EXPLORING THE INFLUENCES OF THE ORGANIZATION ON THE

CLINICAL NURSE SPECIALIST ROLE

by

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ABSTRACT

This thesis pertains to an interpretive descriptive case study, that was designed to explore the organizational influences on the Clinical Nurse Specialist (CNS) role within a specific urban hospital in British Columbia. This study included 12 participants; (n=9 primary participants in semi-structured interviews, and n=3 participants in a semi-structured focus group). The findings of this study potentially inform clinical practice, research, advancement of nursing practice and systemic leadership in the health care systems. The thesis offers a deeper understanding of the CNS’s transformative practice, explores tensions that influence CNS practice, and identifies intentional embedded infrastructures that are perceived by the participants to support the CNS role by the organization. The thesis concludes that organizations have many influences on how the CNS role is supported or constrained within the health care team.
PREFACE

For the purpose of this study, I obtained ethics approval from The University of British Columbia (Vancouver), Behavioral Research Ethics Board. The Ethics Certificate Number obtained was H14-01427.
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<tbody>
<tr>
<td>ACT</td>
<td>Alberta Context Tool</td>
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<tr>
<td>ANCC</td>
<td>American Nurses Credentialing Commission</td>
</tr>
<tr>
<td>APN</td>
<td>Advanced Practice Nurse</td>
</tr>
<tr>
<td>ARNBC</td>
<td>Association of Registered Nurses of British Columbia</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
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<td>CNL</td>
<td>Clinical Nurse Leaders</td>
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<td>CIHI</td>
<td>Canadian Commission of Health Information</td>
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<td>CNA</td>
<td>Canadian Nurses Association</td>
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<td>CNO</td>
<td>Chief Nursing Officer</td>
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<tr>
<td>CNS</td>
<td>Clinical Nurse Specialist</td>
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<td>CNSABC</td>
<td>Clinical Nurse Specialist Organization of British Columbia</td>
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<td>CNSAO</td>
<td>Clinical Nurse Specialist Organization of Ontario</td>
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<tr>
<td>CRNBC</td>
<td>College of Registered Nurses of British Columbia</td>
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<td>NACNS</td>
<td>National Association of Clinical Nurse Specialists</td>
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<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
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<td>OL</td>
<td>Operational Leaders</td>
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<td>Royal College of Nurses</td>
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<td>Registered Nursing Association of Ontario</td>
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<td>VP</td>
<td>Vice President</td>
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Chapter 1: INTRODUCTION

1.1 My Story

I was at an orientation for new graduate nursing students and I was terrified. It was my first time in a university in over a decade. We were all packed in this dark and musty classroom listening to a professor introduce Advanced Practice Nursing (APN), something new to me. I was jotting notes and pretending to listen, but my mind was racing with doubts and distress. I was sacrificing a lot to be here, and making this decision even more difficult, everyone questioned me as to “Why would you even go back to school?” “So you mean you’re going back to school to be a Nurse Practitioner, right? You are not? Then why bother? You are a mom. Isn’t that enough?” I was there for a purpose and I knew I wanted to learn, but I was unsure how to clearly articulate what it was, and how I would apply that knowledge.

I tuned into what the professor was discussing and at that moment, it clicked for me. She began articulating how the role of the Clinical Nurse Specialist (CNS) influences patients, nurses and organizations while staying focused on a particular specialty (National Association of Clinical Nurse Specialists (NACNS), 1998; Canadian Nurses Association (CNA), 2009). That was my ‘ah-ha’ moment; THIS is what I came to school for! I applied to graduate school to enhance my experiential knowledge and inform my practice in the field of mental health and substance use.

As I progressed through the graduate program, I learned many things about the health care system, nursing and myself. For example, I learned that intuitively I align myself within the school of critical social theory: “Change is fostered through consciousness-raising and community building” (Chinn, Smith, & Kagan, 2013; Kagan, Smith, Cowling, & Chinn, 2010, p. 78). I am intrigued by the ideology that knowledge is practical and emancipatory, specifically
regarding the process in which nurses critique the pressing dominant influences that shape our role to move forward into action for change (Browne, 2000; Chin et al., 2013; Kagan et al., 2010). In mental health particularly, there are intersecting tensions that confound the complex health care system for an already marginalized population (Rossiter & Morrow, 2011).

As a community mental health nurse, my perception is that I have very little influence on the overall healthcare system; I work autonomously under, but not in, the framework of a local health authority. My passion is looking at systemic, transformational, and innovative processes that facilitate change and promote recovery for those persons living with mental health issues, who are often marginalized by social and structural inequity. As a nurse working with this population, I often felt drowned out by the organizational demands and struggled to maintain autonomy when collaborating with team members within the system.

The other new insight was that as a CNS, I could influence, change, and promote excellence, quality, and health in patients, nursing, and the overall system to provide these structural changes in building up the mental health community (Chin et al., 2013; CNA, 2009; NACNS, 1998). Still, from my own practicum and study, I had many questions regarding why this CNS role was not so well known, utilized, and researched.

In June of 2012, the Canadian Nurse Magazine profiled the CNS role. Reflecting on this article, two things stood out: The role of the CNS enhances the current health care context; and secondly, this role needs to be clearly articulated within its own diversity (McDonald, 2012). There is need for a common vision, role identification, standardization, and understanding of current barriers and facilitators that influence this important role (DiCenso & Bryant-Lukosius, 2010; Duffield, Gardner, Chang & Caitling-Paull, 2009). My practice question was underpinned by the query that these basics needs identified. I began to explore what influences may affect
CNS practices within the current body of nursing knowledge. In this section, I have located myself in this study and set a foundation for discovery based on a current practice issue regarding the CNS role. In this next section, I will introduce the main purpose for this research study.

1.2 Overview and Summary

The main purpose in this thesis is to explore how an organization influences the role of a CNS. I employed an interpretive descriptive case study approach (Flyvbjerg, 2006; Thorne, 2008; Yin, 1999; Yin, 2009); the organization in this case study is a large urban teaching hospital. I chose this methodology because the approach outlined by Thorne (2008) helps me to ground my exploration in the current body of nursing science, while using a deductive approach to qualitative analysis. The case study approach, which supports individuals to move past simple tasks to higher levels of functioning, provided a way to enhance my experiential learning (Flyvbjerg, 2006).

In this chapter, I will provide a brief history of the evolution of the CNS role, provide a definition for the CNS role, and outline key tensions and facilitators to the CNS role. I also will present a problem statement and articulate the research question with associated sub-questions and assumptions within the interpretive descriptive case study methodology.

1.2.1 Historical evolution.

Hildegard Peplau first promoted the role of the CNS in the United States in the 1950s in the mental health subspecialty of nursing (Hamric, Spross, & Hanson, 2009 p. 15). This was accomplished through the connection of graduate level education in a specific clinical specialty: psychiatric nursing. Peplau fostered the relationship between psychiatric nursing and a graduate level education to facilitate support for nurses in leadership and nursing practice across patient
care (Hamric et al., 2009; McClelland, McCoy, & Burson, 2013; Sechrist & Berlin, 1998). The CNS role initially flourished in the US as a result of the nursing shortage during World War II; subsequently due to the constantly changing and complex needs of health care systems, specialized nurses became essential to providing quality patient centered care (Bryant-Lukosius, 2010; Virani & Associates, 2012). In Canada, the role of the CNS was introduced in the 1960s and was initially well received (DiCenso & Bryant-Lukosius, 2010; Virani & Associates, 2012). In the 1980s and 1990s economic pressures forced organizations to downsize and relegate CNSs to more administrative and -or educational roles (DiCenso & Bryant-Lukosius, 2010; Donald et al., 2010). The recent shifts in the Canadian health care landscape to provide a collaborative holistic approach to patient and family centered care, in more efficient and transformative ways, while being fiscally responsible, has initiated a change in the way health care structures provide care (CNA, 2012; Kilpatrick et al., 2014).

To address these necessities, the CNA set out to promote, advocate, advance and engage nurses and nursing to act as transformative agents for change in the overall health care system; and to address the issues of fiscal responsibility, chronic care, complex disease management and the aging population within these constraints (Bryant-Lukosius et al., 2010); CNA, 2012; Virani & Associates, 2012, 2012). MacDonald-Rencz (2010) attests that APNs are a part of the solution to facilitate equitable high quality health care in Canada. Subsequently, a working group created by the CNA came together in 2013 “To strengthen the role of the CNS in Canada.” This was a direct result of the CNA’s call for action and the APN mandate (CNA, 2012; Virani & Associates, 2012).
1.2.2 Defining a CNS.

A Clinical Nurse Specialist (CNS) is an Advanced Practice Nurse (APN) who has both an expertise in a clinical specialty, as well as a graduate level nursing degree (Canadian Nursing Association (CNA), 2009; Canam, 2005; Clinical Nurse Specialists Association of Ontario (CNSAO), 2014). A CNS provides leadership and promotes excellence in patient care throughout the health care system (CNA, 2009; Bryant-Lukosius et al., 2010; Virani & Associates, 2012). According to the CNA position paper (2009), the CNS role encompasses five fundamental areas of practice: clinician, consultant, educator, researcher and leader.

1.2.2.1 Clinician.

The CNS enhances patient care with expert skills in assessing, planning, and intervening in complex care situations (Bonsall & Cheater, 2008; Canam, 2005; CNA, 2009; Darmody, 2005). Complex case management can be accomplished with increased utilization of clinical expertise and research to inform and change practice (CNA, 2009).

1.2.2.2 Consultant.

In order to navigate the complex and challenging issues that arise in the health care system, a CNS shares specialized knowledge with all members of the health care team while taking into account the complexities of other intersecting and influencing factors (Canam, 2005; CNA, 2009; Darmody, 2005; Dias, Chambers-Evans, & Reidy, 2010). This consultation may occur across the spectrum of systemic leadership, or direct one to one interactions (CNA, 2009).

1.2.2.3 Education.

The CNS supports and enhances an environmental context in terms of education for all members of the health care team and patient/family (Canam, 2005; CNA, 2009, Darmody, 2005).
CNSs provide education from the point of care through to the senior levels of leadership to affect change in the system (CNA, 2009).

1.2.2.4 Research.

The CNS is a stakeholder in promoting innovation in nursing science, and clinical practice through research (Bryant-Lukosius et al., 2010; Canam, 2005; CNA, 2009; Zuzelo, 2003; Virani & Associates, 2012). Peplau (2003-reprint, 1965) postulates that research in nursing promotes overall improvement in the health care system, and if the number of CNSs increases in the system, so will the amount of quality nursing research. However, at this time research is the most “under-utilized” aspect of the CNS role (Bryant-Lukosius et al., 2010; Canam, 2005; CNA, 2009; Peplau, 2003; Virani & Associates, 2012). This under-utilization is often attributed to lack of time, other priorities, and lack of resources (Bryant-Lukosius et al., 2004; Canam, 2005; Kilpatrick et al., 2012; Virani & Associates, 2012; Zuzelo, 2003).

1.2.2.5 Leadership.

The CNS is a leader and “change agent” in “advancing nursing practice,” and promotes client centered care (Canam, 2005; Carter et al., 2010; CNA, 2009). The leadership component encompasses the continuum from local to global advancement of the role through research, education, and clinical expertise (2009).

These five fundamental areas of practice are not linear, but inform each other and are intersected within the spheres of influences of the health care system: patients, nurses, and the organization (CNA, 2009). In the next section, I discuss definition of the CNS in the context of the spheres of influence (NACNS, 1998).
1.2.3 Spheres of influence.

The spheres of influence, also known as the domains of CNS practice, include key groups of stakeholders (patients, nurses, and systems) that are directly impacted by the outcomes of the CNS (Jeffreys, 2005; NACNS, 1998). According to NACNS (1998) the spheres are described as follows:

- The primary purpose of the CNS is the utilization of clinical expertise to improve the health outcomes regarding patient care.
- The nursing sphere is the domain in which the CNS uses research, education and consultation to enhance nurses and nursing practice.
- The organizations/system sphere is where nurses affect change and promote quality care at a systems level.

Each of the spheres interacts and has its own set of competencies that a CNS must ascertain to fully achieve the primary purpose of CNS practice (CNA, 2009). However, the domains of CNS practice are dynamic and unique. A fundamental feature of the CNS role is the understanding of the holistic interaction in which the domains influence each other, while remaining grounded in the primary goals of quality health care delivery, improvement of patient care, and nursing innovation (Fulton, J., 2004; Moloney-Harmon, 1999). Zuzelo (2003) describes the essential characteristics of a successful CNS as being creative, committed, and passionate as well as accountable and autonomous. These characteristics are intertwined with the competencies of the clinician, consultant, educator, researcher and leader, across the spheres of influence regarding patients, nursing, and health care organizations.

However, the CNS role itself is not regulated and many individuals and organizations enact and articulate the role in a way (Bryant-Lukosius et al., 2010; Kilpatrick et al., 2012) that
does not align with the CNA’s position statement (2009). Adding to this, there are many complex and often conflicting organizational, social, and environmental influences such as leadership, culture, and evaluation (Estabrooks et al., 2009; Kitson, 1998, Rycroft-Malone et al., 2004) that lead to further role confusion (Bryant-Lukosius et al, 2010; Hamric et al., 2009, Virani & Associates, 2012, 2012). I have provided a foundational definition of CNS practice; in the next section I begin to explore further the influences that affect CNS practice.

1.3 Barriers and Benefits

The utilization of the CNS as an integral part of the health care team has led to positive nursing outcomes such as significant decreases in hospital stays, readmission rates, and emergency room visits; along with an increase in staff nurse knowledge, core competencies and skill levels; and as well as overall well-being, satisfaction and quality of life of patients (Begley et al., 2010; Fulton & Baldwin, 2004; Hill, Lewis & Bird, 2009; Muller, Hujes, Dubendorf & Harrington, 2010; NACNS, 2013). Bryant-Lukosius (2010) notes that with the increased demand on the healthcare system and the future projected nursing shortages, the utilization of the CNS is vital, as its inherent purpose is to enhance nursing care both in policy and in frontline interventions throughout the organization (McFadden & Miller, M, 1994; McMaster University (ND); O’Connor & Ritchie, 2010; Sechrist & Berlin, 1998).

In 2010, it was reported there were 2431 self-identified CNSs in Canada; however, the approximation based on statistics from 2009 was that only about 800 had a graduate level degree (Kilpatrick et al., 2011). The latter study also identified that in 2009, in British Columbia alone, there were almost 700 self-identified CNSs as reported by the College of Registered Nurses of British Columbia (CRNBC); however, less than 100 met the CNA standards of graduate level education (Kilpatrick et al., 2011). Kilpatrick notes that the Canadian Institute for Health
Information (CIHI) (2011) reports that there was a drop from 2642 to 2222 self-reporting CNSs in the country with the biggest drops being in BC and Ontario. As many provinces don’t regulate or differentiate the CNS role as they do in the Nurse Practitioner (NP) role, there is no other accurate count for the number of CNSs in Canada who have a Master’s degree in nursing and practice in a specialized area (Bryant-Lukosius et al., 2010).

It appears that although the CNA continues to endorse the enactment of the CNS role, they have not initiated title protection or regulation, or standardized the CNS education curriculum (Profetto-McGrath, Negrin, Hugo & Smith, K., 2010). In the US in 2008, the requirements for credentialing, regulation, and title protection for the CNS became even more specific, to protect the unique contribution and value of the CNS to the health care team (American Nurses Credentialing Center, 2008).

There appears to be increasing attention to this role by the CNA and other Canadian researchers, but there is still limited research done in the Canadian context for the CNS role (Bryant-Lukosius et al., 2010; CNA, 2014; Kaasalainen et al., 2010; Kilpatrick et al., 2011). In fact, I noted there is only about a dozen researchers who are experts in the field of Advanced Practice in Canada, and less than that focused on CNS practice. The research that is done addresses:

- Role clarity
- Lack of robust research
- No credentialing mechanism
- Fiscal restraints
- Limited graduate specific education
- No united voice for the CNS
• Unclear role descriptions, resulting in varied role enactment and decrease in the number of CNS roles and CNSs in the country (Bryant-Lukosius et al., 2010; Di Censo et al., 2010 A & B; Donald et al., 2010; Kaasalainen et al., 2010; Kilpatrick et al., 2012, Prevost, 2002).

There is growing concern about the lack of research in the overall field of CNS practice. This could potentially deteriorate the role growth and future expansion of CNS practice, both necessary to meet the demands of the current health care system (Bryant-Lukosius, 2010).

Role clarity is a pervasive theme in the study of influences on the CNS role. This has led to an either-or debate in the CNS and Nurse Practitioner (NP) discourse because the two roles are the only two recognized APN roles in Canada (Donald et al., 2010). The NP is a valued advanced practice role that focuses on clinical practice and promotes the primary care principles of holistic health promotion and care (Bryant-Lukosius & DiCenso, 2010; CNA, 2008; Donald et al., 2010). In May 2012, the BC government announced a commitment to allocate over $22.2 million dollars to create 190 jobs for NPs in BC. The NP role is regulated and licensed; however, as noted earlier, the CNS role is not regulated and has been self-reported and enacted without meeting the guidelines outlined by the CNA in 2009 (Kilpatrick et al., 2011). Donald et al. (2010) further suggest that lack of role clarity in the CNS and role confusion with the NP role could lead to decline of the CNS role.

The comparison between NP and CNS is similar to comparing apples and oranges. Both are fruit but they are two completely different entities. The focus for the NP is primary care, and although the CNS is an also an expert in their respective specialties, their domains of practice extend beyond primary care through nursing practice and further into systems and organizations that influence it (Bryant-Lukosius et al. 2010; CNA, 2009; Carter et al, 2010; Donald et al.,
NP and CNS are both vital roles that should never be put in an ‘either-or’ situation (Elsom, Happell, & Mainias, 2006; Hester & White, 1996).

Another recent issue that influences CNS practice is the utilization of CNSs in health care teams. In Canada, from 2006 to 2009, there was a reduction of self-reporting from 2963 to 2252 CNSs (Kilpatrick et al., 2011). DiCenso et al., (2010 A.) identify this as a result of fiscal constraints, which actually affect all nurses. McFadden and Miller (1994) identified administrative support as an essential organizational resource that facilitates the role of the CNS. Bamford and Gibson (2000) suggest that although CNSs are usually autonomous practitioners there should be guidance and organizational structures in place to achieve optimum efficacy. In this research study, I attempt to uncover individual perceptions of those structures.

The Magnet Certification Program, as deemed by the American Nurses Credentialing Center (ANCC), requires organizations to "develop, disseminate and acculturate evidence-based criteria that result in a positive work environment for nurses and, by extension, all employees,” and is often linked with having APNs, especially CNSs, in the organization (ANCC, 2014). A recent study conducted in a North Eastern Magnet Designated hospital identified a successful program initiated between the CNSs and nursing services (Muller et al., 2010). The establishment of this program was a direct result of the support of the organization. The onus is on the organization to support this and other nursing roles. Similarly, the CNA (2009) also strongly encourages organizations to support nursing leadership to identify administrative gaps while at the same time providing positive organizational influence that will sustain and flourish CNS practice. Kilpatrick et al., (2011) identifies that overall organizational structure is a key factor in facilitating the sustainment and efficacy of the role of the CNS. They further
recommend a need to discover and unpack the essential organizational influences that affect the CNS role (DiCenzo et al., 2010 A; Kilpatrick et al., 2012). Therefore, the rationale of this research study is to further consider those essential organizational influences that affect the CNS role in an organization.

1.4 Problem Statement

Nursing requires information that can be transformed from general knowledge to individual practice (Thorne, 2008 p. 25). Based on my own frame of reference as a nurse in Canada, my experience of working in the US, and my own research of academic and grey literature in this field of study, I suggest that CNSs are vital to cost-effective quality health care. They are change agents to advance nursing practice in the spheres of patients, nurses, and systems (CNA, 2009; Donald et al., 2014; Lyon, 1996; NACNS, 1998; Virani & Associates, 2012). Although there is a paucity of research on the role of the CNS in the Canadian health care context (Bryant-Lukosius et al, 2010), we do have global research to inform how the role of the CNS can influence the spheres of patients, nursing and nursing practice, and organizations/systems (Chien & Ip, 2000; Duffield, et al. 2009; French, B., 2005; NACNS, 1998; Virani & Associates, 2012). There is minimal information on how organizations/systems influence or shape the role of the CNS (Bryant & Lukosius, 2010 et al; Kilpatrick et al., 2011; Profetto-McGrath, Negrin, Hugo & Bulmer-Smith, 2007; Virani & Associates, 2012).

1.5 Purpose

The purpose of this research study is to explore how one organization in British Columbia (BC) is supporting the role of the CNS, by describing the influences shaping those processes and practices. This is significant because it will broaden our understanding of how the CNS role might best be supported.
1.6 Research Questions

The main two questions I asked are:

1. How is this organization supporting the role of the CNS?

2. What are the influences that shape the processes and practices of the CNS role?

To answer these questions, I employed a qualitative case study using an interpretive descriptive methodology. I have a specific practice question that I want to explore through the descriptions of the lived experiences of the participants in this organization (Thorne, 2009).

The interpretive description methodology engages the researcher to ground the discovery in the science of nursing, and immerse the research in a significant practice problem (Thorne, 2009). In doing so, this research is focused on an exploratory analysis of the influences of organizations on the CNS role, not a quest for truth (Sandelowski & Barroso, 2003). My purpose was to enlighten new meaning in a uniquely grounded understanding to further advance discovery (Malterud, 2012). The case study methodology permits the researcher to have a holistic view of relevant social phenomenon (Yin, 2009). Therefore, I used the qualitative interpretive descriptive methodology and a case study sample, that is, a large acute care urban hospital.

1.6. Assumptions

- The role of the CNS is a valuable and vital role in the context of the Canadian healthcare system.

- New discovery in meaning for CNS practice is needed to support the role of the CNS.

- The hospital where this study took place values the CNS role.
1.7 Conclusion

In this first chapter, I have provided an introduction and rationalization of the thesis, including a background to the questions posed, purpose of the thesis and an outline of the research question that is being explored. I have also outlined the assumptions that are foundational in this study. In Chapter Two, I present a literature review pertinent to the research being discovered in the discourse of organizational influences on CNS practice. In Chapter Three, I outline the methodology utilized in the research including: methodology, methods, ethics, and rigor. In Chapter Four I present the findings of the study and in Chapter Five I conclude with a discussion of the findings and appropriate implications and recommendations as they relate to this study.
Chapter 2: LITERATURE REVIEW

In Chapter Two, I will present a comprehensive literature review utilizing the principles of interpretive description. The purpose of this research study is to explore the influences of the organization on the CNS role. The focus of the literature review is to critique what information is available and how that knowledge came to be (Thorne, 2008). More specifically, in this chapter, I will present a critical review of the current literature as it relates to the body of knowledge on the CNS, change agents, influences on CNS practice, organizational influences, and finally organizational influences on the CNS role.

2.1 Search Engines

For this literature review I accessed many databases including: CINAHL, EBSCO, Pub Med, Google Scholar, and ERIC during the time frame from September 2012 to September of 2015. I also used information gathered from courses, textbooks and grey literature during my MSN program. This literature review was an iterative process. It was unclear at the beginning of the process where it would lead; as new meaning was brought forward I had to locate that back into the current knowledge (Thorne et al., 1997).

2.2 The CNS

The CNS is an expert in health care practice in the domains of patient care, nursing practice and organizations and systems, both locally and globally (Bryant-Lukosius et al. 2010; CNA, 2009; Fulton, 2014). Magnet hospitals in the United States demonstrate that the role of the CNS facilitates quality patient care through inter-professional collaboration and balance of understanding of organizational systems (Muller et al., 2010). A CNS is central to balancing the complex needs of the organization, the community and environment, how these needs directly affect the organization, and what factors will influence and sustain it (Bryant-Lukosius et al,
2015; DiCenso et al., 2010 A; Zuzelo, 2003). As a change agent the CNS is central to influencing systems-level policies that affect organizational outcomes (DiCenso et al., 2010; Jeffreys, 2005; Zuzelo, 2003). The CNA defines a CNS:

A CNS is a registered nurse who holds a *master’s or doctoral degree in nursing* and has *expertise in a clinical nursing specialty*. As an advanced nursing practice role within the scope of practice of a registered nurse, the CNS role reflects and demonstrates the characteristics and competencies of advanced nursing practice. CNSs bring value to clients and to the health-care team, with the potential to improve safety for patients, promote positive health outcomes and reduce costs (2009 p. 1).

The Registered Nurses Association of Ontario states, “The role of the CNS is based on autonomy of practice, in-depth theoretical nursing knowledge, clinical experience, and research application (para. 5). This appears to be the in line with NACNS’ definition that also requires a CNS to have a master’s degree or more in nursing, along with clinical expertise in a specialized area (NACNS, 1998). I continue to expand on the CNS competencies as defined by the CNA (2014). This is an important piece in having a unified vision for the CNS role.

**2.2.1 The competencies of CNS practice.**

The CNA (2012) has called for action to transform our current system to “better health, better care, better value, better nursing” for the rising needs of the marginalized, and complex inequities in health care (p.4). Subsequently the CNA, as noted earlier, started the process of *strengthening the role of CNS in Canada* to help meet those dynamic needs (Virani & Associates, 2012). The CNA defined a set of competencies that are central to the CNS role in clinical care, systems leadership, advancement of nursing practice, and research and evaluation.

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1 Italicized words are my emphasis and not in original document
2.2.1.1 Clinical practice.

Hurlmann, Hofer, and Hirter (2001) describe the CNS as being an “expert practitioner.” The competency of clinical care is defined by the CNA (2014) in the following,

The CNS is an independent practitioner within his or her role or identified scope of practice, which uses advanced clinical judgments to assess, intervene and evaluate the clients he or she serves. The CNS uses advanced and expert knowledge, skills and abilities to develop, coordinate and evaluate a collaborative plan of care for highly complex and unpredictable clinical situations with the focus on optimizing health and quality of life for the client. The CNS provides direct and indirect care on the basis of his or her specialty knowledge, practice context and specialty area (p.5).

Kilpatrick et al. (2013) report that the self reported CNSs spend only about 22% of their time engaging in clinical care. This was further clarified to be potentially the result of role confusion, no specified CNS roles, and an unsupportive organizational environment. Hamric et al. (2012) state that an important component of this competency is that a CNS has had time with the population of focus to build a credible expertise. It’s the utilization of this expertise, within focused spheres of influence in which the CNS can affect change in quality patient care, safety, and innovation, (Bryant Lukosius et al., 2010; Pintar, 2013; Scott, 1999).

2.2.1.2 Systemic leadership.

Finkelman (2013) discusses the unique ability of the CNS (related to clinical expertise, area of focus, and knowledge of the complex system) to be major leaders in the health care system. The competency of systems leader (CNA, 2014) is defined as follows:

The CNS is a nursing leader. Systems leadership includes the ability to manage change and influence clinical practice and political processes both within and across systems, including advocating for and promoting the importance of access to care and advanced nursing services, to clients, nurses, other health professionals, the public, legislators and policy-makers (p. 6).

Many authors cite this systems leadership aspect of the CNS role as the key differentiating factor between the CNS and NP roles; the CNS has a systems focus while the
majority of an NP's time is in direct care (DiCenso, 2008; DiCenso et al., 2010 A, 2010; Donald et al., 2010; Hamric et al., 2012). Canam (2005) speaks to the CNS’s understanding of the complex health care system to position them to lead change in the health care system and advance practice. In a study looking at CNS led transitional care there was an indication that the CNSs were potentially facilitating a process by which there was both quality improvement and patient satisfaction, as well as a decrease in expenditure to the overall system (Bryant-Lukosius, et al., 2015, Donald et al., 2014; Kilpatrick et al., 2014).

2.2.1.3 Advancing nursing practice.

“The CNS leads and fosters the professional development of RNs and nursing practice to maximize the scope and depth of practice leading to optimal client outcomes” (CNA, 2014 p. 7). As one of two advanced practice roles in Canada (CNA, 2009), the CNS plays a central role in advancing nursing and nursing practice in the health care system through mentorship, influence, consultation, and collaboration (Altmiller, 2011, Bryant-Lukosius et al., 2010, Hamric et al., 2012; Kleinpell, & Gawlinski, 2005; Macneil, 2011). Each of the above authors mentioned that activities involved in advancing nursing practice were grounded in research. Engaging nursing, and other inter collaborative team members is difficult when the CNS cannot function in their capacity, or is not visible (DiCenso et al., 2010). Part of the issue is that CNSs are often behind the scenes doing work not easily seen, or not sharing their accomplishments, therefore not getting the support, recognition, or credibility deserved (DiCenso et al., 2010 B; Kenny et al., 2013).
2.2.1.4 Evaluation and research.

One way that CNSs facilitate advancing nursing practice is by grounding clinical issues in research and evaluation (CNA, 2014, Darmondy, 2011, Hamric et al., 2012). The CNA defines the evaluation and research competency as follows:

As a knowledge translator, the CNS searches for, critiques, interprets, synthesizes, uses and disseminates evidence in clinical practice and for quality improvement and client safety initiatives. Development and evaluation of programs and services at various levels are often driving factors behind the CNS practice. The CNS acts either as an investigator or as a collaborator with other members of the health-care team or community to identify, conduct and support research that enhances or benefits nursing practice (CNA, 2008 p.8).

DiCenso et al. (2010 B) share that it is through the evaluation and research of a practice problem that systemic change can occur. Ways in which CNSs engage the teams in research are through mentorship, and consultation, as well as their own research (Bryant-Lukosius & DiCenso, 2004).

It is significant to note that each of these competencies is dependent on each other and not a linear progression to a goal. (CNA, 2014, Hamric et al., 2012) Each of these competencies, when enacted by the CNS, facilitates an avenue to change practice or define the CNS as a change agent (CNA, 2009; Gerrish et al., 2012; Hamric et al., 2012; Muxlow, DiCenso, and Bryant-Lukosius, 2010). This understanding of the CNS helps to further clarify the particular issue of this research study. It is with the discussion of the CNS that we explore the concepts of change.

2.3 Change Agent

In the previous section I described the competencies of the CNS in four contexts of involvement in Canada: clinical care, systems leader, advancing nursing practice and in research and evaluation. In this section, I will present the theory of change, and how this understanding may have influence on the CNS role.
2.3.1 **Theory of change.**

The discourse on change agents began in the 40’s and 50s in the field of behavioral science, and was initially described as an individual or system who helps to facilitate a planned change to improve the situation (Ottaway, 1983). Change theory is active in many fields of study, such as psychology, education, leadership and nursing (Carse, 2015; Gbadamosi et al., 2015; Grealish et al., 2015, Maximova et al., 2015, Pantic & Florian, 2015; Smith, 2013). Lewin (1947) expounded on the theory of change, postulating that an “individual’s present or desired being is in a state of balance between both directive and restraining forces” (p.144)

Critics of the theory speak to how this approach takes time, that it is too simplistic, and that it does not account for other forces (Burnes, 2004). However, the rationale for acknowledging this theory is related to how this simple explanation informs my research question, which investigates the organizational influences on the CNS role. My perception is that the current theory does not account for the influence that the present state has on restraining and driving forces. By tweaking this existing model to account for this reciprocating force, a new avenue of study appears which broadens further understanding of the discovery of the organizational influences on the CNS role in a system.

**Figure 2.1 –Lewin, K., (1947) Theory of Force Fields - Modified**

![Diagram](image)

By uncovering that there are forces or influences that affect CNS practice, I identify the pivotal question of interest in this study--What are those influences? In the next section, I
describe what I find in the current literature pertaining to the influences on CNS practice in Canada.

2.4 Influences on CNS Practice

There are a few significant and well-identified influences on CNS practice in Canada. They include the lack of a unified vision, the paucity of research on the CNS role’, the lack of a CNS credentialing mechanism or title protection, and limited access to CNS specific graduate programs (Brown, E., 2010; DiCenso & Bryant-Lukosius, 2010; Kilpatrick et. al, 2013).

2.4.1 Unified voice.

Since 2012, the CNA has been attempting to create a unified voice for the CNS role in Canada, as per the recommendations by the collective community of nurse researchers who took part in the Pan-Canadian Committee on CNS practice (DiCenso et al., 2010; Virani & Associates, 2012). A key area of focus for this committee was to clarify and strengthen the CNS voice in Canada. The CNA took the first step in publishing competencies for CNS practice specific for Canada (CNA, 2014). However, there is still a long way to go. Bryant-Lukosius et al., (2010) suggest that CNSs need to network, to build stronger relationships with key stakeholders, to return to the policy table to carve out their needs for sustainability, and to regain their voice and position as clinical leaders.

2.4.2 The paucity of research pertaining to CNSs

In a synthesis done of the literature in Canada between 2003-2008, Bryant-Lukosius et al. (2010) reported that there were 158 primary studies pertaining to advanced practice nursing in Canada. Of those, only 15 were CNS specific; the remaining 126 studies were related to NP practice. Currently the CNS body of research is growing (Bryant-Lukosius et al., 2015; Donald et al., 2015; Kilpatrick et al., 2014; Rourke, 2012); but without more research grounding CNS
practice in Canada, there is risk of the role becoming endangered or extinct, with little evidence to support the value which a CNS has to the overall healthcare team (DiCenso et al., 2010; Kilpatrick et al., 2013).

2.4.3 CNS specific graduate education.

The CNA (2009) expects individual universities to provide CNS-specific curricula that comply with the outlined competencies for advanced practice at the graduate level. The American Nurses Association (ANCC, 2008) requires this speciality training to be done by an accredited academic institute (ANCC, 2008), whereas in Canada there are no specific requirements for the specialization (CNA, 2009, Virani & Associates, 2012). Martin-Misener et al., (2010) report that 27 out of 31 universities contacted in Canada offer a CNS program but only one university offer a CNS program specifically titled as such. Most of the other universities offer an advanced practice stream.

In South Africa, it is recommended but not required that a CNS should have a master’s degree (South African Nurses Counsel, 2012); while the Royal College of Nurses (RCN) have graduated levels of CNS practice beginning at the undergraduate level (RCN, 2013). Tian et al., (2014) suggest that there are many countries globally that recognize the CNS role, but very few have standardized education or role specification.

In Canada, although the CNA defines the CNS role as being prepared with a master’s degree in nursing, there is no specification regulation of the CNS role to ensure that this is occurring (DiCenso et al., 2010A; Kilpatrick et al., 2011; Profetto-McGrath et al., 2010). Kaasalainen et al (2010) identified that historically there were very few masters-prepared nurses; the ones who were, often were relegated to administrative roles.
Martin-Misener et al., (2010) reflect that the rationale for not having specialty specific education is due to the perceived cost to the system that both the education and credentialing mechanisms would require, and that this cost could not be justified by such a small number of APNs. The study also alluded to the fact that some CNSs come out of the programs ill prepared with the APN curricula they were provided (2010). These issues are but a few of those influencing CNS practice with in Canada. Specifically, for this study, we will explore how the organizational role is influencing CNS practice.

2.5 Organizational Influence

The study of organizational culture is widely researched in business, psychology, anthropology, and other organizational sciences (Carosell, 1992; Duffield, & Lumby, 1994; Hamlin, 2005; Schein, 1984; Sleutel, 2003). Schein (2011) proposed the definition of organizational culture as a configuration of collective fundamental beliefs, values, and practices that the group has strategized and adopted to encompass “external adaptation and internal integration,” which is then taught to other individuals or groups in the organization. These may be policies, nuances, unwritten rules, guidelines and other organizational structures or factors that is at the core of the organization itself.

Ford, Fallot and Harris (2009) view organizational culture as what is essential to comprise a system. The culture ought to extend beyond tasks and assumptions into the understanding of people and with this information how to transform it into knowledge and action. However, this alone is not enough to fully understand the organizational influences (Sleutel, 2005).

Organizational climate refers to the “perceived, subjective effects of the formal system, the informal 'style' of the managers, and other important environmental factors on the attitudes,
beliefs, values and motivations of the people who work in a particular organization” (Litwin & Stringer, 1968, p. 5). Hanson and Wernerfelt (1989), hypothesize that the environmental or contextual factors that influence organizational climate are structures, systems, size and history. There is interplay between how an organizational culture is articulated and enacted, and the way an individual perceives the organizational climate. Roussel (2010) suggests that these two perspectives may not be different, but are actually intertwining and dynamic facets of the same phenomenon. Alternately they suggest that even though the social influence of an organization may hold core values, those same values could be perceived by the organization in a negative context. Therefore, an understanding of the factors that influence both the culture and climate of an organization is needed to fully understand the overall context (Rycroft-Malone, 2004).

Scott-Findlay and Estabrooks (2006) recommend that an understanding of organizational culture not only be located in organizational sciences but also in nursing. This opens the discovery to move past simple specifics in understanding organizations, towards an opportunity for richer discovery and influence, to the science of organizational culture as it is informed by nursing. McCormack et al. (2002) define 'context' as the environment in which practice occurs. They further explain that the consumerist nature of the current health care environment affects this context. The complexity lies in ensuring high quality patient centered care while attending to the complex influences of the sociopolitical environment that may constrain or enhance the context of the health care system (p.97). Meyer et al. (2012) discusses that a key issue of the current Canadian health care system is the balance of the local needs with the global priorities. Scott et al. (2006) link the relationship between healthcare transformations with organizational culture and urge further research is done to identify what constitutes positive culture. Carney (2006) perceives that in order to have a strong organizational culture there needs to be an
embodiment of professionalism and commitment by the organization in support of positive health outcomes. Scott et al. (2006) also noted that using a focused attempt to measure culture (with a single tool) might not fully uncover the culture or climate that is being enacted in the organization.

2.5.1 Alberta context tool (ACT).

The ACT was developed to further understand the contextual factors that influence the uptake of nursing research (Estabrooks et al., 2012). The Promoting Action on Research Implementation in Health Services (PARIHS) is a collaborative effort that since conception in 1989 has been propelled forward by Rycroft-Malone and her team to promote research implementation as a result of a three-tiered relationship between evidence, context and facilitation (Rycroft-Malone, 2004). Context is there defined as the “the environment or setting in which people receive healthcare services” (p. 299). Further unraveling of these contextual influences are the themes of leadership, culture and evaluation. Estabrooks et al. (2012) postulate that context is influenced not by three, but by ten concepts: “leadership, culture, evaluation (feedback processes), social capital, informal interactions, formal interactions, structural and electronic resources, organizational slack-staff, organizational slack-space, and organizational slack time” (p. 2). This definition helps define my understanding of how an organization influences CNS practice from the perspective of the science of nursing.

2.6 Organizational Influences on The CNS Role

Kilpatrick et al, (2012) have reported that in the comprehensive study of practice patterns carried out across Canada, the organization directly influences CNS practice. Earlier in the discussion, we noted that organizational structures are a necessity in advanced practice nursing
(Hamric et al., 2012). However, it is yet to be explored what factors influence CNSs and to what magnitude.

There is very little research on APN or CNS practice and organizational influence. In 2003, Cummings et al. put forth that the overall organization must work in collaborative orchestration for the APN role to be enacted to its full potential. Organizational culture is cited as being influential on nursing practice; however, how that is enacted is yet to be discovered (Gerrish et al., 2012; Kilpatrick et al., 2012; Scott-Findlay, 2006).

In a synthesis study DiCenso et al. (2008) recommend that the systems in health care need to provide leadership support, networking, implementation of role components, interpersonal relationships, and inter-professional collaboration in order for the CNS role to flourish. McFadden and Miller (1994) state that organizational support and resources are central to sustaining the CNS role. Aiken et al. (2002), found in a cross-sectional study of 12 countries that organizational factors, and retention of a nursing staff mix, leads to overall health system transformation. Muller, McCauley, Harrington, Jablonski, and Strauss (2011) explain that there is an iterative relationship between systemic and organizational success and the outcomes of the CNS.

Baker (1987) proposed a six-year plan for sustainable CNS practice in which each domain of CNS practice is further entrenched in the market-driven health care system. She further explains that it is the power of influence, with the knowledge, “flexibility and for-sightedness” of the CNS that can help transform this health care system (p. 122). The assumption is that over this timespan the system itself will retain the CNS role.

What are the factors that enhance the CNS role? Kilpatrick et al., (2012) found that CNSs reported that organizational influences could either hinder or support the role of the CNS
to evolve to its fullest potential. However, these influences or factors have yet to be fully uncovered (DiCenso et al., 2010, Gerrish et al., 2012).

Carter et al. (2013) identify knowledge gaps regarding CNS practice. They found that poor planning and development of the CNS role from the organization led to misunderstanding and enactment for the clinical nurse specialist. Carter et al. cited that cost containment and role confusion, with potential overlap with other roles, are major components of CNS sustainability. Bakker and Vincensi (1995) propose that creating an effective culture or climate is done through leadership and engagement of all team members (Sherman and Pross, 2010). What is missing is a clear understanding of the key factors that systems and the leadership use to create a positive culture for nursing (CNS) practice.

Virani & Associates, (2012) prepared a background report for a Pan-Canadian roundtable that took place in early 2013. They suggest strengthening the role of the CNS in Canada by guiding the creation of a national vision, which would lead to further development and sustainability of the role. This study also found that “championing” the role of the CNS by organizational systems and senior level leadership was central to fostering and proliferating the CNS role in Canada (Virani et al., 2012). Carter (2010) finds that the APN role to date has been supported through nursing leadership throughout the health care systems in Canada. She outlines that it takes systemic planning for advance practice roles. This entails having practice guidelines that help develop the role within organization which includes; the means to engage stakeholders, and secure sustainable funding, resources and processes, while clearly defining the scope of the CNS role.

To my knowledge in Canada, there has been no study designed to uncover what the specific influences are on CNS practice. In this study, I explore some of the perceived influences
on the CNS role by the organization, to provide a broader understanding for support of clinical nurse specialists.

2.7 Conclusion

From an interpretive descriptive standpoint, the literature review has served its purpose when the line of logic lays out the foundational basis for the research questions-- i.e. what else do we need to know? Where do we find this information? How is this relevant? - (Thorne, 2008, p. 64). The CNS role is an essential role in the health care system (Bonsall & Cheater, 2008; Bryant-Lukosius et al., 2010; Canam, 2005 CNA, 2009; Darmody, 2005). The CNA has called for this role to be strengthened and utilized in the Canadian health care system (CNA, 2013, Virani & Associates, 2012). The literature identifies that there are many barriers to the uptake and advancement including organizational influences on the CNS role (Bryant-Lukosius, et al., 2010 A, B; Kilpatrick et al., 2013; Virani & Associates, 2012). However, a clear understanding of what those organizational influences are is yet to be discovered (Bousfield, 1996; Bryant-Lukosius, et al., 2010; Kilpatrick et al., 2013). The key influences identified by ACT (Estabrooks et al., 2012) described responsibilities for nursing leadership in APN role integration (Carter et al., 2010). Identification of factors that influence the APN role (DiCenso et al., 2010) may help frame specific areas of influence on the CNS role. In Chapter Three, I outline the methodology used to design and implement this study.
Chapter 3: METHODOLOGY AND METHODS

For this thesis, I used an interpretive descriptive methodology and case study approach to conduct an exploration of organizational influences on the role of the CNS. In this chapter, I provide justification for the methodology, as well as the theoretical underpinnings that frame the context of the research. I outline the methodology including selection criteria, data collection, analysis, and the dissemination of findings. I also briefly describe issues pertaining to research ethics and research rigor.

3.1 Methodological Framework

In this section I discuss the methodology used in this research study and provide a framework and rationale for interpretive description and case study approach.

3.1.1 Interpretive description.

Nurses inherently want information that is more than a surface portrayal of the obvious. They want to critically uncover how this knowledge can illuminate meaning into practical implications that affect overall health and the interconnected system associated with it (Brown, 2000; Thorne et al., 2004). Thorne (2008) articulates that interpretive description is a “conceptual maneuver whereby solid and substantive logic derived from the disciplinary orientation justifies the application of specific techniques and procedures that is out of the conventional context” (p. 35). Although interpretive description draws on many of the pillars of different qualitative research, it provides a logical structure and a philosophical rational vital to critical qualitative inquiry. Interpretive description emerged when it was discovered that some nursing research does not fit into a particular methodology (p. 34). The philosophical underpinnings of interpretive description are:

- Many intersecting subjective influences shape reality and ought to be studied
holistically.

- Individuals influence and are influenced by each other – We are connected.
- Theory emerges or is firmly set in the data – One theory cannot explain everything (Thorne et al, 2004)

An interpretive descriptive method of inquiry provides a theoretical lens for understanding the “empirical knowledge of a human phenomenon” when a deeper meaning to the context is required (Thorne, 2008 pg. 38). The interpretive descriptive methodology was developed to find the link between knowledge and praxis (Hunt, 2009).

In the theoretical scaffolding of an interpretive descriptive study, I situated this inquiry within critical social theory as an advanced practice mental health community nurse in Canada. Critical social theory aligns with the interpretive description methodology to transform “knowledge, theory and praxis” (Browne, 2000). Specifically, for this study, I am interested in the dominating influences on this particular organization and the consequent and intersecting influences the organization and healthcare system have on CNS practice enactment (Browne, 2000).

3.1.2 Case study.

A case study informs discovery on why something develops in a particular setting (Polit & Beck, 2012 p. 503). The case study method facilitates an avenue by which the researcher can examine any phenomenon in its own context when there are blurred lines between multiple realities (Yin, 2003). Although there are many critiques of case studies, e.g., lack of rigor, inadequate evidence for scientific generalizability, and length of time (2003), within the context of interpretive description, a case study is grounded in systemic discovery to uncover meaning to enhance knowledge, not discover truth (Sandelowski & Barroso, 2003; Thorne, 2008). A case
study aligns with the philosophical underpinning of interpretive description; there are multiple realities, interconnections, and theories that are grounded in the data (Thorne et al., 2004; Yin, 2003). The purpose of this research study is to gain an understanding of the organizational influences that shape the CNS role. I choose to use a case study approach based on the utilization of CNSs across a number of programs in the particular hospital setting. The case of focus in this thesis is a Canadian large urban hospital. In this particular study, the information gathered could inform future research and understanding.

3.2 Methods

In this section, I discuss the methods I utilized to carry out this research.

3.2.1 Participant description.

I collected demographic data (Appendix E) from individuals working in the organization that forms the focus of this research at the start of each interview. The sample population was divided into two groups: the primary participants in the 1:1 individual semi-structured interviews (purposive sample) and the participants in a focus group (theoretical sample). The primary participant sample population included those individuals in senior management or leadership roles (n= 4 participants) who directly support the role of the CNS in the organization, as well as CNSs themselves (n= 5 participants). Eight of the nine primary participants had a nursing background, and seven of the participants had masters in nursing degree. One participant had doctoral degrees and four participants had masters' degrees in fields ranging from administration to health science. The senior leader participants have been with the organization from a minimum of a year and a half to over twenty-six years. The CNSs identified in the study ranged from being in their role from a year and a half to over twenty-six years. Seven participants
identified that this organization has been the place that they have spent the majority of their career.

The focus group consisted of individuals (n=3) who are interdisciplinary team members in the organization (e.g., nurses, allied health professionals, human resource personnel) who affect or are impacted by the CNS role. This small group all had nursing backgrounds; two of these participants have degrees at a master's level, and the other participant is a diploma-trained health professional. The participants have been in their current roles ranging from 5-12 years. The participants from both groups represented senior executive leadership, and five other programs and sub-specialties in the organization.

3.2.2 Recruitment.

I recruited the primary participants through purposive sampling under the guidance of a neutral third party. The purpose of the study was explained in a letter of intent for primary participants (Appendix A) with researcher’s contact information, allowing those interested in participating to directly contact me (the researcher) to express interest and schedule a time. This method was selected so that I was able to remain at arms length from the potential participants (Polit & Beck, 2012).

For the focus group, I used theoretical sampling, which meant that the participants were selected based on how they could further inform or clarify patterns that emerged in the primary participant interviews (Polit & Beck, 2012 p. 518, Thorne, 2008). These participants were recruited based on their influence by, or as a result of, CNS practice. This allowed for me (the researcher) to investigate the intersecting and iterative data and patterns as they emerged through the data I collected from the primary participant interviews (Polit & Beck, 2012; Thorne, 2008). The purpose of the study was explained in a letter of intent for focus group participants.
(Appendix B) with contact information allowing those interested in participating directly to contact me.

3.2.2.1 Inclusion criteria.

- Primary Participants included were senior leadership, management and CNSs who directly influence or have had impact on the CNS role (including those who hire, conduct fiscal considerations, policy, and other infrastructures).
- Focus group participants were interdisciplinary team members who spoke to the organizational influences that shape the role of the CNS. The inclusion of a variety of perspectives enhanced and provided different layers of meaning from the data I had already collected.
- Participants all had a minimum of one year of service with the organization to allow for a basic understanding of the organization. Many participants had spent their whole career within the organization.
- English speaking participants were included only due to the time constraints of the study.

3.2.2.2 Exclusion criteria

Those who did not meet the inclusion criteria were excluded.

3.2.3 Data collection

Each interview took place in a quiet/private setting within the main campus of the organization. The interviews ranged from 45-90 minutes in length (As noted on the Field Notes form (Appendix G). Based on the literature review I conducted, I was equipped with a basic understanding of what CNSs are currently being influenced by in the health care context, thus I took extensive notes on my own bias, self-reflection and other further queries for follow up (Appendix G). This was an iterative process, and the analysis I discovered in one interview
informed subsequent interviews as the primary participant interviews potentially provide a
detailed account of insider information (Lambert & Loiselle, 2007).

In the focus groups, there was interactive engagement that enhanced individuals’ similarity
or contradiction regarding the influences on the CNS role in this organization (2007). I
confirmed that the interview alone was dependent on the social context or the influences of that
particular context, and a focus group was influenced by the result of the social dynamic of the
group in study (Thorne, 2008). Together, the interview and focus group accentuated the findings
found in each mode of discovery and subsequently I was able to discover deeper meaning that
was useful in further analysis (2007).

3.2.3.1 Primary participant interviews.

Once potential participants contacted me either via email or phone, I set up a time and
place for the interview that was convenient and safe for both the participant and myself. The
primary participant interviews were conducted in the natural environment of the participants; this
included a private or shared office space, a conference room, and other areas of the hospital in
which the interviewee felt the most comfortable.

I began each session by going over the consent form (Appendix C) and I obtained
informed consent. After the consent forms had been completed, the participants were asked to
complete a demographic survey, (Appendix E) which included age, profession, educational
background, and their tenure within the organization.

I had a list of prompt questions (Appendix G) that I used to begin the interview; however,
the participants were encouraged to speak freely in a discussion focused on the organizational
3.2.3.2 Focus group.

The focus group included three interdisciplinary team members. The purpose of the focus group was to discover how other members of the healthcare team perceive organizational influence. In a study completed on impact of the CNS role in China (Chien & Ip, 2001), the variety of discourse from the interdisciplinary members uncovered layers of meaning that would not have been known by only studying one group. I chose to limit the group to individuals who were with organization for at least one-year, to ensure that the team members had a solid understanding of both the organization and the role of the CNS within it. I began the focus group session by going over the consent form with each participant and gaining informed consent (Appendix D). After the consent forms were completed, a demographic form (Appendix E) was given to each participant to collect data that included age, profession, educational background, and their tenure within the organization.

The focus group was conducted in a setting that offered comfort and convenience for the members in the study. The focus group was conducted during a time in which the three participants could engage in the process with minimum disruption to shift responsibilities or everyday life. Each of the participants was notified that they could leave the study at any time if they decided they did not want to participate. They all stayed the entire time. The questions for the focus group focused on the main patterns that were a result of the primary participant interviews (Thorne, 2008). Minimally intrusive prompts were utilized for further explanations and clarification of the discussions. I was mindful of the dynamics of the group as well as the length of time for the session (see Appendix F for potential examples of the questions).

A research assistant (a non-participating undergraduate) was present. She ran the audio recording equipment and took field-notes. These field notes included the body language, facial
expression, and any other notes about environmental influences that impacted the focus group session i.e. loud noises, temperature, interruptions etc. These notes were important to help uncover meaning beyond what is being said (Thorne, 2008). The recruitment of the research assistant was done through word of mouth in the nursing department at Trinity Western University and the University of British Columbia (UBC) School of Nursing. Education was provided to the research assistant in terms of what notes to take and how to operate the equipment. A confidentiality form was signed to protect the privacy of the participants and the study integrity.

3.2.3.3  **Data collected in both primary participant interviews and focus groups.**

The data collection was digitally recorded and transcribed by me to ensure that the transcription is an accurate account of what was said. There were recording devices present to record the interviews and focus groups. I manually transcribed the data (over a period of four months) and locked the recordings in data storage to protect them, as well as to have them accessible if needed in the future.

3.2.4  **Data analysis.**

As the process of analysis is iterative and it started upon entry into the field, I tracked my analytic constructions (I was being open about the rationale for my decisions) in field note form both before and after each session (Appendix G - notes about body language, artifacts, and other environmental factors). This included tracking reflections (critical self-reflective notes about the overall process and steps) to outline the process of analysis (Sandelowski, 2002; Thorne, 2008). Analysis of the notes and transcriptions progressed in a three-step continuous process with multiple points of feedback and analysis. I conducted a primary analysis of the data. Further analysis of the transcripts continued upon advisement from the research supervisor to support
me, the novice researcher, and I used NVIVO to organize and identify pieces and patterns (Srivastava & Hopwood, 2009; Thorne, 2000; Thorne, 2008). I was continually immersed in the data for over six months in an effort to fully understand the data (p. 149).

From this point, I used a method of categorizing, versus coding, to identify themes and ideas (Thorne, 2008). Coding is giving the piece of data a label to distinguish it from other pieces of data (2008). Many issues arose from the multiple meanings (data meaning more than one thing); and I often was caught in premature coding (coding too early, therefore not really representing what it should) (2008). I used an alternate method to coding; I kept meticulous marginal notes, color-coding like ideas (2008), and finally noting quotes that appear early on that may be pivotal to the research (2008). This allowed me time to organize patterns versus labeling them into rigid structures (2008). I did this in order to shift focus from fine-tuned interpretation to a broad categorical inductive methodology by allowing for extensive categorization and examining known interactions from all angles (2008). The bound notes of my analyses are kept sealed in a locked storage device.

As patterns were identified through the discovery, I noticed that links to relationships began to be uncovered (Thorne, 2008). In keeping in line with the philosophical underpinnings of interpretive description, data is not just a set of pieces but belong to a complex and interactive whole (2008). This meant I could not just take words or ideas without questioning how they fit in the overall picture. Thorne (2008) directs the researcher to move beyond the obvious, and to employ skills to critically reflect on the patterns and the relationship (2008).

I situated this study as a thematic survey as categorized by the taxonomy of Sandelowski & Barroso (2003). By attempting to place the study as a thematic survey I moved farther from to farther in the data by transforming the description of individuals and collective experiences
(2003). As a novice researcher at a graduate level, this level of analysis is practical, given the constraints of experience and time.

3.2.5 **Ethical considerations.**

The privacy of the participants and the institution involved, perceptions of coercion, and insertion of self into the study are the main ethical concerns of this research study, as there were no patient interactions involved.

As per the requirements of the University of British Columbia (UBC) School of Nursing, I obtained ethical approval through the Behavioral Research Ethics Board (BREB). Upon approval from BREB, and confirmation of site approval, letters of intent were mailed via the recruiter to various employees who fit the criteria. At the beginning of each interview, prior to primary interviews and focus groups, the participants included in the study were given a consent form (Appendix C and D). The consent forms outlined the nature of the study, the purpose of the research and a statement that all information obtained would be for the study purpose exclusively (Polit & Beck, 2012).

The personal information (consent forms and demographic data) of the participants has been kept separate from the transcripts of the interviews and focus groups. All data, along with the field notes are being stored in a secure storage device. All transcripts and field notes have been stripped of personal identifiers and confidentiality will be maintained. This is done to ensure appropriate measures are taken to protect the identity of the participants and the health care facility studied (Polit & Beck, 2012).

In the previous methodology section, a process of location of self in the study was identified. This is similar to reflexivity, which is the process of understanding how the researcher is situated and affects the research process (Malterud, 2001; Polit & Beck, 2012; Thorne, 2008).
As a researcher, I bring with me my theoretical allegiances, my disciplinary context as well as my lived experience, through tracking constructions and reflections. By locating myself early in the study I hoped to avoid the hazards of over insertion of self into the study (2008). Notes on the process of selection, participant understanding about the purpose of the study, and recruitment practice have been kept and analyzed. There were no monetary gifts given to the participants in the interviews; however, participants involved in the focus group were compensated with coffee service and snacks to minimize disruption of their scheduled worked time.

3.2.6 Challenges.

In a study of this design several potential difficulties could occur. The following sections, as discussed by Thorne (2008), outline the potential issues and provide planned solutions around moral defensibility, going native, misinterpreting the data, and recruitment and time constraints.

3.2.6.1 Moral defensibility.

Being trustworthy and perceived as credible is an essential foundation for qualitative research (Thorne, 2008). To avoid being perceived as coercive in recruitment and data collection, I used a neutral internal liaison. The liaison provided neutral access into the organization without demanding engagement. I used two separate consent forms (see Appendix C and D) for the primary participants and for the focus group. I ensured the protection of privacy and confidentiality by removing any of the identifying features associated with the information given and I will keep this information in a secure storage apparatus. Now that the study is finished I will present the findings to the participants in a manner that is readily accessible to them such as a written report or email dissemination.
3.2.6.2 Going native.

In qualitative research, the researcher becomes the vehicle through which data is discovered (Polit & Beck, 2012). Becoming embedded in the environment and taking on the culture of the organization or forming biases may occur, and therefore it is difficult to remain neutral and unobtrusive in the environment of study (Thorne, 2008). In order to avoid this, I practiced comprehensive, critical self-reflections, tracking my constructions of the analysis, and using secondary analysis techniques. I wanted to remain neutral in the analysis as well as in data collection. This was vital as I am a nurse and have been an administrator for the past six years. My own preconceived ideas of organizational infrastructure informed my thinking and guided how I navigated the research from start to finish. By openly tracking my reflections and constructions, I was able to be critical about why and how I came to these constructions or analyses.

3.2.6.3 Misinterpreting the data.

Potential over-analysis or premature closure due to early identification or saturation may occur (Thorne, 2008). Thorne further explains that we never really know all there is about a subject; therefore, there is always something to learn (2008). Saturation is an arguable determination for the endpoint of data analysis. She advises the researcher to be aware of the boundaries and limits of time and other environmental constraints and the realities of life in regards to the endpoint determination. In order to heed her advice, after my first initial analysis of the individual interview transcripts, and accompanying data, I attempted to return to the data sources to expand on the associations (2008).

I reviewed the individual audio files and transcripts, and then sent them to each primary participant via an encrypted email, in which the password needed to access the file was sent via
an alternate email. Further communication between each participant and myself was handled through email, to further expand on their thoughts or allow me to clarify the data with them. Only one participant sent back an edited transcript, and three other participants responded to me via email that the transcripts were sufficient. The remaining participants did not acknowledge the transcripts at all, despite multiple attempts to contact them via email for feedback. I sent my initial data analysis and subsequent analysis via encrypted email to my supervisor to help with the process.

Finally, I was very critical examining the data I collected through the lens of confirming my biases. This relates back to what is known in the science of CNS practice: testing relationships, which involves moving back and forth between pieces and relationships, the data and the collective whole, and finally utilizing outliers to determine what the differences really say, all the while critiquing each step (Thorne, 2008, pp. 158-162). Due to my inexperience in qualitative research, this took an extremely long time.

3.2.7 Limitations.

First, in alignment with Thorne (2008), there is recognition that the there is no absolute truth that is found in this discovery. However, the analysis is utilized to support what is already known, or perhaps uncover new meaning that can be further analyzed in future studies.

Second, each organization is unique to the system in which it is embedded (Scott-Findlay & Estabrooks, 2006). This may potentially limit the discovery of meaning to this particular organization because it may not align with other healthcare systems with different values, beliefs and assumptions. However, this case study did raise valuable observations that merit further research on a bigger scale within a different organization.
Also, many qualitative studies occur over a significant period of time to uncover a holistic picture of the organization. The length of time in which this study confines itself to is a cross-section of time in which multiple, complex, socio-economic, political and moral factors influence the current culture. These influences will fluctuate over time and may or may not be relevant in a different context.

Finally, as stated earlier, the CNS role is influential and influenced by the spheres of patient outcomes, nursing and organizations and systems (Zuzelo, 2003). In this study I focused on the organizational influences in relation to the CNS role as perceived by the nurses and their colleagues.

3.3 Conclusion

In this chapter, I have provided justification for the methodology for this exploration into organizational influences on the role of the CNS. I have outlined the methodology including selection criteria, data collection, analysis, and the dissemination of findings. Finally, I briefly referred to potential issues regarding the ethics and rigor of this study. In Chapter Four, I outline the findings of this study and in Chapter Five I discuss the findings in the context of CNS practice and future research in Canada.
Chapter 4: FINDINGS

The term 'organization' has been defined as a setting in which practice or change occurs (Kitson et al., 1998). How an organization influences the stakeholders within their establishment can be examined through four complex and intersecting elements: leadership, culture, evaluation and other social and environmental influences (Estabrooks et al., 2009; Kitson et al., 1998). As I discussed in Chapter Two, change theory categorizes these influences to be constraining or driving on the present state; however, I added that the present state also affects these constraining and driving influences (Lewin, 1945). In this chapter, I present three intersecting major themes uncovered through the process of analyzing the interpretations of organizational influences on the CNS role as put forward by CNSs and other intra-collaborative members of the health care team located in a Canadian urban acute care setting. These themes are identified as: The transformative practice of CNSs; Intersecting tensions influencing support of the CNS Role; and Intentional embedded organizational infrastructure and support. These three major themes were uncovered through an interpretive descriptive analysis in a specific case study setting. A thematic tree (Appendix H) outlines the themes and associated subthemes.

The three major themes and subsequent subthemes uncovered are based on both the shared and individual realities of the nine primary participants, as well as the three participants from one focus group. The originality and commonality of the participant’s perspectives on the influences of an organization on the CNS role are based on their own personal and professional experiences, within and outside of the organization.

4.1 The Transformative Practice of CNSs

Throughout the discovery process, all twelve participants (nine primary participants and three focus group participants) described awareness that CNSs are essential stakeholders in the
organization who have a significant influence on the CNS role from an organizational perspective. Two subthemes emerged from this theme regarding the CNS as a significant organizational influence on their own role: ‘the vision of the CNS role’ and ‘the uniqueness of the individuals in the role.’

4.1.1 The Vision of the CNS role.

A common thread was found across the participant’s data: The ability to have a clear vision about the CNS role, and then to enact the role in an adaptive and encompassing way, to ensure quality patient care delivery, advancement in nursing practice, and enhancement of the overall health organization or system. In addition, CNSs (individually and collectively) serve as a significant influence on the development of the role in the organization. Recurring descriptions emerged early in the accounts of each individual CNS as they described their role: enhancing individual programs through innovation (e.g., PI)\(^2\), supporting the health care team through research and evaluation (e.g., PB) and providing quality patient care in new and creative means (e.g., PC). One participant provides a description of the role in the following:

I see the CNS role as being an expert; I see them continuing to contribute to the literature and the care with research. I see the CNS as being a leader in the organization or being a leader specifically to a program in his or her own specialty and the entire health care team. The CNS contributes to that team by providing enhanced consultation, enhanced teaching and learning, and enhanced research around their specialty. I also see them playing a critical role with the patient and family by sharing expertise with the patient and family when needed. (PF)

Described here is an already known understanding and articulation of both the spheres of influence around the CNS role, identified as patients, nurses, and systems (Fulton, 2004), as well as the domains of practice of education, research, leadership, consultation, and expert clinician (CNA, 2009). Other participants validated this description.

\(^2\) PA – PL designates the code for the participant interview in which this theme was apparent.
Another participant explains:

I see the CNS role as someone who is able to work across the organization, to provide and serve as a resource to direct care staff with respect to staying current with practice by bringing forward new knowledge into every day practice, while ensuring quality of care for the patients who we serve. Also they are unencumbered by operational responsibilities, so they can have a bit more freedom to work in a broader spectrum across the organization. (PC)

In this perceived vision shared by the participant, we see that the CNS works across the spectrum of patients, nurses and systems with a focus on research, education, leadership, consultation, but grounded in expert practice. What this participant notes are the division of the role from operational responsibilities suggesting the focus of the CNS role is grounded in practice but focused on the system. Another participant describes the learning as a consequence of the unending reach of the CNS role in the following:

I thought when I was a new CNS, I was just supporting the nursing practice, but over the time I realize that I’m not just supporting the nurses; I’m supporting the whole team, the system, the nurses, allied health, the physician, and patients -not just the nurses. (PL)

At least seven participants agreed that the role of CNS encompasses all of the listed competencies (CNA, 2009) in some fashion: “They're all in there. Sometimes I am more heavily focused in one domain than the other…it’s not linear it’s more circular” (PA) and “I spend little bits of time in all aspects of the domains” (PB). A few of the participants did note a lack of involvement in some aspects of the role, e.g., formal research (PC, PH, PL) and actual direct clinical care (PB). Notwithstanding there was a recognition of the competencies described by many participants.

One participant provides this perception of the common traits many CNSs share:

Independent, self-motivated, driven, expert, or capacity to build their own expertise, doesn’t take no for an answer, clear about the goals and vision, clear about the scope of their work, teacher, mentor, thoughtful, and you know we look for fit –someone who matches the values of the organization, who’s going to help ensure we live the mission,
who’s going to help the program achieve its goals, who’s going to bring us to a different level and which ultimately will then to benefit the patients and families (PI)

It could be argued that these are traits commensurate with being a good leader. Other participants also spoke to this with statements like “they are the captains of the ship” (PF) and “expert leader” (PA). In a similar vein, a few participants referred to the CNS role as a leader who facilitates in the system, for example, “I’m like a continuous thread” (PA) or “I am connector or facilitator” (PD).

The salient impression that emerged in the interviews was the collective central vision and articulation of CNSs as change agents who facilitate and elevate nursing practice (PA-PL). Each participant shared specific examples to describe the how of practice which revealed the following sub-subthemes and more in depth descriptions of CNS practice within the organization; these appear to align with the CNA (2014) core competencies of specific contexts, namely: clinical practice, research and evaluation, advancing nursing practice and systemic leadership. Discussions of data findings regarding those contexts are described in the following sections.

4.1.1.1 Clinical practice.

Many participants described the CNS as being the clinical expert; the clinical voice that is fundamental in supporting the team in every aspect of the decision making process regarding clinical practice (PA, PB, PC, PJ). This clinical expert piece was what many participants expected from the CNS. When describing who the CNS is in terms of the clinical care team, PI describes the following.

Clearly with the exception of maybe a couple of physicians, they are the expert in the area, and have helped us move some system level changes that would not have happened otherwise without them.
The recognition that CNSs are “experts” was noted throughout the analysis. For examples, participants stated:

CNS are experienced clinicians, with a wealth of knowledge that contribute to the organization, who contribute to practice, and who contribute most importantly to patients and families. (PF)

and,

Typically, I am responsible for the overall clinical practice, for all aspects of this specific program, and things related to that, and for all the patients that are encompassed with in this organization. (PG)

A few participants agreed that although they no longer do traditional case management there is a strong clinical practice component (e.g., PA), i.e., clinical practice was not limited to the more traditional association with direct clinical care and case management by the CNS. Many participants describe the work done by the CNS as being informed by or influenced by clinical issues. (PA, PB, PD, PG, PH, PL). Participant H describes one specific example that facilitated the amendment of their current understanding of clinical practice in the following interview passage:

So as a result of a particular adverse event, there was a substantial decline in the overall health of an individual, and what was clear was that the nurses needed better decision support. So, we have been focusing on how to support this particular population of patients and identify how the healthcare team (nurses especially) can provide safer quality care. I found practice guidelines on these types of events from other countries that are fairly up-to-date. So we are going to incorporate that in our guidelines and we are building that in. (PH)

In this particular scenario, the CNS was able to engage with evidence-informed approaches and problem-solve and facilitate change in collaboration with the health care team. This CNS was very involved with clinical practice without providing ‘hands on’ care; however, clinical practice was impacted positively through the involvement of the CNS and an evidence-informed approach.
4.1.1.2 Research and evaluation.

As described by many participants the work done is circular and intersecting and most often is informed by clinical issues and associated research and evaluation (PA, PB, PD, PF). Being current with the literature, and making contributions to the body of nursing science as well as collaborative practice, are believed to be fundamental expectations of the CNS role (PG); as one participant shares, “I mean my role as a CNS, right in the job description, reviewing and incorporating information and data from literature, from research etc., and weighing out what’s out there, making decisions” (PF). Similarly, another participant speaks to evidence-informed practice in the following:

The CNS role, in my opinion, brings change to practice, and that change is based on evidence and the CNS looks at it from the planning to the sustainability. So, the CNS is for quality improvement, using the project approach all the way from describing to sustaining it. It is a data driven job, outcomes, that’s what a CNS’s role is all about. (PL)

A specific practical example regarding how evaluation and research may apply is described in the following interview excerpt:

And right about the time I came into the role, we began the process of an extensive evaluation of everything that had already occurred in the project. And what we found was quite disappointing in terms of the uptake and distribution of the tools and education documents for this particular population. And the readmission rates for these patients in a critical time frame were not stellar, so there were some disappointing statistics and indicators. So we looked at that, and we tried to determine why that was so, what were the barriers preventing these things from happening, and we came up with was quite a list of barriers. And so my role became trying to determine how we could address those barriers. (PD)

Here the complexity of the CNS role was elucidated. Through the use of population statistics, it was determined that readmission rates required attention; this prompted an examination of the barriers impacting readmission rates and the development of strategies to address them – work initiated by the CNS who must address clinical needs while at the same time keeping in mind overall systemic functioning.
The use and design of research as a vision for CNS practice is described further in the following by a participant who is not a CNS:

When we have to run a bio, we have to ask the CNS. I mean just everything about the big picture, or practice issues, even from a physician’s point of view, we rely on the CNS. I need to know, what the CNS thinks about that, you know what [the] literature says? I think on the whole, people, particularly in leadership, are getting much more reliant on what the literature says, but they may not have the ability to actually know what it says or how to interpret it. But the CNS does and the CNSs are looking at that piece constantly. (PJ)

As noted by another participant in the following, the CNS role also needs to support others to ensure research is conducted and taken up using the highest standards:

You know, when they make decisions saying there’s research – there’s lots of evidence on it, and I look at the evidence – I may say this is not really good enough evidence. That research with one case study is not enough; we need to look for an RCT, and other evidence. So I did some teaching in how to really do the research and what you need to produce evidence based, or evidence informed document or protocol or practice guideline (PG).

Not only is the CNS grounded in research to inform their own practice, they also educate and elevate the team to push for a systematic utilization of the evidence, and as a consequence advance practice for the organization as a whole.

It’s this very reliance on and respect for CNS expertise and knowledge that assists in cementing the CNS role in the organization. Further, as another participant notes, “CNSs have been very supportive of submitting abstracts to conferences, and publishing, and really promoting continuing education at the bedside, they've really created a culture in the organization that is research driven.” (PE). Similarly, another participant goes on to say, “The culture of inquiry within the organization has been built by the Advanced Practice Nurse, and this elevates the practice of all of nursing around them.” (PI). The creation of a culture of inquiry is vital to the advancement of practice within nursing as well as to health care provision more broadly. As another participant describes, “The CNS guides the direction as to where we want to
go with different programs through research and evaluation.” (PJ). Advancing practice through research and evaluation further supports that the competencies outlined by the CNA (2014) are complementary, and that this piece of the CNS vision is a central element to embedding the CNS role in the organization and to the advancement of nursing practice.

4.1.1.3 Advancement of practice.

The centrality of the CNS role in the advancement of nursing practice and clinical practice in the organization was a shared perspective of all the participants (PA-PL). All twelve participants reflected on how the CNS elevates both nursing practice and health care quality and safety within the organization and throughout the province. Senior leadership participants voiced this in the following words:

If you want to advance the program in all directions and if you want a program to grow and to be innovative, CNSs are a necessary part of that (PA).

and

CNSs have been very supportive in really promoting continuing education at the bedside. They have really championed nurses going back and getting their Masters, presenting at conferences, and the other research based initiatives (PE).

Another inter-collaborative participant notes, “Everywhere that we have placed an Advanced Practice Nurse within the organization, it has elevated the practice all of nursing within that area and beyond…the impact is quite profound…the staff start asking questions as to why are we doing this –this way?” (PI) Participant F further supports this view in the following, “If the health care team members want to do research, they often closely align themselves with the CNSs and this shows how CNSs build that capacity in the team.” There is a general sense that there is a definitive enrichment through research and innovation that occurs when the CNSs are a key figure within the health care team.

In the same vein, a participant note that the attention to research and evidence-informed
approaches is more than just a byproduct of having a CNS in the organization:

That's your job! You get out there, you're responsible for Advancing Practice, you’re responsible for make sure things are evidence-based, you’re responsible for people meeting standards, you're responsible for development of education, of all those things, that's just part of the expectations. (PG)

As this participant identifies, a research and evidence-informed approach to practice is an intentional expectation of the CNS role. Participant G further reveals how this occurs in the following interview selection:

A big part of my job is doing that mentorship, to sort of bring staff along, to confidence build. They might have the knowledge but without the application of that knowledge. And that's why it’s great at the bedside, I go in and I say now “what did we talk about yesterday, remember we said…” and then it sort of gets them. We know how people learn, they have those a-ha things and they always remember those a-ha things. So, I get a lot of people come to me and say, “I had another patient like you and I saw that day, and you know what -I knew exactly what to do because of that… that’s all part of building that capacity.

Participant K endorses this notion of mentorship by sharing that by “challenging norms, and looking beyond the standard,” the CNS successfully advances practices. Participant D goes on to describe the way in which CNSs work together systematically to achieve this goal in the following, “The CNSs meet quarterly and that's where we make decisions about any strategies we’re going to advance or any gaps we’ve identified and how to manage those issues.” This leadership is informed by not the just the organizational needs but the overall context of health care. Another said, “I kind of keep a scan out there, about what’s going on in the health care context. We have external pressures and internal pressures to change practice” (PH).

Participant K (an inter-collaborative participant) further supports this notion in the following:

I think of a particular practice issue and I remember the CNS early on saying, “We need to start the thinking about how to do this different.” I thought this CNS is finally losing their mind. This doesn’t seem right. How can the literature be supporting this radical shift? This doesn’t make sense. Then, 6 months - maybe a year, later it’s like, “Oh, yeah, the
CNS was right.” It’s almost like the CNSs are getting the stuff way before anyone else. As a result, this particular practice has really changed a lot in lots of places.

Here the CNS in the program seems to have insider knowledge about transformation in practice substantially earlier than everyone else. CNS connections to the current health care and related political context is of fundamental importance as well as to the perspectives of those with clinical experience – the other members of the health care team. This ability to oversee, lead, and support clinical practice from a very early stage in improving quality in patient care, and initiate the dialogue is reiterated by others:

I mean because you are a voice for the organization, the patient, and the nurse, so I think that you need to be able to listen to what people are saying. And then when you're collaborating with others you may not agree with, but I think it's important to be open-minded while looking at that bigger picture and asking, “How will I fit into the institution as somebody who will advance practice knowledge.” (PB)

As noted earlier, the circular and intersecting competencies of clinical care, research and evaluation, advancing nursing practice and systemic leadership, appear to rely heavily on each other. This is particularly true with regards to systemic leadership.

4.1.4 **Systemic leadership.**

As discussed earlier many participants expressed varying constructs of leadership as being either a common trait or expectation of the CNS role. For example, some participants described the role as being one of a more informal leader (e.g., PA), or as leaders in shifting the nursing culture (e.g., PE). One participant saw the CNS as very much a part of the leadership team (PC); an experience that was different from what they had experienced in other organizations. This implies that although leadership might be enacted in different ways, it remains a central aspect of the CNS role. One participant describes the leadership role in the following way:
It’s a role of influence not a role of power. It's not you telling people what they should and shouldn't do, it’s you having the skills to influence, and those influential skills I think are much more difficult to grow and to and to be successful at, than just having authority over someone. (PC)

The participant provides a less traditional characterization of the definition of leadership.

Leadership as enacted in this role is less about ‘power over’ and more about influencing outcomes. The leader in this case is trying to influence the followers to enact practice (PC), as one example in particular ways. Participant J shares the following anecdote:

I know that the CNS can drive other team members a little crazy, but they have this ability to support everyone from management to point of care by giving very direct, appropriate feedback, that is sometimes hard to hear when you’re a new leader. I have said “you know every time the CNS comes in my office with feedback, if it is something that really makes me mad, I really then focus on that and think why is this upsetting me so much, and it’s usually because they have found a gap in something I have been missing. And if I reflect on it, and when I’m calmer and I look at it, nine out of ten times I’ve come to realize that this feedback or influence has improved the leader that I am.

In this case, CNS influence is expanded to include leadership in the organization.

A common thread weaving through the perceptions of CNS leadership is this attentiveness to systems and organizations. Participant F (a senior leader participant) articulates this very clearly in the following interview passage:

Although I believe everyone has strong leadership traits, the CNS enacts it in a different way. The CNS has a much more system-based influence, than any other practitioner in the service or in the healthcare team. Much bigger than the physician, much bigger than the bedside nurse, much bigger than the manager, much bigger than the NP, it’s a very different and complementary piece of the healthcare puzzle, it’s much more systems based. (PF)

Other participants further this description. One says, “I get the system, and I understand the system so well, that I know how to keep pushing it” (PH). Then also, in the following excerpt from another senior leadership participant:

We have added a small number of CNSs, where we just really felt there was a significant quality or safety risk that needed to be addressed at a systems level. That needed the expertise of a CNS, just in terms of the work, the research, the lit reviews, the
connections or relationships, and all that had to be done, and then ultimately the training of the staff. In a place where really that’s the kind of role we need: an expert practitioner and leader within nursing, so we put CNS roles in those places. (PI)

Here the participant points to the commitment of the organization to the role of the CNS and the expectation that the CNS bring their expertise and provide leadership to address patient/health care issues at the systems/organizational level. CNSs are placed strategically to support systemic change. Although CNSs in this organization focus on systemic patient and health issues and change, they also bring uniqueness to the role.

4.1.2 The uniqueness of the individuals in the role.

Another significant subtheme is the subtle expression of individuality (PA & PC) that informs both the articulation and enactment of the CNS role as described in the following interview excerpt:

You might not enact the role exactly like I did, things change, time changes; you’re different than I am. You might see issues in other ways and that’s ok, that’s totally legitimate. If you enact it people will get used to that, they got used to me, and as long as you are enacting it in a way that improves practice which you know substantiates all the components of the role. You know everyone's different; I do my role completely differently than a lot of the other CNSs (PG).

Here there is an acknowledgement that each individual lives out their role in keeping with their individual differences; however, whatever the differences, all CNSs are working to improve outcomes, and all are working in keeping with the local need, whatever that is. Participant D speaks to this:

We became involved with the local art institute, the art students were asked to make some posters – for this particular population because it was one of their class assignments (we forged a link to make that happen). And so we gave them all the information they needed, and they were able to produce these amazing pieces. Now we’re still working on that, but it is kind of exciting and it’s never been done before, and it engages the community. (PD)
In this particular example, this participant bridged art and learning to create new avenues to educate the public on a very specific health care issue. This project not only provided individual artists an opportunity to showcase their work, but it was a new and innovative means to reach out and educate the public. CNSs not only brought together their individual passions with need and resources, they also brought their expertise across several dimensions of practice as noted in the following interview excerpt:

It's artificial to separate the two in a way: the expectations of my role and whom I view myself as. I mesh them together. I do compartmentalize it a bit, because I have to, in order to make sure I give the organization what is required of me. But if I sit down and advise some of the other CNSs about research questions they have, or small studies they want to do, or quality improvement issues, I am coming at it as a researcher. You can’t pretend that you’re not and I’m coming at it as someone with my experience and education and I bring that part of me to probably every problem. (PA)

Passion, creativity, drive, need, expertise and other dimensions shape the individual enactment of the CNS role, but also previous experience. Participant A explains this:

I think I was moving towards that kind of work, a lot of people experience that, that they start to do more complex work in whatever the role they were in. Even before they go into a Master’s program or take any advanced practice nursing courses. So I was already there, but I think my masters’ degree in nursing did prepare me for the role. It prepared me to learn more, to never stop learning, and you do develop a lot as you gain experience in the CNS role. (PA)

All of the participants talked about their previous roles and how they shaped their practice as a CNS. As a couple of participants describe, “I have been on a path, although, not necessarily an intentional path, but all have helped move me to where I am.” (PI-senior leadership) and “I think that the educational preparation was really important but I think on top of that my experience of working in previous roles also helped. So I would say a combination.” (PB).

Related to the previous vision for the CNS role, there was an acknowledgement of the expertise or leadership provided by the CNS; however, also the credibility earned by the CNS is
as important a factor. As one participant noted, the “proof is in the pudding” (PK). Participant E (senior leadership) goes on to say, “Those that have worked with really strong CNSs over the years are often the biggest advocates, because they see what CNSs accomplish. But it's often over time, it's not a snapshot.” Participant H further expands on the importance of building credibility:

It takes many years to build credibility. Once you build credibility clinically, you get asked more, and as you parse through evidence, and then you try it out in reality, and any decision made together and have the respect from the various kinds of expertise – you actually can move practice along. Maybe I am deluded that I have changed practice, but I think I have.

CNS experience over time led to change and perceived credibility. Another participant describes the process of building credibility in the following excerpt:

You know it's challenging, to get the credibility - you know the “street cred!” Coming into a new area, people wonder “Who are you?” and “How long are you going to be here?” Also the person that was previously in my role was just temporary, and so I think I felt that some people aren't as familiar with CNS role, and maybe think it's a leadership role, but I’m not someone's boss…. so, I felt a bit of iciness from certain people because maybe they viewed me as someone else. From what I hear from my mentors it takes a little bit longer to get established and really feel comfortable in your role. (PB)

The above paragraph illuminates the difficulty and time it takes to build trust, credibility and support from the team. In a slightly different vein, Participant G speaks to the challenge of building credibility:

I worry about having to bring in novice people for the CNS role; it would take them quite a while to get up to speed, for people to see their contribution as a Clinical Nurse Specialist. And if there are a lot of new people that aren’t up to speed, then people will look at the role and go –you know.

Here, the participant refers to the importance of balancing the hiring of novice CNSs with those with more experience and credibility. Participant K elaborates on this further in the following,
It is difficult because the front liners are very much about where did you work for your experience? If you had nothing, but education, they are reluctant to trust you – so it’s hard to find the balance.

Although the CNSs have a master’s preparation in nursing, without the reality of work experience, it may be difficult to engage others to support the CNS to build what one participant describes as “street cred” … “Every day is a job interview” … “You need to show that you are worth keeping with the work that you do” (PB). There is this sense that perhaps not all CNSs have a sense of security in their role. This may be due in part to many intersecting and confounding tensions that influence the CNS role.

In the above section I have discussed how CNSs influence the development of the role within the organization by bringing their vision of the role and unique expertise to the role as they build credibility with the health care practice team and the organization more broadly. Analysis of the data further points to several challenges to building credibility. In the following theme I explore several intersecting tensions that act as barriers to CNS role enhancement in the organization in which this study took place.

4.2 Intersecting Tensions Influencing Support for Enhancement of the CNS Role

All participants agreed that even though the role is well supported in this organization, there are many tensions that may challenge or impede the enactment of the CNS role. As one participant notes:

I guess I see them as tensions, not barriers, which might be a bit of a strong word, because as I say the foundation is laid for people wanting CNSs to be there and to succeed. But there are tensions. (PA)

The three main subthemes that arose in conversations were positioned around: scarcity of resources, the broader context of the health care changes, and balancing power and agendas.
4.2.1 Scarcity of resources.

Analysis of interview data revealed two intersecting tensions within the subtheme of scarcity of resources that acted as challenges to the development, sustainability and enhancement of the CNS role within the organization: economic constraints and insufficient human resources.

4.2.1.1 Economic constraints.

Economic constraints influence the health care system as a whole (Bryant, 2009). All participants described funding as the primary economic constraint that impacts the CNS role. As Participant A explains, “Like everywhere, we have no extra money, we have not enough, barely enough to pay the bills now - it waxes and wanes, the availability of funds.” Participant H perceives, “If you're attached to a program you are more likely to have funds in some way. I have no budget.” However, it is important to clarify that although a CNS may have attachment to a program, this does not guarantee the funding or resources to sustain the role, but more of a structured avenue to access the resources that are needed.

Participant H identifies how funding scarcity affects the CNS role in the following statement: “I have to be creative in practice and I spend very little time looking for funding.” For this participant, time spent looking for funding was a commodity that could not be spared; this CNS utilized creative approaches to enable support for practice advancement: internal and external collaborations, piggybacking on existing initiatives and the prioritization of emergent opportunities. Another participant describes how limited funding impacts other areas of CNS practice in more detail:

I do find that challenging sometime, trying to make due with what you have, and you might see a better way of doing things. We are trying to improve the patient journey from having the referral, to a particular procedure, to follow up and you know there are barriers because of the restrictions or the limitations you have with the resources. (PB)
This participant uncovers issues: missed opportunities, impact on quality patient care, and efficiency for the overall program due to budget constraints. Participant K expounds on the effect of limited funds as shared here:

I think it would probably be a barrier to the individual and the program. This specific aspect of the program is a big deal, the CNS is so busy with that one aspect, and I don’t know how much of this impacts other areas of the CNS role.

Further analysis of the context of this excerpt brought forward that the impact of having limited funds also strained the individual in the role and the program. If a CNS has to focus solely on one emergent priority in the program, it could be affecting other needed priorities within the program, again affecting quality of patient care, and taxing the CNS role. Participant L expresses one specific example of how the impact of funding constraints affects the CNS role in the following interview transcript:

The CNS is supported to be a researcher and I don’t have extra time to do that. Sometimes we have to ignore the research aspect or do research in a very minimal way, or as one of the last things on your plate. I have research that’s going very slowly because other things take the priority.

Most participants shared this frustration or understood that the time to do research was limited due to pressing priorities in statements like “I don’t have time to do research,” (PH) and “The research piece is probably not getting done due to lack of time” (PC). The implication of this lack of funding and or time to do research impacts overall quality care and innovation.

Economic constraints intersect with funding to limit IT support, office space, and other resources. For example, lack of space was presented as another tension. As Participant A says in the following:

We have a terrible problem. I don’t mind too much but I'm not in the hospital. There’s no space. Right now there are three CNSs sharing a teeny office over in the program center, it is half the size of this room, there’s no space, it's really bad. (PA)
However, the lack of funds as noted earlier is an issue that is ongoing, and universal in terms of health care expenditure (PE). Many participants identified that they had to be creative in how they utilized the limited funds and other resources:

It's easier when you have a very specialized population, and you have a provincial role to get designated funding for the CNS role, because they really see the value of a CNS for program development and practice support for unique, challenging populations. So sometimes that's easier to get specialized funding, sort of a protected funding for CNS (PE).

Further analysis of the context of this excerpt revealed the extensive collaboration this organization has with the Provincial Health Service. These partnerships support the creation, expansion and sustainability of the CNS role within this organization and the province through collaboration of resources and funding, while supporting clinical growth in the overall system.

Participant C expounds on this universal fiscal constraint and how this has impacted this organization in the following: “It really depends on that social political environment: we have to look at things that are tightened up externally from a health budget perspective?” In further analysis this participant speaks to the bigger system in terms of fiscal accountability to the federal and provincial governments. Does the cost of the CNSs in the organization make sense in this context? There is a clear understanding that this lack of funds intersects and impacts heavily on different specific resources needed to sustain CNS growth, and is not limited to internal economic constraints. In the following subtheme I identified how insufficient human resources also act as a barrier to CNS practice within this organization.

### 4.2.1.2 Insufficient human resources.

Human resources seem to be limited in all areas of practice within the health care context (Bryant, 2009; Varcoe & Rodney, 2009; Veenstra, 1982). In the analysis of this subtheme I
identified that the participants seemed to experience the impact of insufficient human capital in
the two aspects of retirement and suitability.

4.2.1.2.1 Retirement.

In 2011, as reported by Stats Canada (Government of Canada, 2014), 42.4% of the work
force population was between the ages of 45-65 years old (‘the baby boomers’). This reality is
reflected in this particular case study setting. Retirement came up as a key challenge to the
continued support for the CNS role in the organization by several of the participants. As
Participant C notes in the following, “When I look at the CNS group across the organization -
retirement is probably the biggest influence of positions. A ton of us are retiring within a year or
two years of each other.” At the time when these interviews were conducted, 42% of the CNSs in
the organization were planning to retire within the span of two years, a problem across several
programs. As participants noted:

In fact, the CNS in our program is coming close to retiring, and I’m already two years
away from it. Oh my! What am I’m going to do? I can’t begin to say how inter-woven the
CNSs are to everything we do to move things forward in our program (PJ),

and

Some of the biggest issues that we’re facing here at this organization are the average age
of our CNS. Like me they are aging, and my fear is I don’t want all that wisdom to go out
the door, and when I look around the room I can see the wisdom could go out the door
very soon.” (PF).

There was a general sense of uncertainty around sustainability of the CNS role in the
organization as it faces a large exodus of CNSs due to retirement. Several participants were
concerned regarding the loss of CNSs due to retirement and the possible consequence of reduced
perceived value (PB), and ultimately, loss of the role.

These conversations seemed to be on the forefront of most of the participants' minds
when talking about the barriers to CNS practice within this organization. This is also in keeping
with the concern for the possible loss of CNS practice across the country (DiCenso et al., 2010). Even those who had no intention of retiring were apprehensive about the consequence of mass retirements to CNSs, their organizations and health care more broadly. Participant J points to a related concern in the following:

So, it will be interesting to see how we approach the gap that is coming with the retirement. In the CNS group, and in senior leadership you will see a lot of people retiring, and you’ll be beginning to see much younger, fresh leaders without much experience and support around them again. When I got into leadership, there were so many people older than me, and much wiser that had lots of experience to help support me through that kind of journey. (PJ)

Others appeared less worried about elimination of the CNS positions due to retirement, “They keep reassuring us the CNS positions are on the table as much as possible” (PA). However, another participant provides a cautionary note as follows, “But maybe if that position is vacant, they may think, do we really need someone with a Masters in nursing to do that?” (PG). Given current fiscal constraints and the prevalence of efficiency discourses (Bryant-Lukosius et al., 2015), CNSs are aware of how vulnerable CNS positions are given the limited resources in health care; limited resources could lead to filling positions with less expensive people or to eliminating positions altogether (PC, PE). This concern regarding the loss of the CNSs intersects with the issue of ensuring the suitability of the individuals filling these established CNS roles in the following section.

4.2.1.2.2 Suitability.

Subsequent to the identified mass exodus of experienced and credible individuals in the CNS roles, many of the participants considered further the impact this loss would have on the organizational system. A few participants identified that currently, prior to the impeding mass exodus due to retirement, there have been a few CNS roles that have not been filled. In further analysis of the context of this observation there appears to be a sense of vulnerability regarding
the security of the CNS role in the organization. For example, “If there are individuals to fill the roles, why are some roles still left open?” (PG) There are varying perceptions as to why this occurs; “Did they try hard enough?” (PG) and:

I think all positions are vulnerable to that [deletion], and I don't think that the CNS is any more vulnerable than any other position. But I think the reality in healthcare today, is that there is a lot of scrutiny for every position, and you know every year we sort of go through our list, and we’re like what can we cut? I never would offer up a CNS position, but I know that there are times when there are vacant positions, and people state: “Oh we’ve managed without so far, you know can we do without for another?” (PE, a senior leadership participant)

Participant C echoed this sentiment:

We always look at all of our non-contract positions whenever one is vacant, but I haven't seen a lot of conversation saying you know “Do you need that CNS role or why are you filling it?” I think that there is general organizational support to maintain the CNS roles. You just have to make sure it’s efficient. (PC, a senior leadership participant)

In the analysis of the above two comments, there is an emerging insight into what drives the agendas that may influence the CNS role vacancy. What appears initially as overwhelming support for the CNS role is subtly shadowed by these faint hints about the cost to the system and the resources required in sustaining the variety of CNS roles within this organization.

Participant E alluded to this issue that they were unable to fill a particular CNS role, bringing to light the difficulty in finding suitable individuals, as reflected in the following:

Another position was created but never filled, because they couldn’t find a suitable applicant or a suitable person. Then it sort of disappeared, I don’t know if that position still exists on the books, and I'm sure that had to do with money. They couldn't find someone (fair enough they did try), but when you have an unfilled position and things are tight, it's pretty easy for that position to just vanish. (PA)

This participant supports the impression that when there is difficulty in finding suitable individuals to take on the CNS roles, they can be left vacant. There is an emerging level of frustration with the lack of effort put forth by “they” in filling the vacant CNS roles, and providing the CNSs the resources to fulfill the current CNS roles to full scope of practice. I
found that most participants did not define or identify suitability in terms of vacancy management. However, many CNS participants agreed that the educational variance might potentially influence suitability, as Participant F explains here:

> When I was in my Master’s program, we specifically had to decide which stream we wanted to go into. Our choices were: CNS, Administrator, or an Educator. I went into the CNS stream, so I wonder if when the streams were so definitive back then (cause they are not now), I wonder if I might have come out and my colleagues might have come out more geared around having that Advanced Practice model in our heads, and in our practice a little bit firmer? I don't know and I think we don't get enough young CNSs coming into the organization to know for sure because we didn’t have a lot of new position, and now there are not many as people graduating with an interest in being a CNS.

In the demographic data (Appendix E) it was unclear if there was an educational variance within the participants in the study; six CNS participants studied in the advance practice stream, and only three identified a clinical specialty attached to their Masters in Nursing stream. As one participant notes, “When I did my graduate work, the CNS wasn’t even talked about, I couldn’t even do a clinical specialty. I could go into three streams and none of them were clinical” (PD).

This variance has produced some tension across CNSs as described here,

> If you really think about it any one who is masters prepared in nursing can say that they are a CNS, whether or not they took the advanced practice stream or not. I have talked to the CNS coordinator at the time, and said: “you need to get the CNS stream back, you need to get people knowing that if they have an area of clinical expertise, they can go, do their Masters in Nursing in the CNS stream, with their own specialty in their particular role. …Then they have their own clinical experience/expertise, and others then have some respect for them in terms of clinical knowledge, and then they can grow into the rest of the CNS role (PH).

Masters prepared nurses who have no advanced practice education or certified specialty can and do occupy CNS roles in some locales and although Participant B took a MSN program without a clinical component, she perceived the program was “excellent,” and in conjunction with her own clinical experience and mentorship, felt prepared as a novice CNS. Of note, even with this difference across educational backgrounds, CNSs fill the gap where needed (PC)—
meaning CNSs are always there to take on whatever role they need to in order to get the work done, and somehow seem to adjust to the requirements of the role, despite many limitations. This supports a previous notion that individuality and experience are key influences of CNS practice, and not just education (see Chapter One of this thesis).

Participant C brought forward an alternate explanation of why some roles are left vacant:

In this program, we were also going through a fairly significant work process redesign. The CNSs were very heavily involved in ensuring that our workflow was supporting patient care and really facilitated the redesign through systems and processes. When that work kind of came to an end, and perhaps even the workload became a bit more manageable, we decided to go with one CNS as opposed to two, because we achieved so much of that work. (PC a senior leadership participant)

The conversation has broadened to a new understanding that the cut in roles may not have been due to the inability to fill the role, but more to do with the changing needs of this particular population. Bringing to light the discovery pertaining to the broader health care context, Participant I seemed to support this evidence:

Thus far when we’ve had a vacancy, and in some cases the vacancies are because of a retirement, and in some cases we’ve had a new vacancy because we have created a new role. So for example, I was really worried about the quality of our care in a particular population and specific protocols to pertaining to the populations needs, and then we needed to train of our staff, so we introduced a CNS role to make the changes at system level, and they have done just a fabulous job. That was a brand new role, and we went out and we did recruitment, and we got excellent applications with real wide variety of applicants for us to choose from, and we try and select the best person.

What appears to be suggested here is that balancing the needs of the programs indicates more a filling of vacant posts than the previous reasons of economic constraints and insufficient human resources. In the next subtheme I begin to discuss how the context of broader changes in healthcare further impacts the CNS role in this organization.
4.2.2 The broader context of health care changes.

Many participants agreed that as health care changes, the CNS role, focus, and priorities will also shift. As Participant A explains:

Well the landscape has changed and we are not doing as much surgery as we used to do, but we’re doing other things that are different. As with all of healthcare the real move away from how we used to do care delivery, you know long hospitalizations and doing everything as inpatients in acute care to many more day procedures and clinic-based care, outpatient-based care and so the CNS role has had to evolve with that. So those are just a couple of examples of how it’s really dynamic and it changes. It’s now about, “is there a new population, and is there a new service we’re delivering that could use advanced nursing expertise to develop the program or to do direct care in a different way or so it definitely influences it.”

The broader changing needs in the health care landscape heavily influences the evolution of the CNS role within the organization. Participant I describe their perceptions of how CNS roles have been enacted to meet these changing needs in the following excerpt:

With the CNS, it depends on the program, and the gap because the CNS can function in a variety of domains, and so it depended on what was required within the Program. In some areas the CNS may have had a real focus on policy changes, and provincial legislative changes that would lead to address some issues we felt important for the patient population. Others focused on an expert level of practice, others brought in changes at systems level, which ultimately benefitted the care we provided, the outcomes we provided.

Other participants describe the evolution of the role being muddied with some operational responsibilities to help span across the organization (PC). Another said, “As the organization shifted from a small site to a big organization, I became a jack of all trades,” (PH) and “In my area I am not under a program, therefore, I am the secretary, I am the maintenance person, as well as the CNS.” (PG) Further analysis of the context of these statements brought forward a perceived tension or barrier around both fulfilling the CNS role to full scope while balancing the agenda and priorities of the system.
Many tensions intersect and confound to influence the CNS role within an organization. For example, if there are no funds, there are no resources; and if the landscape shifts, new needs may arise if those needs can’t be filled due to lack of human resources. This may have been a result of limited individuals who are suitable. This understanding illuminates the reality that there are many powers that influence the CNS role and that need be balanced to further enhance support of the CNS role. In the next sub-subtheme, I discuss the prioritization of power within this organization and the subsequent role this has on the CNS role.

4.2.3 Balancing power and agendas.

Power is not always equally distributed in the healthcare context, and is often allocated to certain groups, and programs based on historical underpinnings and positions. Further analysis of the context of power within the data brought forward three deeper articulations intertwined within this subtheme: role clarity, blurred boundaries, and balancing agendas.

4.2.3.1 Role clarity.

All participants agreed that lack of role clarity played a fundamental role in the tension generated for the CNSs in the organization, which was reflected in statements such as, “I’ve never heard of a position Clinical Nurse Specialist until I started working in the emergency.” (PJ-inter-collaborative team member), “I have been doing this a long time and it hasn’t always been clear to me what the role is.” (PH) and “It’s difficult when you are always needing to explain the role.” (PA). In the further analysis of the context of these descriptions I found that role clarity pertains specifically to the expectations, articulation and understanding of the CNS role. This misconception of the CNS role found in my study appears to align with what is already known across the country pertaining to the impact of role clarity on CNS practice (Bryan-Lukosius & DiCenso, 2008).
The confusion spans throughout the organization, and CNSs themselves are not always fully clear about their own role, which potentially lead to further frustration. For example, “It’s challenging when you have people who are not clear about what a CNS role is in the organization, or even have an understanding of what you can expect from a CNS” (PC -senior leadership). Participant K (inter-collaborative team member) shared how even she has questioned the value of a CNS, “Why do I need a CNS? I am the educator; I can do all these things!”

Emerging here is the notion that CNSs are not essential. However, in a different vein other participants clarified that the work done by other team members is not the same as what the CNSs would contribute to the project, program or organization as seen in the following excerpt:

I don’t think that you get the work done–work may happen, but it certainly wouldn’t be the work that we would have a CNS do. So if we have difficulty, and I can only think of one area where we had a real challenge in filling a CNS role, we put an educator in place to do some work around education, but it was not the role of a CNS. So the work and the change of focus will not get done. The preparation and the understanding are not there. (PI)

Participant E furthers the dialogue on the potential implications of role clarity on CNS practice as described here:

The fact is, that you can implement things without a CNS, and you know there are other people that will step up, and sort of work beyond their role, because there isn’t a CNS. There are a lot of really committed, bright, capable people that will step up to make things happen, and in organizations that don't have a CNS, and they can and do get things done, then they look to a system that has a CNS and they go - “well we were able to do that without a CNS.”

There is a shared understanding by many participants that although the role is valued in the organization, there also appears to be this shadow of uncertainty pertaining to the clarity, articulation, and understanding of the CNS role. A central explanation for this obscurity around the role is perceived to be due to the invisibility of the CNS’s work. Most health care team members have immediate recognition of the work they do, for example giving medications,
starting an IV, implementing a care plan, or providing education. In contrast, Participant B describes her day-to-day work as being “high fruit,” meaning long-term ongoing projects that take time, research, and dedication to accomplish, mainly behind the scenes. Participant E reiterates how CNS invisibility deepens the confusion pertaining to the CNS in the organization.

I think the CNSs can feel a bit vulnerable, because, you know they can implement something here, and you know and all of the work that went into that, a lot of that is not necessarily seen, it’s not visible. And then someone can take that, and implement it somewhere else, and go “We did that without CNS!” (PE)

Participant K (an inter-collaborative team member) shares that point-of-care staff question the role of the CNS when the CNS is not seen as much as clinical nurse leader, educators, or social workers, and that it is often her role to remind the staff of the complex and time consuming work done by the CNS to help advance the program. This pervasive connection between role clarity and invisibility appears to potentially be a significant tension on the CNS role in the organization.

However, Participant K offers an insight into how this barrier is negotiated; both the CNS and other members of the team need clear articulation of the role. Others support this explanation, “So I think it's really helpful to understand what the CNS does and the value they bring to the Organization.” (PE) and “It all depends on whether your leader or your supervisor has the direct experience with working with the other CNS so they can understand what CNSs do or are supposed to do.” (PL). Although it is clear that having the support of the others in articulating the value of the CNS is helpful, many participants expressed that ‘tooting their own horn’ by making their accomplishments known is also needed to help alleviate some of the confusion. Role clarity contributes to the discourse on power, in the sense that without a clear understanding of what the CNS contributes to the patient, nurse and system, there is no value placed in the role or individuals in the role (Zuzelo, 2003). Promoting themselves by being clear
about who they are and what they do is the first step in enhancing support. However, it is important to note that all participants are aware that the CNSs are a part of a collective team as expressed here:

In a collaborative environment where you have an educator that actually does the frontline education and helps support the nurses, and you have point of care leadership, and you have a CNS and you can really have an effective team (PH).

The data above serve as a reminder that collaborative partnerships with all team members are essential for providing quality patient care. However, inter-collaboration means working together, which sets up potential for opposing priorities, and overlap in work. In the following section I describe how blurred boundaries manifest as a power discourse on the CNS role.

4.2.3.2 Blurred boundaries.

As I progressed deeper into the analysis I found participants perceived that the discourse on power extended beyond the issues of role clarity and was often confounded by the inter-collaborative interests that result in blurred boundaries. Subsequently, I began to recognize that perception of role clarity by the participants appears to be situated in an understanding of the role itself--for example, what is a CNS? What are the benefits of having a CNS? Why is a CNS part of the healthcare team? The perception of many participants was that without clarity of their roles, other team members might not fully understand that the CNS works to support clinical practice at a systems level, and is not often in direct patient care. There is risk that team members will perceive overlap or redundancy of managerial roles and the use of the clinical expertise of the CNS at a broader level. Therefore, it is very important the CNS role is well understood and articulated:

People really see the value of the NP, and you know they have such a visual impact day-to-day cause they are looking after patients. Physicians in particular can really see what an NP does, as opposed to what a CNS does. So I think the NPs have been very successfully incorporated in our organization, and although I think the CNS role is very
secure, I could see there being a little bit of “Is this role going to overtake the CNS role, just because people really glom on and see it.” (PE)

This participant substantiates the previously discussed tension of the invisibility of the CNS and further alludes to the misconception about an existing competition instead of the acceptance of the complementary nature between the only two recognized Advance Practice Nursing roles in Canada (Donaldson et al, 2014). Other participants support this misperception between the two roles as Participant F describes:

I have to say prior to taking on this role, I wasn’t crystal clear on the differences between a CNS and an NP, and I am a CNS. But what I’ve learned is, they are two distinct different roles, they are two distinct professionals in different parts of their development.

It is important to disclose that prior to the interviews I recognized an internal bias pertaining to my belief that there would be more discourse on NPs and CNSs misperceptions, however I was pleasantly surprised to discover that within this organization, many of the participants had a clear understanding of the distinct nuances between two roles, as seen here:

The NP is actually doing the practice and leading direct care, almost like a physician assistant in the sense they are doing orders, seeing patients, diagnosing, and prescribing. That’s very different from a CNS, which to me is keeping the practice level across an organization, by knowing what’s current, and what’s evidence informed. A Nurse Practitioner is in my mind not going to have time to actually be doing that, like implementing practice strategies across the program. They are going to be too busy seeing patients, that’s my interpretation of NPs and CNSs. (PJ-inter-collaborative team member)

This clarity of understanding between the two roles was substantiated by (PL), “Our roles do not cross at all because the NPs are very focused in direct care, so I think in my program they know when to approach NP and a when to access a CNS.” Other participants strengthened this perception by identifying how the CNSs and NPs complement one another through collaboration. Participant F discussed her perception of the differences between CNSs and NPs in the following descriptive narrative:
Many of the NPs that are coming out are what I want to call young novice nurses. Not a lot of solid basic experience under their belt, and they are moving into the NP role. It’s interesting, because I was away on holidays, and I was sitting beside this very young gal who wasn’t even in her 20s, and who hadn’t even finished her nursing training. And I said, “What kind of area do you want to work in?” (Thinking she was going to say, “Oh I really like Pediatrics.” or “I really like Emergency.”)

She said “Oh I am going to be a Nurse Practitioner.” and I thought to be myself “Oh boy!” One, I felt like a dinosaur, and two, I thought to myself are we really going to be doing her a service and the profession a service, by having her have the ability to go from general nurse training to specializing in NP. I just share it with you because I certainly wouldn’t have had that a conversation with that young girl saying to me “Oh I am going to be a Clinical Nurse Specialist,” because I think there’s a bit of an acknowledgement that it is an advanced practice role and you have to have experience as a general nurse first.

That is what I see here in this organization. One of the most striking differences here in this organization is the age and experience difference between the NPs and the CNSs. And with that comes all the rest: how comfortable you are in your practice, how knowledgeable you are, how you are able to network, there is a huge difference. (PF)

This participant recognizes that the many young and novice new grads want to be a NP, however, CNSs are more often associated with experienced and specialized nurses. This clear distinction is a key distinction between the CNS and NP roles.

Many participants discussed other nursing roles that were profoundly more muddled with the CNS role, as shared by Participant L:

Where the role clarity needs to be more defined are between practice consultants, performance improvement consultants, CNSs, and educators. There needs to be much more clarity in this organization, because we have other roles that are kind of similar or working parallel with the CNSs. There’s much more overlap between these roles, but we do lots of new projects in this hospital compared to where I came from, and I can see the value of each role and what they bring to the table. I cannot do it alone. But we have to make sure we are not stepping into each other’s roles. We have to be aware of each other’s roles making sure we stay within our scope of practice. It’s good that they are there but since they all have similar role, we have to make sure we have defined roles and we all do the best we can. (PL)

Participant L further supports that a potentially debilitating strain to successful inter-collaboration is often a result of the limited role clarity of each of the roles on the health care team. This subsequently results in multiple avenues for team members having to step into each
other’s roles. Participant G, further expounds on the systemic stress this confusion causes and why:

The Practice Consultants are nurses but I don’t know if they have their masters but they are looking at practice and so are the CNSs. A lot of times now, they are making decisions or doing the work that the CNSs used to do, and that’s what the CNSs are having a hard time with. We see why they brought these roles in, but we think in a lot of cases they are doing some CNS work, or more importantly don’t understand what the CNS does. So they are doing some of the same work. (PG)

The blurred boundaries between the roles that are meant to be complementary can easily be perceived to infringe into each other’s scope and may add to the perceived vulnerability of the CNS role. Participant A explains her perceptions as to why historically the tension is present between nurse educators and CNSs:

So the nursing department was dismantled completely in the 90s. It happened everywhere, we don't have a nursing department. But with it, there was nothing central, no group to do that central piece that needs watching, and managing like you know; what you do about medication reconciliation you can't just do it in each of your programs. You have to have an overall strategy and there was no one to really do that. Nurse educators did it and there were a couple of nurse educators who were general for the whole place. But it became obvious that it was too complex, and there were not enough bodies. The nurse educators probably could've done it, but maybe they needed another skill set than just nurse education.

And so when CNSs started to be added to the programs they were called on to help with that work. And so there was always that tension nurse educators felt, and still feel that I would think. (PA)

Participants perceived that in their experience the educators teach the practice changes that have been facilitated by the CNSs, and the practice consultants (who’s role seemed to be unclear) were brought in to oversee the logistics of the practice pieces that were central to all of nursing. (PA, PG, PH) Participant D identifies that “others will step up” suggesting someone has to fill the gaps, while Participant H furthers the conversation by noting that, “It only take one person to confuse things.” (PH), meaning one individual could step up or outside their scope (usually as there is an identified gap) and confuse the roles for the whole system.
This confusion around the overlap in the roles was not confined to just nursing; it was also perceived by participants to include other health care team members:

Often we have allied health come into our program that have worked in other sites and I think they are quite surprised at how strong the CNS leadership is. I think that in some programs they are used taking some of that leadership (PA).

I am not clear if the non-CNS participants identified these perceived tensions in the same way that the CNS participants experienced them, as this issue was not discussed in great detail with them. However, a primary implication that arises as a result of these blurred boundaries are detailed in following transcript:

We have still have to remind people that periodically, that clinical decisions are made in places where there's no one from practice present, and sometimes they're not good decisions so then you backtrack. Most time CNSs are there, and people will ask you, or drop you an email, or pick up the phone and say we really think you should be part of this. There aren’t many big projects or there aren’t many clinical projects that happen anymore without CNSs. But every now and then something starts, and you realize it's gotten a bit too far and they haven’t included a CNS, and then they backtrack to get that, usually. And I think, they usually realize the error being that they probably should have involved the CNSs much earlier (PA).

As I further analyzed the context of this transcript, I began to understand that although there are blurred boundaries with CNSs and other team members, the clinical expertise of the CNS is wanted, and whether their utilization occurs at the beginning of a project, or only when there is a level of clinical expertise required that cannot be further navigated without a CNS, the CNSs are an integral part of the clinical decision making processes. This ties into previous discussions on how a CNS’s clinical expertise and credibility contribute to the elevation of the program. However, a potential discourse on power pertaining to agendas is nascent, as seen above in the phrase “starting projects.” Who are the people starting the clinical projects and
why? In the next section, I broaden the discourse on power, to include balancing agendas that influence and impact the CNS role.

4.2.3.3 Balancing agendas.

Role clarity and the blurred boundaries of interdisciplinary practice often are further confounded by the intersection of balancing power around agendas. Whose agenda do the organization, programs, or even professionals follow? The participants have already identified that the confusion created by the limited role clarity contributes to a potentially detrimental dynamic between roles in the team that are similar or intended to be complementary.

However, participants identified other agendas that have higher precedence than the CNSs and other inter-collaborative health care team members: “CNS roles are delineated around ‘medical lines’” (PA). This participant recognizes the subtle powers that define the health care system. This tension is further explained here,

Physicians still have a lot of power on healthcare, particularly in this hospital culture, and the physician still have a fair amount of power and may influence on the agenda. The organization does tend to respond to changes the physicians want. It's neither good, nor bad, it just is. It doesn't mean that nurses can’t also lead change, just as leaders don’t just mean physicians. Nurse can bring change. (PA)

There is an explicit discourse on power in the above description, however Participant A furthers the perception of how this power influences nursing practice in the following:

The physicians bring in new techniques, or there's a new procedure, or this new treatment maybe they identify that our patient population needs, because they want to try it to offer care in a more systematic/inventive way. Sometimes it’s nurses that identify that, but more often than not, it's physicians, so we have to respond to that, it’s like we are just jumping because the physician has decided to change X, Y or Z. (PA)

Statements about “jumping” “because they want to try” uncover an unsettling insight into the description that physicians are primary stakeholders in directing the agenda in this organization.
Participant G recalls a personal anecdote that describes this power imbalance in healthcare in the following passage:

So we've gone from my first day here, all the specialists in this program wanted me to come to a meeting, I didn't know what it was about, I was totally naïve. So I went there, and they were all on one side table, and a chair for me on the other side of the table. They proceed to grill me on “Why would anyone think I needed to be here?” They questioned, “What would my purpose or what role was I to serve in this program?” and most importantly they told me “Don't touch my Patients.” They used to write on the orders, “No CNS in this specific program to see!” So we kind of went from that, to now they most often defer to me, and they'll often want to discuss things and they will allow me to explain, often they will go with whatever I said. (PG)

Initially in the description, the physicians are presented as territorial in regards to patient care, the program and the health care team - the nurses (CNS included). Participant G further describes an almost dictatorial description as she recounts everything from the interrogation style covert meeting to the blatant directions given to the team by the physicians. However, through a salient recognition of the transformative practice of this particular CNS by the physicians there is a profound shift in the collaboration between the physicians and the CNS in this particular program. Many other participants validated that the physician engagement is a central hurdle that heavily influences the CNS role, as seen here:

The other barrier was around physician’s engagement, and the use of the preprinted order sets, and I’ll give just you an example of why that's crucial. In one of our analysis, at a partner hospital, what we found was that although our uptake was very poor in the preprinted order set, when they were used… we had a very successful outcome: in terms of whether or not the nurse was able to do the teaching, how well the patient did when they went home, and that illustrated to us that if preprinted order sets are used, the rest will follow. So it became really imperative that we try and get physicians to on admission use that preprinted order set because then the rest would follow.

This participant emphasizes how physician engagement can promote the ease and success of an initiative; however, she also continues to deepen the recognition that physicians have a lot of power. A simple signing of a preprinted order set could enhance the patient outcome, but for
multiple reasons (they were not on the chart, physicians did not see them, physicians ignored them) these known success tools were not being utilized by physicians, and therefore a CNS had to find a variety of creative means to ensure that physicians did use the order sets. Essentially this means that this participant perceived that part of her role was to make things easier for the physicians.

Participant H describes a similar experience of making things easier for the physicians when engaging them in the participation of the care team meetings. She explains that she ensures that the physicians chair the particular committees but she co-chairs the committee to ensure that the agenda is done and all the other details are covered. On further analysis of the context of both descriptions, there did not appear to be any resentment associated by the participant in these two particular scenarios. However, I could not shake the notion that the nurses serve at the agenda of the physicians.

Participant J broadens the conversation on power imbalance to include the impact of gender disproportion:

It takes time getting them in the door with the old boys’ club. It is still alive and well, and in a sense of that old culture of, it is the way it is, and there are not a lot of females in that culture either, so it’s just referred to as “the old boys club,” where the physician and nobody else can do our work, and God forbid anybody take away our ability to bill.

The old boys club idea validates what is already known pertaining to gender disproportion related to positions of power not only in health care but also throughout the Canadian workplace. Statistics Canada identified that in 2012, only 22.9% of the senior management positions in Canada were held by women. In a closer examination of the context of the descriptions related to power I found that although participants only alluded to subtle hints regarding gender disparity, they are there. The intersection between gender disparity and the previous discussion about the reinforced stereotypes regarding the CNS-physician relationship
may potentially influence CNS practice in a negative way. However, these dynamics pertaining to agenda are not the only ones impacting CNS practice. The internal struggle that a CNS has between the program and system obligations appeared to be a central conundrum for many participants.

Participant A summarizes what many other participants perceived as a central influence to the CNS role in this organization as seen here:

There is an expectation that the CNSs contribute to some organizational work and more so before we had as many people in the professional practice portfolio as we do now. For example: “Do I do all my work here in maternity, which is where I've been hired and just do that program work because there's plenty of it, or do I also help with this thing about heparin, that the whole organization needs done.” (PA)

I understood that not only do the CNSs need to accomplish the work within their own program; they need to contribute to the systemic needs as well. Participant L substantiates this expectation, but imparts how this actually impacts her day-to-day experience.

We are expected to take on whatever is coming our way. You can say ‘no’ but then there are some expectations, for me in addition to all the other demands, there are organizational as well provincial groups I’m a part of. But there is nothing being deleted in my program demands, but there is a lot being added. So sometimes it’s a puzzle to prioritize, as there are so many demands.

Participant L, like the other participants, have a lot of demands expected of them, and over time these can and will take a toll without the balance of support and leadership. In this subtheme I identified how the scarcity of resources (both environmental and human) intersects with prioritization of power through lack of role clarity, blurred boundaries and balancing agendas. All can influence the CNS role negatively. In the next subtheme I provide a brief description of how there are internally imbedded infrastructures in place that support the drive of the CNS role within this organization.
4.3 Intentional Embedded Organizational Infrastructures and Support

Although in the previous theme many participants were able to clearly articulate the multiple intersecting and constraining influences on the CNSs within this organization, there is a salient impression brought forward by all participants that there is a sense of deep satisfaction with the organization. Such satisfaction is seen in expressions such as, “I love it here.” and “I feel valued.” (PD, PG). To further elaborate this theme, in the next section I present three sub-themes that appear to be supportive and sustaining influences of CNSs within organizations: an intentional culture, deliberate leadership, and embedded infrastructure.

4.3.1 Intentional culture that protect the CNS role.

The shared assumptions, beliefs and values of an organization act as a continuous force that manifests in the expected behaviors and practices of the community that comprise said organization (Hofstede et. al, 1990). Upon self-reflection, I noted that I had an existing bias constructed around the intrinsic value of the CNS role, based on my own experience and understanding of the organization. This understanding was substantiated with statements such as “I can’t imagine doing my job without the CNS” (PJ) and “I do think that the culture and organization have supported CNSs here.” (PB). Within this subtheme I present a brief description about the historical roots and the current systemic culture, to broaden the understanding of the intentionality of this particular organization that has supported the CNS role.

4.3.1.1 Historical roots.

Many of the participants I interviewed in this study have either spent their entire career, or they have been in the organization for a substantial period of time. For example, some participants have been with the organization for over twenty years (PA, PH, PI). This speaks to a
dedication and a belief in their organization. These CNSs have seen many shifts in the landscape of health care in practice changes, leadership transformation, and the dismantling of nursing departments. (PA, PG, PH)

Two participants reflected on a significant day provincially in healthcare in the 90’s termed as 'black Friday'. “Lots of leaders in health care were let go.” (PF), and specifically pertaining to CNSs: “Other hospitals cut most of the CNS positions and to date, many of them may only have a few.” (PG) While many health authorities in the province were known to cut the CNS role, this organization chose to protect the role as seen here: “My understanding of organization is that the organization has protected the CNS role from that budget-cutting exercise.” In further analysis of the data I found this correlation between 'intentional' and 'protection' as is discussed in the following excerpt,

I actually think that we were very intentional in not cutting our CNS positions, and I think that really reflected on the leadership at the time, understanding what the value of the CNS is. So I think that in other organizations, either the CNO\(^3\) voice wasn't as strong, or as articulate in what the value of the CNS was. People were under huge pressure; you know some decisions made were bad ones at that time, and not just pertaining to the CNSs (PE).

The central narrative of many participants focused in on how the organizational leaders of the time really focused on the bigger picture as seen here in this description from Participant F,

When those cuts were happening provincially the leadership understood and had the long-term vision to say “If we cut the Advanced Practice Role here, what does that mean for us down the road?” So they didn’t react short term to this budget challenge, they made more thoughtful decisions around “What do we need here to sustain us in the long term?” And they chose to keep the Advanced Practice Nurses, and here we are today.

\(^3\) CNO-Chief Nursing Officer
This participant furthers the conversation from purposeful decision-making and keeping sight of the bigger picture, moving to the challenges that these decisions bring. Participant I provided a broader understanding as to why these challenges were worth the risk they posed as seen in the following transcript:

There’s been a couple of budget cutting cycles around the mid to late 90’s, and again just recently, (maybe four-five years ago) where we made a very intentional decision; we would find the dollars elsewhere. This was to ensure we met the legislative requirement for us to have a balanced budget. Because the role of the CNS is so instrumental in improving the system we work in, and the outcomes for the patients, and the knowledge and the expertise for our staff to do the work, it just seemed a no brainer to me that that would be the last thing you want to do, because of the impact to the quality of care CNSs ultimately provide. So we found the money elsewhere.

Other participants substantiate this understanding of the value outweighing the cost: “If you value nursing and want to build a strong base of nurses, you have to have very strong leadership in nursing, and CNSs are a part of that. We are that, we are the practice leaders within the programs and we are seen as that.” (PA). Participant H also supports this idea, stating “Particular individuals understood that CNSs are the ones that are untrammeled by the services that they work in, and if you give them some room, they are the ones that come up with innovations.” This value in innovation brings us forward to the present culture that those historical intentional decisions helped shape.

4.3.1.2 Systemic culture.

As with any organization, there are the mission, vision and values that drive the culture, strategic direction, and functioning of the system (Estabrooks et al., 2012). Many participants described the present culture of the organization to be innovative and inquisitive, focused on being compassionate by being centered in social justice and excellence to provide quality service and care (PB, PC, PF, PJ).
When asked how this systemic culture influences CNS practice, Participant C describes the following, “CNSs support us in being able to better care for a population that others would not necessarily care for, and continue to support them in an organizational context.” Participant C detailed a specific example to give meaning to the above description as seen here:

There was a lot stigma around HIV positive patients, so we as an organization support and care for HIV-positive patients in the acute setting. At the time there wasn't quite the same openness in other programs. So the issue became, how did we demystify HIV for the other programs? People felt they were not adequately able to care for the HIV-positive patients with us. This is where the CNSs working together, to talk about “What’s the profile?” “What are the issues?” “How do we demystify HIV for this program?” The CNS role can help support the care of some of our most complex patients, because they may not receive care elsewhere. We have to be able to provide the care that they need, regardless of whatever their issues may be as a patient.

In the participant statement mentioned above, there is a thread joining the expertise of CNS practice and how the system is driven. That participant went further to say: “Compassion and social justice drives the CNS community to be innovative and excellent in facilitating processes within the system to support a system to continue to provide services for marginalized populations.” Participant F expounds on this further: “It's an organization that is well known for the caring, and the compassion, and the social justice, but layering on Advanced Practice with wanting to make a difference.” As we have heard earlier, “To advance the program and to be innovative, CNSs are a necessary part of that.” (PA)

Participant F also explains how this systemic direction came about, “So we have a CEO, that happens to be a nurse, and I think that makes it so much easier, to have the senior leaders set the vision at the very top and that it filters down.” Participant A provides a broader understanding to the significance of having a nurse as a CEO and also being an active member of the senior leadership team in the following descriptions:
The VP of Nursing position was early on at the senior executive level here. Where other organizations did not put that position at the senior leadership tables. That makes a big difference and that tells you that the organization wants nursing at the table to make decisions. (PA)

So not only do nurses fill senior executive positions, but there is an inclusion of a VP of Nursing or CNO in the senior executive team. This inclusion appears to be grounded in the collective understanding that the higher level of clinical expertise that the CNS has, will have positive influences on the systems and organizational process, particularly pertaining to healing processes and caring. Participant I, elaborates on the impact that this has within the organization and the healthcare system:

There are only a few health authorities in the province, where they have a Senior Nurse at the senior executive table. So in other words they have kept or expanded the medical presence at the most senior table, and nursing is not there anymore, and allied health is not there anymore. Nobody in those Health Authorities is saying anything! Why aren’t you questioning: “Why isn't that a value any longer in your health authority to have your profession at the highest table?” You are there as a senior person representing that voice and input, and it’s gone and it continues to erode. I worry about the structures within the health authorities at the senior levels, and that as the nursing voice leaves those senior tables, who is advocating, and really understands the benefit that nursing brings to the patient?

This reflection conveys a passionate cry to take charge, to bring back the nursing voice, to be represented and included in the vital decisions made in health care, to be a champion for nursing. This participant upholds this overt value of nursing in the organization but strongly urges nursing collectively to utilize their voice to be heard on all levels of health care decision making. This value illuminates clearly the role that deliberate leadership has on the organizational influences of CNS practice. In the next section I describe briefly how deliberate leadership further enhances the CNS role.
4.3.2 **Deliberate leadership.**

Many participants expressed a salient understanding that there are deliberate champions within the organization who support the CNS role as seen here: “We have really good support.” (PB). Other participants concurred with this sentiment: “I definitely feel supported, I feel loved and supported.” (PD), and “The organization has always supported the CNS role.” (PC) Other participants felt 'strong' support from senior leadership; this included the executive team, the program directors, and other managers in this organization. (PA-PL).

Participant A broadens the understanding of what deliberate champions means as seen here: “I’ll just be plain, it’s been deliberate and overt and purposeful—all those words to build and sustain a really strong base of Advanced Practice Nurses.” Another participant further links this deliberate overt and purposefulness to the leadership team as seen here: “The CNO when I started was very supportive of CNSs and she retired, a new CNO came on and they were also extremely supportive of CNSs and they added a lot more CNS positions. And we've recently hired a new CNO, about a year ago. She's also extremely supportive” (PH).

Participant D shares an actual example of what that support looks like:

Currently we meet quarterly as an advance practice group, but this includes the Nurse Practitioners and Clinical Nurse Specialists. What we found was that there were issues that were separate from the Nurse Practitioners that we felt we needed to discuss. So we went to our VP, and we said “we’d like to meet more often with you.” The VP was very open to it and within a short time set about that it should happen. So now we meet monthly with her.

Other participants felt the support from senior leadership as being able to continue education whether it’s their PhD, (PA, PL) or quality training, (PD, PH) or specific training related to their specialty (PG). Participant I, shares their perception of how the senior leadership has supported CNSs within the organization:
Being able to meet with, understand, and support the CNS work, and support the CNSs, and then influence what is required both to get them the recognition they deserve, and the structure that needs to be in place for them to do their best work is part of my job, and then also, to communicate that.

This ability to articulate the value, recognition, and the structures needed for CNSs in the program by the leadership team, facilitates other key stakeholders to engage in the support of the CNSs in the organizations. Participant J corroborates this notion as seen here: “I’ve seen much more support of the CNS role because the Vice-President is so supportive of it, which really helps when you have support at that level.” In further analysis of the context I realize that these concepts of intentional culture and deliberate leadership link together to provide a strong scaffolding of support for CNS practice. However, these two things do not stand-alone; in the next section I provide a brief description of the imbedded infrastructures currently in place that further frame and support CNS practice.

4.3.3 Embedded infrastructures that protect the CNS role.

Although there are multiple tensions that influence support for the CNS role in this organization, many participants are very clear about the sense of value and belonging that CNSs have experienced. There is a collective acknowledgement that the deliberate systems that are in place, serve to protect the CNS role in this organization. The three main embedded infrastructures I identified are dual reporting, the APN community, and steadfast educational requirements for the CNS role in this organization.

4.3.3.1 Dual reporting.

Participants described an established dual reporting system: “It’s a matrix.” (PH), “I report to the clinical VP, and then there's a dotted line, so that CNSs report both through program and through the CNO/VP.” (PE). Another participant further explains the dual reporting relationship:
We have a dual reporting Relationship—I actually don’t report to the CNO—it’s a dotted line relationship. We report to our program director. But some CNSs who work more at the organizational level, for example CNSs who go to all programs, they report to just the CNO/VP. Whereas people who are more programs-based report to the program director and have a dotted line to the CNO. The fact that we report directly to a Vice President, I think it says quite a bit, in terms of what the organization values. (PA)

Participant H further broadens this understanding of why this system came about and the resultant implications:

A previous VP of Nursing said that the reason they had this dual reporting structure is because; “they”

could never make a decision not to have that person (CNS) without the CNO/VP concurring.

In the same vein another participant acknowledges the benefits this protection has:

We have a dual reporting relationship for our CNSs- in that they report to the program director and then they report to the Chief Nursing Officer for kind of professional practice side of that portfolio. So I think the CNS role is kind of well supported and day-to-day relationship with Program Director and then ensuring that there is a relationship with VP/CNO, to enhance the professional practice portion of the CNO role and to create that network for the CNSs connect (PC).

Many participants agreed that this overt protection from having the CNS role erased is a tangible way in which the CNS role is supported within this organization (PA, PB, PC, PH); however, Participant C identifies that the dual reporting also created a network for APNs, and subsequently CNS professional practice. In the next section I describe further how the collective APN community further enhances the CNS role in this organization.

4.3.3.2 APN community.

The APN community in this organization is comprised of the NPs and the CNSs. Many participants share a common perception of what this APN community is: “They are an amazing group of experienced clinicians with a wealth of knowledge.” (PF). Participant B describes this

4 They,∗ being any individual/program with the authority to cut a CNS position
group as being very collaborative, and includes both formal and informal interactions.

Participant L provides a description of these formal interactions:

- We meet with the VP quarterly, it’s about a one-hour meeting with VP and we discuss issues, concerns, and various projects that we do, and whatever concerns we have. This means we have someone to hear our concerns, and it is fully supported by the VP. (PL)

Participant C emphasizes that the formal interactions are where the collective organizational work is accomplished. Examples of how this collective community of CNSs supported the organization are evident through the collaborative work done in quality assurance, accreditation, strategic planning in complex patients, and most recently, succession planning.

As discussed earlier, there are many individuals in the process of retiring. As a result of this impending exodus, many participants reflected on the collective work of the CNS community in succession planning as this excerpt reveals:

- So what I started was, I got a small group together to say can we look at a succession plan for the CNSs? Because my fear is I don’t want all that wisdom to go out the door, and when I look around the room I can see the wisdom could go out the door very soon. My goal for the group is to put a plan in place that they can address the senior leadership team directly and ask, “Can we get some dollars to support succession planning?” What that will mean is, if a CNS is going to retire, can we do some bridging? But even if we can’t do that, could we get some dollars to support CNSs to come back, and actually do that bridging even at a bigger scale: “So what is the role of the CNS? What are the expectations? Where can you take your practice?” I feel passionate about that Advanced Practice Nursing role, because I think that it is so fundamental to the entire team, to the organization. (PF)

In a further analysis of the context of this description, I extrapolated that the succession planning was rooted in the ideas of mentorship. This APN community provides an informal avenue for mentorships. Participant E further broadens the understanding for the need for this mentorship as seen here: “CNSs, new or seasoned, coming in to a new role need support in program or organizational nuances, understanding the role in this specific context, and networking.” (PG).
Situating the understanding of mentorship further in the context of the APN network, I found that many participants perceived that the mentorship relationship was often done through informal interactions as seen here: “I think there are amazing mentors in my program, and I can go to them for things like: getting to know what your role is, knowing what your scope is and ... and you know what it is that you do.” (PB). Other participants describe the mentorship as an intentional structure put in place to support CNS practice (PI).

Regardless of whether this mentorship is done in formal or informal interactions, many participants agree that it is embedded in the structures of the organization to support the CNS role. I also identified that the advanced practice network is a diverse group of Master of Nursing prepared NPs and CNSs. This is not always a requirement for the CNS role, as noted by Kilpatrick (2012). Kilpatrick also identified that throughout Canada and BC there are very large number of nurses who identify themselves as CNSs; however, the actual number of CNSs who are practicing that meet the CNA's criteria for CNSs is still unknown. This steadfast clarity of having the CNA (2009) prescribe recommendation for educational preparation is the final subtheme I discuss in this analysis.

4.3.3.3 Steadfast educational requirements for the CNS role.

This organization adheres to the CNAs (2009) position statement in such a way that all CNSs are prepared with a Masters in Nursing, as seen here, “I know that organizationally we’re very strict that the CNS must have a Masters in Nursing. I think Masters prepared is essential.” (PC). The excerpt from Participant I that follows, broadens the understanding of why this Masters preparation is required:

I have been 100% steadfast that you require a Master’s Degree in Nursing; this is about specialist in nursing, a Clinical Specialist in Nursing. So for us, we have and continue to have, an equivalency statement for the CNS that you require your Advanced Preparation in Nursing because that is the focus. With the CNS given the breadth, for me, it’s
important to have the Advanced Preparation in Nursing; not a MBA, not a M. Ed., not a MHA, and I absolutely appreciate not everybody agrees with that, and does that differently. We may be one of the few that actually do, because I do get asked, every once in a while from the programs, when they think they have someone they are interested in, who doesn’t yet have that Advanced Preparation in Nursing... we haven’t yet gone there.

In the same vein, other participants identified that there may be more applicants who would be successful in the role (who don’t have an MN or MSN); but by opening the door and accepting one person, they would diminish the value that the CNS has in the organization (PG, PH). However, not all participants feel this stringent sense of protection is beneficial to the system, as seen in the following interview excerpt:

You can go to any organization and you’ll see the leaders are old diploma nurses, in this specific specialty, because people have 15 to 20 years of experience, and apply for these jobs, and got them over people with masters’ degrees because they had all the background. So, from a CNS recruitment point of view in my specialty, I’m very nervous, because I’ve worked in this program for 25 years, and I met two nurses with a Masters in Nursing, and whose passion is for this specialty. (PJ)

Participant J reminded me that limited availability of human resources may potentially negatively impact the CNS role when confounded with these strict requirements.

Participant H summarizes the central understanding of this requirement as seen here: “I think a Nursing Masters gives you a depth for scholarships that you don’t have when you have another kind of masters, a depth of scholarship about the discipline.” This reinforces the aspect of expert practice, and the way that CNSs are key stakeholders in informing and influencing their roles in the organization.

In discussion of this theme, I provide a brief description of culture, leadership, and the role protection embedded in the organization that is intentionally placed and maintained, to supportively enhance and proliferate CNS practice. I also note that these supports intersect with
tensions and transformative practice to provide a broader picture of how CNSs are organizationally influenced in this system.

4.4 Summary

In this chapter, I described three major themes that developed from the analysis of the experiential understanding of the collective participants within this case study, examining what they perceive to be the main influences on the CNS role in this organization. From the organizational viewpoint, there was a predominant understanding that transformative practices of CNSs serve to inform and influence the development and enactment of their role. Also, although intersecting and complex tensions influence the role, there is an intentional imbedded infrastructure in place, in that specific organizational culture that protects the growth of CNS practice.

In Chapter Five a discussion of the findings is presented. I then turn to implications for clinical practice, education, research, and for the health care system. Lastly, based on the findings from this case study, I make recommendations regarding organizational supports and CNS practice.
Chapter 5: DISCUSSION OF FINDINGS, IMPLICATIONS AND RECOMMENDATIONS

In this chapter I present a discussion of the research findings. It is important to note these findings are not truths; rather they are a discovery that gives new meaning or supportive descriptions of what is already known (Thorne, 2008). I also outline implications for the areas of practice, education, research, and the health care system. Finally, based on my findings, I recommend areas for further research, and conclude my story.

5.1 Discussion

In this study, many meaningful descriptions brought forward new insights regarding the influence of the organization on the CNS role. The analysis of the findings emerged as three major themes:

- the transformative practice of CNSs,
- intersecting tensions influencing support for and enactment of the CNS Role, and
- intentional embedded organizational infrastructure and support.

These findings are supported by what has been previously described as factors that influence the CNS role in Canada (DiCenso & Lukosius-Bryant, 2010; Kilpatrick et al., 2013).

5.1.1 The transformative practice of CNSs.

In keeping with the literature (Bryant-Lukosius et al, 2010; Hamric et al., 2012; Jeffreys, 2005; Zuzelo, 2003), in the organization under study, participants perceived the CNSs to be central stakeholders who operate as change agents across three spheres of influence; patient, nurse, and organization or system. CNSs are seen as leaders who facilitate the practice of others and who work across organizations, most often without the constraints those others, such as managers may experience (CNA, 2009; Darmondy, 2005 Kelly et. al, 2013). It was also
recognized that CNSs are not generally novice practitioners. Usually CNSs are individuals who have been in the field of nursing for a substantial period of time, and have built their knowledge, wisdom, and expertise as system leaders during their tenure within organizations. This is already clearly identified from other research (Bryant-Lukosius et al., 2010; Kaasalainen et al., 2010; Peplau, 2003). They may be novices to the organization, or even novices to the role; however, they are often experts in their field. Most CNSs are already transitioning into the role of expert practitioner in their substantive areas of practice.

In the study two subthemes became clear: the vision of the CNS role and the uniqueness of the individuals in the role as shaped by personal characteristics of the CNS -- both contributing to transformative practice. The vision of the CNS role is clear for many of the participants. They expressed that the CNS is a change agent who improves clinical-care through research and evaluation, with the goal to advance practice at the patient, nurse, and systems levels. This aligns with the NACNS (1998) definition; but deviates slightly from what is in the literature (Bryant Lukosius et al., 2010; Kilpatrick et al., 2014), where it is noted that a unified vision for CNSs is needed for their role to flourish (DiCenso et al., 2010). Currently the CNA and local provincial jurisdictions are actively working on a unified vision and voice for CNS practice. In 2014, the CNA released a set of core competencies that are central to CNS practice, which is an important step towards a unified vision.

Many participants agreed that CNSs are expert clinicians who may or may not provide direct care; but many suggested that regardless of the amount of time spent in direct care, the central focus of the role is in the provision of clinical expertise. This notion is similar to what is already known (Bryant et al., 2010; Kilpatrick, et al, 2014). In addition, although a few participants noted that there is little time to actually conduct research, all shared a collective
agreement that clinical care decisions need to be based in evidence which is in alignment to what is already seen in Hamric et al., 2012.

The analysis of the descriptions also brought forward the idea that the CNS advanced practice throughout the organization, facilitating not only the practice of nurses, but also that of the entire inter-collaborative team. This notion substantiates what is set forth by the CNA (2009) position statement, research regarding improving systems, and reviews of hospitals with CNSs that have Magnet status (Bryant-Lukosius, 2015; Muller, 2012; Zuzelo, 2003). This finding has also supported what is already known about the ability of CNSs to facilitate transformation at a systemic level, modeling change for the system, nursing and patients (Canam, 2005; Finkelman, 2013; Hamric et al., 2012).

In keeping with the perspective put forward by Virani (2012), the participants in this study noted that the advancement of practice is an expectation of the CNS role, and not just an outcome of what the CNS role can offer; the participants had a very clear idea of the benefits of the CNS role to the organization. This advancement in practice is done through research, and improving quality and safety of the system, but also through mentorship and collaboration (CNA, 2009; Zuzelo, 2003). One particularly significant finding is that the CNS is a systems practitioner, who has clinical expertise in his or her own specialized area, even more so than others on the team. This corroborates the notion of CNSs as experts (Donald et al., 2010). This differentiation helps to clarify and give value to the role, to designate clearer role obligations and negate further confusion.

As noted in the literature (CNA, 2009, DiCenso et al., 2010; DiCenso & Lukosius-Bryant, 2010), many of the participants noted that there are often no clear boundaries between the five practice domains of clinician, consultant, educator, leader, and researcher. These
domains are overlapping and represent the full scope and functioning of the CNS. Also in keeping with literature support (e.g., DiCenso et al., 2010; Virani, 2012; Zuzelo, 2003), the CNS functions autonomously to meet the needs of the organization within a set of expectations of the role. Many participants recognized that CNSs work in the background to support system transformation and improved patient and family care. To this comprehensive description, the CNS also brings individual attributes, passion and creativity.

As put forward by Peplau, (reprinted, Zuzelo, 2003) and noted in this study, CNSs have both a collective and individual credibility that is integral to the continued support for the work of the CNS in this organization. The credibility associated with the work CNSs do is what strengthens the support for the role within the organization. Conversely, this adds to the stress that Baker (1997) says is associated with the perception by many CNSs that “every day is a job interview” (PB). In agreement with the literature (Bryant-Lukosius et al., 2010; CNA, 2009; DiCenso et al. 2010; Muller, 2003; Zuzelo, 2003), the overall consensus of the participants is that CNSs are a vital contributor to the functioning of the overall system and as a result are primary stakeholders within that system.

5.1.2 Intersecting tensions influencing support for and enactment of the CNS role.

It is important to recognize that within this organization, there was an overall contentment and satisfaction with the CNS role, and that the tensions discussed here did not act as barriers to CNS practice. The CNSs somehow navigated around these issues to function in a meaningful way. This substantiates what is already being seen in the literature (Bryant-Lukosius, et al., 2010, Hamric et al., 2012) regarding the creativity and innovation of CNSs to work to influence or shape practice within the constraints of the practice setting.

The tensions described by the participants were related to the scarcity of resources, the
broader context of health care changes, and to a dialogue related to prioritizing power. Scarcity of resources refers to environmental constraints, and limited social capital that Carter et al., (2010), DiCenso et al. (2010), and Estabrooks et al. (2012) also point to as factors that can influence CNS practice. There was a common understanding among the participants that these tensions intersected with one another, thus making the barriers for CNS practice a little more difficult to overcome. For example, if there are no funds, this impacts social capital. However, in much the same way as Bryant-Lukosius et al., (2015); Carter et al., (2010); Kilpatrick et al., (2014), Muller, (2005) describe, people within the organization very much agreed that the benefits of CNS practice outweighed the initial cost.

Limited social capital issues were expressed within the context of the reality of the impending exodus of about 42% of the CNS pool. Many participants expressed this concern to be about whether or not the roles would be filled, or if there are suitable candidates to even fill the role. Historically it was noted that some CNS positions were not filled due to an inability to find suitable candidates, thus supporting the current concern that some CNS positions might not be filled when the CNSs retire. In other cases, it was noted that the positions were not filled because the organization no longer needed a CNS role in the particular area of vacancy. There is very little literature on the challenging issue of large-scale CNS retirement in Canada; an area that I would suggest requires further research.

The salient impression of the participants regarding the context of broader health care changes is that as the landscape of health care has evolved over time, so has the role of the CNS to help support and facilitate resultant needs. Many participants say that CNSs are aptly equipped with their expertise and vision of the system to meet the challenges of dynamic health care systems. This corroborates with positions taken by Muller, (2005); CNA, (2009); Virani &
The discourse on power was complex and intertwined within itself. Although the need for role clarity is a widely recognized issue pertaining to CNS practice (CNA, 2008; DiCenso et al., 2010; DiCenso & Bryant-Lukosius, 2010; Virani, 2012), I found a nascent perception that balancing power was muddled due to role clarity, blurred boundaries, and balancing agendas. The participants recognized that role clarity is an issue pertaining to the role itself. What is a CNS? How do they contribute to patient, team and system? How are they different than other nurses? However, the analysis of the data also broadened the understanding that this confusion contributed to blurred boundaries, resulting in team members stepping on each other’s toes. As seen in the literature (Donaldson, 2010; Kilpatrick et al., 2014), there is a recognition of the potential vulnerability that the NP and CNS relationship. This may be due in part to the alleged invisibility of the CNS role as compared to a more noticeable contribution NPs make through direct patient care. This substantiates what is already recognized in the literature regarding the CNSs invisibility of the CNS role as seen in DiCenso & Bryant, Lukosius, 2004; Kenny et al., 2010). Such an argument about invisibility seems to perpetuate a persistent refusal to recognize the influence that nurses need to assert in sustaining and coordinating care processes. The expert or specialist clinician aspect of the role is often hidden or silenced from view by overt questioning of the CNSs alleged medical authority, or managerial place in the organization. These allegations do not do justice to the CNSs very real influence on sustaining a high quality caring and healing environment pertaining to patients, nurses and the organization itself. Those outcomes are ultimately grounded in the CNSs clinical expertise. That is what it required to care with excellence for patients in a complex organizational environment.

I discovered that the blurred boundaries of the CNS role were mainly focused on
interplay between the practice consultants, educators, and other allied health team members. This is perceived to be a result of the historical context of how other roles were either brought in to fill the gap that the absence of a CNS created, lack of clarity and understanding of scope of each of the roles, or individuals overstepping their role. This notion of blurred boundaries, coupled with the invisibility of CNS practice, uncovered lingering and covert conversation about whether CNSs are really needed or whether there is the political will to support them.

While some participants hinted to be in line with this thought, there were others who completely negated the conversation, stating the work would not get done in the way a CNS would do it. The latter response supports what Bryant – Lukosius et al., (2015) Hamric et al., (2012) already recognize in terms of the value of the CNS. These latter responses also bring forward previous conversations on expertise and leadership as discussed by Bonsall & Cheater, (2008), Bousfield, (2006), Canam, (2005), Darmody, (2005). It was also an important note in the interviews that the CNS does not do it all, but they are an integral part of the whole, and that through collaborative practice, the work gets done.

Although it is recognized that CNSs are the practice leaders and all decisions about practice ought to include a CNS, there are some instances when CNSs are not included in the decision making process for a variety of reasons-- e.g. time constraints, or a clinical decision needing to be made quickly or the CNS may just not be there. However, in keeping with what Bousfield (2006) notes regarding the value of the CNS generally, there was an understanding that the CNS would be brought into clinical decision-making processes to provide further insight on most clinical issues.

The balance of agendas was another point of tension: CNSs did not necessarily want to set the strategic directions for programs; but a tension was described between physicians and
some CNSs in this regard. Kilpatrick et al., (2014) also note that they found that physicians most often lead the direction of clinical programs. However, many CNSs in this organization have built credibility with the physicians and the larger team, with the support of the senior leadership, by engaging the team members and articulating the value of the CNS role early on in their tenure. As found in the literature (e.g., Carter et al., 2010; Lindblad et al., 2010) over time within the organization, CNSs noted they were then called upon for consultation and collaboration. I did recognize that even in this organization the dynamic between the physicians and CNSs continues to reinforce old stereotypes, which regard physicians and nurses mainly by focusing on the power dynamic and gender disproportion. There is a paucity of research pertaining to how these reinforced stereotypes impact CNS practice; and thus may be another interesting area of inquiry.

The last tension is the expression of frustration by CNSs when being pulled in so many different directions, due to organizational and program specific needs. In some ways this relates to the popularity of the role within this organization. Fitzgerald et al., (2003) also make note of this tension regarding enactment of the CNS role. However, as Hamric et al. (2012) describe in the literature, the CNSs in this organization navigate these challenges through team engagement, enactment of expert practice and research.

5.1.3 Intentional embedded organizational infrastructure and support.

It was noted that infrastructure was intentionally created to support the integration of advanced practice nursing roles within the organization; this was done to create a culture that supported the advancement of nursing practice more broadly. While other health authorities have cut CNSs over the years (Kaasalainen et al, 2010), within this organization the role has flourished. It was an intentional decision guided by the insight as noted by Carter et al., (2010) that the CNSs elevate nursing practice, and are valued leaders in nursing and the organization.
Innovation, excellence and compassionate care are values that are central to this organization and tie closely to the commitment of the organization to welcome CNSs whose practice reflects these values by the very nature of the role.

Another important and related aspect is the value placed on nursing leadership, as seen by the fact that nurses are in senior level executive positions in this organization. In addition, one of these individuals is a champion of the CNS role; this individual believes in the value added by CNSs and actively supports the role. This is not always the case. As Bryant Lukosius et al. (2010) and Prevost (2002) note, over the last decade throughout the province and the country, a diminished number of nurses are at the executive table – nurses’ voices are being lost, suggesting a devaluing of nursing more broadly. DiCenso et al. (2010) underline the important role CNSs have in ensuring that nurses’ voices and their clinical expertise are heard by actively providing leadership. Carter et al. (2010) note the importance of creating structures within the organization to ensure that CNSs are supported in this way.

Both formal and informal mechanisms were created over time to support the CNS role. Three main processes to support CNSs were noted in this study: dual reporting, encouraging the APN community, and adhering to CNA (2009) recommendations that CNSs be masters-prepared registered nurses.

One thing that was unexpected for me, was that although the Nurse Practitioner (NP) role has eroded the popularity of the CNS role in some settings (Donald et al., 2010), Elsom & Happel, (2006), most of the participants in the study had clear insight into the differences between the two roles and the complimentary nature the two roles brought to the team. This relationship may be a testament to the collective Advanced Practice Nurse (APN) network in the organization, which facilitates collaboration through shared support. This complimentary
Collaboration is due in part to clearly laid out expectations of both roles in the organization and the work done around educating the interdisciplinary team members to the roles. This work by senior leadership and the organization to clarify the complimentary APN roles is a recommendation noted in the literature for APN practice as seen in Carter et al., (2010), Donald et al., (2010). The extent of understanding the CNS and NP roles beyond where they were located in the organization was not clear and perhaps suggests a limitation of the study and a point for further research.

CNSs in this organization report to both the program director within their specialty and the VP of nursing. There is a dotted line created to the VP so that no one can unilaterally make a decision to cut the role without the cooperation of the VP and vice versa—a strategy supported in the literature (e.g., Carter et al., 2010; Lethwaite et al., 2012). The reporting by the CNS is done monthly in an APN group within the organization, and quarterly in the CNS group who collectively meet with the VP. These meetings are set to provide a venue for strategic planning, problem solving, recognition and networking. It is in this way that mentorship is established (although not formalized); CNSs have created an inter-collaborative mentorship that is meant to provide support for novice CNSs in the organization—something recommended in the literature (e.g., Carter et al, 2010; Kenney et al., 2012). Another benefit noted to be a result of the APN network is the notion of succession planning. The pending exodus of CNSs due to retirement, now widely understood to be a problem, has CNSs actively engaged in identifying potential CNSs within the nursing workforce who can be mentored to advance their practice and go on to do further graduate education.

Lastly, all CNSs must be specialized practitioners with a Masters in Nursing to be a CNS in this organization. In keeping with the perspectives of many in the field (e.g., Martin-Misener
et al., 2010), it is believed that CNSs need the expertise that an advance practice degree in nursing provides. However, it should be noted that there is some controversy in the field regarding what this education should look like, e.g., some believe there needs to be standardized curricula with a substantial clinical component for masters’ preparation (Martin-Misener, 2010).

Through this discovery I presented on how the organization supports and influences the enactment of the CNS role. Although there are many tensions within the organization that can and do challenge CNS practice, the CNSs navigate these tensions seemingly masterfully. They are expert clinicians who use research to advance practice in the context of a largely supportive organization.
5.2 Implications for Clinical Practice, Research and Evaluation, Advancement of Practice and Leadership

Grounded in the findings of this study are multiple implications for clinical practice, research and evaluation, education, and leadership.

5.2.1 Implications for Clinical practice

1. *Unified Vision for the CNS Role within the System.* Having a unified vision of the CNS role within a practice setting promotes role clarity, and ensures that the CNSs are able to work with in an inter-collaborative team to full scope of practice.

2. *Formal Advanced Practice Network.* This network supports the CNSs to have a community of APNs to facilitate strategic direction in clinical care, through research (sometimes shared), mentorship, and collaboration. The network also provides a means by which organizational priorities can be addressed; it would be best if there were representation from senior leadership present.

5.2.2 Implications for research & evaluation

1. *Strengthening a Culture of Inquiry.* CNSs are partners in facilitating the advancement of practice in nursing and the systems. In a culture of inquiry nurses are driven to look for new and innovative ways to provide the best care; CNSs are uniquely positioned due to their scope of practice to help engage the team to do so. This also provides a means by which mentorship and collaboration can occur at the bedside with nurses and with the inter-professional team members.

2. *Canadian Context designed CNS Focused Research.* Without the research, the field of nursing, (specifically pertaining to the CNS) will not grow. Within the past six years there has been a decline in CNS practice in Canada (Kilpatrick et al., 2010). Some have
attributed this to the sparse research available on CNS practice within the Canadian context (e.g., DiCenso et al., 2010 a). Understanding the role and the value the role brings to the team may further secure the CNS role in Canada.

5.2.3 Implications for education

1. *Standardized Curriculum.* A standardized curriculum in Canada for the CNS may potentially enhance CNS practice by providing a strong foundation in clinical practice, research and evaluation, leadership, policy and overall advanced nursing practice within the three spheres of influence – clinical practice, nursing and organizations.

2. *Title Protection and Role Regulation.* As the CNS role is one of two APN roles in Canada (CNA, 2009), title protection can help minimize issues around clarity, practice and scope, while protecting and regulating CNS practice. Currently in partnership with the CNA, there is work being done to move this recommendation forward. Already there have been published competencies for CNS practice (CNA, 2014). There is also work being done on drafting a vision for CNSs in Canada as well as the formation of an association for CNS in Canada.

5.2.4 Implications for leadership

1. *Investing in the CNS.* By investing in CNSs in the organization through education, support and growing and or protecting the role, teams are built with expert practitioners who can lead by influence to facilitate innovation and excellence.

2. *Articulating the Value of the CNS* facilitates a means by which CNSs are recognized for the work they do within the team, and in doing so facilitates a means by which to engage other central stakeholders in the process.

3. *Providing Resources and Structures to Support the CNS in the Organization* means
setting up the cultural, environmental, financial and leadership structures that facilitate optimum CNS practice.

5.2.5 Recommendations for future research

The findings I presented in this study although limited, merit further research in the area of influences of the organization on the CNS role. I recommend that,

1. A study be conducted on a larger scale (within other organizations) to add to what was already found in this study; a follow up study in other locations where CNSs enact or articulate their roles in other ways, or are have varying other organizational influences impacting them.

By altering the location, sample size, demographic new descriptions and subsequent discovery, we can provide further meaning to what has already been identified (Polit, D., & Beck, C., 2012 p. 585).

5.3 Conclusion

In chapter one I located myself in this research study. I had a particular issue in articulating my rationale for engaging in this graduate school journey, specifically about how to advance practice in mental health from my position working in community mental health. By laying out the current literature on the CNS role in Canada, I was able to identify that a further investigation into how the CNS role is affected by the systemic and organizational influences is a significant area of discovery that I was interested in studying. I articulated the question of what are the influences of the organization on the CNS role, based on the current knowledge in the science of nursing. In chapter two, I outlined what is already known in regards to CNS practice, change, influences on the CNS, organizational influences, and organizational influences on the CNS. In chapter three I outlined the interpretive descriptive methodology within a case study
approach I used to enact the research. In chapter four I provided a detailed analysis of the findings; in this last chapter I discussed the transformative practice of the CNS, the intersecting tensions the influence the role, and embedded infrastructure that is in place in this organization to protect the CNS role. I also outlined implications this has for clinical practice, education, research and the health care system with recommendations for future research.

I want to close this research by reiterating the description that threaded this process. The pervasive implication for the organization is to minimize the tensions that influence the CNS role, embed intentional structures to support and enhance the CNS role, and then articulate and engage to recognize and value the role. In doing so there is potential for the CNS to transform practice through the sharing of clinical expertise, research and evaluation and expert leadership and to influence or shape patient outcomes, nursing practice, and organizational change.
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Appendix A: Letter of Invitation for Primary Participants

For the Research Project:
“Exploring the Influences of an Organization on the Clinical Nurse Specialist (CNS) Role”
July 28, 2014

Letter of Invitation for Primary Participants

STUDY TEAM
Principal investigator: Dr. Victoria Smye, University of British Columbia (UBC) School of Nursing. Phone: 604-822-7503, email: Victoria.Smye@nursing.ubc.ca

Primary Researcher: Rubyna Tatlock, UBC School of Nursing. Phone: 604-309-4038, email: rubynatatlock@gmail.com

Co-Investigators: Dr. Geertje Boschma, UBC School of Nursing, Dr. Patricia Rodney, UBC School of Nursing, Alice Chan, UBC School of Nursing

We are conducting a research study to explore how an organization influences the role of the Clinical Nurse Specialist (CNS). The purpose of this research study is to explore how organizations in British Columbia (BC) are supporting the role of the CNS and what organizational influences are shaping that process; this is to broaden our understanding of how the CNS role might best be supported.

To do this we will be taking a two-step process. First in phase one we will be talking to senior leadership personnel and a few CNSs in the organization to explore what organizational factors influence the CNS role. Secondly in phase two, primary participants from phase one will be asked to identify key stakeholders or other interdisciplinary team members who have or are influenced by the CNS role. These individuals identified will be invited to participate in a focus
group to help clarify and further uncovering meaning on how this role is affected by organizational influences.

As a primary participant you will be asked to spend no more than 90 minutes in a location of your convenience to discuss your understanding of organizational influences on the CNS role.

PRIMARY PARTICIPANT INTERVIEWS

If you are a part of the leadership team or a CNS who has influence on the contextual practices and development of the role of a CNS, an employee at Providence Health Care with a minimum of six months of service in this organization we would like to talk to you.

We would like to assure you that your participation in the study and the information gathered would be held in the strictest confidence.

Your time and participation are greatly appreciated.

If you are interested in doing an interview or would like more information, please email inquiries to [rubynatatlock@gmail.com](mailto:rubynatatlock@gmail.com) or call Ruby at [604-309-4038](tel:604-309-4038) at any time.

Victoria Smye RN, PhD
Associate Professor UBC School of Nursing
Appendix B: Letter of Invitation for Focus Group Participants

For the Research Project:
“Exploring the Influences of an Organization on the Clinical Nurse Specialist (CNS) Role”
July 28, 2014
Letter of Invitation for the Focus Group Participants

STUDY TEAM

Principal investigator: Dr. Victoria Smye, University of British Columbia (UBC) School of Nursing. Phone: [redacted], email: Victoria.Smye@nursing.ubc.ca

Primary Researcher: Rubyna Tatlock, UBC School of Nursing. Phone: [redacted], email: [redacted]

Co-Investigators: Dr. Geertje Boschma, UBC School of Nursing, Dr. Patricia Rodney, UBC School of Nursing, Alice Chan, UBC School of Nursing

We are conducting a research study to explore how an organization influences the role of the Clinical Nurse Specialist (CNS). The purpose of this research study is to explore how organizations in British Columbia (BC) are supporting the role of the CNS and what organizational influences are shaping that process; this is to broaden our understanding of how the CNS role might best be supported.

To do this we will be taking a two-step process. First in phase one we will be talking to senior leadership personal and a few CNSs in the organization to explore what organizational factors influences the CNS role. Secondly in phase two, primary participants from phase one will be
asked to identify key stakeholders or other interdisciplinary team members who have or are influenced by the CNS role. These individuals identified will be invited to participate in a focus group to help clarify and further uncovering meaning on how this role is affected by organizational influences.

As a participant in the focus group you will be asked to participate in a group discussion lasting no more than 90 minutes:

If you are an interdisciplinary team member, who has been influenced or influences the role of the CNS and have been an employee of the Providence Health Care with a minimum of 6 months of service we would like you.

We would like to assure you that your participation in this study and information gathered would be held in the strictest confidence.

We greatly appreciate your time and participation.

If you are interested in participating in this research study or would like more information, please email inquiries to rubynatatlock@gmail.com or call Ruby at 604-309-4038 at any time.

Victoria Smye RN, PhD
Associate Professor UBC School of Nursing
For the Research Project:
“Exploring the Influences of an Organization on the Clinical Nurse Specialist (CNS) Role”
July 28, 2014

Consent for Primary Participant Interviews

I. STUDY TEAM
Principal investigator: Dr. Victoria Smye, University of British Columbia (UBC) School of Nursing. Phone: [redacted], email: [redacted]

Primary Researcher: Rubyna Tatlock, UBC School of Nursing. [redacted]

Co-Investigators: Dr. Geertje Boschma, UBC School of Nursing, Dr. Patricia Rodney, UBC School of Nursing, Alice Chan, UBC School of Nursing

II. INVITATION AND STUDY PURPOSE

You have been invited to participate in the study as you have been identified as either an individual with senior leadership experience, a Clinical Nurse Specialist (CNS) or an interdisciplinary team member with insight and information pertaining to organizational influences on CNS practice and have at least six months of experience within the Providence Health Care Organization.
We are conducting a research study to explore how an organization influences the role of the CNS. This is being done as part of a graduate research project for one of the researchers (Rubyna Tatlock). We are interested in exploring how leadership personnel, CNSs and other interdisciplinary team members identify contextual factors that may influence CNS practice. Virani & Associates, 2012 (2013) identifies that the organization plays a key role in the manifestation of the CNS role however what those contextual factors are have yet to be fully uncovered. Therefore, the purpose of this research study is to explore how organizations in British Columbia (BC) are supporting the role of the CNS and what organizational influences are shaping that process; this is to broaden our understanding of how the CNS role might best be supported.

To do this we will be taking a two-step process. First in phase one we will be talking to senior leadership personnel and a few CNSs in the organization to explore what organizational factors influence the CNS role. Secondly in phase two, primary participants from phase one will be asked to identify key stakeholders or other interdisciplinary team members who have or are influenced by the CNS role. These individuals identified will be invited to participate in a focus group to help clarify and further uncovering meaning on how this role is affected by organizational influences.

Primary participants from phase one will not be included in the focus group discussion.

As a primary participant you will be asked to spend no more than 90 minutes in a location of your convenience to discuss your understanding of organizational influences on the CNS role.

III. STUDY PROCEDURES

The primary researcher, a Graduate Research student from UBC, will be talking to you about your experience in senior leadership, CNS, or interdisciplinary team member in relation to organizational influence on the role of the CNS within Providence Health Care.

**Primary Participants** will be interviewed in person, one at a time in a location deemed convenient by you. The length of the interview will not exceed more than 90 minutes. With your consent the interviews will be audiotaped and further transcribed. At any point in the interview you can ask to have the audio recording shut off or erased. An electronic copy of the transcription will be forwarded to you for your review with your consent. The purpose of this is to ensure an accurate and complete account of your experience. The Graduate Research student will conduct the interview. The questions will be semi-structured and open-ended. This means the questions will be asked in such a way as to promote easy conversation and dialogue. The discussion will focus on organizational influences on the CNS role.

1. There are many CNSs within this organization, what do you see as the benefits of CNS practice for clinical practice, nursing and the organization?
2. What are the challenges, if any in having this role?
3. How is the role supported/resourced? (E.g., financially, environmental context, research etc.)
The interview will take place at a time and location that promotes convenience and practicality for the primary participant. A research assistant will be present to take field notes and assist in the operation of the audio recording. There will be a total of 6-9 primary participant interviews.

IV. **STUDY RESULTS**

- The results of this study will be reported in a graduate thesis and may also be published in journal articles and books.
- The main study findings will be published in academic journal articles.
- At the end of this research project a report will be made available to you of the findings of the research.

V. **POTENTIAL RISKS AND BENEFITS**

We do not think there is anything in this study that could harm you or be bad for you. Some of the questions we ask might upset you. Please let one of the study staff know if you have any concerns. The information will not be used for any purpose other than what is outlined in this consent. You do not waive your legal rights by signing this consent form.

We do not think taking part in this study will help you. However, in the future, others may benefit from what we learn in this study.

VI. **CONFIDENTIALITY**

Your confidentiality will be respected. Information that discloses your identity will not be released without your consent unless required by law.

All documents will be identified only by code number and kept in a locked securely in the research office at the UBC campus in the nursing department.

All audio recordings will be kept in a locked secured storage behind locked doors on the UBC campus in the Nursing Department after transcription of the data has been completed.

Subjects will not be identified by name in any reports of the completed study.

All information identifying you or others you mentioned in the study will be deleted from all notes, recordings and documents.

After 5 years the physical data and recordings (audiotapes) will be destroyed.

Only the Primary Researcher and Principal investigator (listed) will have access to the physical documents and audio records as well as has access to research information with your name on it. The co-investigators will only have access to the information without your name.
Each person on the research team will be accountable for abiding with the rules regarding privacy and confidentiality in this study. However, since the recruitment liaison is both a member of the research team as well as an employee of the organization of study, there may be limits to confidentiality.

VII. CONTACT FOR COMPLAINTS

If you have any questions or concerns about what we are asking of you, please contact the study leader or one of the study staff. The names and telephone numbers are listed at the top of the first page of this form.

VIII. CONTACT FOR COMPLAINTS

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at [contact information] or if long distance e-mail [contact information]
PARTICIPANT CONSENT AND SIGNATURE PAGE

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact on your employment at Providence Health Care.

Your signature below indicates that you have received a copy of this consent form for your own records.

- Your signature indicates that you consent to participate in this study.

Do you agree to be audiotaped?  Yes  No

___________________________  _______________________
Participant Signature   Date

____________________________________________________
Printed Name of the Participant signing above
Appendix D: Consent for Focus Group Participants

IX. STUDY TEAM

Principal investigator: Dr. Victoria Smye, University of British Columbia (UBC) School of Nursing. Phone: [redacted], email: Victoria.Smye@nursing.ubc.ca

Primary Researcher: Rubyna Tatlock, UBC School of Nursing. Phone: [redacted], email: rubynatatlock@gmail.com

Co-Investigators: Dr. Geertje Boschma, UBC School of Nursing, Dr. Patricia Rodney, UBC School of Nursing, Alice Chan, UBC School of Nursing

X. INVITATION AND STUDY PURPOSE

You have been invited to participate in this study as you have been identified either as an individual with senior leadership experience, a Clinical Nurse Specialist (CNS) or an interdisciplinary team member with insight and information pertaining to organizational influences on CNS practice and have at least six months of experience within the organization. You have been identified as someone who may have valuable insight into the organizational influences on CNS practice. We would like to invite you to participate in a focus group.
We are conducting a research study to explore how an organization influences the role of the CNS. This is being done as part of a graduate research project for one of the researchers (Rubyna Tatlock). We are interested in exploring how leadership personnel, CNSs and other interdisciplinary team members identify contextual factors that may influence CNS practice. Virani & Associates, 2012 (2013) identifies that the organization plays a key role in the manifestation of the CNS role however what those contextual factors are have yet to be fully uncovered. Therefore, the purpose of this research study is to explore how organizations in British Columbia (BC) are supporting the role of the CNS and what organizational influences are shaping that process; this is to broaden our understanding of how the CNS role might best be supported.

To do this we will be taking a two-step process. First in phase one we will be talking to senior leadership personnel and a few CNSs in the organization to explore what organizational factors influence the CNS role. Secondly in phase two, primary participants from phase one will be asked to identify key stakeholders or other interdisciplinary team members who have or are influenced by the CNS role. These individuals identified will be invited to participate in a focus group to help clarify and further uncover meaning on how this role is affected by organizational influences.

Primary participants from phase one will not be included in the focus group discussion.

As a participant in the focus group you will be asked to participate in a group discussion lasting no more than 90 minutes in a central location and at time convenient for all participants.

**STUDY PROCEDURES**

The primary researcher, a Graduate Research student from UBC, will be talking to you about your experience in senior leadership, CNS, or interdisciplinary team member in relation to organizational influence on the role of the CNS within Providence Health Care.

**Focus Group Participants** will participate in a one-time session of 6-8 participants at a time in a location that is convenient for all members of the group. The focus group will consist of various interdisciplinary team members within the Providence Health Care Organization. The focus group format is designed so that individuals can dialogue within a group to provide insight and information on the research question. The length of the focus group will not exceed 90 minutes. With your consent the focus group will be audiotaped and further transcribed. At any point in the focus group any participant can ask to have the audio recording shut off or erased. The Graduate Research student will conduct the interview. The invitational open-ended questions (meaning questions that encourage dialogue and natural conversation between participants) will pertain to organizational influences on the CNS role. For example:

1. What is your experience working with a CNS in this organization?
2. What are the challenges and opportunities related to CNS practice?
3. What do you see as the benefits of CNS practice within the organization?

A research assistant will be present to take field notes and assist in the operation of the audio recording.
XI. **STUDY RESULTS**

- The results of this study will be reported in a graduate thesis and may also be published in journal articles and books.
- The main study findings will be published in academic journal articles.
- At the end of this research project a report will be made available to you of the findings of the research.

XII. **POTENTIAL RISKS AND BENEFITS**

We do not think there is anything in this study that could harm you or be bad for you. Some of the questions we ask might upset you. Please let one of the study staff know if you have any concerns. The information will not be used for any purpose other than what is outlined in this consent. You do not waive your legal rights by signing this consent form. We do not think taking part in this study will help you. However, in the future, others may benefit from what we learn in this study.

XIII. **CONFIDENTIALITY**

- Your confidentiality will be respected. Information that discloses your identity will not be released without your consent unless required by law.
- All documents will be identified only by code number and kept securely locked in the research office at the UBC campus in the Nursing Department.
- All audio recordings will be kept in a locked secured storage behind locked doors on the UBC campus in the Nursing Department after transcription of the data has been completed.
- Subjects will not be identified by name in any reports of the completed study.
- All information identifying you or others you mentioned in the study will be deleted from all notes, recordings and documents.
- After 5 years the physical data and recordings (audiotapes) will be destroyed.
- Only the Primary Researcher and Principal investigator (listed) will have access to the physical documents and audio records as well as has access to research information with your name on it. The co-investigators will only have access to the information without your name.
- Each person on the research team will be accountable for abiding with the rules regarding privacy and confidentiality in this study. However, since the recruitment liaison is both a member of the research team as well as an employee of the organization of study, there may be limits to confidentiality.
Confidentiality may be limited by the nature of the group dynamics itself, as well as the potential for focus group members to know each other, as all focus group participants are a part of the Providence Health Care Organization.

**Focus Group Participants**
We encourage participants not to discuss the content of the focus group to people outside the group; however, we can’t control what participants do with the information discussed.

**XIV. CONTACT FOR COMPLAINTS**
If you have any questions or concerns about what we are asking of you, please contact the study leader or one of the study staff. The names and telephone numbers are listed at the top of the first page of this form.

**XV. CONTACT FOR COMPLAINTS**
If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at [redacted] or if long distance e-mail [redacted] or call toll free 1-877-822-8598.
XVI. PARTICIPANT CONSENT AND SIGNATURE PAGE

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact on your employment at Providence Health Care.

- Your signature below indicates that you have received a copy of this consent form for your own records.
- Your signature indicates that you consent to participate in this study.

Do you agree to be audiotaped? Yes No

________________________________________________________________________

Participant Signature Date

________________________________________________________________________

Printed Name of the Participant signing above
For the Research Project:
“Exploring the Influences of an Organization on the Clinical Nurse Specialist (CNS) Role”

Demographic Data Collection Worksheet
July 21, 2014

Participant Code ____________________

What is your educational background?

Degree Obtained ___________________________ Year _____________ Location
Degree Obtained ___________________________ Year _____________ Location
Degree Obtained ___________________________ Year _____________ Location

How long have you been with this organization? Please list the different roles/jobs you have held.
What is your current job role or title?

How many years have you been in this role?

How would you best describe your role within the organization?

List any other employment/organizations that you have been a part of that may have impacted your current role.
Appendix F: Participant Semi Structured Interview/Invitational Prompt Questions

Participant Semi-Structured Interview Invitational/Prompt Questions (Leadership)
1. What is your role in the institution?
2. There are many CNSs within this organization, what do you see as the benefits of CNS practice for clinical practice, nursing and the organization?
3. What are the challenges, if any in having this role?
4. How is the role supported/resourced? (e.g., financially [consider office space, research etc.])
5. What is the sustainability plan?
6. What is the vision and mandate of the organization and how do you see this fitting with your support of CNS practice?

Participant Semi-Structured Interview Invitational/Prompt Questions (CNSs)
1. Could you please provide an overview of your role as a CNS in this institution? How has the role evolved over time?
2. What was your educational preparation for the role?
3. What is your sphere of influence (clinical, nursing, organization) – give examples of that influence?
4. What are the internal or environmental structures/systems in place to provide support to your role?
   • Please note that these questions are salient and may be enhanced or eliminated in the discovery and analysis process.
Possible Focus Group Semi-Structure Questions to Facilitate Discussion
1. What is your experience working with a CNS in this organization?
2. What are the challenges and opportunities related to CNS practice?
3. What do you see as the benefits of CNS practice within the organization?
4. How do you perceive that the organization influences or shapes your practice?
* Please note that these questions are salient and may be enhanced or eliminated in the discovery and analysis process.
For the Research Project:
“Exploring the Influences of an Organization on the Clinical Nurse Specialist (CNS) Role”
July 4, 2014
Field Notes

Reflective Field Notes

Participant Code  __________________________

Pre-Interview Goals
______________________________________________________________________________
______________________________________________________________________________

Descriptive/Observational Notes (what happened in interview/focus group)

Interview Date
______________________________________________________________________________

Location of Interview
______________________________________________________________________________

Starting Time  _______________  Ending Time  _______________

Technical Difficulties

Remarkable Words or Phrases

Non-Verbal Indicators

Theoretical Notes (Linking Theory and Observation)

Analysis (Emerging trends, repetitions, patterns, relationships for further inquiry)
Concept Mapping

Methodological Notes (cues and prompts)

How will this interview direct the next interview?

Recommendations for Focus Group Participants

Critical Self - Reflections
Appendix H: Thematic Tree

ORGANIZATIONAL INFLUENCES ON THE CNS ROLE

Intersecting Tensions Influencing Support for Enactment of the CNS Role
- Scarcity of resources
- Broader context of healthcare changes
- Balancing Power and Agendas

The Transformative Practice of CNSs
- Vision
- Individual uniqueness

Intentional Embedded Organizational Infrastructure and Support
- Intentional culture
- Deliberate leadership
- Role protection

Environmental constraints
- Limited social capital
- Retirement
- Suitability

Blurred boundaries
- Balancing agendas
- Clinical practice

Research and Evaluation
- Advancing nursing practice
- Systemic leadership

Historical roots
- Systemic culture

Dual reporting
- APN community
- Educational requirements