CANADIAN CLINICAL NURSE SPECIALISTS: UNDERSTANDING THEIR ROLE IN POLICY WITHIN A BRITISH COLUMBIAN CONTEXT

by

Sarah Nicole Rourke

B.Sc.N. (Honours), British Columbian Institute of Technology, 2006

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTERS OF SCIENCE IN NURSING

in

THE FACULTY OF GRADUATE STUDIES

THE UNIVERSITY OF BRITISH COLUMBIA
(Vancouver)

September 2012

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ABSTRACT

Clinical Nurses Specialists (CNSs) are in a unique position to respond to the evolution of health care delivery for specialized populations with complex health care needs. Specifically, it has been suggested that CNSs engage with policy at different levels of health care as one way of advancing the nursing profession, improving patient outcomes, and contributing to the provision of effective, sustainable health care. Nevertheless, little is known in regards to CNSs’ experience of policy within their practice, particularly within a Canadian context. Therefore the purpose of this qualitative research study was to explore CNSs’ experience of policy at the clinical, institutional and system levels of the health care system, to further enhance our understanding of CNSs’ practice in Canada, and more specifically British Columbia. Interpretive description was used as the research method for this study. 11 semi-structured interviews were conducted. Through an inductive approach to data analysis involving constant comparison four major themes emerged representing the common reality of the participant’s experience: 1) The Perplexities of Policy; 2) CNSs and Policy: A Perfect Match; 3) CNSs’ Influence: Policy as a Vehicle; and 4) Mechanisms that Challenge and Facilitate CNSs’ Policy Work. Findings of this study confirm and extend what is already known about CNSs’ involvement in policy within a Canadian context. These findings have potential application to practice, education, research and more broadly, the health care system.
PREFACE

For the purpose of this study, ethics approval was obtained from The University of British Columbia (Vancouver), Behavioural Research Ethics Board. The Ethics Certificate Number obtained was H11-01549.
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ACKNOWLEDGEMENTS

I think the old saying goes “it takes a village to raise a child”. Well in my experience it takes a village to complete a thesis. I could not have walked this road and completed this journey without the love and support of many special people.

To my Supervisor, Dr. Vicki Smye, thank you for your encouraging words and understanding even in my darkest hours. Your unwavering vision and belief in this work propelled me forward making this all possible.

To my Committee Members, Dr. Helen Brown and Dr. Maura MacPhee, thank you for your thoughtful comments, suggestions and understanding.

To my family, your belief in me makes me who I am. Mom and Dad, your unconditional love and support, encouraging words, and listening ears don’t go unnoticed or unappreciated. I am truly blessed and honoured to be your daughter.

To my friends, thank you for your support in all the ‘crazy’ things I do. Just wait until you hear what I have planned next!

To my professional mentor and friend, Leeann Taylor. Your support in my endeavour to complete this work over the past months is a testament to the amazing leader and person you are. To you I am forever grateful.

Finally, Christopher, though I found your objectiveness and simple outlook on this work infuriating at times, I thank you for helping me put it all in perspective in my most overwhelming moments. Thank you for loving and supporting me through this journey of life, wherever it takes us.
DEDICATION

I am greatly honoured to dedicate this piece of work to the 11 Clinical Nurse Specialists who willingly and generously participated in this study. I find your dedication and passion to the nursing profession, the Clinical Nurse Specialist role and the populations you serve inspiring and contagious. Thank you to each and every one of you for making this work possible.
CHAPTER ONE: INTRODUCTION

This thesis delineates a qualitative research project investigating Clinical Nurse Specialists’ (CNSs’) experience of policy within their practice. This chapter will establish a foundation for this thesis by introducing the major elements of CNSs’ practice, including current challenges CNSs face in relation to their role within a Canadian context. A CNS is defined by the Canadian Nurses Association (CNA) as “a registered nurse who holds a masters or doctoral degree in nursing and has expertise in a clinical nursing specialty” (2009, p. 1). For the purpose of this thesis, CNSs are self-identified Registered Nurses (RNs) who have a minimum educational preparation of a Masters degree, and currently work as a CNS in their practice.

Introduction

CNSs first emerged in Canada as a role to enact advanced nursing practice (ANP)\(^1\) in the late 1960s and 1970s. Currently, some 40 to 50 years after the emergence of CNSs in Canada, little is known regarding CNS practice. A recent Canadian Health Services Research Foundation (CHSRF) report emphasizes the need for further inquiry into the CNS role within the Canadian context (DiCenso & Bryant-Lukosius, 2010a). The CNA indicates in the National ANP Framework that in order to sustain CNS practice, more research needs to be conducted about the role and its contributions to health care (CNA, 2008).

The CNA Position Statement regarding the CNS role outlines five key

\(^1\) The term advanced nursing practice (ANP) will be used in this thesis to refer to the ‘role’ of advanced practice nurses, including CNSs and Nurse Practitioners (NPs). Consistently in Canadian literature, and increasingly in international literature the term ANP is being used to describe the role of CNSs and NPs, including what they do (Bryant-Lukosius, DiCenso, Browne, & Pinell, 2004; CNA, 2008; 2009; CRNBC, 2005; Hamric, 2008, as cited in National CNS Competency Task Force, 2010).
components of CNS practice: clinician, consultant, educator, researcher and leader (2009). Across these domains of practice, it is attested in literature that CNSs work to influence policy at the clinical, institutional and system levels (Canam, 2005; CNA, 2008; Davies & Eng; 1995, Schreiber et al., 2003; Scott, 1999, Seenandan-Sookdeo, 2012, Sparacino, 2000). Despite this, little is known regarding CNSs’ role in relation to policy. This thesis will address this lack of knowledge by examining CNSs’ experiences of policy within their practice at different levels of the health care system.

**Background to the Problem**

The CNS role was envisioned as early as the 1940s, though it was not implemented into the Canadian health care system until the late 1960s and throughout the 1970s (CNA, 2008; Davies & Eng, 1995). During this time period CNSs were employed to provide clinical guidance and leadership to nursing staff, with the intention of improving quality of care and promoting evidence-based practice (EBP) during a time when patient care was becoming increasingly complex (CNA). British Columbia (BC) did not see its first CNS until 1980, at which time fiscal cutbacks of the 1980s and 1990s lead to the elimination of many CNS positions across Canada (CNA; Davies & Hughes, 1995). Though implementation of ANP roles has been sporadic and heavily dependent on fiscal resources, there is a growing urgency to identify and embrace innovation in the provision of health care (DiCenso & Bryant-Lukosius, 2010a; Sparacino, 2000). The CNA indicates that growing concerns related to quality, accessibility, increasing costs, escalating demands, technological advancements, and staffing
shortages necessitate a need to revisit how the CNS role can mitigate these issues into the 21st century.

CNSs are described as being in a unique position to respond to the evolution of health care delivery for specialized populations with complex health care needs (CNA, 2008; Canam, 2005; Seenandan-Sookdeo, 2012). They stand to make significant contributions to the provision of high quality, cost effective health care by applying a unique combination of expertise, primarily with a systems-level focus in conjunction with a population-based health perspective (CNA; Canam). Specifically, it has been suggested that CNSs engage with policy at different levels of health care as one way of advancing the nursing profession and improving patient outcomes (CNA; Fulton, 2010; Seenandan-Sookdeo).

Nevertheless, role confusion also referred to as role ambiguity, continues to be a substantial barrier in the revitalization of the CNS role (Bryant-Lukosius et al., 2004; CNA; DiCenso & Bryant-Lukosius, 2010a; Fulton; Pauly et al., 2004; Schreiber et al., 2003; Schreiber et al., 2005).

In 2008, CNA updated the ANP National Framework. The purpose of the framework was to promote a collective understanding of ANP in Canada and decrease inconsistencies related to roles and competencies. The framework outlines two recognized ANP roles in Canada: CNSs and Nurse Practitioners (NPs). ANP is an umbrella term defined as:

An advanced level of clinical nursing practice that maximizes the use of graduate educational preparation, in-depth nursing knowledge and expertise in meeting the health needs of individuals, families, groups,
communities and populations. It involves analyzing and synthesizing knowledge; understanding, interpreting and applying nursing theory and research; and developing and advancing nursing knowledge and the profession as a whole (CNA, 2008, p. ii).

CNA (2008) further outlines ANP competencies within the domains of clinician, researcher, leader, and consultant/collaborator in their framework. This umbrella definition in conjunction with ANP competencies is meant to encompass both CNS and NP practices. CNA documents themselves illustrate the continuing role confusion CNSs are facing. When examining the CNA National Framework for ANP and CNAs’ Position Statement on CNS practice, inconsistencies exist between the domains of CNS practice outlined in these two documents (CNA, 2008, 2009). Despite efforts to maximize role clarity and illuminate the unique contribution of CNS practice to the health care system, there is a startling lack of understanding amongst administrators, policy makers, doctors, nurses, allied health professionals, and society about the CNS role (Bryant-Lukosius et al., 2004; DiCenso & Bryant-Lukosius, 2010a; Pauly et al., 2004; Schreiber et al., 2003).

Role ambiguity is suggested to play a major part in the underutilization of CNSs. One way to analyze utilization of CNSs is to look at trends in ANP positions across BC. Although the overall number of NPs remains lower than CNSs in BC, NPs saw a 29% increase, while CNSs saw a 7.7% decrease in their respective positions during a similar time period (CIHI, 2010). This could largely be the result of the Canadian Nurse Practitioner Initiative launched in 2004,
which worked towards a model of integration and sustainability for NPs, including recommendations for practice, education, legislation and regulation (CNA, 2008, DiCenso & Bryant-Lukosius, 2010a). Since 2004, BC has instituted NP standards of practice, licensing regulations, and title protection. Alternatively, CNSs lack consistent educational curriculum outside of being Masters prepared, do not have role specific standards of practice, licensing regulations or title protection, all which may substantiate role confusion (Bamford & Gibson, 2000; Bryant-Lukosius et al., 2004; DiCenso & Bryant-Lukosius; Pauly et al., 2004; Schreiber et al., 2003).

It has also been suggested that ANP represents the future of nursing (CNA, 2008; Bryant-Lukosius et al., 2004; DiCenso & Bryant-Lukosius, 2010a). Though the NP role is still in its infancy in BC, in the last seven years NPs have made progress through the Canadian Nurse Practitioners Initiative towards carving out their unique place in the Canadian health care system. CNSs however, are collectively still struggling to explicitly define their role and document their contribution to efficient, high quality health care (DiCenso & Bryant-Lukosius). Bryant-Lukosius et al. (2004) suggest that it is the responsibility of the nursing profession to define and clarify both ANP roles internally, within nursing, and externally for stakeholders. Optimal utilization is dependent on defining and clarifying the effectiveness of the role and documenting the need within the current health care context. Administrators, policy makers, society, nurses and CNSs themselves stand to benefit from a more tangible understanding of the CNS role. Because role ambiguity continues
to exist and the longevity of CNS positions relies on demonstrating CNSs contribution to the current health care system, there is a critical need to develop knowledge about CNSs’ practice and how their activities, such as their involvement in policy work, contribute to improving the delivery of health care in Canada.

CNSs stand to optimize the delivery of health care in Canada by bridging the gap between research and practice through policy work (Bamford & Gibson, 2000; Canam, 2005; De Grasse & Nicklin, 2001; Kring, 2008; Pepler, Frisch, Swidzinski, & Brown, 2006; Seenandan-Sookdeo, 2012). CNSs can influence policy at the clinical, institutional and system levels. It has been suggested that CNSs engage in policy, yet little is known about their actual experiences (CNA, 2008; Canam; Davies & Eng; 1995, Schreiber et al., 2003; Scott, 1999). Gaining a broader understanding of CNSs’ experience in policy will permit a clearer understanding of how CNSs enact their role to not only advance the nursing profession, but also influence how health care is provided at a system and population level (O’Grady & Johnson, 2009).

**Problem Statement**

Currently little is known regarding CNSs’ participation in policy within their practice or their contribution to the delivery of efficient, sustainable health care in Canada (CNA, 2008; DiCenso & Bryant-Lukosius, 2010a). For the purpose of this thesis, policy is defined as “statements (documents) that reflect the ‘standing decisions’ of an organization about a given problem, issue or situation” (Milstead, 2004, as cited in Hinshaw, 2011, p. 2). Policies can be at the clinical, institutional
and system levels.

At the clinical level policies can affect a clinical unit or specialized area of practice. Local protocols, guidelines or pathways are examples of policies at the clinical level. These are sometimes referred to in practice as ‘small (p) policies’ because their scope of influence is often limited to the patients and nurses within the local clinical area. An example of a small (p) clinical policy is a clinical protocol delineating appropriate use of sucrose for pain management in neonatal patients.

At the institutional level including a facility, a hospital, or an organization, a policy has a wider sphere of influence. These more global policies apply broadly across a larger population. An example of an institutional level policy is a hospital wide policy on visiting hours; it affects every unit, practitioner and patient within that particular institution. For the purpose of this thesis institutional level policies will be referred to as small (p) policies.

Broader at the systems level, policies generally encompass larger geographical areas and spheres of influence such as health authorities, provinces or countries. Systems level policies, sometimes referred to in practice as ‘big (P) policies’, sphere of influence is larger and broader than clinical and institutional policies. An example of a systems level policy is the College of Registered Nurses of British Columbia’s (CRNCs) policy on title use (CRN BC, 2011). This policy requires that all individuals using the title ‘nurse’ be registered by CRNBC, The College of Psychiatric Nurses of BC or The College of Licensed Practical Nurses of BC. This big (P) policy has a broad provincial sphere of
influence impacting every nurse practicing within BC.

Literature indicates that CNSs engage in policy within their practice but to what extent remains unclear (Canam, 2005; CNA, 2008; Davies & Eng, 1995; Schreiber et al., 2003; Scott, 1999). Additionally, the context surrounding CNSs’ engagement in policy at the clinical, institutional and system levels is uncertain. The objective of this study was not to compartmentalize CNSs’ policy activities, rather it was to examine CNSs’ experience of policy within all domains of their practice to broaden and expand our understanding of the CNS role. Such an understanding could provide clarity on how CNSs enact their role within the complexities of the current health care system, specifically in relation to policy.

**Purpose**

The purpose of this study was to explore CNSs’ experience of policy at the clinical, institutional and system levels of the health care system, to further enhance our understanding of CNSs’ practice in BC.

**Research Question**

The research question used to guide the exploration of CNSs’ involvement in policy was: What is CNSs’ experience of policy within their practice? Secondary questions that will be explored include:

- How do CNSs describe/define policy?
- How do CNSs engage in policy?
- Why do CNSs engage in policy?
- What activities do CNSs describe as engaging in policy?
- What factors affect CNSs’ experience of policy in their practice?
Assumptions

Two assumptions that were made in reference to this study are:

1. CNSs themselves are best able to describe their experience of policy within their role, and

2. CNSs will be interested and willing to share their experiences of policy.

Thesis Organization

This thesis will be presented in five chapters. CHAPTER ONE is the introduction and provides justification for the study. This chapter included the background to the problem, the problem statement, the purpose, a demarcation of research questions, and identification of assumptions underlying the study. CHAPTER TWO offers a review of relevant literature, including policy and CNSs’ role in policy. CHAPTER THREE outlines the methodology used in the study, including the rational for using a qualitative research approach, selection of participants, recruitment of participants, a description of participants, data collection, data analysis, ethical considerations, rigour, and limitations.

CHAPTER FOUR will present the findings of the study. To conclude a discussion of the findings within the context of current literature and the health care system will be conducted in CHAPTER FIVE. Recommendation in relation to practice, education, research and the health care system will also be presented.
CHAPTER TWO: LITERATURE REVIEW

A comprehensive exploration of literature was conducted and will be presented in this chapter. A review of CNSs’ role in policy as described in literature provides the impetus for this study.

Policy

Before exploring the notion of policy and CNSs’ role in policy, a brief exploration of the frameworks used to describe CNS practice, in the context of ANP, will be presented; this to situate policy within CNS frameworks.

Various comprehensive frameworks exist delineating the domains of ANP. The CNA describes ANP within four domains: clinical, research, leadership and consultation and collaboration (2008). Alternatively, the Strong Model of Advanced Practice recognizes five domains of ANP: direct, comprehensive care, support of systems, publication and professional leadership, research and education (Ackerman et al, 1996). Collaboration, scholarship and empowerment are described as unifying strands or key characteristics, attitudes and attributes that pervade CNSs’ and NPs’ activities within these five domains. Further, the National Association of CNSs (NACNSs) framework utilizes spheres of influence to elucidate CNS practice. According to the NACNSs, CNSs are clinical experts who develop specialized competencies and skills to exert influence within the three spheres of practice. The spheres include the patient or population, the nurse or nursing practice, and the organization or system (NACNS, 1998 as cited in Zuzelo, 2003). Though not always explicitly delineated within each of these three frameworks, policy has the potential to infiltrate all domains of CNSs’
practice and spheres of influence.

Various definitions of policy exist, including “decisions resulting in a law or regulation” (O’Grady & Johnson, 2009, p. 627), “statements (documents) that reflect the ‘standing decisions’ of an organization about a given problem, issue or situation” (Milstead, 2004, as cited in Hinshaw, 2011, p. 2), and “a conscious choice of action, inaction, decisions, and non decisions directed towards an end – a deliberate choice between alternatives” (Clarke, 2010, p. 69). Different levels and kinds of policy permeate every aspect of society including health, health care and nursing practice. Given the complexity of policy, including the diversity in defining it and the contextual factors influencing it, an organizing framework was needed. As such, Lomas’ Framework ‘The World in Which Policies are Made’ was used as a structure for exploring and synthesizing literature and discussing the notion of policy within the context of health care and particularly nursing practice.

Lomas’ Framework

Lomas’ (1997, 2000) Framework ‘The World in Which Policies are Made’ depicts the contextual influences and relationships that exist in relation to policy and policy making. The underpinning of Lomas’ work was to address the disconnect existing between researchers and policy makers in the healthcare sector. The framework seeks to represent the intersection of research and policy, recognizing that neither are products or events, but complex processes existing within complex contexts. Lomas strived to facilitate an understanding between researchers and policy makers, of each other’s worlds and how they intersect;
thus to improve links and communication throughout the research and policy processes to enhance dissemination and uptake of research in policy making (Lomas, 1997; 2000). Lomas’ work has set the ground work from which recommendations have been made to address the interface between research and big (P) policy or healthcare policy. It has also been used at local levels or small (p) policy levels. For example, Cummings and McLennan (2005) used Lomas’ work to guide organizational policy change to support the integration of advanced nursing practice roles within an oncology unit.

Though the primary purpose of Lomas’ framework was to address the connection between research and policy, the framework also recognizes that the notion of policy is complex, messy, multifaceted and dependent on context (1997; 2000). Therefore, as a framework originating in the health sector, Lomas’ work informed this research as a guide for the synthesis and discussion of policy literature\(^2\).

Figure One is a schematic representation of Lomas’ framework.

\(^2\) Lomas’ Framework was also drawn upon in this study in the discussion of the research findings as a theoretical lens. This will be discussed further in CHAPTER THREE: RESEARCH METHODOLOGY.
Lomas delineates three interrelated Domains of influence within the context of policy. The first Domain, located in the middle of the diagrammatic representation of the framework, is the Institutional Structure for Decision Making. This includes formal structures, such as executive and legislative councils, and bureaucracy in the form of implicit and explicit rules of process and conduct, as well as distribution of responsibility and accountability. Within this Domain informal structures, such as stakeholders and citizens, also influence decision making. From these formal and informal structures emerge policies, which in turn influence power relationships and interests (Lomas, 1997, 2000).
Interests are housed within the Values Domain of Lomas’ framework. Interests reflect how one would ‘like’ the world to look or work. Interests often are altered by context and policy. Ideologies reflect how the world ‘ought’ to work, while beliefs constitute how the world ‘actually’ works based on the accumulation of information and knowledge. In Lomas’ framework institutional and personal interests, ideologies and beliefs become input into the Institutional Structure for Decision Making Domain, and subsequently affect policy. Paradigms and epistemology also emerge out of the Values Domain and in turn influence policy by becoming input to the Information Domain of Lomas’ framework (Lomas, 1997; 2000).

Information, the third Domain in Lomas’ framework, generates knowledge. Knowledge and its dissemination affect policy directly by influencing the Institutional Structure for Decision Making Domain, as well as indirectly by changing individuals and institutional beliefs over time, via the Values Domain (Lomas, 1997, 2000).

Not surprisingly Lomas’ framework recognizes that power relationships influence policy and the context in which policies are made (1997, 2000). Lomas suggests that power relationships emerge from policies themselves as well as the Institutional Structure of Decision Making Domain, and effectually impact the Value Domain through interests of individuals and institutions.

Lomas’ framework through the three interrelated Domains attempts to depict the context or ‘world’ in which policies are made. This world is complex, in a constant state of flux and change, and heavily dependant on power, values and
process. Therefore to facilitate a more comprehensive understanding of policy these concepts will be explored in further detail.

**Power and Politics**

Power and power relationships within the context of policy is often referred to as ‘politics’ in literature (Clarke, 2010; Mason, Leavitt, & Chaffee, 2002; O’Grady & Johnson, 2009). Interestingly politics is sometimes referenced as a neutral term (Kendig, 2002; Mason, Leavitt, & Chaffee), though it is most often defined and described in ways that imply an aspect of power or a means to influence. Kendig recognizes politics as “a process by which one influences another’s decisions and exerts control over situations and events” (p. 309), Clarke describes it as “conditions that impede or accelerate policy” which “involves using power to influence, persuade or otherwise change things” (p.70), while Castledine (2003) relates it to exercising power and authority (p. 203).

How to affect policy through the use of power and the navigation of politics is heavily dependent on the context in which policy is made and the individuals involved. Though there are strategies for success that can be considered when engaging in the art\(^3\) of politics. Some suggestions include: look at the big picture, be prepared, frame the issue adequately, develop and use networks, assess the timing, collaborate with others, prepare to take risks and understand and anticipate the oppositions concerns (Clarke, 2010; Leavitt, Cohen, & Manson, 2002). Navigating power and politics is convoluted and multifaceted. It is often dependent on formal positions or designations, credibility, expertise,

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\(3\) Politics has been described in literature as an art; understanding relationships between groups and society and influencing others (Clarke, 2010). It is described as less of a rational act (Shamian & Griffin, 2003), but rather an art or the “science of muddling through” (Lindblom, 1959, as cited in West & Scott, 2000, p. 818).
relationships, resources and timing. Navigating the intricacies of politics within the context of Lomas’ framework adds multiple layers of complexity to the policy world. Similar to Lomas, literature delineates that politics and power come into play when values held are in conflict (Aiken, 2011; Mason, Leavitt & Chaffee, 2002).

**Values**

Policy in and of itself is value ridden, consequently policy development is a value driven process (Aiken, 2011; Mason, Leavitt & Chaffee, 2002). Policy is the ‘shoulds’ and ‘oughts’ and is based on the values, goals and principles of the individuals and/or organizations involved in the development process (Clarke, 2010). The Values Domain, within Lomas’ framework, attests to the substantial influence values hold in the realm of policy and politics (Lomas, 1997, 2000).

In relation to values, it is important to note that the values underpinning a particular policy may be based on individuals and/or bias viewpoints (Clarke, 2010; Lomas, 1997, 2000). Additionally as information, in the form of research and social perspectives, shift so does the associated values held by those influencing policy. Therefore, policy is progressive; policy change is usually gradual and incremental over the long term (Leavitt, Cohen & Manson, 2002). Values play an instrumental role in all aspects of policy, and particularly the policy process through which new policies are generated and old policies are revised.

**The Policy Process**

Policy is, as Lomas acknowledged, not a product or event but rather a
process (1997; 2000). Therefore consideration of the policy process is essential when exploring the notion of policy. An inclusive discussion of the policy process is challenged by its dependency on the formal and informal structures that constitute individual institutions or organizational decision making processes (Lomas, 1997; 2000). As such the purpose of this discussion is to present one framework which describes a potential process from which policies could emerge; this to explore the context and processes in which CNSs may or may not experience policy in their practice.

Health Canada’s Office of Nursing Policy’s (ONPs) Policy Cycle was drawn upon in this research to explore the policy process. The ONP Policy Cycle, formulated from a Canadian perspective, is suggested to be comprehensive and is commonly used within nursing literature within the Canadian context to discuss and explore policy work (Shamian & Griffin, 2003; Shamian & Shamian, 2011; Villeneuve, Shamian, & Skelton-Green, 2010). Not unlike Lomas, the ONP composed this framework as a means to increase the influence of nursing evidence and perspectives in health policy at federal or big (P) policy tables, most notably in relation to healthy work environments for nurses (Shamian & Griffin; Shamian & Shamian). The ONP contends that policy moves through eight stages. Figure Two is a visual representation of the ONP Policy Cycle.
Figure 2: The Policy Cycle

(Adapted from Tarlov, 1999, 2000 as cited in Shamian & Griffin, 2003; Shamian & Shamian, 2011; Villeneuve, Shamian, & Skelton-Green, 2010).

Phase one is heavily dependent on values and beliefs. In order to move a policy issue forward the identification, validation and articulation of the underpinning values and beliefs is essential. In phase two an issue or problem emerges. During this phase a sense of urgency or alignment with current political agendas usually facilitates the issue to move forward. It is important to recognize that the mere existence of an issue does not ensure support or recognition in the policy arena. The issue must be made visible and significant to others, not only those who are directly affected by it. Timing and opportunity impact whether or not a policy issue moves beyond this point. In phase three research and
evidence is consulted to support the existence of the issue and the identification of possible solutions. During phase four the focus is on awareness; educating and informing others of the issue and the potential solutions. Then in phase five, political engagement, buy in, acceptance and support of others in positions of power is sought. During phase six, activation of interest groups, eliciting and expanding support for the issue moves beyond those in power to include stakeholders. During phase seven, policy deliberation and adoption, the issue moves to the policy table and the policy is formulated. Finally in phase eight the new formalized policy stands to set new norms. During this phase implementation and evaluation occur which may in turn produce new information and prompt the policy cycle again (Shamian & Griffin, 2003; Shamian & Shamian, 2011; Villeneuve, Shamian, & Skelton-Green, 2010).

Though the policy process is presented in a cyclic, rational manner here, the policy cycle is rarely factual or logical. In fact, it is driven primarily by values rather than reason and is dynamic and chaotic rather than linear and logical (Villeneuve, Shamian & Skelton-Green, 2010). The movement of an issue through the policy cycle is heavily dependent on politics – social influences, persuasion, attitudinal change, decision making and compromise (Villeneuve, Shamian & Skelton-Green). Regardless, policy is seen as a means to guide nursing practice, move the nursing profession forward and improve patient outcomes. Therefore nurses’ involvement in the chaotic, value and power ridden policy world is essential (Clarke, 2010; Grady, 2011; Mason, Leavitt, & Chaffee, 2002; Villeneuve, Shamian & Skelton-Green; West & Scott, 2000). However, it is
unclear how CNSs’ experience policy, though literature does depict nursing in general and CNSs specifically as politically active.

**Policy: The CNSs Role**

Nursing itself has a long history of influencing policy. In the 1800’s Florence Nightingale lobbied tirelessly, advocating for policy change to improve the provision of nursing care. Issues relating to quality, dignity and equity were notable during Nightingale’s time. Nightingale recognized the importance of evidence informed policy change, bringing statistics and clinical expertise to policy makers to support her positions (Castledine, 2003; O’Grady & Johnson, 2009). Despite nursing’s long history with policy and its fundamental ties to social justice, nurses often shy away from broader issues of politics and policy and focus instead on direct patient care (Kendig, 2002, McIntyre & McDonald, 2010).

Many suggest that nurses’ involvement in policy, from the local to national level, is essential now more than ever. Particularly in light of the nursing shortage, changing models of care, emergence of new technology and scientific knowledge and paradigm shifts in the provision of health care. This argument is not only seen within Canadian literature, but internationally (Affonso & Mayberry, 1989; Aiken, 2011; De Grasse & Nicklin, 2001; Furlong & Smith, 2005; Kendig, 2002; O’Grady & Johnson, 2009; West & Scott, 2000). Broadly speaking nursing’s involvement in politics and policy can offer insight into the human context of health and health care issues. It can also ensure that fundamental concepts central to nursing, like patient centered, holistic care and health promotion and disease prevention, are considered. This is important in
discussions related to quality and access as well as negotiations for resources including money, time, supplies, personal, and information (O’Grady & Johnson; Kendig).

CNSs specifically are in a unique position to influence policy at various levels of the health care system, from broad public health policy to local clinically focused policies and procedures. Regardless of the level of policy and resulting sphere of influence, policy and politics is a means to an ends (Kendig, 2002). Therefore if CNSs want to contribute to the future of health care, the nursing profession and patient outcomes their involvement in policy is non-negotiable. A review of ANP frameworks supports this, as all frameworks either directly or indirectly imply that policy is an essential component of ANP roles (Ackerman et al., 1996; CNA, 2008; Sparacino, 2000; Zuzelo, 2003).

CNSs’ practice is suggested to be at the junction between public policy and the lived experience of those it impacts, which puts them in a unique position to act as advocates (Clarke, 2010; Spross & Hanson, 2009). Furthermore, CNSs are thought to possess essential skills and knowledge, as a result of their clinical expertise and Masters level education, to effectively participate in policy making. This includes shared visions, systems thinking, and effective communication and leadership skills (Spross & Hanson).

Public policy refers to:

“authorities decisions pertaining to health or health care, made in legislative branches of government, that are intended to direct or influence the actions, behaviours or decisions of citizens” (O’Grady & Johnson,
Public policy and policy setting is generally dependent on the political climate, current politics, agenda setting and budgets. Due to Canada’s centralized, publically funded, government run health care system, public policy is particularly important to health and health care within the Canadian context. Therefore CNSs have a vested interest in public policy as it impacts health and health care, nursing and ANP directly (O’Grady & Johnson, 2009; Spross & Hanson, 2009). It should be noted that public policy can originate at any level including global, international, federal, provincial and local levels.

Apart from public policy, CNSs also stand to influence policy directly related to the provision of health care and clinical practice. Evidence-based practice represents a significant paradigm shift⁴ that substantiates CNSs involvement in policy at the clinical, institutional and system levels. Evidence-based practice first emerged in medical literature in the 1990’s and is readily being implemented into all contexts of health care (DePalma, 2009; Hinshaw, 2011). Evidence-based decisions and changes take into consideration rigorous research, evidence-based guidelines, outcomes management, and quality improvement initiatives (Melnyk & Williamson, 2011, p. 87). CNSs are in a unique position in health care to bridging the gap between research and practice (Seenandan-Sookdeo, 2012) through what is referenced in literature as research utilization or knowledge translation⁵. Implementation of clinical guidelines,

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⁴ Until the 1980’s nursing practice was largely based on nursing theories. Nursing theories attempted to describe, explain, predict and control nursing practice and the relationship between nursing interventions and patient’s responses (Pringle, 2010; Upton, 1999). The belief that health professionals should base clinical practice on research and science rather than tradition and beliefs lead to a paradigm shift from theory-based practice to EBP.

⁵ Research utilization also referred to as knowledge translation is a developing area of science which attains to factors
protocols, best practice standards, clinical pathways, and standardization and quality improvement initiatives serve to improve the care of populations and the effectiveness of systems (Antrobus & Kitson, 1999; Bamford & Gibson, 2000; Canam, 2005; DiCenso & Bryant-Lukosius, 2010b; De Grasse & Nicklin, 2001; Kring, 2008; Lewandowski, 2009; Pepler et al., 2006; Urquhart, Roschkov, Rebeyka, & Scherr, 2004). CNSs are Masters prepared clinical experts, who hold a unique set of competencies, perspectives and skills for applying EBP standards effectively. Incorporating rigorous research, through the application of clinical expertise, and respect for individualized patient care are critical components of EBP, all of which aligns well with CNSs’ role, skills and perspectives (Sackett et al., 1997, as cited in DePalma, 2009).

Literature indicates that CNSs engage in policy and that their role is well suited to policy work, though an exploration of CNSs’ experience of policy within their role does not exist. Serving as the impetus for this study, an exploration of CNSs’ experience of policy may provide clarity in defining the CNS role and demystifying some issues related to role ambiguity. It may also serve as a platform for future research aimed at quantifying and communicating CNSs’ contribution to the delivery of effective and sustainable health care, improved patient outcomes and the future of nursing practice.

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that impact the utilization and use of research in clinical practice by health care professionals (Pringle, 2010).
CHAPTER THREE: RESEARCH METHODOLOGY

This thesis employed a qualitative methodology to investigate the phenomenon of CNSs’ experience of policy in their practice. Interpretive description (Thorne, 2000; 2008) was selected as an appropriate design. The rationale for the methodology, selection of participants, recruitment of participants, a description of participants, data collection, data analysis, ethical considerations, rigour, and limitations will be discussed.

Methodology

Qualitative research as a whole adheres to a naturalistic approach which recognizes that phenomena are socially constructed and individualistic (Miller, 2010). As such, qualitative research is based on the notion that multiple realities exist (Polit & Beck, 2008). Since little is known from literature in relation to how and to what extent CNSs engage in policy it is essential to recognize that CNSs likely have different realities of policy based on their individual knowledge, experience, and interests, as well as the social-political context of their practice.

The rationale for employing a qualitative approach in this study comes directly from CNS literature. The CNS role has been described as greater than the sum of its parts (Davies & Eng, 1995 & Davies & Hughes, 1995). This notion has been substantiated through researchers’ application of quantitative study designs in an attempt to further understand CNS practice. In one such study, CNS participants were asked to quantify their practice into components (Davies & Eng). The respondents reported that it was difficult to quantify what they described as qualitative functions (Davies & Eng). Canam (2005) suggests that
past research has done little to illuminate the nature of CNS practice, as lists of roles and competencies do not do CNS practice justice nor does it capture the essence of what CNS practice encompasses.

Interpretive description recognizes not only the value of describing a phenomenon to promote awareness and establish a knowledge base for the generation of new questions, but also emphasizes the need to systematically analyze a phenomenon so that specific observations can lead to broader generalizations (Thorne, 2008). As such, interpretive description methodologies aim to generate descriptions of both individual experiences and participants’ collective reality. Furthermore, interpretive description, developed in nursing, emphasizes the importance of framing the analysis of a phenomenon within the context that it occurs (Thorne). For these reasons, the inductive approach associated with interpretive description provided an appropriate mode of investigating CNSs’ experience of policy within their practice context.

**Selection Criteria for Participants**

Purposive sampling was used to recruit participants from the study population. The following inclusion and exclusion criteria were selected in an effort to ensure that the resulting sample population represents the population construct of CNSs practicing within BC (Polit & Beck, 2008). An attempt was made to include participants from a variety of geographical locations and diverse clinical settings in order to gain a broad understanding of CNSs’ experiences across the province and within different practice contexts.
**Inclusion Criteria**

Participants were eligible for inclusion in the study if they:

1. Were currently working as a CNS in BC,
2. Held an active practicing licence with CRNBC,
3. Had a minimum of a Master’s degree, and
4. Had a minimum of three years of experience as a CNS, either in their current position or a combination of their current and past CNS positions.

**Exclusion Criteria**

Participants were excluded if they were:

1. Non-English speaking, and
2. Unable to meet and volunteer 90 minutes of their time with the researcher in person, over the phone or via Skype.

The reason for including CNSs with a minimum of a Masters degree, related to the educational recommendation set by CNA within the Canadian ANP Framework for CNS Practice (2008). Further, to ensure a level of expertise and experience, eligible participants were required to have a minimum of three years of experience as a CNS, either in their current position or a combination of their current and past CNS positions.

It should be noted that CNSs’ self-identified engagement in policy was not an inclusion or exclusion criteria. As indicated previously, literature states that CNSs participate in policy within their practice, but how and to what extent is unknown. Therefore, self-identified engagement in policy was purposefully not
included as an inclusion or exclusion criteria. As such, if all CNSs are not engaging in policy, then an exploration of why they are not would serve to inform the study results and potentially provide a more inclusive understanding of CNS practice in BC.

**Recruitment Process**

Recruitment began after ethics approval was obtained from the University of British Columbia (UBC) Behavioural Research Ethics Board. Participants were recruited through a Letter of Invitation (Appendix I) which was sent out via email by Dr. Smye to UBCs’ CNS affiliate/adjunct list and the Clinical Nurse Specialist Association of British Columbia (CNSABC) member distribution list. At the invitation of CNSABCs’ president, the researcher also attended a CNSABC meeting, where a brief overview of the study was presented to attendees and Letters of Invitation were distributed. Meeting attendees could either contact the researcher via email or provide their contact information on an Expression of Interest Form. In order to preserve the voluntary nature of participants’ involvement in the study, the researcher did not contact any participants directly until they expressed interest in being contacted as a potential participant. Regardless of if the expression of interest was initiated, via email or at the CNSABC meeting, all interested participants were emailed a copy of the study’s Consent Form for Participants and Inclusion Criteria for review (Appendix II and Appendix III respectively). If after reviewing this information, potential participants contacted the researcher, an interview was set up at a time and location deemed convenient by the participant.
Of the 11 participants, seven were recruited through emailing the Letter of Invitation either to UBCs’ affiliate/adjunct list or CNSABCs’ member distribution list. Two participants were recruited at the CNSABC meeting, while one participant made contact with the researcher both through email and again at the CNSABC meeting. The final participant was contacted directly via email by Dr. Vicki Smye with a Letter of Invitation. The researcher made contact only after the individual agreed to being contacted as a potential participant.

**Description of Participants**

The final sample of 11 CNSs is representative of diverse experiences, backgrounds, and clinical practice areas. The participants’ experience as RNs ranged from 10 to 34 years with an average of 23 years. Their experience as CNSs ranged from 3.5 to 16 years with an average of 6.9 years. All 11 CNSs had a completed Masters degree and worked serving a specialized population. Five of the CNSs worked in an acute care setting, one CNS worked in the community and five CNSs’ work crossed over both acute care and community settings. All 11 CNSs worked primarily in urban settings, though a number of CNSs described their role as having a provincial sphere of influence across BC. 10 of the CNSs worked full time and one participant worked a 0.8 full time equivalent.

**Data Collection**

Self-report was the primary source of data for the study. According to Baumbusch, interviews serve as a key source of data collection in facilitating rich descriptions and detailed reports of participants’ experiences and perspectives of a phenomenon (2010, p. 255). As such, individual semi-structured in-depth
interviews were conducted. The interviews were between 30 minutes and 80 minutes in length with an average length of 55 minutes.

Interviews were all carried out in person, in a quiet, private setting of the participant’s choice. All interviews were conducted by the author, were digitally audio-taped, and transcribed verbatim in a Word document. An electronic copy of the verbatim interview transcript was sent to the participant within one week of the interview. Each participant was asked to review their transcript to ensure its completeness. Participants were encouraged to clarify, change or add to the transcript to ensure it accurately illustrated their experiences. The resulting comments were included in the data set for analysis.

Of the 11 participants interviewed, two follow-up interviews were conducted. One was requested by the participant, after transcript review, to provide some clarifying comments. This follow-up interview was conducted in person. The second follow-up interview was conducted at the request of the researcher in order to clarify aspects of the participant’s experience that were not fully explored during the original interview. This follow-up interview was conducted by telephone and only after the participant agreed to being contacted a second time.

**Interview Plan**

Interview stages as proposed by Baumbusch (2010) were used as a tool to adapt a general interview plan. There are five general stages included in Baumbusch’s interview process. These stages include: 1) The introduction; 2) Beginning the interview with factual focus; 3) Shifting to more in-depth questions;
4) Moving back to factual questions; and 5) Closing the interview. An interview plan based on Baumbusch’s stages was used to guide the conduction of each in-depth interview (Appendix IV). A Demographic Data Sheet (Appendix V) was used at the beginning of the interview to collect general information about each participant, while open-ended questions and prompts facilitated the exploration of each participant’s experience.

**Data Analysis**

Data analysis was conducted as an iterative, concurrent process with data collection (Thorne, 2008). According to Thorne prior to coding data researchers should immerse themselves in the data. Therefore, as audiotapes were reviewed to ensure quality and engagement in transcription occurred preliminary data analysis simultaneously took place. These processes allowed analysis of the details of the interview, like the participants use of specific words, nuances, phrases and the pauses or silent reflection in discussion rather than the overall themes of the interview (Thorne, p. 144). After preliminary review of the transcripts, a more thorough reading was conducted. During this stage electronic notes were made in the margins of the transcripts in an effort to gain an overall understanding of the data. Thorne, Kirkham and MacDonald-Emes’ (1997) suggestion of asking questions such as “what is happening here?” or “what am I learning about this?” (p.174) was utilized. This exercise allowed for the comprehension, synthesis, and re-conceptualization of data to establish more meaningful analytic interpretations, while reframing from premature coding (Thorne 2000; 2008; Thorne, Kirkham & MacDonald-Emes).
As the analytical process progressed broad codes identifying like themes, ideas, patterns and relationships were established using a constant comparative analysis (Thorne, 2008). Pieces of data with similar properties were grouped together and then contrasted to other groupings. The process of iterative inductive reasoning facilitated constant critical reflection and continually challenged interpretations so a shared understanding of the phenomenon could be extracted from individual realities (Thorne). Primarily repetitive emersion in the data and discussions with the research supervisor facilitated this process.

Lomas’ Framework\(^6\) (1997; 2000) ‘The World in Which Policies are Made’ was drawn upon as a theoretical lens in the discussion of the findings, though it should be noted that it was not used to guide data analysis itself. Lomas’ framework addresses the context in which policies are made, and it is important to recognize that experience is dependent on context and vice versa. Therefore, Lomas’ work provided a framework from which to conceptualize and discuss the complexities of policy and the context in which CNSs practice and consequently experience policy.

Member checking was used in the final stages of analysis to ensure that resulting interpretations resonated and held truth with participants (Polit & Beck, 2008; Thorne, Kirkham & MacDonald-Emes, 1997). Participants who consented to participate in member checking during the interview were contacted by email after the final draft of findings and analysis was completed. If still willing, the participants were sent an electronic copy of the draft of findings and analysis and were asked to respond to the questions, “Do these findings reflect your

\(^6\) See CHAPTER TWO: LITERATURE REVIEW for a more comprehensive discussion of Lomas’ framework.
experience and the factors that influence it? If so, in what ways, and if not, what
do you see as the differences?” (Canam, 2005, p. 76). All 11 participants
consented to member checking, seven participants were still willing when
contacted by email, and six participants responded within the allocated time.

**Reflective Journaling**

Throughout data collection and analysis reflective journaling was utilized,
including Field Notes (Appendix VI) and an audit trail (Thorne, 2008). Through
the process of data collection and analysis, reflective journaling helped to clarify
and explicitly recognize how I may have been influencing data collection and the
analytical construction of the analysis (Thorne). Journaling was used to identify
my own preconceptions, thoughts, questions, ideas, and interpretations
throughout the research process. Field notes were included in my reflective
journal. Specifically, time was taken after each interview to reflect on the general
nature of the interaction and initial thoughts about the data collected.

Additionally, an audit trail was maintained to document the details of the
decisions made throughout the inductive process of data collection and analysis
(Thorne, 2008). In particular, the audit trail was used to track the reasoning,
rationales and thought processes guiding the iterative method of establishing
themes and identifying relationships and associations during analysis (Thorne).

**Ethical Considerations**

Ethics approval was sought from the UBC Behavioural Research Ethics
Board (REB). REB is responsible for overseeing all research conducted at UBC,
as such their approval was obtained prior to recruitment of participants.
Ethical consideration was also given to coercion, informed consent and participant confidentiality. Participants were not coerced into participating in the study; the sample population was comprised of volunteer participants. To ensure this, at no time during the study did the researcher contact a potential participant directly with the intent to recruit.

All participants provided consent to participate prior to the commencement of data collection. Signing of the consent was voluntary. Additionally, the consent form clearly outlined that at any time participants could choose to withdraw as a study participant. If they decided to withdraw from the study, all data related to the participant would be destroyed immediately and not included as data in the study or considered during data analysis. This was reiterated by the researcher during the initial stage of each interview.

Finally, steps were taken to ensure that participants’ privacy and identities were protected. All participants were given a code which was used to label digital audio files and transcripts. All identifying utterances were removed from quotes prior to being included in the final write up of findings.

**Rigour**

Various frameworks exist to ascertain rigour of qualitative work. For the purpose of this study Lincoln and Guba’s framework was used to assess rigour, which they refer to as trustworthiness (as cited in Polit & Beck, 2008, p. 569). According to Lincoln and Guba trustworthiness can be described in terms of credibility, dependability, confirmability, transferability, and authenticity. Credibility refers to the accuracy of data and interpretations, dependability is the reliability of
the data over time and across conditions, confirmability is the objective representation of data, transferability implies that the data collected can be generalized to the intended population, and authenticity refers to the researcher’s effort to describe a range of realities. To ensure the trustworthiness of this study’s results, careful thought was given to these five criterions throughout the process of defining and outlining appropriate sampling methods, data collection techniques and the data analysis plan. Consequently trustworthiness is embedded in the methodology of the study. Table One outlines the methodologies used and the criterions each methodological strategy proposes to address.

**Table 1: Methodologies and Trustworthiness**

<table>
<thead>
<tr>
<th>Methodological Strategy</th>
<th>Trustworthiness Criterion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purposeful sampling</td>
<td>Transferability</td>
</tr>
<tr>
<td>Audio taping and verbatim transcription of interviews</td>
<td>Credibility and confirmability</td>
</tr>
<tr>
<td>Transcript review and member checking</td>
<td>Credibility and confirmability</td>
</tr>
<tr>
<td>Reflective journaling</td>
<td>Credibility and authenticity</td>
</tr>
<tr>
<td>Field notes</td>
<td>Confirmability</td>
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<tr>
<td>Audit trail</td>
<td>Credibility and dependability</td>
</tr>
</tbody>
</table>

### Limitations of the Study

The study has one limitation that should be considered. The purpose of the study was to explore CNSs’ experience of policy to further enhance our understanding of CNSs’ practice in BC. It was challenging to recruit CNSs from outside the Lower Mainland. This likely relates to a smaller number of potential participants in other areas of BC as well as the feasibility of reaching those
participants through the recruitment methods used. All 11 participants practiced within the Lower Mainland, an urban setting. Therefore the findings of this study may not be reflective of CNSs’ experiences that practice outside of the Lower Mainland. These CNSs’ practice context may differ in relation to geographical area (rural), health authority (structure and process) and availability of resources.

**Summary**

This chapter outlined methodological issues and considerations accounted for during the planning and conduction of the study including selection of participants, recruitment of participants, data collection, data analysis, ethical considerations, rigour, and limitations. Further, a description of participants was reviewed. The methodologies presented provided a framework for the findings presented in CHAPTER FOUR.
CHAPTER FOUR: FINDINGS

In this chapter, I will outline the four major themes constructed through the processes of data analysis: 1) The Perplexities of Policy; 2) CNSs and Policy: A Perfect Match; 3) CNSs’ Influence: Policy as a Vehicle; and 4) Mechanisms that Challenge and Facilitate CNSs’ Policy Work. A Thematic Tree (Appendix VII) delineates the main themes and associated sub-themes presented in this chapter.

It is important to note that although four main themes represent the collective reality of the 11 CNSs interviewed, each CNS also expressed a unique and personal reality. The uniqueness of each CNSs’ experience of policy within their practice was shaped by various factors including, but not limited to, their personal and professional experiences and beliefs, their knowledge, and the context in which they practice.

The Perplexities of Policy

The perplexities of policy within CNSs’ experience was noted as a common theme woven throughout all 11 interviews. Perplexity can be defined as “a tangled, involved, or confused condition or situation” (Dictionary.com, n.d.). Two sub-themes emerged from the perplexities of policy within CNS practice: Defining and Describing Policy, and Policy and Process.

Defining and Describing Policy

Policy, defining it and describing it, proved to be perplexing to most of the

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7 When referring to CNSs within this chapter I am referring only to the participant population of this study, unless otherwise indicated.
CNSs. In fact, comments like “I’m not sure I have a great sense of that” (P3)\(^8\) were not uncommon. Explicitly defining and describing policy was often puzzling to CNSs, as demonstrated here,

I don’t know what you mean, like what is your definition of policy? (P6)

How would you define it? I don’t know. Is there a definition that says this is policy? (P11)

Unclear of the definition of policy, these two CNSs turned the question of defining policy back to the interviewer.

Drawing upon others’ definition of policy did not seem to facilitate clarity in defining policy either as seen in the following statement,

Because everyone has a different term for policy. Like that has been one of the big things. Is it a policy? Is it a practice guideline? What’s the purpose of it? Lots of confusion around that. (P3)

In fact this quote demonstrates that CNSs are not alone in experiencing policy as a perplexing term.

A few CNSs recognized a disconnect between their personal definition of policy and the definition used within the organization in which they worked.

I think personally I would call it a policy if that makes sense. Because it’s not the protocol, it’s not a, you know you do this, then you do this, then you do this. It is the policy that says that … all patients with whatever will receive this level of care. All patients with whatever, this is the expectation. So it is to me kind of setting the standards of what is expected. (P3)

Much of the perplexity CNSs described in defining policy stemmed from terminology including policy versus protocol, clinical practice guideline (CPG), and clinical decision support tool (CDST). For the purpose of this discussion protocols will be used as an inclusive term referring to what CNSs described as

\(^8\) P will be used to denote Participant when referencing the participant’s code.
protocols, CPGs and CDSTs. Several CNSs described policies as “a predetermined set of prescriptive points” (P2), “thou shall do such and such” statements (P6) and “non-negotiable rules” (P2). Policies were generally considered to be broader and at a much higher level. Some CNSs described policies in terms of organizational, operational, corporate and clinical policies – how the hospital operates. Whereas protocols were seen as the “how you do the policy” (P1) that are essentially used to guide clinical practice. In the following excerpts one participant explores these differences,

Policy tells us what the rules are no matter what specialty you are in. Protocols tell us how we will do business. That is the difference between guidelines and policy,

and

The difference would be what is negotiable. A policy really has been a predetermined set of prescriptive points that have to be followed. … When it comes to guidelines … it is a really strong suggestion of what to do, but it also allows for some latitude, so nurses are enabled to use their clinical judgment as it relates to the context of the patient’s situation. (P2)

Even CNSs who defined policies and protocols similarly, how they individually described these differences varied. One CNS described the difference in relation to applicability to staff versus patients, families and visitors.

Clinical practice guideline it is loud and clear for people who work and ... who are looking after resident, who are looking after patient. But policy can be for the patient, it can be for the family, it can be for the visitors. (P7)

Another CNS described the difference in relation to allocation of resources and day to day activities.

Because we only have a certain amount of resources, so policy sort of helps to allocate resources, where they are best used and needed. Whereas protocols is what we do every day. (P6)
Most CNSs also described bedside nurses’ perplexity with the terminology and the application of policies versus protocols. One CNS stated,

Nurses sometimes say, they sometimes don’t fully understand the difference between a policy and a guideline, because to them it is all rules. (P2)

Other CNSs held a broader more encompassing definition of policy. These CNSs suggested that to them policy exists at different levels and with various levels of influence and impact. For instance, one CNS defined and described her experience of policy using the terms small (p) policy, at the clinical and institutional level and big (P) policy, at the provincial level (P10). Two other CNSs clearly identified that in their practice policy included tools used at the clinical level to guide practice, in addition to more encompassing policies at the provincial and national level which set out standards of care (P5; P8).

Regardless of how participants defined and applied the terms policies and protocols, all of the CNSs described both in terms of setting standards and being evidence informed. The following excerpts delineate this commonality seen amongst all participants.

I think that is why pathways are really important, I think guidelines are really important and policies are really important. Because then you know that you have standardized care, and it is evidence based and it is best practice. (P4)

Policy needs to be evidence informed, it needs to be renewed, it guides what we do and how we do it. (P2)

One CNS went on to explored the notion of standardization using the example of bowel protocols in the following excerpt,

You don’t want to constantly be doing you know, okay this is what we do on this ward only and this is what we do on this site only. Cause
sometimes you need to have a broader policy to help the whole population, sometimes there is too many. Like bowel protocols, there are too may bowel protocols out there. Like how hard can this be? (P11)

Not surprisingly given the variation across how CNSs defined and described policy, engagement with policy also varied. Some CNSs were able to clearly articulate their role in policy while others struggled to express their participation in policy.

One CNS stated, “I have to follow policy… I’m enforcing policy but I’m not writing it” (P1). While another participant who defined policy similarly stated “I believe that I develop policy. I believe that I lead policy as it relates to [name of population] patients” (P2). A number of CNSs described their experience of policy in relation to only big (P) policies. When asked about their involvement in clinically focused protocols they did not regard this as policy work.

Regardless of how each CNS specifically articulated their involvement in policy, all participants described engaging in activities which would be considered policy work as it is defined in the literature. For example, policy can be at the clinical, institutional or systems level and is considered by Milstead (as cited in Hinshaw, 2011) to be “statements (documents) that reflect the ‘standing decisions’ of an organization about a given problem, issue or situation” (p. 2). In this study, all of the participants clearly described their involvement in one or more levels of policy – clinical, institutional and/or systems.

Interestingly in response to being asked if they felt differentiating between guidelines, protocols and policies would be significant to their practice, participants stated that they did not think a more succinct definition would impact
their experience or their practice. In fact, some CNSs stated that they did not like getting caught up or “bogged down” (P11) in what they described as the “details” (P6) or the “nightmare” (P11) of differentiating and defining them.

**Policy and Process**

Another sub-theme woven through the interviews was CNSs’ experience of policy and process. Process can be defined as “a systematic series of actions directed to some end” or “a continuous action, operation, or series of changes taking place” (Dictionary.com, n.d.). Participants’ experienced policy in relation to process in three distinct ways: i) Processes of Care; ii) Policy as a Process and; iii) The Policy Process.

**Processes of Care**

Many of the CNSs conceptualized policy as documents that sustain and maintain a process of care. Some CNS participants described policy for its role in supporting the provision of a particular treatment.

So we created a policy for that process [screening patients at intermediate risk of thrombosis]. (P8)

For this CNS policy and process were interchangeable when she described processes of care.

CNSs also described the importance of continuums of care in relation to patient outcomes and use of resources.

You want to have good teaching upfront, so the patient understands what they are agreeing to, so informed consent. … Then they have the procedure done. And then they need to be monitored at the other side … And then they need to … have management of that procedure. … making sure that the home care nurses are educated and have the right equipment, so that they can actually follow-up…. So those, those pieces linking the whole thing together, is, is a big deal. And if that process isn’t in
place, who suffers? The patient. (P4)

Here the CNS describes how policies or processes of care facilitate smooth transitions throughout a patient’s journey across the health care system.

Other CNSs likened policy to models of care or frameworks. In the following excerpt, one CNS explains how policies are the foundation or ground work to support models of care,

And they [policies] support it [model of care]. So it is like that building there, so you start from the ground and you work up and in the end you have a building right. But you can’t have anything, you can’t do it any other way right. You have to start at the ground. (P10)

Further, the perplexity of policy and process is demonstrated in the following excerpt where the CNS describes policy not only in terms of processes of care but also in terms of the policy process,

“It’s to identify the current process, and then you identify gaps in the current process, then you come up with solutions, then you have a future process” (P4).

**Policy as a Process**

All 11 CNSs experienced policy as a process, an iterative and continual process. One CNS described policy as a “living thing” (P10). They described the need to constantly revisit policy to ensure it is updated, current and reflective of current knowledge and values. The following excerpts reflect the notion of policy as a process.

So I think policy is process because policy it is normative, it is based on values and values change. And so does the work place and what is going on so it is a living thing. So whatever your statement is or whatever your document is, I don’t see that as a permanent thing. (P10)

You know there were lots of documents that were written around all of this and there is still work going on and we are always tweaking that system.
That is the other thing you don’t always leave it [policy] alone because new things happen that, you know things change. (P11)

One participant uses the example of smoking regulations to demonstrate the progressive nature of policy.

Okay policy, you can’t smoke in a place. Okay now you can’t smoke in a place, well now you can’t smoke right outside. And if you can’t smoke right outside then you can’t be within so many meters. Now they are talking about well you can’t smoke in a park. (P11)

CNSs describe how policy, big (P) policy and small (p) policy, progresses as a process in response to changes in knowledge and the context in which it is applied and the values and beliefs of those affected by it.

**The Policy Process**

All participants noted that they experienced policy in relation to the process in which it is developed. In fact, in the following excerpt one CNS, when asked to define policy, defined it in terms of the policy process rather than as an entity or document.

I think of it [policy] as an issue, what do we need to do for that issue, what kind of things….it is almost like the nursing process you know. Assess something, implement, plan, implement, and evaluate it. That kind of thinking. And policy for me is like that too. You know you see something, you think it could be better, you try to make a change with that by you know pulling bright people together, reading certain documents to support it and then you evaluate. (P11)

CNSs described in great detail policy within the context of the process in which it was developed. In fact, their experiences of policy were most often depicted through stories and examples of policy woven through the convoluted policy process. Though some variations existed in terminology and progression, the policy process was most often described in relation to the following stages: i)
Identification of a Problem; ii) Investigation of the Situation; iii) Engagement; iv) Strategizing and Problem Solving; v) Development; vi) Implementation; and vii) Evaluation.

CNSs clearly expressed their experiences of the policy process as iterative and cyclical rather than linear and prescriptive. As such CNSs did not necessarily describe their experience of individual policies within the context of all seven stages of the process. Their involvement in, and experience of, particular policies was dependent on their role as it pertained to specific policies. The variations of CNSs’ role in policy will be explored in subsequent sections with reference to the stages of the policy process in which CNSs most often described specific roles.

CNSs and Policy: A Perfect Match

The fundamental underpinnings of the CNS role relate to nursing, expert knowledge, and population and system foci (CNA, 2008). These fundamental cornerstones were described by CNSs as situating them perfectly within their role to engage in policy as clinical experts or consultants, advocates and leaders.

As nurses, CNSs described themselves as connected to the clinical setting, usually within the clinical practice domain of their role or through past experiences. CNSs articulated that their clinical connection enabled them to understand the demands, challenges and needs that nurses face in current practice. They also possessed extensive knowledge of the health care needs and challenges of the specialized population they serve. Experience as well as CNSs understanding of and emersion in current literature and research facilitated this
extensive knowledge base. These two frames of reference, clinical connection
and knowledge, were described by CNSs as situating them as nursing experts in
their fields. All 11 of the CNSs described their experience of policy within the
context of their role as a nurse expert for their specialized patient population. As
one participant explained,

But I am always aware of my population, it is not just the individual you
see in the bed … It’s that individual with a whole bunch of people that we
haven’t seen yet. (P11)

Another CNS stated,

Because I have the knowledge of what goes on with the populations.
Because Clinical Nurse Specialists, we work with populations right. So I
know what happens with high risk [name of condition] and just regular
[name of condition] and what is going on in the clinical field and what the
evidence is out there for different issues as they come up. (P6)

Similar to this CNS, most CNSs contended that the population and systems
perspective they work within as a CNS afforded them a broader frame of
reference from which to engage in policy in their practice. In the following excerpt
one CNS explained how her systems perspective impacts the clinical site,

Well because I work at a systems level. See the Clinical Nurse Specialist
works at the system … they are looking at a group of patients from a
systems level, and how that patient interacts with the whole system. And
trying to improve things at the system so that the nurses who are on the
floor have the information that they need, or the tools that they need, or
the policy updated with the best practices … Or physicians have a pre-
printed order set that identify what is the best practices. (P8)

Another noteworthy aspect the participants identified as facilitating their
involvement in policy was their education. Many CNSs felt that the Masters
preparation was important in providing them with a knowledge base and tools
from which to engage in policy work such as in the following,
So by going through a Masters and doing a thesis and the courses that I took …helped me to develop the knowledge base that I have to do this work. I think that you need the extra education to be able to consolidate all of the different levels of evidence and all of the sources of evidence, which is the most important thing … To understand whether it is good evidence or whether it is weak. (P6)

As noted in the literature, the very nature of CNS practice makes the CNS role a perfect match to policy work (Sackett et al., 1997, as cited in DePalma, 2009; Spross & Hanson, 2009). This claim was substantiated by the experiences and perspectives of participants in this study. All participants described the complementary nature of their practice and role to the policy work in which they engaged. One participant explained this in the following,

I believe the role affords me the opportunity to be involved in policy at various levels. Whether it is development, interpretation, implementation or critiquing. It is a wonderful role to be able to do that because we are clinically based, we’re nurses, we still have a connection to patients, so we have an expert point of view. So that is really a benefit. I find the CNS role a lovely role to be able to bring together the gap between evidence and practice, and bring the research to the patient. ... It is well within the domains of CNS practice of leadership and research and clinical practice. These domains afford me the privilege and opportunity to engage in policy. (P2)

CNSs enacted their role in policy in numerous ways. As noted previously, many discussed policy in the context of small (p) and big (P) policy. Regardless of whether CNSs were partaking in small (p) or in big (P) policy they described the CNS role as facilitating their involvement in policy work in very similar ways. However, how these CNSs experienced big (P) policy within the context of the policy process was less clear than how they experienced small (p) policy within the policy process. This could be a result of the increasing

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9 Small (p) policy refers to policies pertaining to a particular unit, program or institution.
10 Big (P) policy refers to broader policies encompassing a larger population or geographical area, such provincial or nationally based policies, CDSTs or CPGs.
complexity of the policy process and policy making at broader levels in comparison to more locally based small (p) policy processes. One CNS who described her experience of leading a national policy committee to investigate standardized screening across Canada alluded to these complexities in the following excerpt,

When you are looking at policy at the national level particularly in respect to health care it is very difficult. Because health care is provincial. So all of the provinces can make different decisions. And if there is a federal body you have a chance or a hope but if there isn’t... (P8)

How CNSs described their role as situating them for policy work through consultation or expertise, advocacy, and leadership will be discussed in the following sections. The three roles that CNSs collectively described will also be placed within the context of the policy process.

**Consultant or Expert**

As nursing experts CNSs saw themselves as possessing crucial knowledge related to the clinical setting, nursing practice and the patient population who were the focus of their work. As such, CNSs described being consulted as experts in relation to policy in various ways. All CNSs described being consulted for their expert opinion as a stakeholder in small (p) policy. Participants saw themselves as "representatives" (P3) and "interpreters" (P2) of policy as it related to their specific area of practice and/or population. Several described their expert role in relation to providing feedback as a stakeholder in the engagement stage of the policy process. Furthermore, participants also described being consulted for their expertise in regards to the implementation phase of the policy process. One CNS described her experience in the following,
One part is being a representative of the [name of clinical area] program and being aware of other stuff that is being created throughout the region for policies. And then looking at it from the perspective of how does this affect the population that I work with... It [a policy] was quite well done, but it would actually also have to be utilized on the [name of clinical area] floor if there is a [name of clinical area] patient...So looking at that was kind of like okay I need to give that feedback, we need to figure out how to make it fit. (P3)

Like this participant, all CNSs described how their expertise allowed them to consult on and often plan how implementation would occur within the context of their patient population and clinical practice area.

Some CNSs also described their involvement in operational policy. One CNS recounted her involvement as a stakeholder in the development of an operational policy in the following interview excerpt,

We are a holistic health care team. I work a lot with the operations leaders, the directors, the executive directors, managers who lead a lot of operational policy. They invite me in many times as a clinical expert. Almost a check and balance of the policy to see, is this is going to work in clinical practice? Does this sound logical? What will the impact be on the units? (P3)

Similar to this participant, most CNSs felt that their clinical expertise should be included in the development of operational policies that impact their clinical area. Despite this common perspective most CNSs, unlike Participant Three, indicated that this did not always formally occur in their experience.

Regardless of the type or origin of the policy, CNSs described their expertise as allowing them to bring the patient, population and nursing perspective to policy work and the policy process. As one CNS explained,

When I sit at a table, a physician brings an opinion, an operations leader gives an opinion and I bring another opinion. There may be a variety of opinions at the table, and I hope to bring the perspective of the patient. We all have the patient in mind. But I see myself as always representing the
nursing practice point of view, clinical practice point of view and a patient point of view. (P2)

This CNS clearly valued the expertise that she was able to bring to the policy process, which was not dissimilar to other participants. One CNS articulated,

Sometimes I worry that a policy would have an impact on nursing practice that was not anticipated. ... So when I sit at a table, I like to bring a perspective from the clinical practice environment because I stay connected to it every day. I know what the patient experience is like. The nursing experience, the culture, the workplace. So if it makes sense to me that it would work then, I let them know that. And that is sort of a check and balance. ...Sometimes I think what the patient would expect isn't thoroughly explored. ...Sometimes the impact of the patient gets lost in all that discussion. ...When I enter a room I immediately know what my role is. I know I am responsible for bringing in the nursing practice view and that patient lens view. (P2)

All participants described their contribution, as clinical experts, as essential in ensuring that the implications of policy on nursing practice and the patient were thoroughly explored and considered. Many CNSs saw their expertise as a “check and balance” (P2) or level of assurance that policies were clinically feasible.

Interestingly for many CNSs, like the one in the following excerpts, expertise was a central factor in their decision to get involved in a particular policy,

I would not want to be responsible for developing a policy outside my expertise, in an area I have little understanding, or knowledge of,

and

If I don’t feel like I can provide relevant, current information I may defer to someone else... I may refer them to somebody else. So it has to be directly related to what I am involved in I think. I can’t be... I would not want to get involved in something outside my area of expertise. (P2)

This underlines the importance of CNSs’ role as a clinical expert in policy work.
In relation to big (P) policy CNSs often described being consulted as clinical experts or becoming involved in big (P) policy as a means of sharing the expert knowledge they possessed. Though the overarching theme tended not to be consultation but rather advocacy founded on their expertise. For this reason CNSs consultant role in big (P) policy will be discussed in the next section.

Advocate

Many CNSs also described the clinical expertise they held within their role as allowing them to be advocates for their patient population in relation to small (p) and big (P) policy. One participant explained this in the following,

In some ways I insist in being a part of policy development for my population. Simply because I am one of the few experts, nurse experts in the field for our region. And our population is very unique, they are vulnerable. Most of the time they cannot give consent. So, someone needs to speak for them. (P2)

As the only nurse expert in her field, this participant conveyed the sentiment of many CNSs in the study. The connection CNSs had with the patient population they served was seen as being fundamental to their ability to advocate on the population’s behalf. Another nurse explored this in the following,

I become, I believe a real strong advocate for the patient. It is like I walk into rooms sometimes and I have a whole bunch of people with me that you can’t see. And I am that voice of you know well we got to make this better, let’s think about this, what about that,

and

I guess sometimes I think the things I am most proud of at times is … I’m an advocate for the health of the population and the patients, whoever I serve. (P11)

For this CNS advocating for the patient population was what she valued most in her role and took the most pride in.
CNSs’ clinical expertise was not the only aspect of the role that allowed them the knowledge and opportunity to advocate for their patient population within policy work. One participant explained in the following excerpt,

> When I see a CNS stand up in a big room with a lot of people, such as at conferences or a business meetings or whatever; when I see them stand forth to talk about policy, for the most part it is well regarded and respected. CNSs have a handle of what policy is, and what it means for patients, and what it means for nursing practice. We are still connected, still clinical, still connected to the bedside, so we have a lot of validity and credibility within our role. (P2)

For this CNS the role itself allowed CNSs a degree of credibility from which to engage in policy forums. From the perspective of CNSs in this study, the CNS role was what led to being invited to the policy tables as clinical experts; this sometimes allowed them the opportunity to take part in policy discussions and ensure that the patient and nursing perspectives were considered.

CNSs often described being pulled in during the engagement part of the development of broader policies, most often at the provincial level. CNSs were involved in providing expert opinions and feedback in regards to the patient population they served and from the perspective of the hospital, institution or health authority where they worked. One CNS described sitting on a provincial team to develop Clinical Decision Support Tools as a result of the Health Professions Act. Many other CNSs attended provincial meetings for the planning and development of services for their population. CNSs described how their clinical knowledge and system perspective related to their population allowed them to effectively contribute expert opinion at these tables, for example, as advocates as one CNS described,
It [policy] needs to have the patient as the center. If you are just writing ...without that in mind, then what is the point of it when you are in the health care realm. I think that whatever we do needs to be focused towards ... why are we doing this and is this going to make a difference for the patient we are looking after overall. (P5)

In the following interview excerpt, another CNS explored the importance of being at policy tables for both patients and herself,

Because that is how we think. We think very much big picture and very much around having opportunity and upholding those virtues of fairness and free speech and equality and human rights. And most nurses do I think. Our role just allows us somehow to speak and to be heard. We know the tables to get to. We know where to find the tables and we know the doors to knock on and we know how we can contribute.... My values and beliefs around promoting quality care, patient safety, human rights has been enhanced by my role as a CNS. (P2)

Here the participant described how the CNS role and the core values of the nursing profession allow her to engage and contribute to policy, in addition to enhancing the values she holds as a practitioner.

Similar to Participant Two in the above quote, the CNSs that took part in big (P) policy issues often displayed a very broad pattern of thinking, within their systems perspective. They considered issues in relation to not only larger populations but also the broader social, political and professional contextual factors that may have been contributing to and perpetuating the issue at hand. In the following excerpt one CNS shared her experience of advocating with a group of nurses at the national level to include focused questions on the Canadian Registered Nurses Exam,

... that is where it can make a difference in terms of advancing the issue of [focus area] and making changes. ...Because we felt that not enough people were learning about [focus area] within their nursing curriculums ... because there is a gap in practice, and not enough knowledge about [focus area]. ...advocating for the patient to have better care from that
perspective. ... That this is an accepted part of practice, that it is a policy, this is necessarily, this is a standard of care, this is what we need to be doing in terms of evidence based practice for the different population groups. (P5)

The same participant elaborated on her experience in the following excerpt,

So what is happening in Canada, what is happening in British Columbia around [focus area]. And why can’t patients get in to [focus area] clinics to get their care quickly, why do they have long waiting lists for [focus area] clinics ... So changing and advocating in terms of policy but also in terms of politically trying to get change around that too is a really big thing ... and working as an interdisciplinary team to do that is really important as well ... working with patients ... and acting as an advocate for better ... care across peoples’ life span.

These excerpts demonstrate how some CNSs applied the population and system perspective of the CNS role more broadly to advocate for improved patient care through social, political and professional processes at the big (P) policy level.

**Leader**

CNSs also articulated their role in relation to leading the policy process. The participants all described leading or being the “champion” (P1) or “glue” (P4) of the policy process in regards to revising or developing new policies at the small (p) policy level.

With regards to policy at the small (p) policy level, CNSs most often described their leadership role in the context of all seven stages of the policy process. CNSs explained that the essence of their leadership role in policy was supporting the policy process, essentially leading the policy development or revision from problem identification through to implementation and evaluation. CNSs described wearing a variety of ‘hats’ while leading small (p) policy through all seven stages of the policy process. Some of the ‘hats’ CNSs described
wearing as a leader included: investigator, collaborator, problem solver, facilitator, resource person and researcher.

One CNS, when speaking about her experience of leading a policy change stated, “There is no policy made only by one person, it is a shared work team, group work” (P7). Another CNS echoed this perspective when she articulated, I’ll tell you that I have learned from experience to not impose a policy on anyone. So policy making in my experience has been a whole process of engagement. (P10)

This perspective was shared by all CNSs; ensuring multidisciplinary involvement in the policy process through collaboration was an essential element of their leadership role.

CNSs attributed their leadership in the process of small (p) policy to many factors, all of which were related to their role. When asked why she took on the leadership role of a particular policy, one CNS stated, “they needed a clinical lead with that expert lens to say if this was doable or not” (P9). Two other CNSs shared their perspectives in the following,

The beauty is that we are connected to clinical practice but we are also immersed into the literature so we are actually the conduit between the theory knowledge gap. We are actually in the middle, we are able to have influence or we are able to bring the evidence into the development of a protocol or a guideline and bring in that front line feedback for refinement of the guidelines. We are able to do that really quite well I think. (P2)

I think you really need to have people who have an understanding of the clinical situation and an understanding of the literature, to help kind of build the policy, or guide it. (P3)

Similarly all CNSs described their clinical expertise in conjunction with their knowledge and engagement in current research as situating them perfectly to lead clinically-based policy changes aimed at advancing nursing practice and
improving patient outcomes through evidence-based practice changes.

In addition, CNSs described their systems perspectives in conjunction with their population focus as making them well suited to lead clinically-focused polices within the leadership domain of their practice. Most CNSs also saw their system level perspective and influence as important in allowing them to interpret literature and research and implement it appropriately and effectively into their particular clinical context. Two participants shared this perspective in the following excerpts,

But you still have to take that information and put it into your context. And that takes a particular skill and it takes somebody at the system level to do that. And I think the CNS role is absolutely critical in that process. (P8)

So I think CNS definitely need to be involved. And to me a large part of it [policy work] is trying to make sure it is as evidence based as possible. I think that is really where the CNS can excel and bring that into action…. Hopefully a CNS can have a bigger picture of what is going on. And potentially how different policies can affect other policies, or what sort of other things might be in the works. (P3)

Other CNSs described how their systems perspective facilitated their ability to successfully lead broader policies beyond the clinical area usually within the organization or across organizations. This work was most often described in relation to supporting continuaums of care, processes of care or models of care rather then specific clinically-focused policies. These CNSs described the population and system foci, specific to the CNS role, as facilitating their ability to conceptualize and bring together different programs, departments, agencies, and health care entities across inpatient, outpatient and community sectors. Their population and system focus allowed them to move beyond the clinical area and nursing practice and lead policy within the context of the entire system in relation
One CNS described her leadership in policy work in linking pre, intra and post treatment care across the system including inpatient, outpatient and primary care facilities (P4). Another CNS described leading a collaborative effort between her program and two other programs to ensure that the patient population she served had timely access to emergent treatment (P10). Similarly, another CNS described leading policy that effectively collaborated with community services to ensure first responders were bringing a particular patient population to appropriate facilities where specialized care was available (P11). It was through the system, with a particular population focus central to their role, that CNSs described leading such policy changes.

Interestingly CNSs described their role at the big (P) policy level more in relation to expertise and advocacy rather than leadership. This might be because at the small (p) policy level CNSs were formal leaders whereas at the big (P) policy level they tended to take on informal leadership roles within special interest groups and associations. Regardless, CNSs involvement in big (P) policy as advocates and experts in and of itself demonstrated their leadership within this policy arena.

**CNSs’ Influence: Policy as a Vehicle**

Kendig (2002) describes policy work as a means to an ends. The third theme emerging from data analysis reflected this notion. The following interview excerpts from two different participants illustrate this perspective,

But I think that the impact is … that policy can really guide and change practice. …I mean I guess ultimately …it would lead to … improved patient
Because I'm looking at improving nursing practice, or the care of the [name of population]. My ultimate goal is improving the care of the [name of population]. And I see improving it by developing a protocol or a guideline to help nurses deliver the care to that person. (P1)

All CNSs experienced policy as a vehicle through which to influence change and ultimately improve the care of the specialized populations they served. One CNS asked herself, “What kind of system should be in place that is going to streamline their care and make this population even more healthy?” and noted “Okay we have got to make this better, we got to make this, improve this” (P11). CNSs clearly approached their role from the frame of reference of how they could improve the care and health of the population they served such as in the following,

You know I just thought you are hitting the whole population of this group, you get bigger bang for your buck. That is just kind of the way I thought and it just kind of clicked, I was just like, that is great. Because then I just don’t affect one patients I affect a group. And I feel really strongly about that because if you see, for me, if you see a patient that you are like you know what we need to do this and this and this to prevent that from happening. Well isn’t that possible that that same stuff, another patient. So why don’t we just say it like it is. (P11)

CNSs demonstrated a collective enthusiasm about their experience of policy in relation to facilitating change in this way. Many CNSs made proclamations similar to the following, “As I said I can see the change, I can see the outcome. You know. Ya I love it [policy]” (P7). CNSs enjoyed working with policy and seeing that it could in fact result in a positive change.

CNSs articulated their experience and role in policy as a vehicle for change in numerous ways. Interestingly, all CNSs described their involvement in
policy as a means of addressing issues of quality, access and continuity of care. CNSs explained their policy work most often in terms of addressing gaps in care and working to rectify issues related to quality within the confines of available resources. Most CNSs described their influence through policy as a means to ultimately improve patient outcome in relation to four sub-themes: i) Clinically-Based Policies; ii) Evidence Based Practice; iii) Best Practice Standardization; and iv) Big (P) Policy.

**Clinically-Based Policies**

All CNSs described their engagement in policy at the clinical or practice level as a means to impact practice and influence change. One CNS explored this and the underlying impetus of change in the following excerpt,

> So if it is not a clear cut kind of path then there is a lot of room for maneuverability and judgement and speculation etc. And people don't do their jobs. So in order for them to do it, they need some kind of algorithm or some kind of template to give them clarity, this is what you should be doing. (P1)

The majority of CNSs saw standardization of nursing practice as a key way of improving patient outcomes. Many CNSs, like Participant One above, saw clinically-based policies as a means of providing nurses with clear expectations and guidance in practice.

CNSs saw clinically-based policies not only as setting out standards and guidelines to ensure a minimum level of care was provided to all patients within a particular area, but also as a means of supporting nurses within their practice. In terms of support CNSs felt that good clinical policies offered nurses a tool from which to communicate more clearly. One CNS (P6) described the implementation
of a checklist based protocol as not only setting out standards of practice but also allowing nurses in her area to more clearly communicate and justify their clinical decisions. This policy also gave the nurses a reference from which to substantiate the expectations and responsibilities the physician held in the provision of care for the patient. In the following except one CNS described this perspective,

There was a lot of concern around and misunderstandings a little bit around scope of practice and what was considered double dosing, and just lots of kind of miscommunication and confusion. So having it actually laid out in a nice neat policy, that this is the practice for [name of health authority], helped solve that. (P3)

Some CNSs described this as empowering nurses within their practice, as clinical policies often set forth guidelines to ensure nurses were able to work to their scope of practice, while exercising their nursing judgment and communicating the needs of the patient. In the example above, the CNS articulated how policy can clarify issues where there might be ambiguity such as scope of practice. Communication was also enhanced through policy.

Another CNS described clinically-based policies as supporting nurses in the following excerpt,

The goal of course with policy and guidelines is to support our patients, but it is also to support our health care providers. And help them to feel more comfortable in the care that they are giving. (P4)

Like this participant some of the CNSs recognized the ethical conundrums that nurses can face in relation to the care they provide. In the following excerpt this CNS explained further,

So if there [are] guidelines and understanding of the decision making process and ongoing education and ongoing support then I think that
enhances … I think it strengthens their [nurses] practice. You know it makes them feel more comfortable. Because one of the concerns with [name of population] patients is there can be moral distress, there can be moral regret, they call it moral residue, when you, or something doesn’t quite, like it goes against your values and beliefs. And it will, sometimes it does. And it is not saying anybody is wrong. But if it goes against nurses values and beliefs, and she is seeing, or he is seeing a situation or care being provided and they don’t necessarily agree with it then what is the decision making behind that. And sometimes that just helps them to come to terms with it. (P4)

This CNS points to the value of clinically-based policies that offer nurses a framework in the provision of care. Enhanced understanding and knowledge of the decision-making processes involved in ethically sensitive care can better equip nurses to care for the patient.

**Evidence-Based Practice**

CNSs also used policy as a vehicle to bring evidence to practice. All participants in the study articulated the importance of EBP, such as noted in the following,

> And if the policy is not right or if it is confusing, or if it is not helpful then people are left in you know a quandary of what to do. And you know in our day and age of evidence-based practice I still don't think that the nurse necessarily goes to a computer and looks up an article to guide practice because which article do you look at? … And I think that with the systematic reviews and up-to-date and now we have more of those things … there are more resources at our finger tips, where they take that information and they put it together for you in a way that is helpful. (P8)

With the paradigm shift over the last decade towards more fully employing EBP, CNSs in this study saw the creation and revision of polices as a means of ensuring current practices were reflective of the most recent and relevant literature; thus to improve patient outcomes. Many CNSs recognized that the vast amount of literature available to nurses is not always clinically useful, as
articulated in the above quote. Many CNSs, like Participant Eight, described their role as essential in taking the abundance of literature available and condensing it down to be clinically useful to nurses and other healthcare practitioners. One CNS explained her role in the following,

Part of my role is staying on top of the evidence and the literature. Evidence-based practice has everything to do with my role. You know interpreting evidence, implementing evidence-based practices and protocols. Speaking to staff around why we are changing practice. We change practice because the evidence is telling us we need to. It informs pretty much everything clinical in one way or another. Policy needs to be evidence informed, it needs to be renewed, it guides what we do and how we do it. And my role as the CNS is to help nurses understand policy and how it impacts them in their practice, and how it impacts the patients. (P2)

Here, the CNS saw her role as helping nurses understand policy and how it impacts their practice and patient outcomes. Many other CNSs echoed the importance of helping nurses understand policy and the need to change practice based on research and literature. In the same way many CNSs described policy as a means of disbanding practices – those described as “sacred cows” (P6). Policy work was seen as a process of challenging the status quo and ensuring practices were based on current literature instead of being based on historical practices and opinion.

It is important to note that CNSs’ policy work was not limited to impacting nursing practice. Rather their work most often influenced the collective care provided to patients by the multidisciplinary team. This notion is explained as Best Practice Standardization.

**Best Practice Standardization**

While sharing their experiences of policy work most CNSs described
developing policies that guided practices of the multidisciplinary team. Through this means CNSs described how policy stands to improve patient care through: Addressing Health Care Silos, Removing Bias, and Improving Communication.

**Addressing Health Care Silos**

Policies that guide practices of the entire health care team prevent the provision of “siloed” health care. As one CNS explained,

But the physicians didn’t know about the nurses’ policies and they didn’t care about the nurses’ policies or abide by them. It wasn’t something that dictated their practice and I recognized very shortly after taking on this role that we don’t do our work independently of our physician or midwifery colleagues and that we needed to have policies that reflected what everybody’s role was with a particular policy issue. So we started doing interprofessional policies and inviting people whose work was affected by the policy to engage. (P8)

Many CNSs, like Participant Eight above, described a time when nurses worked from nursing policies that the rest of the health care team either did not consult or were not aware of. The result was often the provision of disjointed health care.

CNSs also worked with policy to support the continuum of care as noted in the following,

I think that Clinical Nurse Specialists, the ones that I know and have worked with are, have worked very hard to develop policies and procedures and guidelines and to really promote that continuum of care so that we are not a silo mentality. (P4)

Here, the participant explained how CNSs’ policy work allowed for continuity of care by outlining processes of care and continuums of care. This was not only described in relation to continuity of care between members of the health care team but also across health care facilities. CNSs saw themselves at the system level as well suited to support the provision of a continuum of care by bridging
the gap between health care providers and acute and community health care
services as noted here,

Well I think they [CNSs] are the ones that are involved at that systems level, they have that understanding. I think that health care can get very siloed and that you know pharmacy can make decisions about things that don’t get communicated and we are trying to figure out well where did that come from. So having people that cross the system can help mitigate that and bring people to the same level, to the same page. (P8)

A more continuous approach to health care through improved communication across disciplines sets a foundation for high quality health care, optimization of resources and improved patient outcomes by addressing gaps in care services. CNSs also described best practice standardization in relation to removing bias’ in the provision of care services.

**Removing Individual Bias**

Many CNSs recognized that the provision of care in the absence of policies was often directed by individuals and relationships between individuals rather than by best practice and evidence. One CNS explained this phenomenon by using a hypothetical scenario and another from an experience in the following interview excerpts,

What happens in the absence of all of those things sorted out [referring to policies] is that you go, you default to relationship. So I have a relationship with Dr. Bloggs and I know how he likes to do things and I change my practice depending on if it is Dr. Bloggs or Dr. Sox. So Dr. Sox does things this way and Dr. Bloggs does it this way. So this patient gets this care and this patient gets that care. So you get different care depending on the practitioner that you have. And that is what we used to have. Very much depending who was on. (P8)

The [name of intervention] one was really interesting because it was based on the values and beliefs of individuals and what we wanted to see is a process that is in place that is based on a standardized care, or guidelines. That’s more equal, so that’s, that is what we are thinking about.
… Also you don’t want to have a process dependent on an individual. You want a process that works on its own. Whether that individual is there or not. And I think that that is why pathways are really important, I think guidelines are really important and policies are really important. Because then you know that you have standardized care, and it is evidence based and it is best practice. So that is the importance, because otherwise … whoever is on will call the shots. (P4)

For many CNSs in the dynamic environment of health care where individuals come and go, policies were a way of ensuring that treatments and processes of care stood on their own rather then being dependent on individuals or groups of individuals. As the latter participant above went on to explain,

When you don’t have a process in place, and that could be your policy, or that could be your guidelines. If we are just relying on the values and beliefs, and expertise of individuals. When that individual moves on, sometimes things get lost …So to preserve that …streamline things, then you really need to have a process, or a policy, or a guideline in place. So, identifying criteria you know for a certain procedure is really important. Looking at the teaching pre and post procedure, that’s important, because that all enhances the outcome for the patient. (P4)

**Improving Communication**

As mentioned previously, CNS policy work was a means for improving communication between the health care team. For many CNSs the practice processes that policy supported also facilitated communication between the health care team and the patient and/or family. One participant explained in the following,

[discontinuation of treatment] wasn’t really talked about up front. So if it’s not talked about up front, it’s really hard to take it at the other end. Because the values and beliefs around [treatment] are such that, you know family members and even the patient themselves, they really have a hard time of stopping something like that. So we really felt that it was important from seeing … some uncomfortable scenarios, that we needed to have those conversations all the way through. … And work with the patients to help them understand when it becomes a burden to the body, and when it’s not. Like when it’s a benefit. (P4)
Here the participant spoke to how the policy, and the processes that it supported, set out expectations for communication and patient/family teaching throughout the course of treatment. This stood to empower the patient/family by providing them with knowledge and understanding from which to make informed decisions or at the very least understand the decision-making and recommendations of the health care team. Another CNS went on to speak to the benefits in the following,

…so they [patients] get great and better quality of the care. Yes. And family as well, so family will be happier because they can see, so they have the nurses have great tools and they are doing a great job when they are looking after the loved one. And even for the system, even at the system level because the incidents are lower and people are happier and the quality of care is higher. Yes, so it is everything. It is all those pieces together. It is staff, it is better for the management, it is better for the whole system, it is better for the residents, family. (P7)

CNSs all demonstrated a similar viewpoint, their policy work was a vehicle for change; it essentially provided them a means to be change agents.

**Big (P) Policy**

At the broader big (P) policy level CNSs’ policy work was also a vehicle to drive change and ultimately improve the provision of care for specialized populations and health outcomes. As one CNS noted,

So that I think is where it is important to get it to that level so that people accept it. That it is an accepted part of practice, that it is a policy. This is necessary, this is a standard of care, this is what we need to be doing in terms of evidence-based practice for the different population groups. (P5)

At this level CNSs’ work stood to impact patient care more diversely and broadly. Similar to CNSs’ work at the small (p) policy level, their work at the big (P) policy level also focused on nursing practice and setting forth expectations and standards for care. On the other hand, much of CNSs’ work at this level was
driven towards cultural shifts; shifts in thinking and conceptualizing health related issues. One CNS explored her experience of this in the following excerpt,

Finally, they [the Ministry of Health] now realize that [health issue] as a disease and they now know that 1 in 4 people have [health issue]. So that is costing them a lot of money. So we should have some policies or something to try to address—the needs of patients with [health issue] in society earlier in the community or perhaps preventing [health issue] from becoming chronic by changing awareness, increasing knowledge and empowering the patient to have the right to good … care. Then these changes in societal expectations re: prevention of [health issue] … can make a difference and hopefully save us money in the health care system down the line. And how if we prevent 1 in 4 people, let’s try to decrease it to 1 in 8 instead, you know. (P5)

As this participant alluded to many CNSs at the big (P) policy level conceptualized their work in regards to proactive prevention strategies rather than reactive treatment standardization.

**Mechanisms that Challenge and Facilitate CNSs’ Policy Work**

CNSs’ experience of policy was clearly rooted in the context in which they practiced. The mechanisms influencing CNSs’ policy work were similar. Interestingly, the contextual factors affecting their experiences were often described not only as facilitators of but also as challenges to their policy work. Sometimes this dichotomy was described within an individual’s experience, and sometimes it emerged between individuals’ experiences. In this section, CNSs’ work with policy including the 11 mechanisms and emerging dichotomies CNSs face will be explored: i) organizational processes; ii) time; iii) associations; iv) awareness of the political environment; v) timing; vi) power; vii) relationships; vii) personal attributes; ix) personal and professional responsibility; x) evidence based practice based on research; and xi) balancing standardization and
individualization.

**Organizational Processes**

CNSs described the organizational processes in which they engaged in small (p) policy to be both helpful and challenging. Many CNSs described helpful resources within their organization which set out clear guidelines and expectations for policy work. One participant articulated this experience in the following interview excerpt:

> There is a whole [name of policy department] that we have, that actually helps, they have developed a process that we are suppose to go through to pass everything, make sure we have key stakeholders involved, lots and checks and balances. (P1)

As this CNS noted, this process can be helpful, however, on the other hand CNSs often found the process confusing and lengthy. It was not uncommon for CNSs to describe the process in regards to having “hoops to jump through” (P6), “onerous” (P11), “endless” (P10) and “fairly lengthy” (P3). Some CNSs used more favourable words when they described their experience of the policy process as a “journey” (P7), while others referred to it as a “battle” (P11). In the following interview excerpt one CNS described challenges of the policy process,

> The challenges of trying to figure out the system and trying to figure out who I need to connect with, how to connect with them, and kind of working that part. … In some ways it is still figuring out that process, and how to connect and who to connect to, and who does what. So often the process can seem very confusing. (P2)

**Time**

CNSs described themselves as the only people still connected to clinical practice but not tied to it, which afforded them the opportunity and time to take the lead on policy work. In truth many CNSs described leading small (p) policy as
an expectation of their role. One CNS stated “if it is a nursing thing it is usually a CNS [leading]. If nursing is involved a CNS should be involved” (P1).

Though time was clearly a facilitator in CNSs’ policy work, lack of time was also seen as a challenge. CNSs often described policy work as “constant” and “endless” (P11). As another CNS articulated,

You know if ... you work only one day, even only as an RN you can realize how, how many CPGs [clinical practice guidelines] or how many policy we need to create or revise. So you know it is very loud and clear if you work only one day with your eyes wide open and have the CNS perspective. You would know how many CPGs and guidelines we need to create.

For this CNS, the volume of policy work she faced in her practice could seem quite overwhelming. As she went on to say,

I wish I had more time to create more, more, more CPGs. I wish I had more resources. I wish I had, ya more time and more resources to create better tools and more tools. You know. (P7)

In a similar vein, other CNSs noted, “I mean I am one person, and my plate is so full, so over flowing (laugh)” (P6) and, “I’m feeling really stretched. This is the down side of a broad role, being so stretched” (P2). Participant Two, like many other CNSs, suggested that in her practice it was not only the volume of policy work that was challenging but the competing priorities she faced in other aspects of her role.

Other CNSs identified that time also impacted their ability to engage in big (P) policy. As one CNS noted,

Sometimes it is a time thing. You know I have to have so much commitment to being here at work and doing a certain percentage of the [Name of Health Authority] stuff. So I can't always be out there doing provincial and Canadian development. But some, a percentage of my time can be devoted towards that. So I guess more of a, the only barrier might
be that I don’t have enough time to do that, to be pulled away to do that work, because there is only so much of you here, and you have to do your work locally as well. And there is, and you have to look after yourself too. You will burn yourself out if you do too much after work sort of thing. (P5)

Here balancing local commitments with her involvement in broader policies impacted this CNSs ability to engage at the big (P) policy level. This participant described a portion of her job being dedicated to broader big (P) policy, though for many other CNSs boarder policy work outside of their organization was not considered part of their job. For these CNSs their involvement at this level was on a volunteer basis or in conjunction with affiliated professional or clinical specialty associations. Balancing personal life with professional commitments was challenging in regards to time and finding a work life balance for some CNSs.

**Associations**

Interestingly all CNSs that described engaging in policy at the broader level did so through affiliation with professional or speciality specific associations, societies or special interest groups. As one CNS noted in the following,

Our association connects to CNA. CNA is really good at poling professional associations for opinions on one thing or another. And as a group we do forward our opinion on policy to CNA. And that is where everything is really filtered up to. So we rely on CNA to speak our voice. (P2)

Affiliation and involvement in these groups provided CNSs with a political platform for which to engage in broader policy issues. CNSs involvement in associations etc. facilitated an awareness of what was happening within their speciality area, nursing and society more broadly beyond their workplace institution. This awareness in itself facilitated CNSs’ work in policy at the small (p)
policy level as well.

**Awareness of the Political Environment (local and societal)**

All CNSs indicated that awareness of their political environment and associated resources, etc. (or lack thereof), impacted their work with policy. Such awareness imparted knowledge for CNSs and a broader understanding from which to engage in their policy work. One CNS who was relatively new in her role stated, “In some ways I feel like I am still getting my feet wet. I’m still trying to gain some knowledge and understanding” (P3). For her a general awareness influenced how she approached her work. As she noted,

And then I would probably say more at the provincial level, just lack of awareness of who to connect with or how to go about it, would probably be at the level beyond [the Health Authority]. (P3)

Here a lack of awareness influenced how this CNS engaged in policy more broadly. Involvement at the provincial level for many CNSs gave them insight from which to understand provincial policies, particularly in relation to the underlying decision-making process. Two participants explained their experiences in the following interview excerpts,

But if I’m not involved in that [provincial policy discussions], so as a point person to sort of understand the literature behind it, evidence behind it and be able to communicate that out to all of the clinical nurse educators and work with them and have some answers because otherwise the frustration at that level is just high and nothing would ever get done because the questions come up and if people don’t understand why they are suppose to do something it is unlikely that they are going to do it. (P6)

It is also good for me to hear other perspectives. It helps me understand and support development or implementation of policy. (P2)

Understanding the rationales and the supporting research behind the policies, as well as differing perspectives, helped CNSs to implement these policies at the
local level. Other CNSs described similar benefits. An awareness of the pressures that impacted the decision-making process gave them more of an inclusive understanding of the whole system, as noted here,

…I would probably say being included in different meetings, or being aware more of what is going on. So when I am involved in more operational meetings, when I am sitting at different tables. I will have a bit of awareness of what else is going on, and how to better, I don’t know if it is policy, but it’s better being able to have things connect or work together. (P3).

Among other things, awareness at this level facilitated CNSs to move forward to support implementation and also gave them an awareness of potential connections between their work and what else was going on more broadly.

Another CNS explained her perspective on remaining close to public discussions in the following,

And also staying very close to the public discussion. Which I do in my personal life as well as in my professional like. Just staying on top of what Canadians want, what Canadians expect and trying to interpret that as it would relate to me as a nurse. (P2)

CNSs described how an awareness of broader societal issues influenced how they approached their policy work. Interestingly those CNSs that recognized the importance of this level of awareness were more inclined to talk about policy in relation to big (P) policy rather than small (p) policy.

**Timing**

All CNSs talked about timing in relation to the success or failure of policy work. Some described it as “the stars aligning” (P8) or “windows of opportunity” (P11). Either way, all participants recognized that “sometimes politically your timing can be wrong and things won’t happen” (P3). As explained by Participant
Eleven, “You know how you can call it politics, you can call it strategy. But you are right the timing of it, you can’t do certain things. The lay of the land isn’t right to do that.” Timing was often described in relation to support from above, but as one CNS described in the following excerpt it could also be related to uptake by those affected by the change,

Recognizing that every idea has its time and sometimes it is too soon. … So I have seen a lot of my projects fail because it wasn’t the right time. … people aren’t ready for it, or it wasn’t umm it wasn’t supported well enough, it wasn’t seen as a priority…. I mean sometimes you plant a seed and it doesn’t grow right away and sometimes you just have to move on right. So part of having to make those connections is to A - be in it for the long haul and not expect success everywhere. But recognize that it is still important work and its day will come. (P10)

Like many CNSs, this participant recognized the challenges of facilitating uptake and sustainability of policies. For some CNSs the timing of policy role outs influenced the success of integrating new processes into practice. Many CNSs spoke to the challenges of this within their experience.

**Power**

Policy and politics cannot be considered without critical attention to power and power relations. All of the CNSs in this study recognized the issue of power in their policy work, some explicitly talked to it while others alluded to it.

The CNS role itself imparted a degree of power to the participants. For them, their role with the associated clinical expertise and knowledge they held placed them in a position of power to talk at policy tables and influence change through their policy work. However, participants clearly recognized the limitations to their power when they made comments such as, “It’s been taken beyond my, my control right now” (P2), “Well you see I don’t have a lot of clout, you might call
it (laugh)” (P6) and, “I’m not sitting at the table; I’m not invited to those tables” (P1). As noted here, some CNSs recognized the importance of having the support of their colleagues,

But we definitely need, you know somebody higher up as a stakeholder so that when we actually have the work, we have somewhere to go and we already have buy in from them. (P4)

Similar to this CNS, most of the participants recognized the importance of having support and buy in of those people in higher positions within their organization when it came to policy work.

CNSs seemed to be aware of and comfortable with their degree of power as one participant demonstrated here,

CNSs don’t always have the power, we don’t make all the decisions, or the power to make any decisions, but we certainly, we can speak to the evidence, we can speak to the impact on patient safety and the impact on nursing practice. Then the decisions are what they are,

and

Yes and that is all I can really ask for, is for our perspective on patient care and nursing practice be raised and included. I am satisfied at that point. We don’t always get our own way. We certainly understand constraints, budget problems, and hallway nursing is not, not an ideal situation for anybody. I understand how difficult these situations are. I want to be a part of the solution. (P2).

For the participants, a perceived lack of power was most often described in terms of not being invited to policy tables and not having the authority to make decisions.

The majority of CNSs depended on awareness and relationships to deal with power issues. Particularly when they thought their contributions would preserve the interests of the population they served. Many CNSs described how
informal networks and relationships often facilitated their awareness of issues relevant to their practice. CNSs sometimes described utilizing formal and informal networks and relationships to deal with situations when their position did not necessarily allow them to be at the policy table. CNSs’ use of relationships will be explored further in a subsequent section.

In the broader policy arena those CNSs who did engage in big (P) policy recognized the relationship between power and critical mass. As mentioned previously, all CNSs pursued big (P) policy issues in conjunction with others through associations, special interest groups and societies. Some CNSs also spoke about partnering with advocacy groups, demonstrating the importance of involving those affected by the policy or issue to strengthen the social movement for change at the broader level.

**Relationships**

All CNSs described the importance of relationships, formal and informal ones, to their policy work. The following two participants explored this,

To be honest 90% of that [policy work] is relationships. Because you develop relationships, so when you develop relationships you develop team, … But when you have the team you build the relationship, and you build the trust and you build the credibility, and then you can move forward and be successful. And I think the key to the CNS role and the key to the success of the CNS role is to build relationships at all levels from the porter and the floor cleaner, and the key people that work in that realm right to the president. Because you are, the changes that you are going to make in your policy are going to affect everybody in between. (P8)

And it’s talking to people … it’s building relationships with people. You know you can’t do it all just sitting in your corner; you have to get out there and work with people and talk to people, and see how we can make it better. (P4)

Similar to the above participants, relationships at all levels were essential
to all 11 CNSs’ work with policy. For CNSs relationships were a way to stay
c connected as one participant explained,

    So that is where I think being a CNS has been really exciting because you
    are connected to so many people. And your connections are like tentacles
    right. And they keep you in touch with the real world right. (P10)

    Others also saw relationships as a way to connect with people, to know
who they were working with and who might be useful to pull into future
d endeavours,

    If I have to mentor I always say there are certain things that I have learned
    and one of the things is to get to know people. And I mean get to know
    them. ... So like you are talking to somebody, you ask them about their
    family, you ask them about their kids. You get to know who these people
    are and it doesn’t always go both ways but that doesn’t matter you need to
    know who you are working with and stuff. So I do invest a lot of time in
    networking. ... I always am thinking down the road we are all going to be
    doing stuff.. see if you can pull them in on certain projects and they know
    who you are. It makes it easier, it is not perfect, it never will be. (P11)

Similar to Participant Eleven, for most CNSs relationships were a means to
engagement. In the following excerpt one CNS described the importance of
relationships and communication in her experience of engaging a physician in the
development stage of the policy process,

    He [a physician] says well to tell you the truth I wouldn’t use this and this
    because quite frankly I don’t agree with the [name of society] statement.
    And I said well that is okay. And he said well what am I going to do? And I
    said well right up here at the top of these pre-printed orders it says you
    can cross it out and initial it (laugh). But you know he didn’t know that. So
    like the different, it’s communication. So much of it is communication and
    relationships and all of that, it.... as far as I am concerned relationships are
    such a key in moving anything forward. (P6)

For this CNS, and many others, relationships and communication facilitated
e engagement during the policy process and helped to disband misconceptions of
stakeholders that might impede uptake and sustainability in the implementation
CNSs also used relationships as a creative means of overcoming challenges in policy work, one CNS explained,

So I have recently made a new best friend (laugh) who is an admin assistant who has them all [stakeholders’ emails]. And so I will write something, this is just a new discovery like last week. Where I will write something, send it to her, and say could you distribute this to blah, blah, blah. And so that, that’s going to be a door that opens a lot of communication hopefully. (P6)

In this excerpt the CNS developed a relationship that helped her overcome challenges associated with engagement and obtaining feedback.

Others used relationships with those in positions of power,

My strategy would be to contact the person who is a part of that decision making process and have dialogue around the questions. So I do tend to do it a little bit more one to one or the little bit more informal way. Another strategy that I do use though is I have regular monthly, and sometimes more often than that, but regular contact with my supervisor, my director and I also use that opportunity to ask questions about something that has been decided and that I don’t fully understand. (P2)

This CNS like many others used relationships to enhance their awareness and understanding of policy decision-making processes that they may not have been directly involved in but impact their population. This often helped them address issues of power in policy work.

Relationships were also described as a two way street. One CNS stated,

I have a good relationship with the executives and so they actually, they do ask me my opinion of things. And they will ask me to find out about things. So I will go to the literature to find out. (P6)

The relationships formed had some dependence on credibility, and informally addressed power relations.
Personal Attributes

CNSs demonstrated and identified specific qualities or personal attributes that helped them navigate and be successful in their policy work. In order to be an advocate for the population they served, most of them were not intimidated to talk about controversial issues with those in power. One participant explained,

I sometimes you know say to people that I have been put in this career so that I will force these issues. And I will talk tough issues with administrators, physicians, whoever, cause I have to for the patients. (P11)

Other CNSs stressed that policy work was not personal; if they were going to be successful they could not “take it personally” (P10), they had to have “thick skin” (P11).

Sometimes I go to meetings and … you need a kevlar vest on you know. And you are talking about patient care, but there are other dynamics that are in that room that have nothing to do with patient care sometimes. And you know you need to be tough to do this sometimes. You walk away and you just think, wow I can’t believe this. But then again why me? Going in there and getting attacked and needing the kevlar jacket on, but why not me … I'm the perfect one to do this and take it on and yep people can maybe not like me at the end of it but I know I did the right thing for the patient. (P11)

Like this CNS another CNS shared her experience, in the following quote, of making herself available to be “blasted” by those who were opposed to a policy change.

I would make myself available to get blasted at every opportunity (laugh). Why not? … So anyway whenever I did get blasted I made sure that it was in a group setting, so that I could model my response to the blasting. Because I didn’t…. like sometimes it was sort of aggressive, angry, we don’t want to do this, and then I could just be sort of inquisitive and try to get right down to what is it and that kind of thing and invite that sort of dialogue. (P6)

A similar point of view was shared in the following excerpt,
… we agree as a group that this is the route that we have to go down and it makes sense with the literature and everything to do this, and we are going to do it and we are all in it. But sometimes you can be the only one standing there (laugh). You have to be, you have to be kind of comfortable with that and I think that kind of takes awhile. (P11)

These CNSs like most of the CNSs interviewed displayed strong character and great will to do the right thing on behalf of the population they served. Even if that meant being in difficult and sometimes uncomfortable situations. One CNS stated “personality is probably as much of a factor as the education. Where you don’t just take no for an answer or you ask the right questions” (P10). CNSs described being assertive, autonomous and visionaries in their roles. One CNS who displayed all of these qualities stated “I’m not intimidated by it [policy work], I quite enjoy it” (P2). These qualities not only allowed CNSs to pursue policy work and be successful in their work, but also enjoy it at the same time, even if it was personally and professionally challenging.

**Personal and Professional Responsibility**

Generally CNSs who advocated at provincial and national levels described feeling a professional responsibility to do so, to advocate for improved care for the population at large. Two participants explored this in the following excerpts.

But in terms of bigger policies … that is more of a professional responsibility from my sense. And advocating for patients to have better care in terms of their overall health care. So you know you see the gaps, you see the problems and so you want to, you want to work beyond where you are working. You want to work and make a difference across the country and your own province, and belong to groups that are advocating to try to change policies. (P5)

I do, as a nurse absolutely I feel strongly that nurses should be a part of public policy development. Absolutely. We have relationship with patients and families and our perspectives are important to public policy. Patients can be defined as communities. The nurse-patient relationship is
grounded in wanting the good for the all, wellness and good health. Policy development on health should involve nursing perspective. This perspective needs to be a part of the mix for sure. (P2)

Other CNSs felt a personal responsibility beyond even their professional responsibility to engage in policy to improve the health of all,

It’s [policy] the right thing to do for the public. And I hope that people do that for, you know are thinking about my health when I am in there to. And think about ways to help not just me but the whole population. (P11)

This participant’s personal beliefs and feeling of responsibility impacted her involvement in big (P) policy work.

**Evidence-Based Practice Based on Research**

Research and literature clearly guided much of CNSs’ policy work, in many cases new research acted as the impetus for revising old policies and developing new policies. Even so, research was just as clearly a challenge to CNSs in their policy work. When current research findings were weak or inconclusive devising a policy based on literature was difficult. One CNS when talking about devising a policy stated “It just depends on if the evidence is there to support the development of a particular policy” (P5).

Another CNS explored the challenge of using research to guide her policy work in the following excerpt,

Trying to back it [policy] up with you know, good quality systematic reviews, trying to really have good evidence to back it up. It gets a little hard when I can’t back it up, so when there isn’t much there. That is when I will start to look at what other sites have done. (P3)

In the absence of rigorous research CNSs were often left to draw upon other sources to make decisions as one CNS demonstrated when she said, “there is not a lot of evidence to support it [policy], to tell you the truth. So we have to
come up with something to say that we will do this” (P6). In situations like this CNSs would look to other sites, expert opinions and best practice recommendations to guide the development of policy. This created its own challenges related to “where to draw the line” and adjusting the line (P8). This CNS stated,

I think in terms of policy you are trying to get the lines right in the sand about which ones do and which ones don’t. And that sometimes that line has to move a little bit and that is okay. See people don’t like grey. Policy is all about what the rule are and people are very uncomfortable in the grey. Do I or don’t I? Tell me what I need to know, is this, do I put this in or do I not? So when it is grey it is uncomfortable for people. And especially as the policy leader or the policy maker you are not sure then people get, it can be uncomfortable because they just want to know. (P8)

CNSs used transparency and communication with those they engaged with to overcome some of the anxiety and discomfort encountered with ‘grey’ policies developed on weak research findings and expert opinions.

And when you don’t have the answer you have to be really clear in saying this is where we are drawing the line in the sand cause this is the best evidence we have right now, or this is the best decision we can make right now. But if you do need to adjust, it is not that you got it wrong, it is just that you learned and I think people are so afraid to put themselves out there to say you know this is where I think it should be that it doesn’t happen or the decision doesn’t gets made. Nobody wants to be responsible for making that decision. There is a fear about being wrong and it is not that you are wrong it is just that you are trying to make the best decisions with the information that you have. (P8)

CNSs, like the participant above, articulated the importance of helping others recognize that policy and policy changes are not about getting it wrong. Rather, it is about making the best decision based on current research and knowledge and recognizing that research is progressive and thus so are policies and care that they guide.
Balancing Standardization and Individualization

As discussed earlier, standardization is one of the central goals of policy work. Standardization of care ultimately aims to improve patient outcomes by setting forth standards of care, improving knowledge, understanding and communication, integrating evidence into practice and bridging gaps in and discrepancies of care.

All CNSs described the benefits of standardization, while some also recognized the challenges of “trying to put people on a certain path but recognizing that not every patient falls into that” (P11). Another CNS went on to explain,

You see we are struggling with that [standardization] right now with the [name of health issue] stuff because we have groups of patients that are at higher risk of having [name of health issue]. But the woman in front of us is over 35 and is a smoker and her BMI is up a little bit but she exercises 4 times a week and she has got 3 other kids and she is running around and she is not sitting around. So even though she meets criteria as a higher risk patient, this individual person is not at risk. So we are really struggling with that right now. … because it is the applicability of generalized information to an individual person. (P8)

Like this participant, many CNSs identified standardization of care as potentially jeopardizing individualization of care. Another participant explored this further,

It is the protocol stuff that excites me because it is based on the literature and there is usually no right answer. … like there is evidence, but we have to remember that one of the sources of evidence is what that [patient] wants. And so that is why it excites me. … At the protocol level it is interpretation of all the bits of evidence …it is the whole gamut. You know what does the patient want? Or what are her concerns, or you know what do we need to do for her because it is patient specific. You know it is just about her. But you know we are applying this protocol that is based on big numbers that might not be generalizable to her. (P6)

This CNS conceptualized the application of a standard policy to an individual
patient as exciting, though she like others, recognized that generalizing standard protocols to individual patients can be problematic.

For CNSs finding the balance between standardization and individualization in policy work was important. One CNS struggled with this,

..what you are creating is a guidance of what the evidence will say and the literature says is best practice but you still individualize that even if it is a pre-printed order, you don’t pick everything, you pick the things that apply. So we provide the menu of the best options and then the practitioners pick the best options for that patient. But they have to have the menu, well they don’t have to. I mean we struggle, we actually struggle with having too many pre-printed orders so that your role as a practitioner becomes a tick, tick, tick as opposed to making those medical and clinical decisions for your patients. So it is trying to find a balance there, so that you are not just going tick, tick, tick. (P8)

Like this CNS, other CNSs recognized that it is essential to safeguard individualized care when standardized policies exist. To achieve this balance CNSs described working with practitioners to ensure that they knew and understood where their latitude existed within standardization to protect patients’ individuality and maintain and respect practitioners’ autonomy and clinical judgement.

Summary

This chapter presented and discussed the four main themes that emerged from participants’ collective reality of policy work in their experiences as CNSs. Primarily CNSs’ experience of policy emerged through the perplexities of defining and describing policy in their practice, the aptness of the CNS role to policy work, policy as a vehicle to influence change and the mechanisms that challenge and facilitate their experiences of policy.

In CHAPTER FIVE, a discussion of the findings will be presented within
the context of current literature. Implications in relation to practice, education, research and the health care system will also be presented.
CHAPTER FIVE: DISCUSSION AND IMPLICATIONS

In this Chapter I will provide a synopsis of the findings of the study. I will then discuss the findings in the context of current literature to confirm and extend what is already known about CNSs’ experience of policy within their practice. To conclude, implications for nursing (specific to CNSs) in the areas of clinical practice, education and research and, more broadly, the health care system, will be discussed.

Synopsis of Findings

The purpose of this study was to explore CNSs’ experience of policy at the clinical, institutional and system levels of the health care system, to further enhance our understanding of CNSs’ practice in BC. Through data analysis of 11 interview transcripts four major themes emerged: 1) The Perplexities of Policy; 2) CNSs and Policy: A Perfect Match; 3) CNSs’ Influence: Policy as a Vehicle; and 4) Mechanisms that Challenge and Facilitate CNSs’ Policy Work.

CNSs’ experience of policy was perplexing in relation to first defining and describing policy and second with regards to policy and process. There was substantial variation to how CNSs described and defined policy as it pertained to their practice. Consequently how CNSs articulated their role in policy within their practice also varied considerably. Though all CNSs, regardless of how they personally articulated their role, did describe policy work as a central component of their role. Most notably many CNSs did not consider their work with clinically-based protocols, what I referred to as small (p) policy in this thesis, policy work.

Three distinct associations emerged between policy and process in CNSs’
experience. Firstly, CNSs described policy in terms of sustaining and maintaining processes and models or frameworks of care. Second, policy was ascertained by CNSs as an iterative and continual process or living thing that was continually reviewed, revised and updated to reflect current knowledge and values. Finally CNSs articulated their experience of policy extensively within the context of the policy process; how it was developed and revised. The following stages represent the collective reality of how CNSs experienced the policy process in their practice: i) Identification of a Problem; ii) Investigation of the Situation; iii) Engagement; iv) Strategizing and Problem Solving; v) Development; vi) Implementation; and vii) Evaluation.

CNSs and Policy: A Perfect Match was the second theme that emerged through data analysis. Primarily CNSs described their clinical expertise, Masters education, and systems and population based perspectives as providing them with the knowledge, resources and viewpoints from which to effectively engage in policy and the policy process. CNSs’ experiences of policy were most often realized through the roles of clinical expert or consultant, advocate and leader. CNSs also described their role, in and of itself, as situating them in a position from which to engage in and effect policy at various levels.

The third theme that transpired from analysis was CNSs’ Influence: Policy as a Vehicle. Kendig (2002) describes policy as a “means to an ends”. Similarly, in this study, CNSs described policy as a vehicle from which to effect change. Through policy work at various levels CNSs described being able to influence clinically-based policies and implement evidence into practice. CNSs policy work
also allowed a venue from which to move the provision of health care towards best practice standardization, primarily by addressing health care silos, removing individual bias’ and improving communication between the health care team and the health care team and patients/families. Some CNSs also recognized that by engaging in big (P) policy they were able to broaden their sphere of influence and affect change on a larger scale.

The fourth and final theme constructed through the analysis of CNSs collective reality of policy was entitled, ‘Mechanisms that Challenge and Facilitate CNSs’ Policy Work.’ Much of CNSs’ experiences of policy were grounded in the mechanisms and contextual factors that either facilitated or hindered their involvement and ability to effectively engage in policy and the policy process. Many of the mechanisms CNSs described were identified as both challenges and facilitators to policy work in their practice. This was dependant on the individual CNS and the context which they experienced policy. A total of 11 mechanisms were identified by CNSs. These included: i) organizational processes; ii) time; iii) associations; iv) awareness of the political environment; v) timing; vi) power; vii) relationships; viii) personal attributes; ix) personal and professional responsibility; x) evidence-based practice based on research; and xi) balancing standardization and individualization.

**Confirming and Extending What is Known**

The findings of this study largely substantiate what is known in literature about CNS practice in the area of policy. This study validates current literature and serves to extend literature as it pertains to CNSs’ collective reality of policy.
within their practice. The findings of this study will be discussed under three subheadings: 1) The Complexities of Policy; 2) CNSs and Policy; and 3) The Impact of Policy.

**The Complexities of Policy**

Policy and the policy process is complex, multifaceted, dynamic and heavily dependent on values, relationships, power and politics (Clarke 2010; Lomas, 1997; 2000; Shamian & Griffin, 2003; Shamian & Shamian, 2011; Villeneuve, Shamian, & Skelton-Green, 2010). Likened to policy literature CNSs' experience of policy was complex. This was clearly articulated throughout CNS interviews, particularly in relation to the perplexities of policy and the context, or facilitators and barriers, which they described.

CNSs in this study struggled individually and collectively to clearly describe and define policy and their role in policy within their practice. The perplexity and variation in CNSs' experience of policy and process further substantiates the convoluted nature of policy itself and the processes by which it evolves (Hinshaw & Grady, 2011; Lomas, 1997; 2000; Mason, Leavitt, & Chaffee, 2002; Shamian & Shamian, 2011; West & Scott, 2000). The discrepancies between how CNSs described policy in their practice is not surprising given the variations in definitions of policy that exist in literature (Clarke, 2010; O'Grady & Johnson, 2009; Milstead, 2004 as cited in Hinshaw, 2011; West & Scott, 2000). Policy itself is a broad and inclusive term which serves to encompass an infinite range of 'standards' or 'decisions' that guide 'action' or 'inaction' in almost any setting with a varying degree of influence and impact (Clarke). Some CNSs
recognized the complexity and diversity of policy when they spoke of small (p) and big (P) policies. In this context, they described the variation in which policy guides practice and processes of care. In addition, they spoke of policy as an evolving and responsive entity that is created and revised through the policy process.

Participants’ rich description of facilitators and barriers to their work in policy fit well with Lomas’ (1997; 2000) Framework ‘The World in Which Policies are Made’ and the ONP Policy Cycle (Shamian & Griffin, 2003; Shamian & Shamian, 2011; Villeneuve, Shamian, & Skelton-Green, 2010). CNSs, like Lomas and the ONP, recognized and possessed an awareness of the complex and dynamic context in which they partook in policy work. The most notable example was that CNSs, like literature (Clarke, 2010; Hinshaw & Grady, 2011; Lomas) recognized relationships and stakeholder engagement as essential to the success of policy work. In fact, CNSs described how they employed various means to establish and draw upon relationships to engage stakeholders and elicit support in their policy work. However, although all CNSs clearly articulated the importance of relationships and stakeholders in their policy work, most of them only alluded to the notion of ‘power and politics’ when describing their experiences of policy, i.e., only a few CNSs explicitly called it such. Certainly CNSs displayed political acumen and rhetoric in their accounts, but they did not always label it and/or necessarily recognize it as such – power and politics being a phenomenon noted in much of the policy literature (Clarke; Fulton, 2010; Kendig, 2002; Lomas; Manson, Leavitt, & Chaffee, 2002; O’Grady & Johnson,
In this study, all 11 participants validated the overall claim in the literature (Ackerman et al., 1996; Canam, 2005; CNA, 2008; Davies & Eng, 1995; Schreiber et al., 2003; Scott, 1999; NACNS, 1998 as cited in Zuzelo, 2003) that CNSs participate in policy within their practice. In fact, in this study, all participants described extensive involvement in policy within their practice. Moreover, CNSs’ experiences aligned with the complexities of policy, process and context described in literature (Clarke 2010; Lomas, 1997; 2000; Shamian & Griffin, 2003; Shamian & Shamian, 2011; Villeneuve, Shamian, & Skelton-Green, 2010). Whether or not CNSs recognized and described policy work as such and in relation to ‘power and politics’ was heavily dependent on their individual definition of policy. Therefore, much variation existed in how CNSs explicitly described and articulated their role and experience of policy.

CNSs in this study indicated that a more succinct definition of policy would not impact or change their day to day work. It would seem, given the findings, that it might provide a common language and frame of reference for CNSs to clearly and collectively articulate their role and practice in policy, thus addressing issues related to role ambiguity.

**CNSs and Policy**

There is a growing movement in nursing (e.g. clinical practice and education) urging the politicalization of nursing in response to the current issues and challenges facing the health care system, clients (individuals, families and/or communities) and nurses (Kendig, 2002; McIntyre & McDonald, 2010). The
involvement of nurses in policy is essential given their unique and privileged position at the frontlines of healthcare where policy, practice and patient care intersect (Affonso & Mayberry, 1989; Aiken, 2011; De Grasse & Nicklin, 2001; Furlong & Smith, 2005; Kendig, 2002; O’Grady & Johnson, 2009; West & Scott, 2000). Additionally, CNSs inherent connection to and understanding of clients affords them a certain credibility from which to speak (Grady, 2011; RNAO, 2006). Though nurses at large serve to contribute a critical and much needed perspective to policy work, CNSs by virtue of their role, education, expertise and systems and population perspectives/experiences are situated perfectly to engage in policy at various levels (Antrobus & Kitson, 1999; Bamford & Gibson, 2000; Canam, 2005; DiCenso & Bryant-Lukosius, 2010b; De Grasse & Nicklin; Kring, 2008; Lewandowski, 2009; Pepler et al., 2006; Seenandan-Sookdeo, 2012; Urquhart et al., 2004).

The collective experience of CNSs in this study supports the inherent suitability of the CNS role and practice to policy work. In fact, CNSs themselves describe their connection to nursing, their expertise (founded on knowledge, experience and emersion in current literature), their Masters education, their systems and population perspectives and, the CNS role itself, as intrinsically facilitating and fostering their work in the policy realm. These factors CNSs describe as facilitating their involvement in policy work, in actual fact impart CNSs with power from which they can act (Aiken, 2011). In some literature this is referred to as ‘expert power’ while in other literature CNSs’ knowledge, expertise, education and perspectives is described as empowering CNSs (Aiken).
Regardless, both the literature (Antrobus & Kitson, 1999; Bamford & Gibson, 2000; Canam, 2005; DiCenso & Bryant-Lukosius, 2010b; De Grasse & Nicklin, 2001; Kring, 2008; Lewandowski, 2009; Pepler et al., 2006; Seenandan-Sookdeo, 2012; Urquhart et al., 2004) and the experience of CNSs, as ascertained from this study, attest to the fact that CNSs are well situated within their practice to engage in policy work. Within the study, CNSs describe their involvement in policy in relation to three main roles: expert or consultant, advocate and leader. CNSs’ experience as experts or consultants in the realm of policy as described by participants likens to what Aiken (2011) referred to as ‘expert power.’ Essentially CNSs described their clinical knowledge, expertise and role as placing them in a position from which others sought out and respected their opinion. Though not referenced specifically by Aiken, in this study CNSs’ experience of ‘expert power’ appeared to be dependent, not just on the expert knowledge they possessed but also on the position they held as a CNS. Similarly participants described their ‘expert power’ as placing them in a position from which to advocate, not only for patients and particular populations but also for nurses and nursing. In this study CNSs described their experience of advocacy in policy in relation to collaboration through professional associations and upholding fundamental underpinnings of their personal and professional ideologies and values.

Participants most often described their work with policy in relation to their role as a leader. Leadership is a core domain of CNS practice (Ankerman et al., 1996; CNA, 2008; NACNS, 1998 as cited in Zuzelo, 2003) and in some literature
has been suggested to be a process by which to influence policy; the collective experience of CNSs attests to this (Antrobus & Kitson, 1999; Hanson, 2000). As leaders in the area of health care, through policy work, participants were able to enact their role as change agents. Most of the CNSs in this study were involved in policy work across the policy cycle, from identification of the issue, through to initiating, planning and implementing change at unit, institutional and system levels. A few CNSs also referenced their experience of leading evaluation and research to quantify outcomes related to policy changes they led.

As leaders in health care and corresponding policy work the CNSs in this study described drawing upon various personal and professional attributes and knowledge to effectively engage others and lead the policy process. Antrobus and Kitson (1999) described nursing leaders as ‘bi-cultural’; having an innate knowledge of the values underpinning nursing and nursing practice while understanding and recognizing the contextual ideologies influencing the provision of health care. Similarly, CNSs in this study identified these perspectives as essential in facilitating their ability to navigate policy and effect change as consultants, advocates and leaders. In fact, CNSs ‘bi cultural’ nature not only helped them affect change, but also helped them to close the gap between research, policy and practice through interpretation and translation during development and implementation of policies (Antrobus & Kitson).

*The Impact of Policy*

CNSs are described as being in a unique position to impact policy as a means to guide nursing practice, move the nursing profession forward, improve
patient outcomes, and improve the provision of safe, effective and sustainable health care (Antrobus & Kitson, 1999; Bamford & Gibson, 2000; Canam, 2005; Clarke, 2010; DiCenso & Bryant-Lukosius, 2010b; De Grasse & Nicklin, 2001; Grady, 2011; Kring, 2008; Lewandowski, 2009; Mason, Leavitt & Chaffee, 2002; Pepler et al., 2006; Villeneuve, Shamian & Skelton-Green, 2010; West & Scott, 2000; Urquhart et al., 2004). CNSs in this study through anecdotal means largely authenticated this. Primarily, CNSs described their policy work as a vehicle to impart change related to clinically-based protocols (e.g. developing and implementing a checklist based protocol and pre-printed orders), evidence-based practice (e.g. developing evidence informed screening and prophylactic guidelines for at risk populations), best practice standardization (e.g. building continuums of care across departments and health care sectors for specialized populations), and more broadly through big (P) policy (e.g., advocating for increased awareness at the national level by including questions about a specialized population on the Canadian RN licensing exam).

In the literature EBP is pervasively described as the gold standard in health care (DePalma, 2009; Hinshaw, 2011; Melnyk & Williamson, 2011; Pringle, 2010; Upton, 1999). In fact, EBP has been described as synonymous with ‘best practice’ (Pringle). The Institute of Medicine (2001) contends that patients should receive care based on the best evidence available and that care should be delivered in a seamless and coordinated fashion (Institute of Medicine, 2001 as cited in Melnyk & Williamson). Consistent with literature, CNSs in this study described their work with policy as a means to implement EBP into the
clinical setting to ultimately initiate and support best practice standards and improve patient care. In keeping with the perspective of the Institute of Medicine, most CNSs in this study also saw policy as a way to bridge gaps in care by streamlining processes, primarily through what was described as best practice standardization. For CNSs in this study best practice standardization addressed health care silos, removed individual bias and improved communication between both the health care team and the health care team and patients (e.g., developing policies to support processes of care to maintain continuums of care across healthcare sectors independent of individual practitioners and their values and beliefs). Through their policy work to support best practice standardization CNSs described being able to improve the consistency of care provided to individual patients and enhance the continuity and continuum of care as patients moved within and across the health care system. It is worth noting that CNSs described their work in policy as not only affecting the care provided by nurses but, in many instances, the care provided by other health professionals on the health care team.

CNSs’ experience of policy and its impact, in this study, fits with much of the literature related to CNS practice in policy (Antrobus & Kitson, 1999; Bamford & Gibson, 2000; Canam, 2005; Clarke, 2010; DiCenso & Bryant-Lukosius, 2010b; De Grasse & Nicklin, 2001; Grady, 2011; Kring, 2008; Lewandowski, 2009; Mason, Leavitt & Chaffee, 2002; Pepler et al., 2006; Urquhart et al., 2004; Villeneuve, Shamian & Skelton-Green, 2010; West & Scott, 2000). However, very few participants in this study actively partook in formal evaluations to track the
effectiveness of the policies they worked to develop and institute. In fact, many CNSs described challenges related to fostering uptake and sustainability of new policies at the clinical level and finding the time and means to evaluate the effectiveness and impact of policy changes. These challenges were often troubling to CNSs.

Research utilization and knowledge translation literature recognizes the challenges of integrating research, knowledge and new policies and processes into practice (Kent & McCormack, 2010; Pringle, 2010). In fact, much work is currently being done in relation to research utilization and knowledge translation (Pringle; Upton, 1999). The findings and theories of this work could serve CNSs well in addressing issues related to uptake, sustainability and evaluation.

In this study the majority of CNSs described working to improve nursing practice, patient outcomes and the efficiency of the health care system at the small (p) policy level, though a few participants also described their advocacy work at the big (P) policy as a means by which to effect change more broadly. Many CNSs attributed their lack of involvement in big (P) policy to time, a lack of awareness of how to engage in broader policies, as well as employment expectations and scopes of practice. The need for nurses and CNS involvement in broader public policy is well documented in literature (Canam, 2005; Davies & Eng, 1995; Kendig, 2002; Schreiber et al., 2003; Scott, 1999) but within this study only a few CNSs actually participated actively in policy issues outside their institution for the reasons mentioned above. Addressing these issues may facilitate an increase in CNSs’ involvement in broader big (P) policies; thus
expanding their sphere of influence on nursing, client outcomes and the effectiveness and sustainability of the health care system.

**Implications**

Based on the findings of this study implications for nursing (and in particular CNSs) in clinical practice, education, research and the health care system have been identified and will be presented here. The implications have been purposefully outlined in point form for the purpose of clarity, conciseness and accessibility.

**Implications for Practice**

1. **CNS Mentorship.** New CNSs should be provided with the opportunity to create and foster a mentorship relationship with an experienced CNS who can role model, advise and encourage neophyte CNSs in regards to leadership, policy and politics. Mentorship relationships are essential in professional development and success (Leavitt, Chaffee & Vance, 2002). Therefore mentorship relationships could serve as a strong foundation and resource for new CNSs to learn, grow and flourish in their role and policy work.

**Implications for Education**

1. **Standard CNS Curriculum.** Standardizing CNSs educational curriculum at the Masters level will provide a common foundation for nurses entering into ANP as CNSs. This could serve to enhance and standardize the level of CNS practice across Canada.

2. **Policy Course.** According to literature (Ackerman et al., 1996; Canam,
2005; CNA, 2008; Davies & Eng, 1995; Schreiber et al., 2003; Scott, 1999; NACNS, 1998 as cited in Zuzelo, 2003) and the findings of this study CNSs engage in policy at various levels within the health care system. Therefore standard curriculum should include at least one policy course, focusing on the policy context, power, organizational structure and engagement. This would provide CNSs a foundation from which to engage and navigate policy, the policy process and politics. It could also provide CNSs with the knowledge and frameworks from which to more clearly and consistently conceptualize and articulate their work with regards to policy in their practice; this to mitigate issues related to role ambiguity.

3. **Leadership Course.** Leadership is a core domain of CNS practice (Ackerman et al., 1999; CNA, 2008, NACNS, 1998 as cited in Zuzelo, 2003) and was identified in this study as the primary role CNSs assumed in their policy work and in health care more broadly. For this reason a leadership course should be included in the standard curriculum of CNS education to foster strong leadership skills.

4. **Research Utilization and Knowledge Translation Course.** CNSs in this study largely referenced their policy work as a means of integrating evidence into practice. CNSs described themselves in this study as the conduit between research and practice. As such, a research utilization and knowledge translation course should be included in CNSs’ core educational curriculum to promote and enhance CNSs’ ability to use research to guide practice as well as facilitate uptake and sustainability of
Implications for Research

1. *Outcomes and Evaluation Research.* CNSs in this study, in keeping with the current literature (Fulton & Baldwin, 2004) attest to the fact that work in policy results in improved nursing care, client outcomes and the provision of more efficient and sustainable health care. Unfortunately little research exists to support such claims, particularly in the Canadian context. Therefore CNSs and researchers should be attentive to focusing future research on evaluating the impact of CNS practice by concentrating on changes in nursing practice, measuring patient outcomes, and improvements/shifts in the health care system; this to substantiate and validate the practice of CNSs and their contribution to the health care system through policy work.

2. *Policy Process Evaluation Research.* For some CNSs in this study the internal organizational structures defining and guiding policy work were seen as barriers rather than facilitators. Therefore research examining structures that facilitate or constrain the policy process might serve to inform organizations in the development of more efficient internal policy structures and processes.

Implications for the Health Care System

1. *Increase the Number of CNSs in Practice.* CNSs in this study, not unlike literature (Lomas; 1997; 2000) note that substantial gaps exist in the implementation of EBP. The first gap participants described related to the
availability of research and its utilization into policies, the second gap described existed between policy and practice; that is the uptake of a policy into practice and patient care. These gaps were extended by the sheer volume of policy work CNSs described in this study. Therefore by increasing the number of CNSs in practice settings, CNSs can work to decrease these gaps and address the volume of work that CNSs currently face. Additionally with more CNSs in practice, arguably there would be more CNSs available to engage in broader big (P) policies in order to effect change more broadly across health care and the population at large.

Conclusion

This qualitative research study explored CNSs’ experience of policy within their practice. Using an interpretive descriptive approach to data analysis four consistent themes emerged out of the 11 participants’ collective experiences. These common themes related to the perplexities of policy, the innate suitability of the CNS role to policy work, policy as a vehicle for CNSs to affect change and the consistent mechanisms that either facilitated and/or hindered CNSs’ policy work.

This study found that CNSs do engage in policy at different levels of the health care system (clinical, institutional, and systems) to effect change aimed at improving and advancing nursing practice, patient care and the health care system at large. In fact, participants’ experiences of policy primarily involved navigation of complex policy processes and contexts in order to affect change. CNSs, as clinical experts/consultants, advocates and leaders collectively
described their unique contribution to the provision of health care by ensuring that the patient and nursing perspectives were heard and considered at policy tables. Consequently, key recommendations of this study focus, first on supporting CNSs in their policy work within their role, and second on substantiating, through research and evaluation, the critical role CNSs play in the provision of high quality continuums of evidence-based health care for the specialized patient populations they serve.
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http://www.nacns.org/docs/CNSCoreCompetenciesBroch.pdf


APPENDICIES

APPENDIX I: Letter of Invitation

THE UNIVERSITY OF BRITISH COLUMBIA

School of Nursing
T201- 2211 Wesbrook Mall
Vancouver, B.C. Canada V6T 2B5
Tel: (604) 822-7417
Fax: (604) 822-7466

Letter of Invitation

“Canadian Clinical Nurse Specialists: Understanding Their Role in Policy Development within a British Columbian Context”

Are you a Clinical Nurse Specialist (CNS) working in British Columbia?

If you are a practicing member of The Registered Nurses Association of BC, are Masters prepared and have 3 or more years experience as a CNS we would like to talk to you!

Interviews will be a maximum of 90 minutes in length at a time and location of your convenience. If you are located outside the lower mainland interviews can be arranged via telephone or Skype.

We would like to assure you that your interview will be held in the strictest confidence. Your time and interest is greatly appreciated.

If you are interested in doing an interview or would like more information please email inquiries to xxxxxxx@xxxxxxxxxx.xxx.ca

Principal Investigator: xxxxxxxx xxxx – xxx-xxx-xxxx
Graduate Student: xxxxx xxxxxxx – xxxxxxx@xxxxxxxxxx.xxx.ca
APPENDIX II: Consent Form for Participants

THE UNIVERSITY OF BRITISH COLUMBIA

For the Research Project
“Canadian Clinical Nurse Specialists: Understanding Their Role in Policy Development within a British Columbian Context”

Consent Form for Participants

Principal Investigator (Supervisor): xxxxxxxx xxxx, University of British Columbia (UBC), School of Nursing, phone: xxx xxx xxxx
Primary Researcher (Graduate Student): xxxxx xxxxxxxx, email: xxxxxxxxx@xxxxxxxxxxxx.xxx.ca
Supervisory Committee: xxxxx xxxx, UBC School of Nursing, xxxxx xxxxxxxx, UBC School of Nursing

What is this Project about?
As a Graduate Nursing student at UBC I am conducting a research study to explore Clinical Nurse Specialists' (CNS) experience of policy development. I am interested in examining CNS experience in relation to health policy development at different levels of the health care system to expand our understanding of the CNS role and their unique contributions to the Canadian health care system within British Columbia (BC).

To do this I will be talking to Masters Prepared Registered Nurses currently working as CNSs within BC. The overall goal of the study is to explore CNSs experience of policy development within their practice as a means of providing insight into the dimensions of CNS practice and dismantle some of the confusion and ambiguity related to the CNS role within a British Columbian context.

You have read the Letter of Invitation inviting you to participate in the study, and the details have been explained to you to your satisfaction. You understand that the purpose of the study it to explore CNSs experience of policy development within their daily practice.

What does the Study involve?
The primary researcher, a Graduate student from UBC, will be talking to you about your experience as a CNS in relation to policy development within your
practice context. You will be interviewed in person at a time and location deemed convenient by you. If you are located outside of the lower mainland you may choose to partake in the interview either via telephone or Skype. The length of the interview will not exceed 90 minutes. With your consent the interview will be audio-taped and later transcribed. At any point in the interview, you can ask for the tape recorder to be turned off or have the tape erased.

Following transcription, with your consent an electronic copy of your interview transcript will be forwarded to you for your review. In an effort to ensure completeness you will be encouraged to clarify, change or add to the transcript to ensure it accurately illustrates your experience.

Finally on a voluntary basis, and with your consent, an electronic copy of the final draft of the studies analysis may be forwarded to you for your review to ensure resulting themes and relationships hold truth with participants.

**Risks and Benefits**
There are no risks or benefits associated with participating in this study. The information will not be used for any purpose other than that outline in this consent. A copy of the final results of the study will be made available to you if you so wish. You do not waive any of your legal rights by signing this consent form.

**Protecting Privacy and Confidentiality**
The information you provide (identifiable data) is strictly confidential. Your confidentiality will be protected in several ways.

1. Your name will not be used in the study or in any reports or articles written about the study. Instead, a number code will be given to each study participant.
2. You will not be identified in any of our discussion with other participants of the study.
3. Information that could identify you or others you refer to will be deleted from all notes and documents.
4. Only the Primary Researcher and Principal Investigator listed above will have access to research information with your name on it, the Supervisory Committee will have access to information without your name on it.
5. Each person on the research team is accountable for the safekeeping of the information and for maintaining privacy and confidentiality.
6. All information will be locked securely in a research office.

**Consent**
Your decision to be in the study is completely voluntary. If you decide to be in the study, and then change your mind, you are free to drop out of the study at any time.

If you have any questions about your rights as a research participant, you can
contact Director of the University of BC Research Services and Administration, in
Vancouver at xxx-xxx-xxxx or if long distance e-mail to RSIL@ors.ubc.ca.

If you have any questions or comments about this study, you can contact Ms. xxxxx xxxxxxx, UBC Masters Student, at xxxxxxxx@xxxxxxxxxxxx.xxx.xx or Dr. xxxxxxxxxx xxxxx, UBC School of Nursing, at xxx-xxx-xxxx.

By signing this consent form you agree to participate in the study described above. You have received a copy of this consent form, which you can keep.

Do you agree to be audio-taped?
Yes □    No □

Do you agree to participate in reviewing your interview transcript?
Yes □    No □

Do you agree to participate in member checking of study’s draft analysis?
Yes □    No □

__________________________  ______________________
Signature of Participant      Date

__________________________
Please print your name
APPENDIX III: Inclusion Criteria

Inclusion criteria for the study:

- Currently working in BC as a CNS
- Have an active practicing licence with CRNBC
- Minimum of a Masters Degree
- Minimum of 3 years experience as a CNS
APPENDIX IV: Interview Plan

(Adapted from Baumbusch, 2010)

<table>
<thead>
<tr>
<th>Topic</th>
<th>Details</th>
<th>Comments/Thoughts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thank You</td>
<td>• Thanks for taking the time to volunteer and participate in the study</td>
<td></td>
</tr>
<tr>
<td>Introduction to study</td>
<td>• Sarah Rourke – MSN Student UBC</td>
<td></td>
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<tr>
<td></td>
<td>• Research study is being conducted in conjunction with my thesis for my</td>
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<td></td>
<td>Masters program.</td>
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<td></td>
<td>• The purpose of the study is to gain a more in-depth understanding of</td>
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<td></td>
<td>CNSs practice, specifically in relation to CNSs experience with policy</td>
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<td></td>
<td>within their daily practice</td>
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<td></td>
<td>• The interview will be a semi-structured interview and it will be audio-</td>
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<td></td>
<td>recorded to facilitate transcription of data</td>
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<tr>
<td>Consent</td>
<td>• Ensure that the participant has had time to review the consent form (sent</td>
<td></td>
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<tr>
<td></td>
<td>to them electronically)</td>
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<td></td>
<td>• Participation is voluntary; if they choose at any point to withdrawal</td>
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<td></td>
<td>as a participant in the study, all documents and audio recordings</td>
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<td></td>
<td>pertaining to their interview will be destroyed and not included in the</td>
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<td></td>
<td>study’s analysis.</td>
<td></td>
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<td></td>
<td>• Every effort is being taken to ensure participant confidentiality.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Have participant sign consent form (a copy to be given to participant)</td>
<td></td>
</tr>
</tbody>
</table>

**Begin with a factual focus**

**In-depth questions**

<table>
<thead>
<tr>
<th>Asked</th>
<th>Question</th>
<th>Thoughts/Themes/Directions</th>
</tr>
</thead>
</table>
| Start with a broad opening question | “Tell me about your practice as a CNS”  
“Do you use an APN/CNS Framework to guide your practice?” |                           |
|                            | “What other kinds of activities do you engage in as a CNS?”                                           |                           |

Questions to facilitate participant to explore policy within their practice
"How do you define policy?"
"statements (documents) that reflect the 'standing decisions' of an organization about a given problem, issue or situation"

Tell me about the kinds of activities you engage in within your practice that affects policy?"

Tell me about a time you engaged in policy in your practice?"
"What informs your work on policy"

If your work does not impact policy, what would you need to do to shift this?"
"How do you see policy fitting into the domains of your practice?"

Questions to facilitate a thorough exploration of policy within the participants practice.

"What impacts your decision to engage in activities surrounding policy?"

"Why do you engage in policy?"

"What supports your engagement with policy?"
"Why don’t you engage in policy?"

"What limits your ability to engage in policy?"

"Is policy an important aspect of your practice? Why or why not?"

Closing question to wrap up the interview

"Is there anything we have not discussed that you would like to comment on?"

"Is there anything we have discussed that you want to elaborate on or clarify?"

Prompts

"hmmhmm"
"Say more"
"Interesting"
"Tell me what that was like for you"
"Tell me more about (blank) or (that)"
"Was that surprising to you?"
"Can you tell me more about that?"
"Was there anything else at play there?"
"Why do you think you did/do that?"
"I’ve heard similar things from others, and I’d love to better understand that. Can you tell me more?"

Moving back to factual questions

- Review the consent form (ensure copy is provided to participant)
- Verify participant’s willingness to take part in
  - **Transcript review** (electronic copy of interview transcript to be emailed to participant within one week of interview. Participant to review for completeness and offer any clarification).
  - **Member checking**. Draft of analysis anticipated to be ready between April and May. Participant will be contacted to prior to participating in member checking to ensure their continued interest, details will be provided at this time.
- Confirm contact information with participant.

### Closing the Interview

**Thank You**
- Thank participant again for participating. Your time and interest is appreciated. If you have any further questions or concerns please feel free to contact myself or my supervisor, xxxxxxxx xxxx, at any time. Stop audio-recording
APPENDIX V: Demographic Data Sheet

THE UNIVERSITY OF BRITISH COLUMBIA

School of Nursing
T201 - 2211 Wesbrook Mall
Vancouver, B.C. Canada
V6T 2B5
Tel: (604) 822-7417
Fax: (604) 822-7466

For the Research Project
“Canadian Clinical Nurse Specialists: Understanding Their Role in Policy Development within a British Columbian Context”

Demographic Data Collection Worksheet

Participant Code:

What is your educational background?

Degree obtained __________________ Year_______ Location_____________

Degree obtained __________________ Year_______ Location_____________

Degree obtained __________________ Year_______ Location__________

How many years have you been an RN?

How many years have you worked as a CNS?

What is your current job or role title?

What is your job description?

How many years have you been working in your current job?
What is the geographical location of your current job (City/Town, Health Authority, rural/remote)?

City/Town______________________________________________________________

Health Authority ________________________________

Rural/Remote________________________________

Clinical practice area (community/acute care, clinical context):

Community/Acute ________________________________

Clinical Context ________________________________

Patient Population ________________________________

Do you have any previous CNS experience? How long? Where?

Job Title ________________________________________________

Years in the position ________________________________

City/Town ________________________________________________

Health Authority __________________________________________

Rural/Remote ____________________________________________

Community/Acute _________________________________________

Clinical Context _________________________________________

Patient Population _______________________________________

What is your background? What did you do prior to being a CNS?
APPENDIX VI: Field Notes

(Adapted from Loiselle, Profetto-McGrath, Polit & Beck, 2011, p. 246-247)

Reflective Field Notes

Participant Code: ____________

Pre-interview Goals: ____________________________________________


Descriptive/Observational Notes (objective, contextual information, what transpired)

Interview Date: ____________

Location of Interview: __________________________________________

Starting Time: ____________  Ending Time: ________________

Technical Problems: ____________________________________________

Content: (key words, phrases, topics noted) _________________________

Nonverbal Behaviours: __________________________________________
Theoretical Notes *(interpretive attempts to attach meaning to observations)*

Analysis: (themes, trends, questions, patterns, relationships)

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

Concept Mapping
Methodologic Notes *(instructions/reminders about subsequent observations)*

How will this interview direct next interview, or participant recruitment?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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Personal Notes *(my own feelings during the interview process)*

Personal thoughts, influences, biases, reactions:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
APPENDIX VII: Thematic Tree

CNSs’ Experience of Policy

The Perplexities of Policy
- Defining and Describing Policy
  - Process of Care
  - Policy as a Process
  - The Policy Process

CNS and Policy: A Perfect Match
- Consultant or Expert
- Advocate
- Leader

CNSs’ Influence: Policy as a Vehicle
- Clinically-Based Policies
- Evidence-Based Practice
  - Best Practice Standardization
    - Addressing Health Care Silos
    - Removing Individual Bias
    - Improving Communication
  - Big (P) Policy

Mechanisms that Challenge and Facilitate CNSs’ Policy Work
- Organizational Processes
  - Time
  - Associations
  - Awareness of the Political Environment
    - Timing
    - Power
    - Relationships
    - Personal Attributes
    - Personal and Professional Responsibility
    - Evidence-Based Practice Based on Research
    - Balancing Standardization and Individualization