in today. Please tick as many boxes as are relevant and indicate approximately the total amount of time during the shift (in minutes) you spent on this activity. Tick the column marked S* if the activity in which you were involved included consultation/checking with your designated preceptor/supervisor either in person or by telephone.

In which of the following Administration and / or Management Activities were you involved:	YES	Time spent overall on activity (mins)	S*
Reviewing patients nursing and medical records			
Completing patients nursing/medical records			
Ordering Investigations and/or interpreting the results of investigations			
Participating in ward/unit rounds with medical and / or nursing staff			
Attending ward / unit / department meetings for whatever reason			
Using / answering the telephone			
Writing / reviewing practice protocols / standards			
Planning & undertaking activities involved in bringing about changes in practice/organization			
Other (please state)			

DAY 1: ACTIVITY ANALYSIS

EDUCATION, COUNSELLING & TROUBLE-SHOOTING ACTIVITIES (NOT DIRECTLY INVOLVING THE PATIENT)

This includes any activity perceived as teaching, counselling, and / or trouble-shooting formal or informal, with students, relatives, nursing and other professional colleagues - **but not with patients on a 1:1 basis.**

Which of the following education, counselling and / or trouble-shooting activities were you involved in today. Please tick as many boxes as are relevant and indicate approximately the total amount of time during the shift (in minutes) you spent on this activity. Tick the column marked S* if the activity in which you were involved included consultation/checking with, or supervision by, your designated preceptor/supervisor either in person or by telephone.

In which of the following activities were you involved:	YES	Time spent overall on activity (mins)	S*
Counselling / conveying information to the patients family / relatives / friends by you			
Giving health education / teaching to the family / relatives / friends			
Formal or informal teaching of nursing staff, including nursing students by you			
Formal or informal teaching of junior medical / para-medical staff by you			
Advising/trouble-shooting for nursing colleagues regarding patient care questions/problems			
Advising/trouble-shooting for medical colleagues regarding patient care questions/problems			
Presenting a seminar / case presentation to nursing and / or medical colleagues			
Other (please state)			

DAY 1: ACTIVITY ANALYSIS

OTHER ACTIVITIES THAT YOU HAVE BEEN INVOLVED IN TODAY

This includes any other substantial activity you have been involved in today, for example, research or acting as a 'change agent' or sitting in on a clinic etc.
Please state the activity you were involved if relevant, and if the activity involved your preceptor / supervisor.

Type of activity	Time spent overall in activity (mins)	S*

DAY 1: ACTIVITY ANALYSIS

YOUR PRACTICE AND EDUCATIONAL DEVELOPMENT :-

What new / advanced skills, procedures, or nursing activities have you been involved in today, that you consider to be advancing your practice. These can relate to any aspect of your role, and can be activities you consider you are continuing to develop, not simply carrying out or being involved in for the first time.. Please state what the activity was, who was involved in teaching it (if relevant), and to what degree you were involved in the skill, procedure or activity. For this purpose please tick the appropriate category

O = You simply observed the activity being demonstrated;   G = you were guided through and actively involved in the activity;

S = you were supervised undertaking the activity and given minimal prompts when necessary; and I = You independently carried out the activity, without supervision.

Your description of the skill, procedure or activity	Taught by (please circle)	O	G	S	I
	Nurse Preceptor Doctor Lecturer Other (specify)				
	Nurse Preceptor Doctor Lecturer Other (specify)				
	Nurse Preceptor Doctor Lecturer Other (specify)				
	Nurse Preceptor Doctor Lecturer Other (specify)				

DAY 1: ACTIVITY ANALYSIS

FACTORS THAT HAVE HELPED OR HINDERED YOU IN YOUR PRACTICE TODAY

The penultimate page of today's activity analysis asks you to identify ANY factors that YOU considered to have aided or impeded your practice today. The factors can relate to anything, such as, time; equipment; the environment; the demands of nursing colleagues; the demands of medical colleagues; the support of staff; the types of patients you have been dealing with; pressures outside work; uncertainty about your role; and so on. Anything that you feel is relevant to the development of your practice.

WHAT FACTORS HAVE HELPED YOU IN YOUR PRACTICE TODAY?	
WHAT FACTORS HAVE HINDERED YOU IN YOUR PRACTICE TODAY?	

DAY 1: ACTIVITY ANALYSIS

GENERAL COMMENTS / CRITICAL INCIDENT (OPTIONAL)

The final page of today's activity analysis is an open page for you to comment on absolutely *anything* related to the role you are now undertaking and/or the concept of advanced practice. If you are inclined, you may wish to describe an incident that occurred today that to your mind demonstrates the concept of advanced practice. Likewise, you might like to describe an incident that prevented you from acting in an advanced nursing capacity. The choice is yours.

PLEASE TICK THE BOX (and comment if desired) IF YOU WERE OFFICIALLY UNDERTAKING YOUR 'OLD' ROLE TODAY (see page 3) [   ]

(i.e. Only tick if your role is *officially* [as determined by your managers] divided into 'advanced practitioner' part-time, and your old 'F'/'G' grade part-time)

GENERAL COMMENTS / CRITICAL INCIDENT DESCRIPTION

MANY THANKS FOR YOUR HELP IN COMPLETING THIS DOCUMENT. LW.

EXAMPLE OF A CONTACT SUMMARY SHEET.

Contact Summary Sheet

Name of Participant: XXXXXXXX - Clinical Nurse Manager

Case Number: 3

Date of Visit: 5/3/96   Site of Visit: Neonatal unit

Type of Visit: Interview / ~~Observation~~

Interview/~~Observation~~ Number   One

1: What were the main issues and themes that struck you about this contact?

* The nurse manager accepted that the ANP will be providing the same roles and skills that junior doctors have previously undertaken and that for a lot of the time they are likely to be liaising with Consultants and registrars for the care they provide.

* She sees the ANP role as an holistic role with the practitioner assessing, diagnosing, treating and following up babies in their care. Only liaising with the registrar or above when necessary.

* Consequently the role is seen as bridging the gap nursing and medicine, along with developing practice in both these areas.

* Perceived roles and abilities include; diagnosis; evaluating and prescribing care; taking on a caseload of patients; undertaking research & audit; teaching nurses and doctors and following patients up in out-patients.

* The only boundary of ANP care identified was in the area of providing a prognosis for care with a sick child - this was seen as the doctors area of practice.

* The characteristics required of the ANP include; good communication and interpersonal skills; a leader; experienced in the field and someone with credibility with nursing and

medicine.

* When defining the role of the ANP it was envisaged that initially most of the role would involve direct care, and that the medical team would have a big input into defining the role. The manager did note the need to develop practice in in-direct care activities in order to avoid stress and burn-out in the long term.

*Barriers to the implementation of the ANP were identified as primarily being a conflict from existing nursing staff in acceptance of the new role. The are also potential problems in competing for skills and experiences with other staff keen to develop their own practice.

* The main role of the nurse manager in the process is acting as a support and facilitator for the ANP.

* As yet, the method of evaluating the ANP has to be determined, but the nurse manager has some thoughts as to how this might be achieved.

* With regard to pay, the ANP will be going back on a trust scale - not Whitley grading.

2: Anything else interesting about this contact

*There appears to be a strong medical orientation to this role, with the medical staff taking a lead in determining the practice of the ANP. Whether this is merely political manoeuvring which may alter once the ANP is in place remains to be seen.

ROLE DEVELOPMENT DIARY - SUMMARY SHEET.

Diary Code 9- OCT 96: No of days documented: 5   Clinical Speciality: Respiratory Medicine/Elderly care:

SUMMARY

Total time spent in clinical speciality: (34.5 hours)
Total time spent involved in direct care activities: 14 hours 20mins (41 % overall)
Total time spent involved in Admin/ management: 10 hours 40 mins (31% overall time)
Total time spent involved in Education Counselling: 6 hour 25 mins   (19% overall time)
Total time spent involved in other: 3 hour 5 mins   (9% overall time)

VENUE OF PRACTICE:

Base Ward (95% overall time)

DGH (4% of overall time)

Another ward in hospital (1% overall time)

PERCEIVED NEW ADVANCED ACTIVITIES / SKILLS DEVELOPED DURING WEEK:

Redesigning nursing documentation + arranging to pilot (independent)

Physical exam of ill patient + undertook & interpreted ECG (independent)

Prescribing drugs (supervised - Dr)

Being referred patient in follow-up clinic by doctor.

Diagnosis - spirometry (independent)

Clinical management of patient (independent)

Discussion of patients management with GP (independent).

FACTORS PERCEIVED TO HAVE HELPED OR HINDERED PRACTICE DURING WEEK:

Helped: Communication with respiratory nurse specialist - facilitated role as she has
vision/motivation.

Liaison with Physio

Only GP on-call at weekends - more inclined to work autonomously.

Encouragement of Consultant

Increased confidence

Hindered: Time & resources - having to do mundane admin - off duty etc + routine work.

Staff sickness

Having a locum doctor

Lack of understanding by management of new role

GENERAL COMMENTS

Perceived increase in status & confidence

Perceived difficulty/tension in undertaking old role & new ANP role

Perceived could undertake service provided by junior doctor (cheaper) on ward

SPECIFIC DOMAINS:

DIRECT CARE: (Most frequent activities undertaken with care of 28 patients documented)

Physical Examinations: 13

Standard Nursing interventions: 26

Teaching/advising : 9

Diagnostic investigations: 4

Nursing / medical history: 4

Counselling: 15

Advanced interventions: 5

Other: (Discharge planning) 3

ADMINISTRATION & MANAGEMENT ACTIVITIES

Reviewing Records: 3 hrs 35 mins

Other: Off duty/budget etc: 3 hrs 35 mins

Organizational change act: 1 hour 50 mins

Ward Rounds: 1 hrs 40 mins

Telephone: 55 mins

Ordering Investigations: 35 mins

Protocol Development: 10 mins

EDUCATION & COUNSELLING:

Seminar/Case presentation: 1 hour 30mins

Counselling / health Ed: 1 hour 20 mins

Advising/ troubleshooting nursing: 1 hour

Advising/ troubleshooting medical: 50mins

Teaching nursing staff: 40 mins

Teaching junior medical staff: 20 mins

OTHER ACTIVITIES:

Supervision & Assessment of ENCC nurses as their preceptor: 2 hours

Organising for night staff cover: 30 mins

Organising admin for pt exercise programme: 20mins

Liaising with Physios: 15 mins

Part of the 'index tree' of case study 3

10* Role Development & Practice Innovation (*Category title*)

└

    10.1* Discretion and Novelty *(Sub-category title)*

    └

        10.1.1* High Novelty *(Code title - node contains 7 text units)*

    └

        10.1.2* Discretion *(Code title - node contains 4 text units)*

        └

            10.1.2.1* Day-to-day *(Code title - node contains 27 text units)*

        └

            10.1.2.2* Limited overall *(Code title - node contains 12 text units)*

        └

            10.1.2.3* Control by Consultants/Managers *(Code title-67 text units)*

Numbers relate to the node address as a unique identifier.

Final list of main categories along with common sub-categories.

List of five main categories and common sub-categories.

1. Entering the transitional process and gaining legitimacy

    1.1   Academic Preparation

    1.2   Legitimising practice

2. Personal Development and Managing the Transition

    2.1   Biographical data

    2.2   Intrinsic traits for managing the transition

    2.3   Personal changes

3. Intervening conditions in the transitional process

    3.1   Defining the parameters of role transition

        3.1.1 Scope and Focus

        3.1.2 Involvement of others

        3.1.3 Stake-holder priorities

        3.1.4 Lack of understanding and role ambiguity

    3.2   Organizational governance and the clinical context

        3.2.1 Deployment and locus of control

        3.2.2 Implementation of the role

        3.2.3 Nature of the clinical environment

        3.2.4 Barriers to implementation

        3.2.5 Evaluation

        3.2.6 Feedback

    3.3   Transitional relationships

        3.3.1 Managers

        3.3.2 Doctors

        3.3.3 Nursing colleagues

        3.3.4 Support

        3.3.5 Clinical credibility

4. Role Development and Practice Innovation

    4.1   Discretion and Novelty

    4.2   Benefits

    4.3   Leadership and practice innovation

    4.4   Boundaries

    4.5   Differences between ANP & nurse

    4.6   Autonomous practice

    4.7   Protocols

    4.8   Direct care activities

    4.9   In-direct care activities

    4.10 Skills

    4.11 Organization of advanced practice

    4.12 Risk-Taking

    4.13 Nurse Prescribing

    4.14 Impact of the ANP

5. Establishing a new nursing identity

    5.1   Lack of understanding of advanced practice concept

    5.2   Recognition

    5.3   Professionalisation

    5.4   Clinical status

    5.5   Loss of belonging.

The following is a set of propositions which were developed following 'cross' case analysis on completion of the study.

1: Entering the transitional process & gaining legitimacy

1.1 Academic preparation for role transition leads to personal development - (i.e the development of cognitive skills and knowledge base) - but does not necessarily lead to the development of new skills or practice innovation *during* the formal educational process. This occurs at a later stage.

1.2 Undertaking a Master's degree serves to 'legitimise' either, existing, or future clinical practice, by affording the practitioner academic credibility.

1.3 Understanding and clarification of 'advanced practice' as a concept emerges from contact with student peers, some clinical colleagues and through increased self-awareness during the transitional process. University lecturers have little credibility to define the key concepts of 'advanced' practice as they relate to the practitioner's clinical context.

1.4 Full-time academic preparation for role transition, resulting in prolonged time away from the clinical setting can create a mis-match between the practitioner's expectations of the new role and the expectations of colleagues in the work place. In addition, this may lead to problems with the practitioner's re-integration into the work place.

2: Personal development and managing the transition

2.1 Academic preparation for role transition leads to cognitive development (e.g.'changed way of thinking' and increased knowledge base) and affective changes (increased confidence and assertiveness). The development of clinical skills does not necessarily occur. All three of these domains are consolidated and developed further as role transition progresses.

2.2 The traits of the individual influence how the transitional process will be managed in the absence of a prior role model. [These include the practitioner's: motivational characteristics; their regard for 'nursing' values; ability and desire to be in control of the transition; (non-) 'risk-taker' characteristics; and their response to the intervening conditions which mould the transition].

3: Role development and practice innovation

3.1 The nature and pace of role development and practice innovation are contingent upon the prevailing *intervening conditions* (see category 4) within the practice setting and organization. Where intervening conditions are predominantly impediments to practice development, progress and practice innovation are

sporadic, stalled or even halted. Where intervening conditions are predominantly facilitative to practice development, progress and practice innovation occur.

3.2 Whilst practitioners are afforded varying degrees of discretion *within* the parameters of their role transition, the scope and focus of practice development and innovation is moderated by the organization (see *organizational governance,* a sub-category of intervening conditions). Consequently, role development and transition are either oriented toward the practitioner delivering direct patient care, or toward enhancing the system of care delivery.

3.3 Limited opportunity to engage in new or novel practices results in negligible role development and practice innovation, however, personal development may still be evident. This signifies either, delayed role development, or the legitimation of existing practice.

3.4 Where the practitioner engages in new or novel practices, role development and practice innovation will follow. Personal development is an inevitable consequence of role development. The extent of role innovation is regulated by degree of novelty and organizational governance.

3.5 A distinction can be made which differentiates the contrasting orientations of role development. When new or novel practices are "clinical" in nature, practice innovation is oriented toward the delivery of direct patient care. When new or novel practices are "non-clinical" in nature, practice innovation is oriented toward enhancing the system of care delivery.

3.6 In the absence of any prior frame of reference, new role boundaries are initially ambiguous. On a daily basis, practice boundaries are mediated by: the orientation of role development; the nature of the clinical environment; existing practice policies and protocols; and the 'risk-taking'/self-awareness characteristics of the individual.

3.7 When role development is oriented toward the delivery of direct patient care the advanced practitioner is distinguishable from other nurses by her: clinical competence; knowledge base; the possession of practice privileges; greater autonomy and practice independence; the focus and context of care delivery; and recognition of clinical expertise.

3.8 When role development is oriented toward enhancing the system of care delivery, clinical practice activities are similar in nature and standard to that of other experienced practitioners in the area. In this case, the advanced practitioner is distinguishable from other nurses by her: knowledge base; focus and the context of in-direct care activities; and recognition of her clinical expertise.

3.9 When role development is oriented toward the delivery of direct patient care the practitioner engages in clinical activities which differ in focus and standard from other nurses within the specialism. These activities predominantly relate to the assessment and management of patients with acute or chronic conditions.

3.9.1 Role transition is oriented toward the acquisition and development of the skills required to become effective in the new role. The nature of skill acquisition is determined by the specific clinical context in which role development occurs.

3.9.1.1 In the high dependency environment, skill acquisition is likely to include the goal of achieving competence in a variety of technical / invasive procedures, as well as the development of assessment and diagnostic skills, and increased familiarity with patient management strategies and clinical decision making.

3.9.1.2 In the acute/low dependency environment, lower priority is given to the development of technical / invasive procedures, with skill acquisition focusing more on: the development of assessment and diagnostic skills; increasing familiarity with patient management strategies and clinical decision making; and involvement in counselling and/or patient teaching. Furthermore, assessment and management of care is documented in the medical as well as nursing records, demonstrating an overlap in practice boundaries.

3.10 When role development is oriented toward enhancing the system of care delivery the practitioner engages in activities which differ in focus and standard from other nurses within the specialism. Skill development and activities predominantly relate to: staff development & teaching; clinical supervision; advising and 'trouble-shooting' for nursing and medical colleagues; and policy / protocol formulation. When called upon, the practitioner also acts in a consultant capacity to other wards and departments within the organization. Consequently, the practitioner acts as both an instigator and agent of change within the organization.

3.11 The demands of role transition toward either the delivery of direct care, or toward enhancing the system of care delivery, result in the practitioner having little active involvement in research or audit, despite an acknowledgement by stakeholders of the importance of developing these skills and activities.

3.12 When role development is directed toward the delivery of direct care, its impact on the delivery and organization of care performed by other nurses within the environment is minimal. When role development is directed toward enhancing the system of care delivery, its impact on the outcome of the delivery and organization of care performed by other nurses is in-direct and difficult to measure.

4: Intervening conditions in the transitional process

4.1 Defining the parameters of role transition
4.1.1 There is a lack of consensus and understanding of the concept of 'advanced practice' amongst nursing personnel and other professional staff.

4.1.2 Stakeholders within the organization have different priorities and expectations for the role development and practice innovation of the practitioner. Key stakeholders, i.e. senior managerial and medical staff, are actively involved in defining the parameters for the role transition. (This is part of organizational governance)

4.1.3 The parameters of role transition and practice innovation are framed within the context of the practice discipline; the specific clinical environment; and the organizational agenda. A lack of consensus and understanding can result in conflict between the practitioner and other stakeholders regarding the goal of role transition.

4.1.4 The aims of role transition and practice innovation are idealised by most stakeholders when initially defined - based on a wish list - as opposed to being pragmatically located within the constraints of the clinical and organizational setting. This can result in a mis-match between the expectations of the practitioner and other stakeholders regarding role transition and practice innovation.

4.1.5 The novelty of the transitional process leads to problems in identifying and establishing appropriate evaluation criteria to measure the success of role development and practice innovation. Consequently, role evaluation is ad hoc, and based upon varying conceptualisations and interpretations associated with the aim of the role transition.

4.2 Organizational governance and the clinical context.
4.2.1 When the practitioner is expected to manage the transitional process whilst maintaining the roles and responsibilities of a prior post, role transition and practice innovation are delayed or stalled. This results in the practitioner feeling frustrated and 'under-used'. There is a relationship between the rate and degree of role development and practice innovation and the way in which the practitioner is deployed within the organization.

4.2.2 The way in which the practitioner undergoing the transitional process is deployed within the organization is primarily resource dependent.

4.2.3 Whilst key stakeholders are actively involved in initially defining the parameters for the role transition, feedback on progress and role development are informal, infrequent and based on vague and varying interpretations of the aims of the role transition.

4.2.4 The number, and type of medical staff employed in the work environment influences the role transition process and outcome. Where there is an identified need to 'supplement' or 'replace' the delivery of medical services, the orientation of role transition is toward the delivery of direct care. Where there is an identified need to 'support' the medical services, or, medical services are adequate, the orientation of role transition is directed toward the system of care delivery.

4.2.5 The orientation, rate and experience of role transition is mediated by organizational governance and the clinical context. The key variables influencing the transitional process relate to: organizational stability; the availability of time to sustain practice innovation and development; the resources (physical & financial) available to the organization and within the clinical environment; control over the discretion of role development and practice innovation; deployment within the organization; the nature of professional relationships; and financial recognition for the practitioner.

4.2.6 When role transition and practice innovation are delayed or run contrary to the expectations of the practitioner, alternative employment may be sought.

4.3 Transitional relationships

4.3.1 Instrumental, verbal, and emotional support influence the process of role transition and practice innovation. Where support is present, role transition may proceed relatively smoothly and practice innovation occurs. Where support is minimal, role transition is perceived to be problematical and practice innovation is slower to occur.

4.3.2 During the process of role transition and practice innovation the practitioner experiences 'conflict' as well as 'support' from professional colleagues. Conflict occurs when: other stakeholders feel threatened by the role transition; disagree with the nature of role transition; or when the role transition fails to meet with their expectations. Conflicts reduce as acceptance of the role transition increases over time.

4.3.3 When role development is directed toward the delivery of direct care, the practitioner works more closely with medical staff, signalling a change in practice focus and boundaries. When role development is directed toward enhancing the system of care delivery, the practitioner works more closely with nursing staff, although relationships with medical staff also change throughout the transition period.

4.3.4 Throughout the role transition the practitioner is required to maintain clinical credibility with professional colleagues. When role development is directed toward the delivery of direct care, clinical credibility is measured against comparable practitioners (e.g. junior doctors). When role development is directed toward the system of care delivery, clinical credibility is measured against experienced nursing colleagues. Clinical credibility is enhanced by the possession of a relevant Master's degree qualification.

5: Establishing a new nursing identity.
5.1 The establishment of a 'new' nursing identity occurs as an outcome of role transition.

5.2 The establishment of a 'new' nursing identity relies upon the concept of recognition. This is afforded in a number of ways, including: 'professional' recognition within the clinical nursing structure (at a national level); a perceived change in status within the organization; a change in work title to 'advanced nurse practitioner'; altered relationships and work practices with professional colleagues; and increased prestige for the organization following the practitioner's role transition.

5.3 Recognition is not always afforded to the practitioner who has undergone role transition. Some stakeholders and other individuals either fail, or choose not to recognise any change in 'status' of the practitioner. Moreover, some organizations fail, or choose not to afford financial recognition to the practitioner, via a change in salary.

5.4 When role transition and practice innovation is oriented toward the delivery of direct care, the development of a new nursing identity is embedded in the 'clinical status' afforded the practitioner whilst involved in clinical practice. This is manifest by the practitioner being more empowered in practice, having greater authority, and having greater practice independence and autonomy in the day-to-day organization of practice and delivery of care.

5.5 When role transition is oriented toward the system of care delivery, the development of a new nursing identity is manifest in the different focus of the activities in which the practitioner is involved and the development of their knowledge base.

5.6 When role transition and practice innovation result in the development of a new nursing identity, clinical competence and practice independence (in the absence of nursing role models), are compared to the competence and practice of junior medical practitioners.

5.7 Whilst undergoing role transition and establishing a new professional identity, the practitioner can experience a sense of 'loss of belonging' from both their occupational group and the work-place in which they are employed. This phenomenon can be experienced for a prolonged or extended period (i.e. 12 months +).

5.8 Throughout the transitional process the practitioner's 'new' identity remains rooted within a nursing paradigm - as opposed to a medical paradigm - despite some change in practice boundaries. As such, the development of a new nursing identity may be viewed as a further move toward the 'professionalisation of nursing'.

5.9 Whilst developing her own practice in new and different ways, the practitioner appears to act as a 'gate-keeper' for the protection of nursing values in the delivery of patient care. However, where role orientation is directed toward the delivery of direct care, the practitioner's identity may become synonymous with that of a junior doctor in the eyes of some nurses and colleagues in the clinical setting resulting in the advanced practitioner experiencing a tension with their professional identity.

The following case study summaries are identical (with the exception of the removal of names and places for purposes of confidentiality) to those that were sent to ANPs for purposes of verification following completion of data collection. Due to practical and resource considerations, summaries were not sent to the other case study participants involved in the research.

The inclusion of the symbol - (?) - in the text relates to issues, questions and interpretations in the summary that required confirmation or rejection from the ANP. The quotations included in the summary are all utterances of the ANP as the inclusion of quotations from other case study participants would have compromised confidentiality. The data collected from the other study participants was however included indirectly when compiling the case summary. The summaries are divided into five initial working 'themes' which emerged from the data. These are titled:-

1: The Individual; 2: Relationships; 3: Professional Identity; 4: Clinical Practice; and 5: Factors Influencing Implementation and Evaluation.

CASE STUDY 1: RESPIRATORY MEDICINE

1: The Individual

The advanced nurse practitioner (ANP) has been a 'G' grade sister on an elderly care/respiratory medicine ward in a community hospital for 4 ½ years(?) More recently she has been temporarily acting-up as clinical manager for the hospital. Prior to commencing the Master's degree ... the ANP did not possess a first degree, but had undertaken a number of ENB courses and study days related to respiratory medicine and rehabilitation.

The ANP's motivation for undertaking the ... course was to gain academic and research skills in order to further improve standards of care and to gain legitimation for some practices she previously undertook (?)

"...it's basically giving me the academic skills that I need" (Interview 1: Jan '96).

"...and also I think to legitimise some of my practice, like drug prescription..." (Interview 1: Jan '96).

The ANP considers herself to be a progressive practitioner and a risk taker.

"I mean I've always been progressive and a risk taker". (Observation 13: Oct '97)

"... a lot of what I am doing hasn't got a protocol, you know, erm, so if I was sort of up in court I wouldn't have a leg to stand on with, I mean, I fly by the seat of my pants and... with a lot of what I do and I think, I want to sort of be able to have the ability to be able to write protocols for what I do..." (Interview 1: Jan '96).

The ANP however felt that she was already acting as an advanced practitioner in many ways before commencing the Master's degree course.

"This is one of my advanced practice days doing pulmonary rehab, however, I'm doing everything I would have done before the course". (Observation 1: June '96)

When the ANP started at the university she found the course to be at a lower academic level than expected, although the workload itself was perceived to be heavy. In her view some of the lecturers lacked clinical credibility as they had been away from practice for some considerable time (?)

"....a lot of them have been in just education for ages ... they haven't got a realism about nursing." (Interview 1: Jan '96)

Whilst the course was perceived to help legitimize many practices the ANP was involved in, emphasis appeared to be given to academic components (?) Consequently, the appropriateness of the course as a preparation for advanced *clinical* practice was questionable(?) Furthermore, in some ways the course was even perceived to be detrimental, as being away for a full-time year led to certain problems. This caused the ANP to reflect on her choice to undertake the course and it's benefits.

"I thought the course was really a waste of time and in some ways was detrimental". (Observation 13: October '97)

"If I knew what I know now I would never of done the course, I would have gone off and done and M Phil and completed my profile.(Observation 3: Aug '96)

Moreover, the ANP appeared to experience a loss of 'belonging' whilst undertaking the course and being away for a protracted length of time (?) although this feeling did not persist once she returned from the course (?)

"I feel like it's not my ward anymore. I hate it. It's like you just go onto it for things". (Observation 4: Aug '96)

The ANP expressed that fellow students on the course and work based colleagues were the most useful resources in considering the concept of advanced practice, rather than university based lecturers (?) Whilst on the course the use of learning contracts, and the jargon associated with them, led to some problems and their

usefulness as a learning resource was questioned(?) Despite these reservations about the course the ANP still considered a Master's degree to be important for advanced practice.

"I think it shows that you've got the knowledge and that you can work at a high level." (Observation 13: October '97)

On completion of the course the ANP returned to the ward as the 'G' grade sister. The ANP increasingly found herself undertaking her old role whilst at the same time trying to develop advanced practice. Whilst this caused frustration for some time, the ANP still held her 'traditional' nursing values in high regard.

"I'm still doing bed baths and all the normal things, working as a sister, which is what I still want to do". (Observation 5: Nov '96)

However, shortly after the ANP had completed the course she became pregnant. As the pregnancy progressed she lost motivation in developing her role. However, on return from maternity leave the ANP appeared to become motivated once again in attempting to develop her role further(?)

"While I'm pregnant I don't think I'm going to get anywhere while I'm like this, so I'm not going to do anything till I've had the baby and come back". (Observation 10: Feb '97)

The ANP is recognised as a knowledgeable, confident and assertive practitioner, and all of these characteristics were seen to increase following completion of the Master's degree course. The ANP is seen to have increased autonomy following the course (?) and to be more involved with clinical decision making.

"I mean I've been making loads of decisions and things like that. I mean I've virtually been prescribing a load of drugs with the exception of not writing it on the chart". (Observation 13; Oct '97)

2: Relationships

Before undertaking the ... course the ANP considered the hospital managers to be forward thinking and empowering of the nursing staff. However, changes in the management structure of the hospital has meant that latterly relationships are not as they once were and she now feels that managers have little idea her role (?)

"...they don't really have a clue about it". (Observation 8: Jan '97)

Whilst the ANP works in close collaboration in the rehabilitation programme with physiotherapists and occupational therapists, there appears to be some conflict between these groups, with the ANP's perception being that nursing roles are being eroded and lost to these groups(?)

416

When the Physio left, E stated that "they're trying to take over again and get all the credit - and I'm not having it". (Observation 10: Feb '97)

The ANPs relationship with senior and middle grade medical staff appears to positive, with the ANP is widely acknowledged as having the respect of the consultants.

"They respect, they certainly respect me as one of their colleagues..." (Interview 1: Jan '96)

Whilst having a good relationship with the consultant medical staff, the ANP also considers that on occasion they unjustly take credit for initiatives for which she has been responsible.

"the Consultants get all the credit for the service, but they don't do anything" (Observation 3: Oct '96)

However, overall the ANP has what she considers to be a good team working relationship with the medical staff (?) Part of her role is spent advising the staff grade doctors about patient treatments on the ward and with senior medical staff about pulmonary rehabilitation options for patients (?). The ANP considers the need to strengthen relationships between nursing and medicine to be important for the future development of nursing (?)

"I think what nurses need to do is make strengthen the relationships with doctors, not as handmaidens, but so they can understand more what we are about". (Observation 6: Nov '96)

The ANP considers that medical staff have greater understanding of the significance of the advanced role than do the nursing staff or managers This support is seen to be helpful in the development of her role (?).

"Generally, the entire medical staff understand the significance of the role and help and encourage. However, nurses and managers don't seem to have a clue..." (Role Development Diary: Nov '96)

The ANP has good relationship with the nursing staff on the ward and is treated the same as she was before undertaking the Master's degree course(?). However, the ANP is viewed to be a threat by some older nurses. The ANP herself considers that the significance of her achievements is not appreciated by the ward staff.

"I don't think the girls on the ward really appreciate the significance of the achievement, but it's made me feel different, even in every day life". (Observation 5: Nov '96)

The ANP has experienced general support in her endeavour to develop advanced

417

practice from all staff groups within her place of work, including nursing colleagues, junior and senior medical colleagues, managers - especially those in post before the course commenced, the hospital's other advanced practitioner, and fellow students on the Master's course. This level of support has been important for the ANP (?) More recently however the ANP has experienced a lack of support and understanding of the role, particularly from the hospital manager.

In addition to support, clinical credibility is seen to be an important factor in the development of the ANP role (?) The ANP had a lot of clinical credibility before undertaking the Master's degree course, however, since it's completion, her credibility has been seen to further increase and her practice become legitimised (?) However, in order to maintain clinical credibility it is believed to be important for the ANP to be seen as a role model, not only in her 'advanced practices and activities', but whilst undertaking basic nursing care on the ward.

"I know a lot of what I'm doing is the mundane stuff at the coal face, but I'm going to carry on doing them. It's the only way to have credibility with the girls, otherwise they'll just think, look at her all high and mighty.". (Observation 5: Nov '96)

3: Professional Identity

Upon completion of the course she took the title of advanced nurse practitioner, although it is acknowledged that there was some confusion over the meaning of the term. The identity of the ANP is known throughout the hospital and she is recognised for her clinical expertise (?) The need to be recognised as an advanced practitioner appears to be important to the ANP(?)

"... there's the things of seeing your practical outcomes with your patients, but I think the recognition for it, for instance...being invited to speak at the British Thoracic Society meeting. You know, like being recognised by all disciplines ..." (Interview 1: Jan '96)

The ANP is recognised by medical staff for her clinical expertise as is evidenced by patient referrals for pulmonary rehabilitation from Consultant physicians and GPs. However, once again, this is a practice that occurred prior to her undertaking the Master's degree course.

Once the ANP had completed the course and had become re-established in clinical practice, she perceived her status within the organization to have changed and with the exception of the ward nursing staff, felt she was treated differently as a result(?)

"It feels different putting my name and qualifications on letters and things. I think I am treated differently because of it." (Observation 5: Nov '96)

Acting as clinical manager for the hospital is seen to have raised the profile of the ANP and her skills to other staff in the hospital. Consequently, she is seen as somebody different by the staff throughout the hospital(?) However, the ANP still

418

considers herself to be a nurse and not a 'mini-doctor', although she does acknowledge that many things that medical staff routinely undertake on her ward could be performed by herself (?)

"At the time of the visit there was Nigerian Locum doctor whom, E thought "was not very good". She suggested that "now that's one of the things I could have done and for half of the money, but they haven't thought about that".(Observation 5: Nov '96)

The formal Master's degree qualification and change in status is seen to have given the ANP authority in her role and the power to effect change in practice (?)

4: Clinical Practice
On completing the Master's degree course the ANP returned to ... [the] ward and resumed her post as the 'G' grade sister. Due to various imposed restrictions, such as limited resources, the ANP was initially unable to implement the role as desired. However, over time, these restrictions are perceived to have lessened and the ANP now has some discretion in determining how to utilise her time on a day-to-day basis in developing the advanced role (?)

"Yes, I can choose what I want to spend time on, of course there are some things that need to be done, but compared to before I've got a lot more say in how things work. ..I've got a lot more control now and I really like it.". (Observation 12: Sept '97)

Despite differing expectations of the ANP role, the ANP is expected to define and own the role herself. However, whilst attempting to implement the role she and others readily acknowledge that it involves few new or novel practices that the ANP had not previously undertaken prior to the Master's course.

"Well it's not really that new at all. Some bits are, but a lot of it is what I was already doing before". (Observation 12: Sept '97)

The ANPs practice is organised between undertaking her 'old role' as ward sister, developing and running in-patient and out-patient rehabilitation programmes, and more recently, acting up as clinical manager. In the pulmonary rehabilitation clinic the ANP conducts patient assessments and plans treatment programmes aimed at improving respiratory function. Whilst she has had a major role in developing and delivering this service she has also involved some of staff from the ward and developed them as respiratory nurses to assist in the running of the clinic.

Both the ANP and others consider her practice to be autonomous. Examples of autonomous practice being; running the rehabilitation clinic independently; determining the need for certain patients to be admitted; and acting as a consultant to other wards(?)

Whilst many of the direct patient care activities the ANP is involved in are not necessarily different from those other qualified nurses on the ward perform, some aspects are clearly different. Examples of these include; conducting physical

assessments of patients - particularly respiratory assessment including spirometry; health education and counselling of patients - e.g. re drug and inhaler use/technique; performing chest physiotherapy; setting up nasal ventilation and determining the appropriate settings, based on diagnosis and interpretation of blood gas analysis. The ANP does however emphasise that the development of advanced practice is not simply the development of 'technical' skills(?)

"In the beginning I thought advanced practice was all about skills, but I don't think it's anything to do with what particular skills you've got." (Observation 3: Aug '96)

Whilst the ANP is involved in delivering direct care, a majority of her time is spent in activities that do not involve patients (?) (Role development diaries: Oct '96-Feb '97). These activities include; teaching other staff members, both on a formal and informal basis, as education is seen to be a prime advanced activity (?); being used as a resource and support for nurses throughout the hospital; acting as a change agent for such things as revising nursing documentation, as well as considering future changes such as the re-organization of the delivery of care and developing an assessment tool for respiratory rehabilitation(?); auditing the progress of pulmonary rehabilitation patients; acting as clinical leader for nursing staff on the ward; and advising medical staff about the treatment of patients. A substantial amount of time is inevitably spent involved in administrative and managerial duties associated with being the ward sister (?)

The majority of the activities that the ANP identifies as being indicative of advanced practice are predominantly associated with patient management and assessment. To a lesser degree, advanced practice is associated with invasive procedures and technical skills, teaching and supervising others, and initiating change (?) (Role development diaries: Oct '96-Feb '97).

It was hoped at the outset that the ANP would be able to prescribe medications for patients, however, because of the legal position, she has been unable to be involved 'officially' in prescribing medication. Despite this fact she has often advised, guided and influenced medical staff in their prescribing practices and has adjusted medications on her own initiative (?)

"I mean I've virtually been prescribing a load of drugs with the exception of not writing it on the chart". (Observation 13: Oct '97)

"... I think their steroids should be increased", and he'll sort of say "what do you think?" and I'll sort of say". (Interview 1: Jan '96)

However, the ANP takes it upon herself to alter inhaler therapies as she is seen to be the most knowledgeable practitioner in this field.

"I mean inhalers they leave all just, not only to me but to all the nurses". (Interview 1: Jan '96)

The difference between the ANP and other nurses is seen to be her superior clinical and assessment skills. The other key difference is perceived to be the knowledge base of the ANP and her increased ability to access information to enhance practice and change. The main impact of the ANP role is perceived to be in the development and delivery of pulmonary rehabilitation on an in-patient and out-patient basis. Whilst the benefit of the ANP acting as role model for ward and hospital nurses is recognised, to date there has been little impact on the day-to-day organization and delivery of nursing care on the ward, although this was not an anticipated outcome by managers. Other benefits of the ANP role have been identified as empowering nurses to develop their practice; improved standards of care; and other potential benefits trust wide.

"...I'll be like, still empowering the E' grades, but why shouldn't I be a Primary nurse and let the patients, the patients should benefit from my skills".(Interview 1: Jan '96)

However, the ANP considers that she is practising in an advanced capacity that is not always obvious to her colleagues (?)

"I feel I am practising as an advanced practitioner but that it's not always in an obvious way". (Observation 8: Jan '97)

5: Factors Influencing Role Implementation and Development
Whilst the potential benefits of deploying the ANP is a supernumerary capacity have been recognised, limited resources have meant that she has not been able to be released in such a capacity. As a result she is often required to fulfil the role of 'G' grade ward sister, with all the managerial and administrative responsibilities that go along with such a post. This has led to the development of the ANP role being stalled and delayed (?) As a result the ANP feels that her expertise and skills are being under used.

"But I just feel totally under used". (Observation 10: Feb '97)

A further reason for delay in the development may be linked to a general lack of understanding of the ANP role (?) Subsequently, the ANP has only received informal feedback regarding her role and progress as an advanced practitioner (?)

"Well I think I know what it is, but I don't think the staff and managers have a clue about what it is." (Observation 13: Oct '97)

Whilst it was perceived to be an expansive role and the potential for implementing it in a variety of ways were suggested, limited progress has been made (?)

"I mean if they want they could employ me on a supernumerary basis on the ward to make a big impact here, or they could employ me to work throughout the hospital or even on a trust wide basis where I could go out and run outreach clinics and what have you, but they're not doing any of that. Nobody here has got any vision " (Observation 8: Jan '97)

Others have suggested more recently that the ANPs priorities should be toward an educational role and acting in 'troubleshooting' capacity across the hospital as a whole.

The main barriers to implementing the role however were repeatedly identified as limited resources and insufficient time, and the ANP having to carry on in her old role as ward sister, despite this problem being anticipated as a potential barrier by managers at an early stage. A final personal barrier for the ANP is that she considers that she is not being appropriately financially rewarded for both her achievement and for what is anticipated from her as an advanced practitioner.

"You can see what I'm doing is not advanced practice. If they want me to do the Consultants clinics and things they're going to have to give me more resources. I mean they haven't given me the 'H' grade that I wanted, and if they expect me to do the job without providing the resources, well then I leave and get another job somewhere else. I'm sorry but that's the way it is". (Observation 6: November '96)

There are no formal plans to evaluate the ANP role and in the future, whilst it is hoped to deploy the ANP in a different capacity in order to maximise her potential, this is by no means certain or secured, and as such the future development of the role remains uncertain (?)

CASE STUDY 2: ADULT INTENSIVE CARE

1: The Individual

You are an experienced ITU nurse, having gained broad experience in the UK and USA and have often pushed yourself forward to gain new experiences. Prior to commencing the Master's degree... you had already completed a diploma in nursing and first degree in health studies. You were a 'G' grade sister on a 3 bedded ITU at ... hospital from July 1994 - November 1997, a unit which had been set up specifically with advanced nurse practitioners in mind. Having an interest in the concept of advanced practice you were encouraged and supported to apply for the ... course by your then clinical manager and clinical director. You appeared keen to take up the opportunity in order to not only progress your career, but to enhance your opportunity for promotion, further your education, and increase job satisfaction by improving patient care(?)

When you started at the university you found to your surprise that the organization of the course to be somewhat chaotic, due in part to prolonged sickness of some key academic staff members and the newness of the programme(?) Furthermore, rather than focusing on clinical practice issues associated with becoming an ANP, the course was perceived to be similar to a general Master's degree in nursing. Overall you questioned the value of many parts of the course as an adequate preparation for advanced practice, on the basis that whilst some of the course content was interesting and useful for personal development, it was perceived to be of little use in the practice situation.

"Q: In what ways do you think the course has prepared you to be an advanced practitioner do you think?
A: Not very well really. I think most of the preparation for the role has been what you've done rather than the lectures." (Interview 2: August '96)

This view was reinforced by the perception that a number of the lectures lacked clinical credibility with the course members and were seen to be divorced from practice. Together, these factors served to support the notion of a theory-practice gap(?)

"I think my concern is whether the course will prepare me adequately for this role, because I don't know really if erm, the academics really understand this role. They're doing what they think is right, but they're not in touch with reality." (Interview 1: Jan '96)

The university based teaching was supplemented by tutorials from your consultant and attendance at some SHO lectures. The problem with these were that they tended to have a 'medical' focus. In addition, the use of learning contracts throughout the course was perceived to be particularly problematical, both in terms of guidance for their use and completion. The following quotes suggest that conflicting expectations of supervision during the course, especially in terms of what had been committed to in the learning contracts, along with the uncertain future of the unit, were a

423

considerable cause of stress to you at that time(?)

"...I had several meetings with him [preceptor] and told him that I was really fed up and threatened to the point of giving up.". (Interview 2: August '96) as he was not giving you the input that he had initially agreed.

"...with not knowing what's going to happen to my unit, and the politics and the running of it, that's one of the things that is really a stress at the moment". (Interview 2: August '96)

Whilst you considered yourself to be at the 'specialist' level of practice before the course commenced, the following quotes appeared to suggest increasing ambiguity and confusion in the differentiation of advanced and specialist practice whilst undertaking the course, and to some degree following it(?)

" I don't know what advanced practice is. It's all very confusing. I think the [traditional medical] skills are really specialist level, not advanced.". (Telephone conversation: November '96)

"I have a problem with separating certain things, which is advanced and which is specialist that's the trouble...". (Interview 3: June '97)

Despite a number of problems identified with course, the view prevailed that a Master's degree is an essential requirement for advanced practice. One reason given for this, was that by having undertaken the course, the concept of advanced practice became 'legitimised'.

On completing the course you returned to the unit as a 'G' grade sister and over time became increasingly dissatisfied with the limited prospects of promotion, despite having undertaken what you believed to be a considerable amount of work(?)

" because they're not going to promote. That's one of the reasons I went for another job. ... [they] dangled the carrot of potential promotion but it isn't going to happen because ..[they've] got cuts in budget." (Interview 3: June '97)

Turbulence and uncertainty about the future of the unit and the hospital had a detrimental effect in moving the role forward. Your inability to develop the ANP role in the way you envisaged, due to increasing organizational constraints and managerial control, appeared to compound your frustration(?)

"But I can't do what I want , I have to do what they want. The management so to speak." (Interview 3: June '97)

You are recognised as a knowledgeable and confident practitioner. Both of these attributes were perceived to have increased following the ... course. You were also seen as the 'clinical nursing expert' on the unit and were often called upon for help

and advice by nursing and medical colleagues.

2: Relationships.

When you returned from the ANP course you were treated differently by the medical staff, although some of them did feel threatened when they learnt you were an ANP. Your relationship with the consultant staff both on and off the unit has generally been a positive one(?)

"... they're great, I get on very well with the Consultants, they respect my opinions and vice-versa." (Interview 1: Jan '96)

Whilst they have always respected you, your credibility was seen to increase further by having undertaken the ANP course. You experienced some conflict with one consultant, especially over the use of learning contracts and clinical supervision. These problems stemmed from the belief held by a number of people that experienced ITU nurses were already acting as advanced practitioners. Consequently, the consultants attitude appeared to be that you 'knew everything' before you went on the course and as such his input was not really required. Whilst he saw his role as being facilitator and keeping expectations in perspective, you felt his interest in development of the ANP role waned over time and he failed to keep the commitments he agreed in the learning contract. Some of the consultant staff have been seen to try and exploit ANPs in order to achieve their own ends. Arguably, this may be one reason medical staff are in favour for the role.

A lack of middle grade doctors on the unit meant that most of your contact was with either consultant or junior medical staff. Much of the time you spent with both senior(?) and junior staff involved guiding and advising them about the care of patients on the unit. Furthermore you played a major part in supporting the teaching of the SHOs. As such, it is acknowledged that many of the tasks that doctors undertake and about which you gave advice, nurses are equally able to perform and in some cases may perform to a higher standard(?)

"Many tasks that doctors do, nurses do better, for example, the classic is IV drugs. If I had the choice of being given my IV drugs by a nurse or a doctor I would choose the nurse every time." (Interview 1: Jan '96)

"Sometimes I'm advising them when they might be putting a central line in, I've done that skill but I'm not allowed to use it." (Interview 3: June '97)

In your time on the unit as an ANP you have had two clinical managers. The first manager showed initial interest in applying for the ANP post herself, however, during your time on the course her interest in the role too appeared to diminish and she later left following the merger with ...[a neighbouring] NHS trust. Whilst she was your manager, despite an initial positive relationship, you experienced some conflict relating to the development of the role. This included her not being able to provide the time she had promised to help you develop the role during the course, and excluding you from meetings about how the role could progress. Furthermore, she

objected to the medically focused skills in your learning contract that she had initially agreed upon.

"I was told that we didn't want these skills. I said you read my learning contract with the more medically orientated skills, when you read my learning contract you never had any objection before.". (Interview 2: August '96)

Following her resignation, despite reservations, you got on quite well with your new manager. However, you received little feedback from any of your managers about how you and the role were progressing, despite initially asking them how they wanted the role to develop(?)

"Q: How much feedback do you get on how your role is progressing?
A: I've had one session with [my manager]...
Q: No informal sort of feedback?
A: No." (Interview 3: June '97)

Your relationships with your nursing colleagues and fellow students on the course has been generally one of support for the role. However, during the course there was some resentment toward the role because its relevance to nursing was not apparent. Additionally, because the course was full-time and you were away for a whole year, some colleagues expressed suspicion toward the concept. Upon returning from the course, there was notion that you had to prove yourself to show the time had been worthwhile and that the role had relevance to nursing. Credibility with both nursing and medical colleagues was seen as being important to the success of the role. One notable example of this conflict and suspicion was with one of the 'G' grades, whom feeling threatened, had a number of disagreements about the ANP concept which eventually needed be resolved by recourse to your manager.

3: Professional Identity
Upon completion of the course you took the title of advanced nurse practitioner, however, when dealing with patients you did not introduce yourself as such, due to their lack of understanding of the concept. You acknowledge that some people view the ANP role as being a 'mini-doctor', you however do not, and consider your identity to be predominantly that of a nurse(?)

"I'm not a doctor, nor do I intend to be, and I'm not doing it to be a mini-one." (Interview 3: June '97)

The concept of ANPs is seen by some to give nursing more respect and to provide a career structure. The role is however seen by some to straggle the boundary between nursing and medicine, not as a junior doctor replacement, but as a different role. The title has however generated some confusion, not least of all for yourself, in as much as you consider your role to be closer to that of a clinical nurse specialist than anything else(?)

"I don't know how much, whether I'm an ANP or a clinical nurse specialist. I don't

really know, because it hasn't developed in all the areas that I would have liked to developed into." (Interview 3: June '97)

This perception of the role is shared with members of the university staff who defined the role in terms of a series of sub-roles often associated with the clinical nurse specialist.

Some believe there is a loss of nursing identity associated with the ANP role. Having undertaken the course and upon becoming an ANP your status has been seen to have changed with both the medical and nursing staff. That said, you were still considered to be one of the 'G' grades in charge of the unit and viewed as part of the nursing team. However, not everybody recognised this change in status, notably, one member of senior medical staff still considered you to be just another 'G' grade.

4: Clinical Practice

The experience of the ANP is considered to be an important issue in terms of credibility of clinical practice. Identifying advanced clinical practice on the ITU is however problematical, as much nursing practice was already considered to be advanced(?)

"...although, our scope of practice in ITU is quite advanced anyway and we've already been teaching many skills for the hospital staff". (Interview 1: Jan '96)

When you took up post you were eventually deployed in an 'ANP' capacity for 6 of the 13 shifts you worked (i.e. 46% of the time). In effect, this time was often relinquished due to the need to cover for sickness and manage the unit.

"The unit is tight on numbers and we're having to use agency staff to cover sickness and so on. I also act as on-call hospital manager...these days are taken out of my 'a' days" (Telephone conversation: Nov '96)

During the time you were not employed in an ANP capacity, you were acting in an ordinary 'G' grade capacity on the unit, often taking charge and holding the hospital bleep. As part of your new ANP role you became involved in number of groups and committees. Much of your practice was already perceived to be at a high / advanced level, and a number of things you were doing in your ANP role were not new to you as you and your ITU colleagues had already done a number of them before(?)

"Because I'm not doing a great deal more than anybody else anyway." (Interview 3: June '97)

"The idea is that they don't want me to particularly do anything different, or if I'm doing anything different, I'm going to feed it down to the other staff eventually anyway. They don't see the role for that." (Interview 3: June '97)

Consequently there was little in terms of the provision of direct care that was novel

427

to you, although you took a bigger role in decision making and patient management decisions in association with your medical colleagues(?)

"... I play a greater role in decision making than I think possibly the others [nurses] do".(Interview 3: June '97)

You had learnt one or two new clinical skills, but had little opportunity to use them. The major difference in the role was that you were involved in new indirect activities such as clinical supervision, audit and protocol development(?)

When acting in an ANP capacity, you had a great deal of discretion in how you organised your activities and time on a day-to-day basis. However, you had far less discretion in deciding in what areas the role could be developed due to being given a list of objectives to meet and having less than 50% of your time allocated to the ANP role(?)

"Well I've got those targets to achieve which I need to achieve. But on the days that I'm supernumerary, I can work that day, that workload as I want." (Interview 3: June '97)

When acting in an 'official' ANP capacity, the majority of your time was involved in activities to do with change, education, and consultancy(?) These included activities such as: working on the clinical supervision project; writing and reviewing protocols; being used as a practice and educational resource by nursing and medical colleagues; teaching nursing staff both informally and formally, including university teaching; being involved in the change process including promoting change and identifying deficits by questioning practice; developing new ITU documentation; and carrying out an audit of the attendance of the medical staff. Only minimal time was spent in new direct care activities and research, although you did become involved in audit(?)

Whilst there was an expectation for ANPs to take a lead in research, this was identified as their weakest trait. Consequently, the time you spent in an ANP capacity was seen to take you away from the bedside and often off the unit.

In terms of direct care activities with patients, you consider a number of the skills you have developed to be at the 'specialist' rather than 'advanced' level of practice. This particularly relates to the development of what might be termed 'technical/ medical' type skills, as opposed to assessment and patient management in which you played a greater part in the treatment decisions following the course. Due to the nature of the unit (i.e. not having 24 hour medical support) a number of other nurses by necessity have become competent in similar 'technical/medical' type skills. Consequently, there was little demonstrable difference between yourself and some of your nursing colleagues in terms of this aspect of practice, although you consider your competence in some skills to have increased(?)

" I don't particularly expect to be doing additional clinical skills that other nurses in

ITU don't already do. Although I originally thought that part of this role was being able to do skills that other nurses couldn't do. But that doesn't appear to be the case". (Interview 2: Aug '96)

Subsequently, your manager wished to see this aspect of the role expand. However, you struggled to get time to learn and develop new clinical skills, despite spending time with consultants in theatre gaining practice in such things as endotracheal intubation.

It was hoped at the outset that as an ANP you would be able to prescribe medication for patients, however, because of the legal position, you have been unable to be involved officially in prescribing medication, although you often advised and guided medical staff with regard to this issue. Sometimes however, you have 'bent the rules out of necessity'(?) eg. Starting IV fluids, altering rates, a practice acknowledged to take place by your managers.

"... we are bending the rules and people are starting IV fluids and altering rates and so on. I think my manager knows that it happens and she isn't very happy.
But because we've not got intensivist consultant cover after 9pm and no middle grade doctors it tends to happen". (Telephone conversation: Feb '97)

Whilst it is acknowledged that you have advanced your knowledge, and in this way you are advanced when compared to others, practice on the unit as a whole was not considered to have advanced noticeably. One reason stated for this is that nurses in the ITU were already seen to be practising at an 'advanced' level. As you were not seen to be anymore or less autonomous than other 'F' and 'G' grades, changes in practice were difficult to attribute to your role.

Whilst your clinical skills (i.e technical skills) were not perceived to differ greatly from those of other senior ITU nursing staff, the main differences between yourself and other nurses predominantly related to: your increased knowledge base; your professional awareness; your problem solving abilities; and some of the activities in which you were involved, such as clinical supervision and protocol development(?)

"So I get used as a knowledge base and am respected for that." (Interview 3: June '97)

One impact of the role has been to take ANP away from service, due to the nature in which they were deployed. Consequently, the role is seen to have had little Impact on the organization and delivery of nursing care, or reduction of junior doctor hours, although the latter was not particularly anticipated. One potential benefit of developing the ANP role is acknowledged in terms of a quality enhancement that may improve the development and practice of nursing staff in the longer term. For example, the ANP is seen to make nurses and medical staff think about their practice and question it, thus in-directly influencing care(?) One potential side effect of the ANP role that was identified (although it did not come to pass) was that the ANP could cause both nurses and doctors to become de-skilled if employed in large

enough numbers in a predominantly 'medical' role.

5: Factors Influencing Role Implementation and Development

There was, and remains, considerable confusion about what constitutes 'advanced nursing practice' (?) At the outset, you thought the role would involve predominantly expanding into medical areas, whereas nurse managers saw it as advancing nursing via a predominantly teaching role. Subsequently, your nurse managers had a great deal of control in defining into what areas the role would develop(?) Based on this, and a recognised need to evaluate the role, a set of objectives were agreed. Some of the expectations you had about the way the role would be develop were perceived to be unrealistic and over-optimistic by your managers. Some of your nursing colleagues and yourself also realised that not all the objectives were achievable. Whilst you acknowledged that advanced practice was to do with developing services, as opposed to simply the development of skills, the role in fact turned out to be very similar to that of a clinical nurse specialist.

The decision to deploy you and your ANP colleagues within the trust on a shared 50:50 basis, between the ANP role and 'G' grade manager, was seen to be resource driven. It was also recognised that as the ANP time was predominantly spent away from the bedside, if ever the ANP was deployed full-time in a supernumerary capacity, the result could have been the de-skilling of the ANP. Despite the intention to have approximately 50% supernumerary time to devote to the ANP role, in effect, much of this time was compromised by various situational factors leading to abandonment of planned ANP activities. The result of this unpredictability was to slow down the evolution and development of the ANP role (?)

In addition, further barriers to implementing the ANP role were identified. These included: the uncertain future of the unit prior to and during the merger with Heartlands, which resulted in a stalling of the role being initially developed; the lack of a consultant intensivist inhibiting the development of clinical skills (?); conflict with some nursing colleagues; organizational constraints, including staff shortages; and a lack of time.

An evaluation of the development of the role was to take place using the objectives you were set, although the difficulty in identifying measurable outcomes was recognised. Prior to this evaluation you were given little feedback about how you and the role was developing. It was suggested that the difficulty in identifying demonstrable differences and benefits of having ANPs was potentially damaging. Furthermore, It was pointed out that some 'F' and 'G' grades in ITU are already doing a number of the things associated with a higher level of specialist practice. Consequently, there was question as to whether a 'formally educated ANP' was needed to fulfil the role, as there were few new or novel practises occurring that could be attributed to the ANP. Despite these statements, the managers' expectations of what the ANP would have achieved at the end of one year in post were met.

In December 1997 you took up post as ITU coordinator ... elsewhere, which is predominantly a managerial post(?) Does this mean that the future development of

your practice will be in the realm of management and as a facilitator of change(?) Or will you be able to develop and 'advance' your clinical skills further in order to still be recognised as an advanced practitioner, as opposed to a unit manager(?) How do you anticipate the future direction of your role developing(?)

CASE STUDY 3 : NEONATAL INTENSIVE CARE

1: The Individual

The ANP is an experienced nurse, having worked predominantly in neonatal nursing since 1985. She has gained a lot of experience working on night duty and enjoys the intensive nature of the work. She was eventually promoted to a 'G' grade sister and as a consequence often took charge of the neonatal unit as the coordinator. Prior to commencing the Master's degree ... she had undertaken the ENB 405 course and had started her Diploma in Nursing (?) In terms of developing clinical skills, the ANP had undertaken a short, 'skills' based, in-house course that allowed her to practise a number of invasive procedures, such IV insertion, phlebotomy, and intubation (?)

When the opportunity to undertake the ... course arose she was attracted by the programme being at the Master's degree level(?).

"... and the fact that the advanced nurse practitioner course ... was going to be a Master's degree and it was nice opportunity". (Interview 1: February '96)

When she started at the University ... the course was not what she expected it to be (?) To her surprise the delivery of the course, especially in the first term, was seen to be chaotic and disorganised(?)

"Yes it really only this term that it's been organised properly. It was chaos, we felt it was absolute chaos last term". (Interview 1: Feb '96)

The problem with the course organization appeared to resolve following the arrival of a neonatal pathway coordinator shortly after it had commenced(?) The academic workload related to the course was seen to be considerable and caused problems in creating time for gaining relevant clinical experience, which was predominantly left to the ANP to organise(?)

"... I think basically its left to all of us to decide what's best and when to get on with it". (Interview 1: February '96)

Consequently, as opposed to being clinical in orientation, the emphasis of the course appeared to be toward meeting academic requirements. As a result, the amount of time spent in clinical practice was limited and considered to be inadequate in preparing her to undertake certain aspects of the advanced practice role upon her return to the neonatal unit (?) As such, she considered that when she first returned to work following the course she had to 'start from scratch' in developing her clinical skills to be able to perform the role expected of her(?)

During the course, she also had reservations about the academic 'level' required to become an advanced practitioner. Whilst acknowledging that the UKCC had set the level at Master's degree level, she wondered if it was too high(?)

The ANP was successful in completing her Master's degree and a number of benefits

from undertaking the course were identified by herself and others. These included: an increased knowledge base; becoming more reflective and questioning of practice; increased confidence and assertiveness in practice; and gaining multiple qualifications from the one course(?) However, the ANP considered that these benefits were primarily associated with her 'personal development', and that consequently the course had only been of in-direct benefit in developing the clinical skills required of the advanced practitioner(?)

On completing the course she returned to the Neonatal Unit on a trust contract and was employed in a new capacity as an advanced neonatal nurse practitioner. Following some lengthy negotiation, involving union representation, a job description and separate pay structure for the ANNPs was agreed.

When she first returned in her new capacity, she was extremely nervous and unsettled and had mixed emotions about meeting the expectations of her new role and consequently felt vulnerable(?) These feelings are perhaps a reflection that whilst the ANP does not consider herself to be a 'risk taker' in practice, her new role has the potential to place her in 'risk' situations(?)

"... I've never been one to throw caution to the wind. I err on the side of caution all the time. (Interview 1: February '96)

A number of specific issues were identified as being the cause of the ANP's initial anxiety. These included: having to work in an 'on-call' capacity, unsupervised; having a different relationship with medical staff; presenting babies on ward rounds; and the potential loss of some of her nursing skills(?) As a result of these anxieties the ANP was viewed initially to be lacking in confidence in the performance of her new role(?) Over time however, the ANP is seen to have become less anxious and more confident in her practice.

"... I am feeling more confident and, what's the word, less timid about putting my view forward". (Observation 20: October 97)

It appeared to take 9 months for the ANP to fully settle into practice, however, she now appears to be more comfortable in the role she is performing(?)

"I've been a lot happier in the role over the last two weeks or so". (Observation 17: Jul 97)

2: Relationships
On returning from the course the in her new capacity the ANP had to re-establish relationships with her nursing and medical colleagues on the unit.

Support for the ANP and the concept of advanced practice appears to have been an important issue in the implementation of the role(?) During the ... programme, the ANP received considerable support from her colleagues on the course and family, managerial

support was however considered to have been lacking. (?)

"...I think we feel we haven't been supported particularly well, I've got to say, by our nurse managers, various aspects of the course... we've felt a bit let down by them so far". (Interview 1: Feb 96)

On return to the unit, managerial support was seen to remain ambiguous(?) The nursing staff on the unit however considered that they were supportive toward the ANPs (?) Furthermore, the ANP felt that the junior medical staff and registrar were of help in providing instrumental support(?)

"I have to say though that the SHO's have been helpful and supportive, and
we do get feedback from them, and think we're doing OK". (Observation 15: Jun '97)

Whilst senior medical staff and managers have been very supportive of the 'concept' of advanced practice, they have not been seen to provide instrumental support(?)

"I'm really fed up at the moment. We're not getting any support from the consultants and from the managers". (Observation 15: June '97)

Due to changes in accountability, the relationship between the ANP and the clinical nurse manager on the unit is also seen to have changed. It is the ANPs perception that the clinical manager initially felt threatened by the new role(?)

"I think should does feel threatened by us". (Observation 14: March 97)

The change in lines of accountability does appear to have created some confusion regarding the expectations of each party toward the other, and communication between them at times has been problematical(?)

The ANP has received a mixed reaction from the Consultant medical staff, despite initial support in providing tutorials and learning experiences throughout the ... course(?) There appear to be a number of different factors that have created this feeling of 'tension'. The first relates to differences in conceptualisation of the advanced practice role(?). The consultant staff view the role as primarily a clinical one, effectively delivering a similar service to that of an SHO. The ANP however does not envisage the role in the same way(?)

"They want us to have this 90% clinical role, and we don't see it like that, so that's creating a lot of hassle". (Observation 11: Jan '97)

As a result, the ANP feels that the implementation and orientation of the role is being dictated and controlled by the medical staff [and managers] (?)

"... the Consultants don't like the idea of the new rota... they want us to be clinical all of the time...". (Observation 15: Jun '97)

This was particularly evident when the ANP first returned from the course in that a lot of her time was spent working under the direction and supervision of medical staff (?) It is also likely that as the ANP is now clinically accountable to the consultants that they feel they have 'control' over the development and implementation of the role (?) This is evident in that the ANP recognises herself that she is going through a similar socialisation process to that of junior doctors (?)

" It's like the only way you have any credibility is by going through the same process as they went through as doctors, you know being dropped in at the deep end, being excluded. ...".(Observation 14: March '97)

Additional causes of frustration between the ANP and the consultant staff relate to a lack of feedback and being 'excluded' and treated differently(?)

"...the other thing is that we don't get any feedback from the Consultants". (Observation 15: Jun 97)

"Also, I feel we're not being included in the decision making process, especially on the rounds. If we start presenting a case you're just not allowed to finish. Either the notes are taken from you or the Consultants just divert the questioning to the registrars and SHO's. (Observation 14: March '97)

A different reason suggested for the 'strained' relationship between the Consultants and ANPs is related to the newness of the role and the fact that consultant staff are not used to dealing with nursing staff who propose changes in medical working patterns(?)

"We're having problems with the consultants - as soon as we suggest something they're immediately against it - I think it's because they're not used to ANPs who question.(Observation 11: Jan '97)

However, recently, the relationships has begun to improve between the ANP and Consultant staff(?)

"...I think the consultants are more used to us now. They don't seem to getting on to us as much as they used to, they've backed off a bit, so that's quite good. (Observation 20: Oct 97)

Consequently, the reaction to the concept of the advanced nurse practitioner on the unit have been mixed. Whilst the Master's degree qualification is seen as providing academic credibility to the ANP, some acknowledge that the ANP has had to prove herself and her clinical ability, especially to her medical colleagues(?) Junior medical staff on the unit at the time the ANP role was originally implemented viewed the role as being identical to that of their own, in that the ANP was seen to perform all of the same functions and activities as they performed.

"Well no, they've just replaced the SHO who isn't here.".

As such, some problems were encountered between the ANPs and the career paediatricians, as both groups were initially competing for the same experiences(?)

"The SHO's who are on GP rotation appear to be more accepting us than the career paediatricians who are aggrieved at having to compete for opportunities with us to develop their skills...". (Observation 11: Jan '97)

Despite these types of problems, the relationships between the ANP and the junior medical staff have on the whole been positive(?)

It has been identified that nursing staff on the unit perceive the ANP role to medically oriented and that the ANP is no longer perceived to be 'one of the nurses' (?) Despite this perceived change in identity, the relationship with nursing staff on the unit, particularly with those colleagues who were known to the ANP before undertaking the Master's degree course, are not perceived to have altered(?) As such, the ANP is seen to have the respect of the nursing staff on the unit, which she previously held in her capacity as a 'G' grade sister. However, it is acknowledged that the ANP was initially viewed as a threat by some of the more senior nurses (?) In recent times, these problems have lessened as nursing staff on the unit become more familiar with the ANP role.

The ANP has also found considerable support in the role from her fellow ANPs on the unit. Some, however, have viewed this relationship negatively, in that she and the other ANPs are seen to be too dependent upon each other(?)

3: Professional Identity
Upon completion of the course, the title of advanced neonatal nurse practitioner was adopted and a new contract of employment outside of the nurse clinical grading structure was negotiated. This had the effect of sending a message that the ANPs had a different professional identity than their nursing colleagues on the unit(?) This inevitably led to comparisons between the role of ANP and that of other nurses and junior medical staff on the unit(?)

Consequently, nursing colleagues of the ANP appeared to primarily compare her clinical competence with that of junior medical staff, and on occasion, the ANP herself compared her practice with that of medical colleagues(?)

"It's nice because we can read your writing and can understand better what you want us to do".(Observation 16: Jul '97)

"I wasn't very happy with the new SHO even though she's done neonates before. I had to keep telling her to do things properly. She didn't extend the neck properly, she wasn't doing cardiac massage properly, so I thought we better have a registrar here....".(Observation 12: Feb '97)

It is recognised that the ANP is becoming increasingly competent and confident in practice, with the expectation that at the next intake of SHO's the ANPs will be more

competent than the junior doctors(?)

Another indicator in the change in professional identity of the ANPs was also evidenced by the fact that the ANP had to seek additional practice indemnity insurance from the medical defence union(?)

Whilst the ANP acknowledges that the role she is currently performing is similar to that of the SHO, she sees her professional identity as a nurse (?) This movement back toward a nursing orientation is corroborated by some colleagues(?)

"... actually it was quite gratifying the other week because one of the nursing staff said to me I can see you... are beginning to move away from the doctors". (Observation 15: Jun '97)

Nursing staff and midwifery staff do however, often appear to treat the ANP in a similar way to they would treat the medical staff(?). This was apparent by numerous interactions between the ANP and nursing and midwifery colleagues of which the following are just two examples.

'The ANP asked one of the midwives for a referral form, the midwife said to one of her colleagues "the *paeds* want a referral form" This appeared to be stated automatically without any thought or intent'. (Observation 15: Jun '97)

'The ANP went back to the baby she had undressed and examined it. When she had finished the examination she started to dress the baby. One of the nursing staff said to her, "Do you want me to do that?", the ANP replied "No, it's alright. I'm still a nurse'''. (Observation 7: December '96)

The senior medical staff also view the ANP to have a different identity to that of other nurses on the unit, as can be evidenced again by a number of interactions.

'A HCSW approached the ANP to deal with a query from pharmacy (that could have been dealt with by any of the nursing staff). The Consultant who was present said, "That's a nursing role, not an ANP role, you've got to learn to say no to that type of thing". (Observation 14: March '97)

The view held by some nursing colleagues and senior medical staff is that the ANP has got to be seen as different from the other nursing staff or junior medical staff on the unit, and create their own identity. However, it has been recognised that this has almost resulted in a loss of professional identity for the ANP (?) as is shown in the following example.

The ANP said "I was in room 1, and one of the babies in room 2 needed resuscing. So the nurses crashed the SHO and Registrar, nobody came and got me, and I was in the next room. It was only after they'd [medical staff] arrived that I realised what was happening. So there is a communication problem. At the moment I'm feeling excluded all in all and I'm neither one thing or another". (Observation 14: March '97)

Overall, there does seem to be evidence to suggest that the ANPs are perceived to have a different professional identity within the organization (?)

4: Clinical Practice

When the ANP took up post she was deployed in a full-time, 'advanced practitioner' capacity, and thus not included in the nursing staff compliment. Immediate priority was given to learning and gaining competence in the 'medically' focused skills which were needed to be able to fulfil the role. (?)

Consequently, much of the ANP's time is spent in undertaking medically focused activities, virtually identical to those of junior doctors(?)

"As far as we're concerned, we're not going to be junior doctors were going to be, junior doctors plus, if you like. Doing lots of their roles and skills, but also keeping our hands on the babies and looking after the babies and families as well. (Interview 1: Feb '96)

The 'medical' orientation to practice is evident from the way in which the ANP's working day is organised(?) For example, in a morning the ANPs join with the medical staff to review the babies in each of the rooms. During this period the ANPs perform in a similar capacity to the SHO's in terms of conducting physical examinations, reviewing nursing records and results of investigations, and completing the medical notes. Further examples include the ANP attending resuscitation's and deliveries in the labour ward and conducting 'baby checks' on the post natal wards. Perhaps most indicative of the medical orientation of the role is the partial inclusion of ANPs on the SHO rota, even though the ANPs have their own duty roster(?)

Whilst the ANP has plans to develop other aspects of the advanced role, to date, most of her time has been spent in clinical activities(?) Consequently, whilst she has lot of discretion in her day-to-day work, especially over the care she delivers and the autonomy to make decisions, she has limited discretion to choose how the role is implemented and developed in more expansive ways(?) The main reason for this is that she is restricted by the unit's routines, and the need for ANPs to replace junior medical staff activities such as wards rounds, daily examinations and treatment and post-natal baby checks(?) More recently however, the ANP has allocated extra time in her rota, along with her colleagues, to develop other activities within the scope of advanced practice. However, much of the time allocated for these activities has been compromised due to the need for the ANP to meet clinical commitments on the unit(?)

'She felt that there was some discretion but that when it was very busy the ANPs were pulled back in to do the clinical work'. (Observation 15: June 97)

"It's just been too busy, so the non-clinical time has gone by the by. I mean we've just had a lot of holidays, so we have been covering for each other and some of the SHO's". (Observation 20: Oct '97)

When in practice, the ANP is involved in what could be termed few 'standard' neonatal nursing interventions or practices(?) Much of her activity and training has been directed toward 'medical' assessment, arriving at differential diagnoses (?), and the treatment

and management of sick neonates. Whilst the ANP had acquired a number of 'enhanced' clinical skills before commencing the ANP course, she has continued to develop additional clinical skills where necessary. These have included: physical assessment and examination skills, such as auscultation and palpation; invasive procedures such as insertion of UACs, lumbar punctures, and intubation; and skills relating to investigation interpretation - such as X-ray interpretation. Whilst many of these are skills are medical in orientation, competence in them is seen to be essential in order to fulfil the requirements of the advanced practitioner role(?) The ANP is acknowledged to have achieved competence in a number of skills, however, she continues to find some new skills difficult to master, namely identifying heart murmurs and X-ray interpretation. The ANP is nonetheless perceived to be technically competent by the senior medical staff, and is seen only to need to refer to medical staff when dealing with something outside her ability or experience.

In addition to developing clinical skills the ANP plays a role in advising and 'trouble-shooting' for the nursing staff in the unit. In having a neonatal nursing background and following development of her clinical skills, she appears to be increasingly used as a resource by the nursing staff for help and advice about the care and management of neonates(?) As the ANP role has become established in the unit, she and her ANP colleagues are being called upon more than the SHO's to provide advice and help(?) The range of advice requested is varied as can be seen in the following examples.

'The nursing coordinator for the day then arrived and asked the ANP if a baby that was being transferred from the unit to another hospital would need the high dependency team or just a nurse. The ANP advised that only a nurse was required on this particular occasion'. (Observation 11: Jan '97)

'Whilst at the nursing station one of the nursing staff came to the ANP asking about the discharge planning for a baby in her care'. (Observation 13: Feb '97)

'One of the nursing staff attracted the ANPs attention to ask her advice about when Vitamin D should be given and the correct dosage.' (Observation 8: December 96)

As well as being involved in the day-to-day routine management of neonates the ANP plays an increasing role in the resuscitation of babies, both on the neonatal unit and in the labour ward. Following on from this she is also involved in the transfers of babies to other units, taking over the role that junior medical staff used to provide(?)

Whilst the role has predominantly focused on clinical practice to date, the ANP has also been attempting, along with her ANP colleagues, to initiate changes in the neonatal unit. These have included: the development of new documentation for admissions; developing guidelines for drug-compatibility: and initiating the neonatal forum on the unit.(?) The ANP has also become involved in teaching nursing staff and new SHO's on the unit, both on an informal and formal basis. Additional teaching has been carried out with students on the ....Master's course and on a neonatal unit ...[elsewhere] (?)

However, due to the majority of time involved in clinical activity, changes attributable to the presence of the ANPs have to date been limited(?) For the same reason (?) the

ANP has had little opportunity to develop the research activities, which are identified in her contract of employment.

The ANP role is perceived to be both new and novel, consequently, a number of identifiable differences between the practice of the ANP and that of experienced neonatal nurses in the unit are evident. The primary differences are perceived to be: the ANPs knowledge base; her ability to undertake physical assessment and initiate treatment and investigations based upon her findings - i.e. patient management; prescribing privileges; and certain psychomotor skills - although enhanced nurses also perform a number of similar skills(?) These differences all suggest that the ANP has greater autonomy in decision making in practice(?) However, the ANP feels that for a considerable amount of time she was prevented and excluded from developing her clinical decision making skills, by the presence of medical staff(?)

"..you may have noticed on the round that most of the discussion was between the doctors, and [names another ANP] and I are being excluded. The most we were asked to do was look at an X-ray".(Observation 7: December '96)

"I don't think I've made one single treatment decision whilst I've been in this role, except when being on resuscitation in theatre or labour ward, and even then, the last time that happened the registrar took over when he arrived. ...there are just too many doctors and they tend to take over". (Observation 14: March '97)

Problems developing decision making skills were not perceived to be an issue in the view of the junior and senior medical staff with whom the ANP worked(?) Both groups perceived the ANP to be developing her decision making skills appropriately. More recently however, the ANP perceives that she has become increasingly involved in the treatment decisions affecting the neonates in her care, a view supported by observation of her practice(?)

'I asked if she was becoming more involved in decision making, she replied "yes, I think I am making more decisions now. I am feeling more confident and, what's the word, less timid about putting my view forward. (Observation 20: October '97).

As many of the activities in which the ANP is involved are either relatively new to her, or legally sensitive, such as drug administration, she uses a set of guidelines originally compiled for the medical staff. In some cases, specific protocols have been written purposely for the ANP, such as the drug administration protocol. This protocol enables the ANP to order and administer a wide range of medications, including anti-biotics(?), with the provision that the order is signed within 24 hours by a member of the medical team. This policy is currently being reviewed in light of some concerns that it is not always being adhered to within time-frame specified(?). Whilst the ANP uses existing guidelines she has also been involved in writing protocols for the post-natal wards, including one on hypoglycaemia, hypothermia and one baby checks and the most common conditions encountered by paediatricians(?)

A number of actual and potential benefits have been identified and associated with presence of ANPs. These include: recognition as a highly skilled practitioner providing

440

a better standard of care for the infant - especially in comparison to SHO's; a continuity of care - identified with stability of the ANP in contrast to the rotation of SHO's; being a role model and resource for the nursing and medical staff; communicating with patients on a more appropriate level; improved record keeping - which is already evident; and a better induction for junior medical staff(?)

The ANP is however perceived to have had little direct impact on the delivery or organization of nursing care.(?) However, ANPs are seen to have an impact on the number of SHO's now employed in the unit. This is perhaps an additional factor that associates the ANP with acting as a doctor replacement, although she is perceived to have had little direct impact on the working hours of those SHO's employed in the department(?). A potential negative impact of the implementation of the ANP role has been identified as de-skilling doctors and adversely affecting their training. However, senior medical staff view this as an inevitable effect of the necessity to reduce junior doctors hours.

Overall, the ANP is perceived to be a competent and autonomous practitioner.

5: Factors Influencing Role Implementation and Development
A number of factors have influenced how the advanced practice role has developed and has been implemented to date.

Of key significance in determining the way in which the ANP has been deployed, is that the number of SHO's rotating through the neonatal unit has reduced (i.e. less GP trainee junior doctors). This led some to believe that the primary purpose of the ANP was to replace those SHO's no longer rotating through the unit(?) and was consequently responsible for the ANP's taking on those activities previously performed by doctors(?)

"Q: Do you feel that because you are one SHO down in reducing the number of doctors hours, that the evolution of the [ANP] role is primarily a clinical one?.
A: I think that is the main reason for the role developing like it is".(Observation 19: September '97)

The ANP however identified some benefits to the advanced practitioner replacing the junior doctor in this way(?)

"... I still think at the moment he thinks we're going to take up the slack with the junior doctors going. And I think we will do to start with, because I think that will be good way to get in there a gain some of the experiences in assessment and diagnosis, treatment and all that kind of thing". (Interview 1: Feb '96)

The way, and the rate at which the role has developed also appears to have been influenced by the ANP being employed on separate contract and deployed in a supernumerary capacity from the nursing compliment(?) This has meant that the ANP has not been called upon to fill gaps in nursing staff shortages and has been able to dedicate all of her time to developing the role.(?)

Initially, however, there was considerable confusion amongst staff on the unit as to what the ANP role involved. This led to a degree of ambiguity in their understanding and expectations of the ANP.(?)

"It is difficult because the senior nurses see the role as one thing and the doctors as something else, and we see it something in between". (Observation 3: July '96)

"At the moment the nursing staff see us shadowing the doctors and might consider us to be more like doctors, but a the present time a lot of people are unsure." (Observation 11: Jan '97)

This ambiguity led to one or two confrontations with members of nursing staff(?) The ANP relayed the following account of one such incident.

"She said well you work with the doctors, you socialise with the doctors, you have lunch with the doctors. Does anybody know what you are doing! It's all secretive behind closed doors!". (Observation 15: June '97)

However, following contractual negotiations, a job description was agreed outlining the main responsibilities of the role. Subsequent to its agreement, the ANP has kept her nursing colleagues and others informed of how the role is developing. (?)

"I said we do have a job description which is available if anyone wants to see it. We've also been holding these forums where we've updated people what we're doing". (Observation 15: Jun '97)

A feeling has remained however, that the senior medical staff have had considerable control over the deployment of the ANPs(?) Consequently, the ANP considers that the role has been largely dictated to her by the medical staff.

"...they felt it should be 90% clinical duties and 10% of the time for all the other things. And we don't see it like that at all. We want to do a lot of other things, we're not just here as replacements for junior doctors". (Observation 10: January '97)

'The ANPs both felt that the Mangers and Consultants on the unit wanted them to be responsible for implementing the changes, but at the same time wanted to be in control - which was causing problems to the implementation of the role.' (Observation 11: Jan '97)

This perception of the role as a replacement for junior medical staff created some problems between the ANP and a group of SHO's who believed the role to be similar to that of their own(?) As a consequence of these problems, the ANP felt that the Registrars and SHO's didn't have a full understanding of her role and has subsequently planned to ensure that when the doctors change over in the future that the ANP role and responsibilities are fully explained to the new staff(?).

In appraisals with her manager and consultant, the ANPs progress has been seen to

442

have been positive. However, the ANP appears to desire more feedback about the her performance, which to date seems to have been sporadic(?)

"We need to have more feedback. At the moment nobody says anything to us, so we don't know if we're doing OK, are rubbish or what". (Observation 14: March '97)

In terms of evaluating the impact of the new role, the expectations of what the ANP would have achieved at this stage in her development have been met for all the senior staff. However, they acknowledge that the potential of the role has not yet been fully achieved (because of the factors outlined above).

In the future, it appears that the ANPs intend develop the role into other areas and to redress some of the problems they have experienced whilst acting largely as clinical replacement for SHOs. With the number of ANPs increasing to 4 in the near future, there is a likelihood that time may be made available to achieve this goal(?)

CASE STUDY 4: GYNAECOLOGY

1: The Individual

The ANP has been an 'F' grade sister working on a gynaecology ward since December 1994. Whilst keeping herself up to date in her speciality, she had not undertaken any further education prior to commencing the Master's degree ..., other than an ENB course and occasional study days. Whilst she relished the challenge that undertaking the Master's degree would pose and saw the course as a way of progressing her career, she anticipated that her lack of academic qualifications would inhibit her chances of being accepted onto the programme. Initially, this proved to be true and she was not accepted onto the course. However, she was later offered a place when somebody withdrew.

When she started at the university, she found the surroundings intimidating. Furthermore, she found the course to be stressful and struggled to cope with the demands it placed on her and with some of the course content(?) Additional pressures, which related the course, included its short duration and the emphasis on adult learning, which was new concept to her(?) Consequently, the workload associated with the course was seen to be considerable.

"... it was very difficult for me, I think knowing my own limitations and pushing my own boundaries to the very limit..." (Interview 5: October '97)

However, she was successful in completing the course, stating that peer group support played a significant part in helping her get through (?)

"The peer group support was just fantastic, and without it I don't think I would be where I am today, and that's a genuine comment.". (Interview 4; July '97)

Whilst the ANPs perception of the course was that the more academic and theoretical components were essential to underpinning advanced practice (?), on reflection, she considered that some aspects of the course were not relevant as preparation for advanced practice(?)

"...I'm not really sure that everything that was on that programme was really relevant. I'm sure that big chunks could have been easily left out and we wouldn't have been hindered by that. .." (Interview 4: July '97)

"I think the course really just gave a lot of academic support and credibility, I don't really think the course taught you what advanced practice was or is. (Interview 2: October '96)

It was the view of the university however, that the main goal of the course was to facilitate the students to become independent, thinking practitioners, and consequently the development of 'practical' skills was given a lower priority. It was subsequently the responsibility of the ANP to arrange her own clinical placements. However, due to the theoretical emphasis of the course and the amount of academic

work which needed to be completed, the ANP found that time spent on developing clinical practice skills to be restricted (?) The time involved in clinical placements however, was seen to be one of the most beneficial aspects of the course(?) Many of the learning experiences that she arranged were medical in the focus and orientation, often involving her observing or assisting in surgical procedures in theatre. However, since returning from the course she has not been directly involved in any further theatre activity(?)

"I think we should have done a lot more clinical stuff.... I think the weighting between the academic commitment and the clinical commitment just seemed a little bit out of balance.". (Interview 2: Nov '96)

The university adopted a strategy of using Learning Contracts as a way of meeting the individual learning needs of the students who came from the various specialities. Whilst they were perceived of as being a good idea in principle, they turned out to be a significant cause of stress and were found to be very difficult to use, with little guidance for their use being provided(?)

On evaluating the course, the ANP concluded that it provided an academic grounding for advanced practice, as opposed to providing 'clinical' preparation for the new role(?)

"I couldn't tell you I don't think about how having a Master's helps in the clinical sense...because there was very little in the way of practical gynae experience in the course, but the theory underpinning research and evidence based practice definitely assisted me ..." (Interview 5: Oct '97)

The ANP considers that undertaking the course has increased her self-awareness and confidence and has given her the academic credibility to implement the role. At the same time she is very aware of own her limitations and does not consider herself to be a natural risk taker, a view held by others who know her(?)

"... I mean obviously I don't do anything that I have not been shown or taught and deemed competent. I mean with all the professional accountability it would be completely stupid". (Interview 2: November '96)

The process of having undertaken the course has had a significant impact on the ANP as an individual, in that she perceives herself to have changed as a result of the experience(?) The ANP is now recognised as a more knowledgeable and confident practitioner since gaining her Master's degree qualification and is seen as the clinical 'expert' with all things to do with the early pregnancy assessment clinic.

"Some of them may find it quite hard because I'm not the same old xxx that I was before". (Interview 1: Feb '96)

On completing the course she returned to her post as the 'F' grade deputy ward sister on a gynaecology ward, where she has since remained. Over time, the ANP

has become increasingly disillusioned with the way that her role has developed. Despite, developing and running the early pregnancy assessment clinic, most other initiatives have been delayed. As a result, the ANP considers that her skills are being under-used, causing her to become frustrated(?)

"...I want to develop all the advanced things but I just haven't got the time with everything else. I haven't done a protocol or anything. I'm really fed up". (Telephone conversation: February '97)

Such is the degree of frustration that the ANP has considered applying for other positions(?)

"I even applied for a job because I felt I'm being so under used here." (Interview 3; February '97)

A further source of dissatisfaction for the ANP is that she has not, until recently, had a change in grade or been financially rewarded for the job she feels she is performing. Whilst this has changed recently, her grade increase only relates to the time she spends in the EPA clinic, and for the time she spends back as deputy sister on the ward. As a consequence she remains frustrated(?)

2: Relationships

On returning from the course the ANP had to re-establish relationships with colleagues in her new capacity. This was not perceived to be too problematical as the ANP had experienced an exceptional amount of support for the role, not only at a senior nursing and ward based level, but also from the senior medical staff(?)

"...I know I'm well supported, and because the support is coming from the top down, as well as from the bottom up, I'm sort of in the middle somewhere knowing there's support from both directions.(Interview 1: February '96)

This level of support afforded to the ANP was seen as having a significant influence on her success both during the course and following its completion(?)

"...I don't think I would be on this course today without the support that I've had." (Interview 1: February '96)

"The transition is easier if you've got the right kind of support". (Interview 2: November '96)

Consequently, the ANP perceives she has good working relationships with most staff groups(?) The ANP's nurse manager was perceived to be particularly supportive at the outset and placed considerable faith in the ability of the ANP. However, her absence due to maternity leave was also on occasion seen to be problematical in progressing the role forward(?) In addition, the lack of progress in the ANP achieving

446

a change in grade has strained relationships between the ANP and her manager(?)

The ANP also believes she has good working relationship with the medical staff with whom she works. Her consultant preceptor was key in providing support and learning experiences throughout the course(?) The ANP has joint accountability for her practice, firstly to the consultant for her clinical practice in the clinic setting and secondly to her nurse managers for her ward based practice(?)

The relationship between the ANP and junior and senior medical staff is seen to have altered since she has been back in practice, in as much as she is now respected more for her practice and her opinions in her new capacity than she was previously(?)

"Q: Do you think that that relationship has changed then?   A: It's definitely improved. Definitely a closer working relationship. If I say this has happened, that has happened, they will accept my opinion" (Interview 4: July 97)

Whilst the ANP is treated differently by some medical staff, it is acknowledged that many doctors in the unit do not realise she is an advanced practitioner, and merely view her as an experienced sister who runs the EPA clinic. Those medical staff who do realise she is an ANP have on the whole responded positively toward her(?). Two reasons are put forward for this reaction, firstly, is the view that she is of help to the medical team in terms of freeing them up to undertake other activities when they would otherwise be in the EPA clinic. Subsequently she is not perceived as a threat to them or their practice(?) Secondly, is the nature of obstetrics and gynaecology, which means that medical staff often have to work with midwives who are viewed as independent practitioners and whose practice overlaps with that of medicine. The relationship between the medical staff and the ANP is seen to be similar to that with midwives(?)

The ANPs relationship with her immediate nursing colleagues on the ward and in the clinic is once again perceived to be on the whole a positive one.

"I have a good relationship with all of my colleagues." (Interview 1: Feb '96)

However, when the ANP initially returned from the course there were some minor problems in getting her colleagues to appreciate certain aspects of her role and the fact that she had to leave the ward each morning to attend the EPA clinic. These problems however were soon resolved (?) and the belief is that the ANP is treated no differently by the nursing staff on the ward than she was before undertaking the course, although she is respected for the role she is performing.

"But you know the respect is there, almost in an informal way..." (Interview 5: Oct '97)

In addition to some initial settling in problems on the ward, the ANP also experienced a few problems with the nursing staff in the clinic setting. The origin of these problems was related to a few experienced nurses who felt threatened and

envious of the ANP(?) This caused a few problems in terms of non-cooperation with the ANP, however, she acknowledges that it is really of little significance to her (?)

"They see me breeze in and have the respect and confidence of the consultants. They [the consultants] leave me with their patients and let me do it, and they [the nurses] have great difficulty in helping me, because I'm a nurse they expect me to do everything. They would help the doctor, but they won't help me." (Interview 2: Nov '96).

An important feature of the relationships with other practitioners appears to relate to the concept of the ANP's clinical credibility(?) Whilst the ANP's Master's degree preparation and increased knowledge base have provided academic credibility to her role(?), she has also had to prove herself and her clinical ability, especially to doctors, in the EPA clinic (?)

3: Professional Identity
Upon completion of the Master's degree course the title of advanced nurse practitioner was adopted. However, when dealing with patients the ANP does not introduce herself as such, due to their lack understanding of the concept(?).

The ANP acknowledges that some people perceive the advanced nurse practitioner role to be that of a 'mini-doctor'. She however does not, and considers her identity to be predominantly that of a nurse. However, she does acknowledge that certain skills and activities may overlap and that there are some benefits to be gained from observing her medical colleagues (?)

"...if [doctors name] got somebody that she knows she's got to sort out, then I'll sit and I'll be an observer. I haven't got a problem with that either. Because listening, you know it does help. It makes you think, oh I wouldn't have thought to ask that question. Little things come into your head, and Oh I must remember that when I'm dealing with this. (Interview 2: Nov '96)

As the ANP has become more experienced she recognises that she has become as accomplished in her skills and practice as some junior medical staff, especially when working in the EPA clinic(?)

As a result of taking on the ANP role some perceive her status within the organization has changed(?) The ANP also considers that her Master's qualification has added status to her position, in that it acts to help legitimise her practice(?)

"I think it's important so that people know that there is a difference, because you can call yourself a specialist nurse or an advanced nurse and have no proof of that." (Interview 4; July '97)

Interestingly, her change of status appears to be predominantly with members of the

medical staff as opposed to the nursing staff (?)

"Q: Do you feel that you've got a different status or are treated differently by other people? A: I think that is happening. That is definitely starting to happen.
Q: Who are you seeing it mostly from? A: From the medical staff, more so. (Interview 2: Nov '96)

Whilst there is a change in status, the degree of influence that the ANP is able to exert, especially in influencing the directorate agenda is largely unchanged(?) It is acknowledged however that she may be in a position to influence directorate decisions in the future.

4: Clinical Practice

When the ANP completed the ... course she returned to her ward in the same capacity as she left (i.e. deputy ward sister). Initially, the role was negotiated so that the ANP could spend two shifts developing advanced clinical practice, one shift on non-clinical activities such as teaching, research and audit, with the remaining two shifts acting in her capacity as deputy ward manager(?) It soon became apparent that this ideal was not achievable within the resources available in the directorate. Consequently, the role has predominantly evolved so that the ANP spends two to three hours each morning running the early pregnancy assessment clinic, a service previous run by doctors and which is now independently run by the ANP, and the remainder of her time is spent on the ward in a deputy ward manager capacity(?)

"I still do the early pregnancy assessment clinic and then I come back to the ward and either have to take charge, if the ward managers not there, like today. (Interview 5: October '97)

The ANP believes that most of her 'advanced' practice activities take place in the clinic setting(?) In running the EPA clinic she believes that she provides a 'holistic' service to the women attending the clinic. Consequently, the boundaries of her practice when in the EPA clinic, are defined in terms of the limitations she identifies to her own practice and the limitations imposed by hospital and national policies, such as an inability to prescribe medications or 'gain consent'(?) Consequently, the ANP perceives that she is practising independently whilst in the EPA clinic(?)

"If they've got a complete miscarriage or if they need a D and C, the only thing I can't do for them at the moment is gain their consent". (Interview 2: Nov '96)

"But I would imagine, 95% of ladies who come through that clinic, I see and deal with myself. And the medical input is now minimal..they (doctors) are quite happy
for me to carry on..." (Interview 5: October '97)

The skills that the ANP has developed and consolidated as result of her training and practice in the EPA clinic include; assessment skills - encompassing physical assessment, such as vaginal examination(?); making provisional diagnoses;

performing smear tests; counselling and advising patients; arranging for admission and theatre procedures; and discharging patients from clinic who require no further treatment. Additional skills that the ANP has begun top develop include; venipuncture; inserting and removing ring pessaries; and in future plans to learn ultrasound scanning(?) Whilst the ANP is becoming increasingly proficient in these skills(?), gaining competence in others skills is proving to be more problematical, such as the auscultation of heart and lungs(?)

However, the ANP is believed to have already been in possession of many of the basic skills that she has developed as part of her role(?) Furthermore, some suggest that by undertaking the Master's degree course the ANP is seen to have become more confident and has developed these skills further (?) To the contrary, the ANP herself perceives that 50% of the activities in which she is now involved in the EPA clinic were new to her following completion of the course(?)

"Some of it is new, you could probably say 50% is new..." (Interview 5: Oct '97)

When the ANP is practising in the EPA clinic, she has her own patient caseload and is seen to practice autonomously, although she does refer to medical staff when she perceives there is a need(?)

"So running the clinic the way I do, treating everybody as an individual, practising in an autonomous way and being able to everything for that patient, except consent...". (Interview 5: October 97)

Subsequently, the ANP has greater authority for making clinical decisions that affect the treatment of the patients attending the clinic that she was previously used to(?)

"Because now, instead of not needing a doctor if everything is OK, I can now just take that one step further and say well, if it's not OK, the lady needs to go to theatre, I can explain what needs to happen,.... I can fill in the relevant forms and book them into theatre". (Interview 4: July '97)

The way the role has developed to date means that the ANP has primarily been involved in developing the EPA clinic and the skills necessary to run the service competently. However, she acknowledges that the ANP role could involve other in-direct practice components such as teaching, audit and research(?) However, she finds it difficult to separate these components out in the milieu of clinical practice(?)

"I still feel that advanced practice to me is a very clinical role, with some research, evaluation, audit, monitoring, and that is not little packages that you can split up, it all happens almost, while I'm doing this and that, I'm looking at what's happening there and saying, "Oh, she hasn't got a named nurse", you know everything seems to blend in together.(Interview 2: Nov '96)

However, due to limitations on her time, the ANP has had to develop the other components of her role, such as teaching others and developing protocols,

surreptitiously and opportunistically whilst on the ward (?)

"If it's not too busy and there's people with not a lot to do, we will set up an informal teaching session..and I will do that on an impromptu basis..." (Interview 4: July '97)

The ANP is seen to have a lot of discretion in her day-to-day practice, in terms of delivering the early pregnancy assessment clinic service.(?) However, at the present time, she has limited discretion to develop the role in other ways, due to her commitments to the EPA clinic and her responsibilities on the ward(?) Consequently, it has been identified that the ANP needs to become supernumerary if she is to progress the role further at this stage(?) Limited resources in the directorate are however preventing her from being replaced on the ward, and consequently her ANP role is predominantly limited to the EPA clinic(?)

A number of differences between the practice of the ANP and that of her nursing colleagues have been identified. These differences predominantly relate to her practice in the EPA clinic and are seen to relate to her competence in assessing and performing physical examinations; the ability to perform certain invasive procedures - such as using a speculum; and ordering and interpreting investigations(?) Other differences identified between the ANP and her nursing colleagues relate to her knowledge base and confidence in practice and the additional responsibilities she carries. However, a significance difference between the practice of the ANP and that of her colleagues is seen to be her independence in practice, in that she does not need to refer to a doctor in order to make treatment plans and decisions, unless she chooses to do so(?)

Consequently, the way in which the role has evolved to date means that the ANP has had the biggest impact in the EPA clinic, in that it is now run more effectively and efficiently. However, because of organizational and situational factors, the ANP has had little impact on the organization and delivery of nursing care on the ward or the reduction in junior doctors hours(?) However, there are perceived to be in-direct gains for junior medical staff, in that their absence from the EPA clinic means that their opportunities for additional training have improved.(?)

5: Factors Influencing Role Implementation and Development

When the ANP role was first implemented, there were differing expectations from the various staff groups about what it would involve(?). This initially created some confusion in the understanding of the concept of advanced practice(?) Whilst there was some difficulty in articulating this 'new' concept, it was recognised by others that there has been a history of informal 'advanced practitioners' in the obstetrics and gynaecology clinic setting who were allowed to develop and extend the scope of their practice.

However, the ANP and her directorate manager did share a similar vision of how the role would develop(?)

451

"... you know, my directorate manager was the new deal nurse for doctors. She's got the vision. Our visions are exactly the same, for me to be off the ward clinically so that I can develop the role".(Interview 4: July '97)

The 'directorate' identified that problems existed with the EPA clinic and decided to deploy the ANP, primarily to fulfil a role that had previously undertaken by SHO's, to solve them.(?) Because of this, some saw the ANP acting as a replacement for junior doctors(?)

Subsequently, the ANP was deployed to meet this specific need within the organization and initially experienced few barriers to the implementation of the role on her return from the course (?)

"I don't think I've had many hindrances, apart from the initial, sort of 'what you doing? Where you going?...". (Interview 4: July '97)

The main problems identified in preventing the ANP from progressing her role are limited financial resources, compounded by environmental factors such as staffing shortages and time limitations due to day-to-day work load pressures(?) This has had the effect of delaying developments in practice, other than the EPA clinic, as the ANP has had to spent a significant amount of her time acting in her 'old' role as deputy ward manager(?).

"When I'm back here all my time is taken up just being deputy ward manager". (Interview 3: February '97)

"That's another thing ... it's slow progress".(Interview 4: July 97)

There is however a 'desire' to release the ANP from her ward duties so as to be able to spend all of her time developing the role. This however appears to be dependent on appropriate resources and contracts being secured.(?)

The implementation of the ANP role to date is viewed as being a success(?) An audit of the EPA clinic run by the ANP was carried out and the service provided was shown to be efficient and effective (?) . The results of the audit were presented at a major meeting and were viewed so positively that the trust has been asked to establish a similar service on another site. The ANP herself has however received little formal feedback on her progress in delivering the EPA service or other aspects of her performance (?)

"I don't actually get formal appraisal". (Interview 4: July '97)

However, on reviewing the progress of the ANP to date, the expectations of those at a senior level have largely been met in terms of what they expected her to achieve within the limitations identified..

The future development of the ANP role is at present uncertain(?) This will depend on acquiring additional resources and contracts to allow the ANP to be released in a supernumerary capacity(?) However, the ANP appears to be becoming increasingly frustrated with the limited progress of her role and the financial reward she is receiving. It is conceivable therefore that she may seek employment in a different organization in the future(?)

CASE STUDY 5: ACCIDENT & EMERGENCY DEPARTMENT

1: The Individual

The ANP is an experienced 'G' grade sister who has spent all of her nursing career in the accident and emergency department since her qualification in 1989. As she gained experience she became increasingly passionate about, and committed to, accident & emergency nursing. Prior to commencing the Master's degree .... the ANP had completed a diploma and first degree in nursing. Characteristically, she was continually seeking new educational opportunities and experiences in order to develop her practice skills and progress her career(?). An example of this was that immediately prior to commencing the Master's programme, the ANP had been away from the A&E department for 10 months leading some in-house training for the trust looking at the development of the nurses' role. Whilst being aware of regional developments exploring the concept of advanced practice, it came as a surprise to her when she was contacted by her manager and asked if she would like the opportunity to go on the ... course. Whilst acknowledging that she was little apprehensive initially, she subsequently took up the offer to commence the programme. Being enthusiastic about A&E nursing, she had a strong desire to develop the role in A&E(?) and was initially excited about the challenge it presented. Of further significance was that the course was believed to be 'clinically' focused and lead to practice development(?)

"You know it's not just a case that you're forced to be an advanced practitioner, you must want to develop that". (Interview 1: Feb '96)

"I must admit that the attraction of this course for me was that there was clinical development as well, or there was seen to be clinical development." (Interview 1: Feb '96)

On reflection, the ... course was not what ANP expected. She believed that to its detriment (?), the course tended to focus on 'global' nursing issues, as opposed to specific clinical matters. In some ways, the ANP felt that the clinical modules were not given the same priority as the more theoretical modules(?) With the emphasis on the latter, the 'academic' workload associated with the course was perceived to be considerable (?) The use of learning contracts in the course was unfamiliar to most people (including the course lecturers) and consequently they were perceived to be the cause of a number of problems. For example, the ANP was required to compromise when negotiating her contract with her pathway coordinator and look at aspects of her practice in which she already felt competent(?) Furthermore, the learning contracts were considered to be jargon laden and have a predominantly academic focus and purpose as opposed to being oriented toward practice development (?) Overall the use of the learning contract involved considerable work and was perceived to be a cause of extreme stress to the ANP.

"We had to start off with learning contracts where we had to identify what we were going to achieve in the first stages of the course. I found that extremely difficult. Very, very stressful.(Interview 1: Feb '96)

The benefits of undertaking the course included increasing the ANPs assertiveness, increasing her knowledge base, and enhancing her ability to access information, however, due to the academic emphasis she actually felt less skilled on her return to work, especially when compared to other ENPs (?)

"I actually felt de-skilled when I got back from the course, because a lot of the time was spent in academic activities". (Observation 8: Nov '96)

Consequently, the overall impression of the course was that it was seen to be inadequate preparation for the development and implementation of advanced *clinical* practice (?)

"A lot of it isn't relevant to what I'm doing, I think that they should prepare people more to deal with all the frustrations that I have had to deal with here". (Observation 13: July '97)

On completing the course the ANP returned as a 'G' grade sister to the A&E department, which was located in a new building. The plan was to initially deploy her in 50:50 capacity between acting in an 'advanced capacity' and the remainder as conventional 'G' sister in the department. However, due to staffing shortages and increased patient attendances, much of the time allocated for developing the advanced practice role was forfeited in order to provide managerial cover for the department. Inability to develop the ANP role in the way envisaged and at the rate anticipated due to these organizational constraints caused the ANP considerable frustration to the point of considering resignation(?)

"...there is absolutely no way that that can go ahead whilst things are like they are, there's no point....I'm not at all happy. To the point that I've considered resigning.". (Telephone conversation: Jan '97)

The ANP is seen to be a confident and assertive practitioner and one willing to challenge managers on issues of principle. Furthermore, following completion of the Master's degree course the ANP was perceived to be 'different' in character, being more confident and competent, as well as being enthusiastic about the ANP role.

2: Relationships

On returning from the course the ANP had to re-establish relationships with her colleagues in her new capacity. At first, the junior nursing staff in the department were unsure of the ANP and her role, predominantly due to a lack of familiarity with her previously. The majority of senior nursing staff, with whom the ANP was familiar, appeared to be positive about the implementation of the role once she had had time to re-established herself in practice. It is acknowledged however that when the ANP initially returned, some senior nursing staff felt threatened and resentful toward her, and the ANP herself felt uncomfortable(?) The ANP also experienced an unfavourable reaction from her nursing colleagues when she had a change in grade following the start of her part-time lecturer appointment at ...[a local university](?)

In contrast, the reaction from the senior medical staff in the department to the implementation of the ANP role was on the whole positive, as anticipated.

"I don't think I'll have any problems with the medics. I've always had good working relationships and a degree of credibility".(Interview 1: Feb '96)

However, the ANP did experience some conflict with a new consultant in the department. The ANP considers the A&E department to be medically driven and subsequently felt that the consultant did not value the role that nursing had to play, and in particular lacked understanding of the role of the ANP. This resulted in a number of confrontations in which the consultant was very aggressive toward her and toward nurses in general(?)

"It all stems because the unit is medically driven and the nurses aren't valued, and on the shop floor he's been very intimidating and aggressive toward the staff". (Observation 13: July '97)

Latterly, the relationship between the consultant and the ANP has improved(?)
Whilst some people considered the ANP was treated no differently by the medical staff following her return from the ... course, others felt that she was viewed differently and became a 'target' for the medical staff to help promote their agenda(?) Whilst there is some confusion over whether she is or is not treated differently, it is perceived that she is shown increased respect for the role she is performing by both nursing and medical staff.

Support for the ANP role was seen to be vital for its success. Furthermore, the need for the ANP herself to be instrumental in gaining support for the role was considered to be important. The ANP considers that she has achieved support for the concept of the role from a variety of staff groups, ranging from the nurse executive in the hospital, to the nursing and medical staff in the department (?) However, much of the support is perceived to be merely verbal, and not instrumental on a daily basis. This is because the ANP considered that she was not a priority on their agenda(?)

"the verbal support is there, but it's just not being backed up". (Observation 7: Nov '96)

Initially, following implementation of the role the ANP felt more and more unsupported(?) a fact that was acknowledged by others in the department.

"I just don't feel supported here". (Observation 13: July '97)

The ANP generally had a good working relationship with the medical staff (?) however since returning in her new role she has had a closer working relationship with the senior medical staff in the department than she held previously (?) This new relationship is primarily associated with educational initiatives and is not to do with changes in clinical practice per se(?) A lack of visible difference in terms of the clinical practice of the ANP, in that she is viewed as one of a number of 'G' grades

in the department, is evidenced by the fact that junior medical staff in the department are on the whole unaware of the ANP role (?)

Professional relationships with managerial colleagues were initially strained when the ANP returned from the ... course, the perception being that they provided little support(?) In addition, the ANP feels that managers are using her presence in the department as a 'status symbol' for the unit, rather than developing her role in an operational capacity (?)

"They're just using me as a trophy. Someone to pick off the shelf, and say, look we've got an advanced practitioner...". (Observation 12: April '97).

"They held me up to show what you could achieve in nursing". (Observation 16: Nov 97)

As time progressed, it was the ANP's perception that there were communication problems with her clinical manager, the reason for this being that her manager felt threatened by the role(?) However, the manager's perception was that the ANP role complemented her own.

The ANP increasingly negotiated the focus of her role with nursing managers(?). The expectations of others in the department for the ANP to effect immediate change increased pressure on her, even though she herself did not anticipate any sudden change(?)

"And the other thing is, if you don't effect any change immediately...that can affect your credibility as well, can't it? I... don't see change immediately. (Interview 1; Feb '96)

During the negotiating the ANP job description, clinical credibility was seen to be an important issue(?) Managers, medical staff and the ANP herself recognised the need to remain clinically credible. However, the ANP feels that her nursing colleagues tend to associate 'credibility' primarily with psychomotor clinical skills and not with the other activities in which she is involved (?) Additionally, the credibility of the ANP is threatened by the fact that some of her nursing colleagues see her job more aligned to a managerial position than a clinical post. In this sense the ANP is required to prove herself and the benefit of her role to her nursing and medical colleagues when involved in clinical practice (?)

"We had a really busy Saturday night and at the end of the shift and throughout he [consultant] was asking me my professional opinion on this and that and at the end of the shift he came and said, we really worked well tonight. So I don't know if somebody's said something to him or that now he's worked with me and seen I know my stuff, I just don't know". (Observation 13: July '97)

However, the reputation of the ANP with nursing colleagues was increased when she took on the role of staff advocate in a stand about staffing issues in the

department(?) The result of this advocacy role was that the ANP felt that she was responsible for initiating the staff mix review.

I asked who instigated the skill mix review, she replied "I suppose I did really, when I compiled that report and submitted it to the chief exec". (Observation 12: April '97)

The credibility of the ANP was seen to be further enhanced by her Master's degree qualification. Whereas this did not necessarily contribute to clinical credibility, it provided academic and 'street' credibility(?) More recently however the ANP recognises that her 'clinical' credibility has the potential to be seriously compromised in that her time and organizational commitments are now shared equally between the University ...and the A&E department.

"So in some ways this role might have a de-skilling effect, which I'm determined won't happen, but I can see that it could quite easily happen if I don't prevent it.
Then, I'd be in the situation of teaching the ENP course and on the 199 at the university without doing any practice myself. Then what credibility would I have?" (Observation 16: Nov '97)

At the present time, nursing and medical colleagues perceive the ANP's primary role to be that of educational leader on the emergency nurse practitioner programme and the involvement in other educational and staff development initiatives, such as the training and implementation of advanced triage.

3: Professional Identity
Upon completion of the course, the title of advanced nurse practitioner was adopted, although this was subsequently changed to 'lecturer-practitioner' on appointment to a part-time lecturer post at the university. The change of title was associated with a change in grade and may have been a deliberate strategy to avoid setting a 'financial' precedent within the trust for other advanced practitioners (?) However, for others the 'advanced nurse practitioner' title was seen to be a cause for concern and viewed as being potentially divisive(?)

The status of the ANP within the trust was seen to change and consequently in some ways she was treated differently from other 'G' grade sisters in the department(?) Until the ANP settled into the role, she felt strange, especially because the unit and many of the administrative procedures were new to her(?) However, the ANP did not consider that she was recognised for her achievements and the role she is trying to implement (?)

"...I wont move for a 'G', but if they went to a 'H' I'd consider it, because nursing just doesn't get any recognition from this trust." (Observation 13: July '97)

Some nursing colleagues were unsure of the professional identity of the ANP, seeing it as a cross between an experienced nurse and junior doctor. However, the ANP is seen as a nursing expert by some nursing and medical colleagues and to be someone who is developing practice. However, others, whilst respecting the ANP's

458

knowledge, do not consider her to be a clinical leader in the department. The reason for this appears to be that 'clinically' the ANP is seen to do little different to the other 'G' grades in the a&E(?)

4: Clinical Practice

When the ANP took up post she was deployed in an 'advanced' capacity for half of her time, with the remaining time being spent in a 'G' grade sister capacity within the department. The original plan was for the ANP to spend one shift of her clinical time managing the unit and the remainder acting as an emergency nurse practitioner. In doing so, the ANP hoped to be involved in both major and minor trauma. The other 50% of the time would be spent involved in staff development, research and audit. a job description to such effect was drafted.

"They agreed that the role would be split between 50% clinical practice and 50% staff development, research and audit". (Observation 1: June '96)

Whilst still undertaking the Master's degree course, the ANP was able to find time to practice as an ENP in the department and to bring her skills back up to date (?) However, once she returned from the course, time to practice in an ENP capacity became increasingly restricted, whilst correspondingly she was spending increased amounts of time acting as a 'G' grade sister in charge of the unit. This involved her acting as coordinator in the department in a similar capacity to other 'G' grade sisters. Consequently, many of the 'clinical' activities she was involved in were similar to those carried out by her senior colleagues, such as; acting as an emergency nurse practitioner - i.e. assessing, diagnosing, treating and discharging patients in defined category; performing standard nursing interventions in the ... [different] sides of the department; and acting in a triage capacity. As such, the ANP's clinical skills are seen to be no different to those of other experienced a&E sisters(?) Furthermore, the ANP does not possess any specific practice privileges which are not also available to other nurses trained as ENPs in the department.

The ANP recognises the importance of maintaining competence in skills and despite making attempts to develop new skills, such as intubation, she found difficulty in obtaining the relevant experience.

"She informed me that she was having problems gaining access to theatre time in order to practice her intubation skills. But that she was still pursuing avenues to resolve the problem". (Observation 4: Aug '96)

However, whilst the ANP is not used to trouble-shoot on issues of 'direct clinical practice' any more or less than the other 'G' grade sisters in the department, she is used extensively as a resource with regard to professional and educational issues.

Because of early difficulties resulting from staff shortages and increased attendances, much of the time the ANP had allocated for developmental activities was sacrificed in order to meet the service commitment in the department (?)

However, when time was available the ANP was involved in leading a number of activities which were intended to bring about a change in the clinical area. These included being responsible for taking the lead on creating a Nursing Development Unit within the department. However, despite initial progress, compromises in the time that she was able to spend on developing this new initiative and other organizational factors meant that the project was 'temporarily' abandoned(?) However, the ANP has been involved introducing other changes and developments into the department, including, introducing national triage standards with the aid of other nursing colleagues; re-organising the resuscitation area to make it more efficient; and introducing a new induction programme for new members of nursing staff. The ANP has also conducted a review and audit of the ENP service. Whilst acknowledging that there is a research component associated with the ANP role, she has not been involved in any research initiatives in the department(?) other than when she was undertaking a study of X-ray interpretation for her Master's degree (which she has subsequently written up for a joint publication). She does however, recognise the potential of progressing some of her auditing activities into more substantial research projects(?)

Overall it is seen to be a challenge for the ANP to introduce change into the department, as there appears to be a lot of apathy and resistance to change, although this has begun to change(?)

"I'm very committed to everything I do, but there does seem to be a lot of apathy in the department at the moment." (Observation 5: Oct '96)

The introduction of the orientation programme for new nursing staff was perceived to be one way in which the ANP could make the nursing staff reflect and accept change(?)

".. the intensive induction programme for the new staff is one way of getting the staff to reflect and change their thinking".(Observation 10: Feb '97)

In an attempt to consolidate the role (?) the ANP spent some of her time initially liaising with another ANP in ITU to explore how their roles would overlap and complement each other. In addition, along with other ANPs in the trust, she was asked to head up the clinical supervision pilot project in the a&E department, although this has since ceased.

Many of the initiatives and developments that the ANP is now involved with are concerned with developing practice in-directly, i.e. via teaching and staff development. Consequently, the ANP is not perceived by some to have advanced clinical practice within the department. Furthermore, because of the way in which her role has evolved, she is not seen to be any more skilled or autonomous in her clinical practice than any of the other 'G' grade sisters in the department. Some however, do consider her to be more autonomous and advanced in her practice (?)

When the ANP is not acting in a clinical capacity she is acknowledged to have a lot

of discretion on a day-to-day basis in deciding how to organise her time and the activities in which she is involved. Over time, the ANP perceives that the degree of discretion she has in the role has increased(?)

"Things have moved on for me. I'm being given much more of a free hand to do things." (Observation 14: Aug '97)

However, in terms of determining how the ANP role 'should ideally' be implemented, she has had little discretion in following her original ideass a she has been channelled into primarily developing the role as an educational resource for staff in the department (?) This is evident in terms of the educational activities in which she has both taken a lead and become involved. These include; leading the development and teaching of ENP programmes; teaching casualty officers on their induction course; teaching on university courses, particularly the ENB 199; acting as an ATNC instructor; and implementing and teaching regarding national advanced triage. Other educational related activities include undertaking an educational audit of the nursing staff; being responsible for staff development and training in the department, and being responsible for the training budget. As the ANP took up a part-time university post in November '97 with responsibility for delivering and developing the ENB 199 course, virtually all of her time is spent in educational activities, and is a further reason her title has changed to 'lecturer-practitioner'(?)

"My biggest concern at the moment is with education and training". (Observation 10: Feb '97)

It is the ANP's involvement in these educational activities that identifies her practice as being different from that of other nurses in the department. The other main differences between the ANP and her colleagues are seen to be her knowledge base, academic preparation, and understanding of research. She hopes in the future that she will be able to have greater impact on practice and demonstrate clinical practice at a higher level, however, at this stage in her development this is not perceived to have happened(?)

a number of benefits of having the ANP in post have been identified, these include; the ability to present articulate arguments; making nurses reflect on their practice; being available as a resource to nursing staff; and future benefits in terms of ENPs and triage are anticipated. The impact that the ANP has had is perceived to have been slow to take effect, this is due in a large part to organizational and deployment problems (?) Consequently, a view prevails that it is still too early to see any real benefits of having an ANP in post.

"I'm just not making any huge difference here. Looking at the components of advanced practice I feel that all I'm doing is looking at the teaching component, I'm making little impact elsewhere". (Observation 12: April '97)

Because of the various factors identified above, there has been little impact on the organization and delivery of nursing care, or, on the reduction in junior doctors hours.

The latter however was not perceived as a priority for the ANP role due to the continual presence of a doctor on-site and development of ENPs in the department(?)

5: Factors Influencing Role Implementation and Development

There was, and remains, a considerable degree of confusion about what 'constitutes advanced nursing' practice amongst staff of the accident and emergency department. Part of this confusion is seen to emanate from the lack of guidance and consensus about the concept of advanced practice from the governing bodies.

"...it's been identified that nobody knows what this advanced nursing practice is". (Interview 1: Feb '96)

The nature of the clinical environment is seen to be significant factor in determining how the ANP role is implemented. The characteristics of the patient population, the number of medical staff, and the development of ENPs, and the goals of the organization, in effect dictated how the role would develop(?) Based on these factors, a job description was eventually negotiated for the ANP, which was broad in nature, but not entirely what the ANP expected(?). The development of the job description was described as "a painful process" by one party. Despite a number of directorate meetings and the development of a job description, a lack of understanding of the concept resulted in problems in identifying and agreeing what the ANP role would actually involve(?) Initially, this led to a perception that the ANP was not being used appropriately in the department. This demonstrates that different organizational groups have differing expectations of the ANP role (?) This has resulted in inappropriate expectations being made of the ANP from her nursing colleagues (?)

"But they don't seem to understand this new role, they still have an expectation that I will be managing the unit, and working weekends and shifts. Well, with this new role it's just not possible or practical." (Observation 16: Nov '97)

Furthermore, some of the expectations that the ANP herself had about how the role would develop when she returned from the course were seen by some to be equally unrealistic. The novelty of the role, coupled with the absence of a role model, or prior experience of an ANP, was seen to cause problems in terms of what was expected. On occasion, the ANP admitted losing a sense of direction herself (?), a fact noted by her nursing colleagues.

However, the biggest single factor influencing the implementation of the ANP role when she first returned from the ... course, was the problem the department was experiencing in terms of patient through-put and staff shortages. The unit was having to cope with virtually a one-third increase in patient attendances, whilst at the same time suffering high levels of staff sickness. Consequently, the service commitment the ANP had to meet as a 'G' grade sister far outweighed the time she had been allocated for developing the ANP role. Furthermore, the time the ANP had been away from the department (nearly 2 years) meant that she was perceived to find it difficult to settle back into a routine(?) Staffing shortages persisted for several

months and resulted in preventing the ANP from developing other initiatives associated with her new role.

"I've looked at the staffing and the skill mix and at the moment we're 7 trained staff under compliment - that's 35 shifts a week. You just can't go on with that kind of staffing. (Telephone conversation: Jan '97)

This time was considerable cause of stress to the ANP and morale within the department was perceived to be very low(?)

"...for the last X years, a&E have always had a Christmas party in the staff social club, well this year, it's had to be cancelled because there's no interest". (Observation 9: Nov '96)

In addition to the nature of the clinical environment the ANP (and others) identified a number of barriers to implementation of the role. These included; policy and legal restrictions such as an inability to prescribe or 'officially' interpret X-rays; a lack of time to develop the role; more recently, competing organizational demands between the university and the department; and excessive bureaucracy and control over the development of the role.

".. I feel there is a lot of control over the role, not so much now, but certainly initially. It was the fact that all the decisions had to go through the directorate meetings for the medics to say OK." (Observation 13: July '97)

However, the ANP identified the main barrier to her development as being the necessity to undertake her old 'G' grade sister role for a considerable length of time upon her return to the department.

"Well because for 2 or 3 shifts a week I'm out there in charge ... I should be out of the shift system but be out there supporting the staff....But all that happens at present is that I am in charge ...as any G' grade.".(Observation 12: April '97)

Plans to evaluate the ANP role appear to be unclear despite the ANP being given a set of targets to achieve(?) However, it appears that the ANP has received no feedback about her development and performance to date.

Despite these factors influencing the implementation of the role, the expectations of what the ANP would have realistically achieved at this stage in her development were perceived to have been met. However, a question remains as to whether a trained advanced nurse practitioner is required to perform the role as it has currently evolved. Some consider that a 'lecturer-practitioner', not necessarily an ANP, could deliver the role as it has currently developed(?) It is interesting therefore, that the ANP's title has changed to become that of "lecturer-practitioner". As the role does not include any new or novel clinical practices, a view is held that the ANP dd not necessarily need to undertake the Master's degree ... as preparation for undertaking the role. This is based on the conclusion that on return from the course the ANP was

463

seen to have become more knowledgeable and to have a deeper understanding of issues, but not necessarily to have advanced in 'practice'.(?)

The future of the ANP role seems set to continue primarily in an educational vein. Indeed, this is seen as the main priority for the role by other staff members (?) This however creates a conflict for the ANP in that she identifies a potential problem of becoming clinically de-skilled whilst trying to satisfy competing organizational demands. Furthermore, the change in title from ANP to lecturer-practitioner is perhaps recognition of the fact that the role will not develop into a clinical role as originally anticipated (?).

Appendix 13:
CASE DESCRIPTIONS AND CHARACTERISTICS

Case study 1 - Respiratory Medicine / Elderly Care, Community Hospital.

Case study 1 took place within the context of a moderately sized semi-rural 'community' hospital which comprised a small number of wards, an out-patient clinic, a day-case theatre, a small casualty unit and a large physiotherapy unit. The ANP was employed on a 20 bedded ward which provided rehabilitation for elderly patients with chronic medical disorders and respiratory problems. The ANP was employed as the only 'G' grade sister, with the remainder of the nursing work force comprising equal numbers of qualified and unqualified staff. Of the qualified staff, the majority were junior grades, with limited experience. The ward was covered by three consultant physicians who conducted weekly ward rounds, but who only visited

Table A13.1 Composition of Case Study 1.

Case study 1 comprised:-

- The Advanced Nurse Practitioner / student - the key informant.

- Consultant Preceptor - the consultant who agreed to supervise and mentor the ANP throughout their preparation and initial stages of practice.

- Hospital manager (1&2) - (2 different managers were in post over the duration of the study and each was interviewed)

- a member of qualified nursing staff from the ward

- University pathway coordinator - a university lecturer with responsibility for coordinating the practice and learning experiences specific to the ANPs practice discipline whilst undertaking the Master's programme.

NB: This case did not include a clinical manager or junior doctor as neither were employed in the hospital. a staff grade doctor was unable to be recruited into the study despite several attempts.

at other times upon request. Two staff grade doctors were employed throughout the hospital to provide medical cover to *all* the wards between 9.00am and 5.00pm on week days. Medical cover in the evenings and at weekends was provided by local General Practitioners who were not on-site. Table A13.1 details the composition of case study 1.

<u>Case study 2 - Adult Intensive Care, District General Hospital,</u>

Case study 2 took place within the context of an adult intensive therapy unit (ITU) in a modern district general hospital. The hospital was opened in the early 1990's, was moderately large in size and was centre for nursing and medical training. The ANP was employed on a 3 bedded adult ITU which catered for a wide range of patients requiring intensive care, including surgical, orthopaedic and medical admissions. The unit was new and had been purpose built and consequently was well equipped. At the outset of the study the ANP was employed as the one of three 'G' grade sisters. The remainder of the nursing work force comprised of various grades of qualified staff with varying degrees of experience. There were no unqualified staff working in the unit. The ITU was managed by a 'H' grade clinical manger who was located on-site. One consultant intensivist managed the care of the patients whilst they were in the ITU in collaboration with specialist medical and surgical teams who maintained overall responsibility for the patients. Day-to-day medical cover was provided predominantly by junior doctors from the specialist medical/surgical teams and senior house officers (SHOs) from the anaesthetics department. There was no on-site consultant cover after 8.00pm in the evening or at weekends, although consultants were on-call and available for consultation via the telephone.

Shortly after the study commenced the health authority in which the hospital was located merged with a larger neighbouring health authority. As a result of the merger, the future of the hospital and the ITU in particular was placed in doubt. The threat of closure or relocation of the ITU was potential outcome of the political and financial conditions prevalent at the time. However, after approximately six to nine months of uncertainty, during which a campaign to keep the hospital open was mounted by the local community, a reprieve was granted and the hospital and the ITU remained open. In the meantime a number of services were transferred to the neighbouring larger hospital, including surgical services. This resulted in the ITU only receiving admissions of medical patients with a far narrower range of conditions.

Table A13.2 Composition of Case Study 2.

Case study 2 comprised:-
• The Advanced Nurse Practitioner / student - the key informant.
• Consultant Preceptor - the consultant who agreed to supervise and mentor the ANP throughout their preparation and initial stages of practice.*
• Clinical nurse manager* (2 different managers were in post over the duration of the study and each was interviewed).
• Directorate nurse manager (appointed following the hospital merger).
• a member of qualified nursing staff from the unit.
• a junior doctor (from one of the anaesthetic teams covering the ITU).
• University pathway coordinator* - a university lecturer with responsibility for coordinating the practice and learning experiences specific to the ANPs practice discipline whilst undertaking the Master's programme.
* Indicates the participant left their employment during the period of the case study.

The uncertainty generated by the potential hospital closure led to a large staff turnover in the hospital, resulting in the consultant intensivist and clinical nurse manger on the ITU resigning from their posts during this period. Table A13.2 details the composition of case study 2.

Case study 3. Neonatal Unit, Large General Hospital.

Case study 3 took place within the context of a neonatal unit (NNU) in a large city general hospital. The ANP was employed on a 24 bedded unit which catered for a wide range of neonates requiring intensive, high dependency or short-term care. Whilst the unit did not cater for neonates requiring specialist surgical procedures, it often received babies transferred from smaller units who required intensive medical treatment. The NNU was used as a centre for both nursing and medical training, with twice yearly rotations of paediatric SHOs. At the outset of the study the ANP was one of two 'advanced neonatal practitioners' on the unit who were undertaking the

Master's degree programme. By the end of the study the number of ANPs on the unit had increased to three. This was the only case study in which the ANP was employed on separate contract, including a locally agreed salary outside of the nursing pay grade structure (i.e approximately equivalent to a 'H' grade). As a consequence, the ANP was deployed in a supernumerary capacity to the nursing establishment on the unit. The nursing work force comprised of a large number of mix grade qualified staff with varying degrees of experience. In addition, there were a small number of

Table A13.3 Composition of Case Study 3.

Case study 3 comprised:-

- The Advanced Nurse Practitioner / student - the key informant.

- Consultant Preceptor - the consultant who agreed to supervise and mentor the ANP throughout their preparation and initial stages of practice.

- Clinical nurse manager.

- Directorate nurse manager.

- a member of qualified nursing staff from the unit.

- a junior doctor.

- University pathway coordinator - a university lecturer with responsibility for coordinating the practice and learning experiences specific to the ANPs practice discipline whilst undertaking the Master's programme.

unqualified staff working in the unit. The unit was managed by a 'H' grade clinical manager, with the title 'clinical nurse specialist', who was located on-site. Three consultant paediatricians managed the care of the neonates in the unit. The remainder of the medical staff comprised a senior registrar, two registrars, and three SHO paediatricians. There was 24 hour medical cover on the NNU and part of the ANPs' responsibilities included being partly incorporated into the SHO rota to provide 'medical' cover on specific evenings, nights and weekends. Table A13.3 details the composition of case study 3.

Case study 4 - Gynaecology, Large General Hospital.

Case study 4 took place within the context of the gynaecology directorate in a large city hospital. The ANP was employed on a 25 bedded gynaecology ward which catered primarily for patients with a variety of gynaecological conditions. The ward was modern, well equipped, and laid out in 'patient bay' format. At the outset of the study the ANP was employed as the 'F' grade deputy ward manager. The remainder

Table A13.4 Composition of Case Study 4.

Case study 4 comprised:-

- The Advanced Nurse Practitioner / student - the key informant.

- Consultant Preceptor - the consultant who agreed to supervise and mentor the ANP throughout their preparation and initial stages of practice.

- Directorate nurse manager

- a member of qualified nursing staff from the ward

- a junior doctor

- University pathway coordinator - a university lecturer with responsibility for coordinating the practice and learning experiences specific to the ANPs practice discipline whilst undertaking the Master's programme.

NB. This case did not include a clinical manager as one was not in post within the directorate.

of the nursing work force comprised the 'G' grade ward sister, and fourteen junior grade qualified staff. In addition there were six unqualified staff working on the ward. The ward was covered by four consultant gynaecologists, who conducted weekly ward rounds, and admitted patients for both elective and emergency surgical procedures. Two senior registrars, five registrars and four SHOs comprised the remainder of the medical staff covering the ward. The ANPs main clinical responsibilities however, when not acting as 'deputy ward manager' were carried out in the out-patient clinic of the maternity hospital. Table A13.4 details the composition of case study 4.

<u>Case study 5 Accident and Emergency Unit, Large General Hospital.</u>

The final case study took place within the context of an accident and emergency (a&E) unit in a large general hospital. The ANP was employed in the a&E unit which catered for a wide range of patients requiring treatment for varying degrees of minor and major trauma. The unit was opened in 1995, having been purpose built. It was primarily divided into four separate areas. The first consisted of the triage station and patient waiting area. The treatment areas were divided into resuscitation and emergency area, comprising of 10 cubicles and 5 resuscitation beds equipped with trolleys and equipment to deal with major trauma, emergencies, and emergency referrals from General Practitioners. The second area comprised of 8 cubicles and dressing stations designed to deal with minor injury and trauma. The final area was an observation unit with 5 beds which was used for short-term/overnight observation of patients awaiting admission/discharge. The unit also had its own operating theatre for minor surgical procedures and a plaster room.

At the outset of the study the ANP was employed as one of five 'G' grade sisters within the unit. The remainder of the nursing work force comprised of various grades of qualified staff with varying degrees of experience. In addition to the qualified staff there were twelve unqualified staff employed in the department. The unit was managed by a 'H' grade clinical manger who was located on-site. Three consultants had overall responsibility for the patients going through the unit. The remainder of the medical staff comprised a senior registrar and eight SHOs who rotated through the unit every six months. There was 24 hour medical cover on the unit, with a minimum of three SHOs being on duty at any one time. At the outset of the study it was identified that the number of nursing staff required to meet the needs of the department was seven whole time equivalents under the recommended establishment. a number of problems were associated with the staff shortage including, increased sickness and absenteeism, nursing staff working extended / double shifts to cover staffing shortages, and low morale amongst nursing staff. Table A13.5 details the composition of case study 3.

Table A13.5 Composition of Case Study 5.

Case study 5 comprised:-

- The Advanced Nurse Practitioner / student - the key informant.

- Consultant Preceptor - the consultant who agreed to supervise and mentor the ANP throughout their preparation and initial stages of practice.

- Clinical nurse manager

- Directorate nurse manager

- a member of qualified nursing staff from the unit

- a junior doctor

- University pathway coordinator - a university lecturer with responsibility for coordinating the practice and learning experiences specific to the ANPs practice discipline whilst undertaking the Master's programme.