CLINICAL NURSE SPECIALISTS
DEFINE ADVANCED NURSING PRACTICE
AND DESCRIBE THEIR PRACTICE
IN RELATION TO CLIENT HEALTH OUTCOMES

By

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A THESIS SUBMITTED IN PARTIAL FULFILMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SCIENCE IN NURSING

in

THE FACULTY OF GRADUATE STUDIES

The School of Nursing

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA
April, 1996

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Date April 17, 1995
Clinical Nurse Specialists Define Advanced Nursing Practice and Describe Their Practice in Relation to Client Health Outcomes

Advanced nursing practice (ANP) is a term well utilized in the literature and in nursing discussions, yet it is not clearly understood. Recently, nursing authors have been strongly supporting the need to develop a clear definition of ANP. The current focus on outcome measures throughout health care has prompted efforts to examine discipline specific, as well as broad influences on client health outcomes (CHO). The need for nurses in ANP to be able to articulate their practice in relation to CHO has been heightened during the last few years. This is due to factors such as the examination of various nursing roles during times of decreasing health care resources inherent in health reform.

The purpose of this study was to explore and describe how Clinical Nurse Specialists (CNSs) define ANP and describe their practice in relation to CHO. An exploratory-descriptive qualitative methodology was used for this study. Data were collected through semi-structured, audio-taped interviews with 6 female and 1 male CNSs who had a master's degree and had been in their role for a mean of 6.3 years.

From the thematic analysis of the data, three broad categories or descriptors that were common to participants were identified and developed. Together these three broad categories represent participant attempts to define ANP and describe their practice in relation to CHO. The first category relates to difficulties in clearly defining ANP. The second category relates to descriptors of ANP. The third category relates to possible relationship between ANP and CHO.

These findings revealed that ANP is a term that is broad and vague in nature and not amenable to a clear and concise definition. Furthermore, it was found that it may not be possible to articulate a direct relationship between ANP and CHO in an interdisciplinary collaborative practice environment. The implications for graduate education, policy and administration as well as research are identified in light of research findings.
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CHAPTER ONE
INTRODUCTION

Advanced nursing practice (ANP) is a term utilized throughout nursing literature and in discussions yet is poorly understood. Over the course of the last few years, there has been a heightened interest by health policy decision makers and funders to evaluate outcomes of health care practices. This interest has been prompted by current health care expenditures, gaps in primary health care and awareness that some health care professionals, such as nurses, are not able to practise to their full scope (Henning & Cox, 1993; Ministry of Health, 1993; Roch 1992). Clinical Nurse Specialists (CNSs) are nurses recognized as practising under the umbrella of ANP. Consultants from the British Columbia (B.C.) Ministry of Health, inter-ministerial health policy decision makers, professional regulatory bodies and nursing authors, generally express concern that there is not a clear understood definition of ANP and how this practice links with client health outcomes (CHO).

Background and Significance of the Problem

The term ANP is utilized extensively in nursing discussions and in the literature, yet nurses are not able to clearly articulate what it is (Calkin, 1984; Canadian Nurses Association, 1992; Fenton, 1985; Haddad, 1992a; Schaefer & Lucke, 1990). Despite this lack of clarity, CNSs are recognized and identified as conducting ANP (American Nurses
Association, 1985; Canadian Nurses Association, 1992; Fenton, 1985; Sparacino, 1992; Spross & Baggerly, 1989). Other nurses are also recognized as advanced nurse practitioners, for example, nurse practitioners, certified nurse midwives and certified registered nurse anesthetists (Inglis & Kjervik, 1993).

In Canada, CNSs are generally educated at the master's level and practice in a variety of settings that include: hospitals, clinics, community health units and independent practice. CNSs are active members of interdisciplinary teams attempting to meet current gaps in primary health care. The CNS role is quite well established in North American health care systems. In Canada, there are approximately 220 CNSs (Jessie Mantle, personal communication, September 7, 1993). In B.C., there are approximately 50 CNSs employed primarily in hospitals in the Lower Mainland and Victoria. At the time of this research, there were 3 community health CNSs in B.C.: 2 employed in the Vancouver Health Department and 1 in Community Home Care Nursing Services in the Ministry of Health.

During times of economic restraint, there is a heightened need for nurses to define ANP and subsequently develop a model of this practice (Spross & Baggerly, 1989). Nurses who are in ANP roles are paid salaries higher than other nurses, and therefore are viewed as "costing" the health care system "more" than other nurses (Brunk, 1992;
Sparacino, 1992). Despite salary issues, numerous articles identify benefits of employing advanced nursing practitioners such as CNSs (Brunk, 1992; Girouard, 1989; Hawkins & Thibodeau, 1989). Authors argue that the system wide client care benefits result in overall cost savings to the health care system (Fralic, 1988; Gournic, 1989; Koetters, 1989).

Despite these benefits, nursing roles such as those of CNSs are being examined particularly during times of health care budget crunches. There is a growing trend that CNSs are being asked to take on more administrative responsibilities in their various agencies. This has the potential to spread the CNS "too thin" or cause a loss of the clinical emphasis in their overall practice.

The CNS role will continue to be challenged as program administrators and managers are forced to engage in increasingly cost-effective approaches to health care (Brunk, 1992; Schaefer & Lucke, 1990). The identification of a definition and model of ANP will enable CNSs to clearly articulate and demonstrate the competencies (knowledge, skills, attitudes and judgements), inherent in their roles. This may assist administrators/managers to continue justification and potential expansion in the employment of nurses in ANP (Spross & Baggerly, 1989).

Currently in the B.C. health care system, there is interest in exploring CHO due to an increased focus on self care, health promotion, client advocacy and contracts between
clients and providers. The need for cost-effective health care practices, plus the appropriate use of health care providers, have become critical concerns (Ministry of Health, 1993; Seaton, 1991). With the current "hospital to community shift", inter-ministerial staff are questioning "do we need more nurses in ANP?" and "can nurses in ANP demonstrate the impact that their practice has on CHO?"

Minimal research has been done with CNSs to examine their actual practice (Amos-Taylor & Elberson, 1989; Sparacino, 1986). Various nursing researchers have identified interest in examining ANP from a qualitative perspective (Beecroft, 1992; Brown & Waybrant, 1988; Schaefer & Lucke, 1990). Limited efforts have been made to explore the rich, direct, and unique contribution that nurses can make to the health outcomes of clients. Although work has been done in identifying competencies of CNSs (Fenton, 1985), the next step is to determine the effectiveness of these on client lifestyle and health (Brown & Waybrant, 1988), as well as other outcome measures.

It was the researcher's belief that CNSs, as nurses in ANP, did positively and significantly influence CHO somehow, yet this had not been clearly reflected in the literature. It was also the researcher's belief that nurses in ANP could do much to shape health care during health reform. In order for nurses to maximize accountability, and for ANP to continue and grow, two areas were worthy of further
exploration: nurses in ANP defining their practice and describing how it relates to CHO.

**Conceptual Background**

A specific theory or framework that could clearly be utilized as a guide for this study was not available. Although there existed an extensive amount of nursing literature related to ANP and some with regard to CHO, there had been no comprehensive, systematic study done from the perspective of this research. Therefore, qualitative exploratory-descriptive research was appropriate for the phenomena of interest.

There were three well known nursing leaders who developed "theories" related to expert and ANP, namely Patricia Benner (1984), Mary Fenton (1985) and Joy Calkin (1984). Although the work of these nursing scholars did not provide a specific structural "theory" for this study, it formed both a basis and a rationale for further study of the link between ANP and CHO.

Benner (1984) conducted research using an interpretive method, specifically that of hermeneutic phenomenology, and, in her book *From Novice to Expert*, identifies five levels of professional nursing competency in clinical practice, namely: novice, advanced beginner, competent, proficient and expert. The highest level of professional competency is "expert." Although expert practice has received extensive scrutiny primarily because of Benner's work, what is not clear is if
there is an implication that expert practice is the same as ANP or whether ANP is a sixth level?

Benner began to use the term ANP but does not differentiate expert from advanced practice. Often there is the use of the term "expert" in conjunction with "advanced," such as,

the expert practitioner has not always been an expert. The nurse entering practice, like the person learning to fly an airplane, requires all the guidance possible to avoid mistakes so that patients and nurses alike survive long enough to develop advanced skills (p. 20)

An additional example: "the exemplars taken from expert practice demonstrate the notion of good and the knowledge embedded in advanced levels of practice" (Benner, 1989, p. 21).

Benner’s use of "exemplars" to support her conceptualizations is well known. She alludes to the link of expert practice and CHO by publishing only those exemplars "where the nurse made a positive difference in the patient’s outcome" (Benner, 1984, p. xvii). These exemplars illustrate only immediately recognizable CHO. Benner’s work does not address long term CHO that may directly result from any of the five levels of nursing competencies, nor does it consider whether there may be differences in these outcomes dependent upon the "level" of nursing practice. In addition, one is left wondering if CHO can be directly linked back to the nurse. What about other influencing factors in client care?

Benner subsequently co-authored another book with Judith
Wrubel (1989), entitled the Primacy of Caring. The book is "devoted to an interpretive theory of nursing practice as it is concerned with helping people cope with the stress of illness" (p. 7). This work outlines that caring is a central component of effective nursing practice and is key for expert practice. A component of caring is concern and "within each arena of concern are many different ways of caring" (Benner & Wrubel, 1989, p. 87). If nurses are concerned, they are alerted to the knowledge of the features of the situation that make a difference and are attuned to the cues that signal a change in status (Benner & Wrubel, 1989). Is there a difference in the concern that nurses in ANP have in the features of the situation they identify, and the cues to which they are attuned, and how is this reflected in their caring?

All nurses can clearly identify colleagues who represent expert practice in nursing. Often these nurses are highly competent yet may be educated at the diploma level. If, traditionally, nurses engaged in ANP require at least a master's degree, must there not be some difference in ANP versus expert practice? If not, then how can there be justification for the time and financial costs associated with educational preparation for nurses at the master's and doctoral level?

Fenton (1985) conducted an ethnographic study that identified common competencies of master's prepared CNSs.
Using Benner's (1984) description of expert practice, Fenton confirmed that CNSs are nursing experts. However, Fenton identified some behaviours of CNSs that had not been noted by Benner in expert nurses, such as: organizational and work role competencies, consulting role, monitoring and ensuring the quality of health care practices (Fenton, 1985). She also found that CNSs clearly identified the important role of being supportive to staff nurses. Additionally, CNSs often "massage the system" for the goal of improvement in client/patient and nurse situations (Fenton, 1985). This leadership function is often unrecognized by administrators and therefore not traditionally found in job descriptions. Fenton's work represents a clearer attempt to address how ANP differs from expert practice.

Calkin (1984) outlines what she describes as "a model for advanced nursing practice." In this model, she differentiates the practice of nurses according to their experience in relation to human responses to health problems. She refers to Benner (1984) and uses the same terms to describe the nurses. She attempts to define ANP but the definition is vague and applicable to a wide range of nurses. She recognizes that "it is important to think about the essence of advanced nursing practice" (Calkin, 1984, p. 24). Additionally, she notes that "the identification of positive responses to actual and potential health problems provides nurses with high-quality outcomes or goals for nursing
interventions" (Calkin, 1984, p. 27). It is interesting that she uses the phrase "high-quality outcomes or goals." The two are not necessarily the same, in that goals can direct nursing interventions but outcomes result from nursing interventions and may be more specific than goal attainment.

In Calkin's (1988) discussion on specialization in nursing, she notes that "for more than a decade I have used the term 'advanced nurse practitioner' to refer to the master's prepared nurse in an attempt to avoid using the term specialization" (p. 285). She also recognizes that given the current trends in health care it is not possible to keep a command of the "breadth of knowledge needed for precision in practice" (p. 280). Thus "Clinical Nurse Specialists with advanced knowledge and skill are required" (Calkin, 1988, p. 280). It is interesting to note that the title of the CNS contains the word "specialist." How do the terms: expert, specialist and ANP relate? Calkin claims that nurses will need to come to terms with the educational requirements that are most appropriate for ANP. This may be key!

All of these nursing scholars have made a link between ANP and CHO, yet none of these linkages has been clearly articulated. They allude to nurses influencing CHO, yet how this influence is achieved is not discussed, let alone measured. Nurses must be able to make the links between ANP and CHO in order to:

• increase understanding of the effectiveness of different
levels of nursing practice;
• enhance decision making by themselves and with clients;
• develop standards to guide nursing and health care
decision makers in optimizing the use of resources
(Epstein, 1990); and,
• articulate the value and benefit of graduate nursing
education.

Statement of the Problem

The literature reveals an increasingly important need to
clearly define ANP as well as to articulate the influence
that this practice has on CHO. Nurses in ANP can be the
victims of "staffing cuts" and elimination of positions, or
change to administrative roles with organizations lessening
the clinical component emphasis. It is important for nurses
in ANP to be able to clearly discuss the value and
significance of their role particularly during health care
reform. Competencies to do this will not only be of
assistance in the continuation of clinically based positions
within organizations but will also provide opportunities for
nurses in ANP to positively shape health care. This study
sought to answer the following question: "How do Clinical
Nurse Specialists define advanced nursing practice and how do
they describe their practice in relation to client health
outcomes?" These phenomena remain not well understood within
the nursing community.

For clarification, CNSs were not the only appropriate
source to define ANP and its relationship to CHO. Other sources that could have been contacted include clients, educators, nurse practitioners, staff nurses, nurse midwives and health policy decision-makers. The researcher had a personal interest in further understanding ANP and its links to CHO from the perspectives of nurses in the CNS role.

**Purpose of the Study**

The purpose of this study was to explore and describe how a group of CNSs as nurses formally recognized as conducting ANP, articulated two areas of their practice:

- How did they define ANP; and,
- How did they describe their practice in relation to CHO.

**Definition of Terms**

Two similar definitions of a CNS were used for this study. The first states that the CNS is a registered nurse who is an expert practitioner holding a Master’s or doctoral degree in nursing, having majored in a clinical specialty (Registered Nurses Association of British Columbia, 1988). The second states that a CNS is a registered nurse "who, through study and supervised practice at the graduate level (master’s or doctorate), has become expert in a defined area of knowledge and practice in a selected clinical area of nursing" (American Nurses Association, 1985). The first definition refers to graduate education in nursing whereas the second does not specify the faculty focus of graduate studies.
For this study, it would have been helpful if "expert" was clearly defined in the literature. As was alluded to earlier, although Benner (1984) uses the term expert, she does not explicitly define it. Her work does not attempt to clearly define the levels of nursing practice but rather describes these levels from the perspectives of the nurses interviewed and observed (Benner, 1984). In the glossary section of Benner's book *From Novice to Expert* (1984) "expertise" is defined as:

> Developed only when the clinician tests and refines theoretical and practical knowledge in actual clinical situations. *Expertise* develops through a process of comparing whole similar and dissimilar clinical situations with one another, so an expert has a deep background understanding of clinical situations based upon many past paradigm cases. *Expertise* is a hybrid of practical and theoretical knowledge (p. 294).

English (1993) further develops the argument that Benner needs to define *expert nurse*. However, for the purposes of this research, expert was defined as the nurse who may or may not have an underlying theoretical education but is none-the-less consistently accurate in her/his clinical judgements of complex client scenarios.

At the beginning of this study, neither ANP nor CHO was pre-defined. The researcher was interested in determining if and how participants defined these terms and how they related them to their practice. In the literature section of this report, some other definitions related to this study are explored. These were compared in the analysis of findings to participants' own ideas about the phenomena of interest.
**Assumptions**

The following assumptions were recognized: a) if the participants were practising in a CNS role and met the eligibility criteria (presented in methodology section of this report) they were participating in ANP; b) the participants would be able to define ANP and this would be a familiar topic to them; c) the participants would be able to describe ANP in relation to CHO despite how they defined client (individual, family, group or community); and, d) participants have an important and significant role in the future of nursing and health care.

**Limitations**

All participants were from one large hospital society in one region of B.C. As CNSs, participants met regularly and their consistencies about ANP and CHO may have stemmed from the organizational culture, previous educational course work, professional experiences as well as discussions that they had with each other and as a group. In addition, all participants had described themselves as being clinical experts prior to their graduate education. Even those participants who undertook non-nursing graduate education maintained a clinical speciality focus during their studies. These factors, plus the small sample size pose limitations to the generalizability of the study’s findings. Finally, CNSs represent only one group of nurses that are recognized under the umbrella of ANP. This study is not inclusive of all
nurses in ANP. For example, Nurse Practitioners have been studied extensively and have demonstrated many positive outcomes of their practice (Brunt, 1988; Ontario Ministry of Health, 1993), which may be explained by their emphasis on direct client care (Williams & Valdivieso, 1994).

Chapter Summary

This chapter has presented introductory information for the study which sought to answer the question: "How do Clinical Nurse Specialists define advanced nursing practice and how do they describe their practice in relation to client health outcomes?" In this chapter, the research problem was described from a nursing perspective which provided rationale for the study. The conceptual background that was used as a basis for the study was described. Additionally, terms central to the research question were explored and assumptions and limitations of the study were outlined. In the following chapter, the existing literature pertinent to the identified research problem is reviewed.
CHAPTER TWO

LITERATURE REVIEW

The purpose of this chapter is to present an exploration and analysis of pertinent literature related to ANP and its relationship to CHO. The literature was reviewed initially for the purposes of gaining a preliminary understanding of what authors had discussed, as well as what questions were raised. In qualitative research, the literature is generally not reviewed extensively at the beginning of a study in order to eliminate the risk of developing a sedimented view (Burns & Grove, 1987), or for the researcher to be constrained and/or stifled in creative efforts by the knowledge of it (Strauss & Corbin, 1990).

However, for this inexperienced researcher, an initial review of the literature assisted in having a more precise understanding of the phenomena under study, as well as the notion of what the results of a qualitative study of this nature would look like (Ammon-Gaberson & Piantanida, 1988). Additionally, reviewing the literature at that point allowed for the study to "build on" existing work, rather than progressing with research that had already been well documented. The literature review is organized into general knowledge, research-based articles and other literature related to ANP and its relationship to CHO. For clarification, literature related to other nurses involved in ANP, such as nurse practitioners, was not reviewed as the
researcher was interested in the phenomena of interest from the perspectives of CNSs only.

**Advanced Nursing Practice**

Nursing literature frequently incorporates the term ANP but authors rarely define it (Brunk, 1992; Calkin, 1988; Hawkins & Thibodeau, 1989; Nichols, 1992; Sparacino & Cooper, 1990). In practice settings, nurses accept and frequently use the term ANP, yet authors of nursing literature identify the need to clearly define it (Fenton, 1985; Forbes, Rafson, Spross & Kozlowski, 1990; Patterson & Haddad, 1992; Spross & Baggerly, 1989). If definitions of ANP are given they are often vague, in that they could apply to many nurses, such as those prepared at the diploma level. What is not clear, from these authors, is how preparation at the master’s in nursing level differentiates ANP from other practice.

There is a wealth of nursing literature related to the CNS roles and subroles. These are often listed as educator, consultant, expert practitioner and researcher (Barron, 1989; Calkin, 1984; Hawkins & Thibodeau, 1989; Koetters, 1989; McCaffrey, 1991; McGuire & Harwood, 1989; Priest, 1989; Spross, 1989). However, the common thread that interlinks the roles associated with ANP and clarifies their common goal has not been made (Patterson & Haddad, 1992).

Although the term "advanced level" is used in definitions, it is not defined, let alone clear. For example, it is not clear how CNSs as advanced nursing
practitioners differ from expert nurses, if at all. Examples of this are the definitions of Calkin (1984) and King (1990).

Calkin's definition of ANP is:

Advanced nursing practice is the deliberative diagnosis and treatment of a full range of human responses to actual and potential health problems. Advanced practitioners can provide a rationale for choosing diagnostic and treatment processes. Advanced practice is accompanied by specialized knowledge and skill in dealing with a human response that cuts across health problems (e.g. pain) or with a cluster of human responses to an identifiable actual or potential problem (e.g. diabetes mellitus) or a cluster of age-specific human responses to health problems (e.g. infants) or a combination of these (e.g. changes in self-concept in pregnant adolescents) (p. 27).

King (1990) notes that:

being an expert, a CNS practitioner provides patient care from a nursing perspective at an advanced level and is able to model a nursing practice that demonstrates a high degree of clinical competence with skills in professional judgement and the possession of a knowledge base (p. 174).

The following definition by Haddad (1992a) is clearer but some components present challenges to measure:

An advanced nurse practitioner...may be described as a nurse with nursing preparation at the Master's level, with a clinical speciality who practices within that speciality and is committed to ongoing learning, education, and development within the discipline of nursing. He/she also maintains currency in recent developments in nursing and health care, has attained and maintains a level of knowledge and skill beyond that of that of staff nurses, and utilizes that knowledge and skill to develop and advance nursing practice through active roles in education, consultation and research (p. 7).

There is a frequently noted assumptive leap with expert practice to ANP in the literature. The researcher believes that there are differences but is not able to clearly
articulate what they are. Despite the lack of clarity about ANP, there is renewed interest in further exploring and developing it in Canada (Canadian Nurses Association, 1992; Haddad, 1992a; Haddad, 1992b; Patterson & Haddad, 1992; Registered Nurses Association of British Columbia, 1990; Schroer, 1991; Van der Horst, 1992). Is it that health care professionals intuitively know that nurses in ANP offer something that is unique and worth further development but are just not able to articulate what it is? In order to decrease this lack of clarity related to ANP, further exploration can assist nurses to define, continue to develop, and explore ANP in ways that meet some of the ongoing needs of the nursing profession and the clients that are involved in nurse/client interactions.

**Research-Based Articles Related to Advanced Nursing Practice**

In a cursory review of the literature, minimal research-based reports could be found related directly to this study. The related ANP research-based literature was reviewed to attempt to link what was reported with the study. Schaefer and Lucke (1990) conducted a study to describe clinical practice as reported by practising CNSs. The sample consisted of 17 Master’s prepared CNSs who had functioned in the role of a CNS for a minimum of one year. Additionally, they used three recorded case studies found in the literature as a part of the analysis. Using grounded theory methodology, the researchers concluded that scientific and
humanistic caring was the central component to the practice of CNSs. The CNSs cared for clients and their families but were also of major support to the staff. These findings were subsequently validated in the literature. Schaefer and Lucke asked the question: Does caring differ depending upon the educational preparation of the nurses? They also noted that their study did not examine the impact of CNS practice on client/patient outcomes.

In relation to the exploration of the role of the CNS in community health, Mason, Knight, Toughill, DeMaio, Beck and Christopher (1992), conducted a needs survey which consisted of two questionnaires:

one to assess the current and future needs of community health agencies for Master's-prepared nurses in community health nursing and the roles in which the agencies would use these nurses, and another to assess the interest of baccalaureate-prepared nurses in attending a graduate program in community health nursing (Mason et al., 1992, p. 8).

This survey suggested that "community health agencies may not be clear about the benefits of employing this advanced practitioner" nor how to use the community health CNS most effectively (p. 6). Their sample included 126 agencies and 256 individual nurses. Findings of both groups reflected a lack of understanding of the role of the community health CNS. However, the findings also demonstrated that community health agencies have great present and future needs related to Master's prepared nurses. Of interest, study participants wanted to put community health educated CNSs into management
roles.

Mason and colleagues (1992) identified that the community health CNS is "desperately needed to advance clinical practice in community health nursing and to promote the health of communities. This need will only be fulfilled if an adequate number of these specialists are not only educated but utilized properly" (p. 12). They also add that "if nursing will promote this speciality of nursing, it will also be promoting the health of communities" (p. 13). Although this was an American study there are implications for the B.C. and Canadian context given the current focus on community health.

The researcher believes that Mason and colleagues (1992) underscore the need for more nurses in ANP to be employed in the community in B.C. The current "shift" of clients from hospital to home requires a previously undeveloped and untapped expertise of community nurses. For community nurses to develop this expertise and be supported in their ongoing efforts, ANP support is mandatory. The researcher wondered if the current study participants would identify their roles in relation to the community as client.

Benner, Tanner and Chesla (1992) published a portion of a larger phenomenological study related to skill acquisition in the practice of critical care nursing through use of the Dreyfus Model of Skill Acquisition. This study was another attempt to clarify the five levels of practice previously
identified by Benner (1984). Although this research is only peripherally linked with this study, it is worth noting since the authors reinforced the need to differentiate between expert and advanced nursing practice.

Their sample consisted of 130 nurses who practiced in Intensive Care Units. Of these nurses, 98% were baccalaureate prepared. Findings from their study further develop the notion of practice from the clinical worlds of nurses' varying levels of experience. The discussion in the article relates to an individual nurse caring for an individual critically ill client although the nurse may involve the client's family in that care. The focus in the exemplars is clearly client specific and strongly related to the medical model of practice. This experiential learning is clearly linked to development of expert practice.

Other Literature Related to Advanced Nursing Practice

Spross and Baggerly (1989) identify two concepts that they believe are essential to a model of advanced nursing practice. These are "exquisite clinical judgement and effective leadership" (p. 21). Exquisite clinical judgement is defined as:

a complex intellectual process of decision-making which typically includes: (1) decisions regarding what to observe in a patient situation; (2) inferential decisions, deriving meaning from data observed (diagnosis); and (3) decisions regarding actions that should be taken which will be of optimal benefit to the patient (p. 21).

Effective leadership is defined as:
uses communication processes to influence the activities of an individual or group toward the attainment of a goal or goals in a given situation. For the CNS this includes guiding staff nurses in the acquisition of clinical skills and knowledge, interpreting nursing practice to nurses and non-nurses, developing innovative approaches to clinical practice, promoting interdisciplinary collaboration, and advancing the practice and profession of nursing (p. 21).

These authors note that any advanced practice model that incorporates these two elements can assist CNSs to analyze their advanced practice. They add however, that "conceptualizing advanced practice and being able to discriminate it from the practice of a neophyte or an expert by experience is vital" (Spross & Baggerly, 1989, p. 39).

English's (1993) critique of Benner's model prompts another dimension for consideration. He notes that "aspects of expertise are described, but expertise is not clearly defined" (p. 387). In addition, he outlines that "according to this model it is unclear at what stage one becomes an expert, and if there are better experts than others, i.e. are there stages of expertise or is 'expert' a unique and final state" (p. 389)?

In order to explain, justify and support different levels of nursing practice, Spross and Baggerly (1989) outline the following models of ANP: Benner's Model of Expert Practice (1984); Fenton's Application of Benner's Model to CNSs (1985); Roy and Martinez' Conceptual Framework For CNS Practice (1983); Holt's Theoretical Model For Clinical Specialist Practice (1984); Calkin's Model of Advanced
Nursing Practice (1984); and, Brown's Model: The CNS In A Multidisciplinary Partnership (1983). In the critiques of these models done by Spross and Baggerly, they note that "it is clear that none are fully developed in terms of advanced practice and the CNS" (p. 39). Having fully reviewed these models of ANP, the researcher agreed with this conclusion.

Patterson and Haddad (1992) add to this in that "it is our contention...that the attributes and behaviours of advanced practitioners have not been made explicit in the literature" (p. 18). These authors presented a list of some possible behaviours and attributes associated with ANP. They are clear to point out that this list is not all-inclusive and that further refinement and expansion of all of the concepts are required. Interestingly enough, the list contains attributes and some behaviours/indicators that are not consistently found in the literature. Their list includes the following:

<table>
<thead>
<tr>
<th>Attributes</th>
<th>Some behaviours/indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Taker</td>
<td>* identify and develop a nursing perspective in new areas of health care</td>
</tr>
<tr>
<td>Visionary</td>
<td>* utilize and evaluate nursing research to guide client care</td>
</tr>
<tr>
<td>Inquiring Mind</td>
<td>* participate in nursing research</td>
</tr>
<tr>
<td>Flexibility</td>
<td>* identify and comment on current issues in nursing</td>
</tr>
<tr>
<td>Ability to Articulate</td>
<td>* articulate and disseminate nursing knowledge by informal and formal methods</td>
</tr>
<tr>
<td>Leadership Skills</td>
<td>* demonstrate the use of theory-based practice to other nurses</td>
</tr>
</tbody>
</table>

Despite the identification of these attributes and
behaviours/indicators, Patterson and Haddad (1992) add that, in their review of the literature related to ANP, very little attention has been paid to the characteristics of the individual that would be necessary to fulfil the demands of an ANP role.

**Clinical Nurse Specialists and Client Health Outcomes**

Decision makers in Canada's health care system conduct an expensive business without any outcome measurements, goals or plans (Rachlis & Kushner, 1989). In attempts to improve quality of health care, "outcomes matter most" (Health Services Research, 1992, p. 175). In recent years, the B.C. Ministry of Health has focused efforts on evaluation and outcomes. There is renewed interest in explaining and analyzing current health care practices so that funding decisions can be made on positive outcomes. It is well known that funding decisions have traditionally not been clearly linked to CHO. In the last couple of years in particular there has been renewed interest in attempting to make this link explicit.

Increasingly, funding decision makers are recognizing the value of evaluation prior to consideration of funding and budget issues (Wood, 1989). Nurses participating in an established ANP role are a worry to health care funders since they often secure higher wages than most nurses (Sparacino, 1992). Yet these same nurses are educated to conduct research and evaluation of their practice, as well as outcome
measures of this practice (Waltz & Sylvia, 1991).

Donabedian (1992; 1988) is a well known leader of outcomes management and incorporates a classic triad to define the quality of care, specifically that of: structure, process and outcome. Some of the attributes of quality in health care include: effectiveness, efficiency, optimality, acceptability, legitimacy and equity (Donabedian, 1992). Outcomes may be defined as "states or conditions of individuals and populations attributed or attributable to antecedent health care" (Donabedian, 1992, p. 356). Another definition is that "outcomes are the end results of care, the changes in a patient health status that can be attributed to the delivery of health care services" (Naylor, Munro & Brooten, 1991, p. 210).

Nurses, are however, in the early stages of research related to outcome measures that can be linked to nursing practice (Bond & Thomas, 1991; Higgins, McCaughan, Griffiths & Carr-Hill, 1992). Additionally, CNSs are in a pivotal position to assure the delivery of quality nursing care (Naylor, Munro & Brooten, 1991), and have the potential to be a strong voice for care quality, often lost in the discussions of cost-effectiveness (Redfern & Norman, 1990). Yet "research to date...has not adequately shown that the nursing practice of the CNS positively affects patient outcomes" (Montemuro, 1987, p. 109).

However, it is important not to focus only on the
positive outcomes. Both unintended and unexpected
"consequences of nursing interventions are equally valid as
outcomes and indeed could be important and revealing" (Bond &
Thomas, 1991, p. 1494). As far as this researcher is
concerned, nurses need to examine more than just "immediate"
CHO. They need to begin exploration of "long term" nursing
care outcomes and CHO. As "increasing numbers of
exploratory, descriptive, and correlational studies lay the
groundwork for changes in nursing practice, research on the
effectiveness of nursing interventions becomes more critical"
(Stewart & Archbold, 1992, p. 477).

Research-Based Literature Related to

Clinical Nurse Specialists and Client Health Outcomes

As noted earlier, minimal research-based information
could be found related directly to this research. Two
studies which support efforts of the research were found.
Fitzpatrick and colleagues (1991) conducted research with
experienced CNSs using the Delphi technique and a four-round
survey to capture information related to research priorities.
The results, interestingly enough, did not focus on potential
specific clinical research but rather overall general
clinical nursing research priorities. The results indicated
that top priorities for nursing research are: "(1) factors
which influence longevity in clinical nursing practice, (2)
patient delivery systems as related to nurse satisfaction,
and (3) indicators of quality of nursing care" (Fitzpatrick
et al, 1991, p. 94). Clearly there is the recognition by these CNSs of the value of outcomes from client, patient and professional domains.

Higgins, McCaughan, Griffiths and Carr-Hill (1992) conducted research related to assessing outcomes of nursing care. The researchers recognized the difficulty identifying which outcome variables could be attributed to nursing alone. As a result, they focused on immediate outcomes that "would then reflect a result that could be related with some confidence to nursing intervention via direct observation" (p. 562). This approach went beyond the traditional outcome studies such as those "exclusively concerned with measuring the clinical outcomes of care such as changes in patient's symptoms and survival following diagnosis" (p. 566).

These authors collected data from outcome measures in acute medical and surgical wards at seven hospital sites. At the same time, the Quality of Patient Care Scale (Qualpacs) was used. Measures focused on the outcomes of care delivery. The amended Qualpacs instrument was used to measure the process of nursing care in five areas: psychosocial care, physical care, general care, communication on behalf of the patient, and the professional implications of care. Despite identified limitations, the main purpose of the data analysis was to test for the reliability and validity of the outcome measures, and a high degree was demonstrated. As a result, the researchers present their chosen outcome measures as a
possible way to assess the outcomes of nursing care. They identify the lack of other studies of nursing and outcomes, which results in their inability to make comparisons. This work represents a good beginning effort to link nursing practice and CHO in a general way.

Other Literature Related to Clinical Nurse Specialists and Client Health Outcomes

Nurses, as participants in total quality management, have been directed to evaluate programs and to explore outcomes of client care (Beecroft, 1992; Stanhope & Lee, 1992). However, this task is often not positively received and can become the responsibility of a variety of personnel. Total quality management has routinely examined structure and some process, but rarely outcomes of health care practices. General health outcomes, or in particular CHO, are both relatively new areas of interest for nursing and other health care professionals (Bond & Thomas, 1991). Waltz and Sylvia (1991) note:

It is essential that validation of CNS effect on patient outcomes be undertaken and that studies designed for this purpose employ the most relevant and appropriate outcome variables to be studied across practice settings and that they be measured in a manner that allows for applicability and hence comparison across studies, settings, and times (p. 203).

Under the umbrella of ANP, the consistent focus of the CNS is on client-based practice. For any CNS, the ultimate goal is to improve the overall quality of care delivered to clients/patients by nurses (Sparacino & Cooper, 1990).
Despite this goal, CNSs often lack formal education to prepare them to partake in total quality management. Noll and Girard (1993) outline the CNS curriculum from the University of Texas Health Science Center School of Nursing in San Antonio, which has recently added a course in quality assurance to formally prepare CNSs for this major aspect of their role in health care. This approach has not traditionally been a routine component of CNS graduate education.

If the CNS is to be involved in measuring the effectiveness of nursing practice, what outcomes should be included and measured? At the present time in nursing there is a lack of consistency in what is measured and often these outcomes are not clearly documented on client/patient care records. Anecdotally, authors may observe a positive immediate client/patient outcome when the CNS becomes involved with someone whom the staff has identified as "difficult" (Koetters, 1989). Moritz (1991) notes that "there is considerable research work to be done to determine the best measures to reflect the outcomes of nursing practice" (p. 114).

What about other outcome measures that can clearly be influenced by nursing care? Examples include: functional status, mental status, stress, overall well-being, satisfaction with care (including accessibility, continuity, thoroughness, humaneness, informativeness and effectiveness),
burden of care, quality of life, and cost of care (Beecroft, 1992; Donabedian, 1992; Naylor, Munro & Brooten, 1991; Roch, 1992). Are these currently being measured? And if so, how? Very little effort to date has been directed at assessing the effect of nurses' contribution to the outcomes of client care (Higgins, McCaughan, Griffiths & Carr-Hill, 1992).

CNSs are in a key position in that they recognize excellence in client/patient care. They have clearly displayed interest and enthusiasm for nursing care that will improve outcomes for clients (Beecroft, 1992; Kerr, 1991). CNSs are also keen to develop and adopt "new ideas to maintain or improve quality patient care in a timely and cost-effective manner" (King, 1990, p. 174). Yet their role related to total quality management or quality assurance has not been emphasized (Noll & Girard, 1993). Authors are beginning to make the link between the CNS role and outcomes via total quality management but the linkage is not yet well established.

Beecroft (1992) supports the role of CNSs in relation to outcomes. She says that "in this era of increased emphasis on clinical, financial, and health outcomes, I believe the time is right for CNSs to apply their research skills to outcomes management and bring themselves to the forefront of the health care arena" (Beecroft, 1992, p. 175). Girouard (1989) adds to this when she notes, "the CNS has responsibilities related to the advancement of the
profession, working with others to plan and evaluate health programs for people at risk and to address health care trends" (p. 367). Societal trends and health care policies are directly linked to health-related outcomes and health behaviours (Girouard, 1989).

Waltz and Sylvia (1991) strengthen this view by claiming that, in order to document the worth of nursing programs and services, investigations must be undertaken related to the relationship between nursing process and outcomes. Through the process of linking outcomes to nursing practices, "CNSs will more clearly define those health outcomes that they are in the best position to influence" (Naylor, Munro & Brooten, 1991, p. 214).

**Final Word on the Literature Review**

After review of the literature, it became clear that this research was timely. It is appropriate that nurses as individuals and the nursing profession as a whole, have answers to these key areas of inquiry.

To date, there has been a definite lack of knowledge related to a clear definition of ANP despite its widely accepted use. Nor has there been a clear effort to directly link ANP with CHO. Given today's health care environment, the resultant pressures for fiscal restraint, and the need for measurement of CHO, this study provides further knowledge about the phenomena of interest. It also provides research that others can build on to further explore relationships
between ANP and CHO.

**Chapter Summary**

In this chapter, pertinent literature related to ANP and its relationship to CHO was reviewed. Although a wealth of literature is available related to the phenomena of interest, minimal research has been published that further clarifies these definitions and/or relationships. Through this literature review process, the need for this study has been validated. The following chapter describes the methodology that was used for this study.
CHAPTER THREE

METHODOLOGY

Since this study is in a relatively new area of inquiry, it was not possible to define the terms ANP and CHO and their relationship precisely. Therefore, for this research a qualitative methodology was appropriate so that the research participants could offer their definitions and relationships among the phenomena of interest (Ammon-Gaberson & Piantanide, 1988; Strauss & Corbin, 1990). The study utilized an exploratory-descriptive method to generate thematic analysis of the interviews between the researcher and participants.

This chapter commences with an overview of the research design. Following that, the selection of participants, data collection and data analysis are described. The chapter concludes with a discussion of the study's ethical considerations.

Research Design

This study did not clearly and directly "fit" any of the traditional qualitative research methods. The use of an exploratory-descriptive method was appropriate since the literature reflected that there have not been indepth studies of the phenomena of interest (Brink & Wood, 1989), particularly from a Canadian perspective. As a result, nurses have little clear theoretical or factual knowledge about ANP, let alone its relationship to CHO (Carter, 1991). Because CNSs are understood as a focused culture in
nursing (Morse, 1991), the use of ethnographic methods would have been ideal. However, the research plan included interviews only. Although interviews are valuable, they represent only one component of an authentic ethnographic study (Agar, 1986; Brink, 1989; Field, 1982; Hammersley & Atkinson, 1983; Leininger, 1970; Morse, 1991; Spradley, 1979). However, ethnography still provided considerable guidance to the data collection and analysis phases of this research. The research report will describe how participants knew, understood, and gave meaning to experiences of their world (Hunt, 1991). These findings will contribute to the development of nursing knowledge and ANP (Muecke, 1994).

Specifically, the ethnographic tradition helped the researcher to be clear about the emic and etic sources of data, as well as how they were presented (Boyle, 1994). Every effort was made to have research findings emic in nature, in that they were derived from the participants' view of their experiences and practices, as opposed to any influence of the researcher (Field & Morse, 1985).

Selection of Participants

Using an exploratory-descriptive design, the participants become contributors in the generation of new knowledge about topics where little is known (Burns & Grove, 1987). A purposive sample is one sampling design used in qualitative research, whereby participants are selected because of their abilities to discuss the phenomena of
interest knowledgeably (Burns & Grove, 1987). The following is a description of the selection criteria, procedures for recruitment of participants and the characteristics of the CNSs who participated in this study.

Selection Criteria

The following criteria for selection of participants were developed for the purpose of ensuring a sampling of informants who were experienced in an ANP role, and therefore knowledgeable about the phenomena of interest. Each participant was required:

- to have a master's degree (Registered Nurses Association of British Columbia, 1988); and,

- to be currently employed and have been practising in a CNS position in a clinical setting for a minimum of one year (Haddad, 1992a; Sparacino, 1992).

Rationale for the criterion of a master's degree is provided in the literature. The researcher made a conscious decision not to focus solely on participants who had master's degrees in nursing due to the recognition that there are currently some nurses in ANP with non-nursing graduate degrees. A minimum of one year in the CNS role was viewed as enabling participants to offer "real" or "experiential knowledge" rather than solely academic knowledge to discussions.

Procedure for Recruitment of Participants

As was noted above, a purposive sample was used for the
research. The Vancouver Island based CNSs, employed in a large hospital society, were recognized by their peers and their supervisors as Advanced Nursing Practitioners (P. Fullerton, personal communication, October 9, 1992). The final number of participants needed for the research was related to saturation of data categories (Simms, 1981; Strauss & Corbin, 1990). This was achieved with seven participants in total. Appropriate documentation was completed and the proposed research was designed to ensure that the principles of non-maleficence were maintained (Polit & Hungler, 1991). The research design was reviewed and approved by The University of British Columbia Behavioural Sciences Screening Committee For Research and Other Studies Involving Human Subjects.

The Vancouver Island CNSs were sent a personally addressed letter (Appendix A, p. 194) that introduced them to the research. This letter outlined the type of research and the reasoning behind it, the areas of interest, what their involvement would entail, the assurance of confidentiality, as well as contact names and numbers. In addition, the letter outlined that, if the potential participant did not contact the researcher within two weeks, then the researcher would establish telephone contact in order to inquire about interest and to answer any questions or address issues the potential participant may have had. At no time did the researcher use pressure or coercion with the potential
participants. All seven participants telephoned the researcher to say they were interested in participating in the study.

When potential participants contacted the researcher for inclusion in the study, the researcher asked questions to determine if the participants met the eligibility criteria. Appendix B, (p. 196), lists these questions as well as outlining the demographic information that was collected. If the participants met the eligibility criteria, an interview was arranged.

**Characteristics of Participants**

A total of seven CNSs, six female and one male, participated in the research. For the purposes of anonymity, all will be here-after referred to as females. Their ages ranged from 40 to 62 years with a median of 47.4 years. Specifically ages were distributed as follows: two age 40, two age 46, one age 49, one age 50 and one age 62.

All participants had a master’s degree with 5 being in nursing, 1 in health sciences and 1 in science. They had all been employed in the CNS position in a clinical setting for a minimum of one year, specifically 2-13 years with a median of 6.3 years. This experience was distributed as follows: 2, 3, 3.5, 5.5, 7, 10.5 and 13 years. Their specialty areas of practice were: rehabilitation, maternal child, mental health with a sub-specialty in gerontology, pain management, geriatric psychiatry and two in gerontology. All were
employed in a 1639 bed hospital society which includes acute and extended care beds.

**Data Collection Procedures**

Once participants consented to participate in the study and it was found that they met eligibility requirements, interviews were set up and data collection began. Semi-structured interviews, which are appropriate for exploratory-descriptive design were held (Brink, 1989; Burns, 1989; Corbin, 1986; Hammersley, 1990; Hunt, 1991). This type of interview is purposefully flexible (Brink, 1989), and allows for participants to reveal as much as they wish about the topic under discussion. The aim of the semi-structured interview is to "elucidate the respondent's perceptions of the world without imposing any of the researcher's views on them" (Polit & Hungler, 1991, p. 279). Appendix C (p. 197), outlines prompts that guided the initial interviews. These prompts guided the researcher in attempting to operationalize the questions during the early phases of the interviews (Swanson, 1986).

Since the researcher was inexperienced, it was important to consult frequently with the chair of the thesis committee in order that: relevant information was captured; openness to data was present without being clouded by nursing, medical or psychologically oriented viewpoints; researcher confidence could develop during verification of data; the researcher could be reminded that flexibility and ambiguity were
integral parts of the qualitative research process (Corbin, 1986); and, in sense could be made of the data (Field & Morse, 1985).

The setting for the interviews was determined by the participants and all wished to hold them in their offices. The researcher was prepared to request uninterrupted time during interviews but this was not required. Participants put their phones on "call forward" and closed their office doors without being asked. The researcher accommodated the participants' choice of time. This assisted in efforts for a relaxed atmosphere since participants did not feel they should be somewhere else at that particular time.

Interviews were approximately one hour long. Participants all consented to interviews being audio-taped. If taping was not acceptable, then detailed notes would have been taken. The audio-tapes were supplemented by field notes made immediately after the interview which included researcher thoughts and observations.

At the beginning of the initial interviews, in order to establish a sharing relationship, the researcher again informed participants what was being studied and why, as well as what had aroused the researcher's interest in the topic (Brink, 1989). Since the researcher was a colleague of the Vancouver Island CNSs, data collection became more quickly focussed and efficient than if the researcher were unknown (Field & Morse, 1985). However, the researcher was also a
CNS so reflexivity was a factor in data collection (Boyle, 1994; Hammersley & Atkinson, 1983).

During the interviews a tone was set that encouraged sharing, interest, respect and appreciation for the time the participants were taking to participate in the research. This approach further promoted the relationship and assisted in encouraging follow up interviews (Chenitz, 1986).

Each participant was assigned an identification number and an interview number. As soon as possible after the interview, the audio-tapes were transcribed by a typist, using wide margins on the right hand side of the paper so that notations and codes could be entered by the data. The lines of the transcriptions, as well as the pages were numbered to make retrieval of data easier and to facilitate organization. A face sheet was attached to the transcribed interview data that assisted in retrieving demographic data and specific content of the interviews (Swanson, 1986).

Accuracy of the verbatim transcriptions was checked by the researcher re-listening to the tapes while following the transcripts. The researcher listened to the audio-tapes once or twice more so that she could acquire a sense of each participant's implied or expressed meanings, changes in tone or voice and significant pauses and/or inflections (Field & Morse, 1985; Polit & Hungler, 1991). These were noted on the transcripts.

As soon as possible after the initial analysis of the
first interviews, findings were clarified, elaborated upon, and/or validated with the participants. These additional interviews (arranged as noted earlier) allowed for checking the researcher's observations and interpretations, as well as increasing the depth and richness of data (Corbin, 1986). There were two to three one hour visits between the researcher and each participant.

Inherent in qualitative research is the interpersonal interaction between the researcher and the participant. The researcher was aware of personal preconceptions, values and beliefs and noted these in a journal. These assisted in the maintenance of researcher awareness of the data and its meaning to the participant (Hutchinson, 1986). Anything that the researcher was a part of either verbally or non-verbally by way of experiences, feelings, sight and hearing, as well as general impressions during interactions, in other words, the "dynamics of the setting" (Field & Morse, 1985, p. 96), were kept as additional field notes. These were written up immediately after the interview, further clarified while re-listening to the tapes, and were included with the taped interviews (Field & Morse, 1985; Lincoln & Guba, 1985; Swanson, 1986).

Data Analysis

The research question was broad in nature and it progressively narrowed and became more focused during the research process. The research data analysis "requires a
fluid, flexible, somewhat intuitive interaction" (Brink, 1989, p. 151), between the researcher and the data. In addition to the flexibility and intuition, data analysis requires researcher insight (Carter, 1991).

Qualitative thematic analysis is made up of two types of coding that facilitated this narrowing, namely open coding and axial coding. Data analysis and data collection occurred simultaneously and moved from inductive to deductive thinking and back again (Guba & Lincoln, 1981; Strauss & Corbin, 1990). The researcher offered flexibility, intuition and insight throughout all phases (Brink, 1989; Carter, 1991; Pollick, 1991).

Open coding occurred when the data were initially broken down line by line and paragraph by paragraph so that persistent words, phrases, concepts and themes were identified. These were coded and developed into categories. This ongoing analysis allowed for the refinement of prompts so that subsequent interviews further elaborated emerging categories or themes.

Axial coding followed and the categories were re-examined and re-connected by use of a coding paradigm involving conditions, context, action/interactional strategies and consequences (Strauss & Corbin, 1990). The researcher was constantly asking questions of the data throughout analysis (Corbin, 1986). Significant statements, thematic descriptions, and verbatim quotes were organized
around each category or theme.

Through ongoing data analysis, concepts and their relationships were discovered to be relevant or irrelevant to the research question (Morse, 1994; Strauss & Corbin, 1990). Phenomena were discovered, developed and provisionally verified through systematic data collection and analysis (Strauss & Corbin, 1990). The researcher developed skill related to theoretical sensitivity as the study was conducted by: periodically stepping back and asking questions; maintaining an attitude of scepticism; and, following the research procedures with the guidance of her thesis committee (Strauss & Corbin, 1990).

The researcher developed a data filing system that included a flexible storage system, as well as procedures for retrieving the data (Field & Morse, 1985). Due to the researcher's previous lack of expertise in qualitative data analysis, it was challenging to develop an appropriate method of "filing" or "organizing" the data. This unfolded as the study progressed and the researcher became more knowledgeable about the capacity of her computer, as well as utilization of "cutting and pasting" transcriptions.

Throughout any phase of data analysis the researcher returned to the field, through interview, when there was a need to further clarify and/or validate data (Corbin, 1986; Strauss & Corbin, 1990). The information that participants shared was similar in basic structure to what the researcher
had generated (Corbin, 1986). If, through the verification process, the thematic analysis did not hold up, then it was discarded and the process began again (Corbin, 1986).

Literature was reviewed throughout data collection and analysis in order to: stimulate theoretical sensitivity, stimulate questions, direct theoretical sampling and to provide supplementary validation (Strauss & Corbin, 1990). The literature was used to expand and clarify codes and to become sensitized to additional ways of exploring the emerging data analysis (Charmaz, 1983). After data analysis and the emergence of categories, the literature was again reviewed to determine if others had identified the same categories and what they had said about them (Burns & Grove, 1987; Strauss & Corbin, 1990).

Once the conceptual categories and properties were established and their interrelationships evaluated, the resultant information was used to describe the phenomena of interest (Simms, 1981; Strauss & Corbin, 1990). The description consists of categories that are both dense with concepts and saturated to the degree that a range of variation was accounted for, hypothesis testing verified and the categories integrated (Corbin, 1986; Strauss & Corbin, 1990).

Qualitative rigor was assured through the following:
• truth value - the theory developed contains faithful descriptions or interpretations of participants. The
researcher verified data with participants and ensured that it was "true" so they recognized it as their own (Guba & Lincoln, 1981; Sandelowski, 1986). Journal entries (field notes) documented how the researcher was influenced by participants so that their experiences were clearly separate from those of the researcher.

- Applicability - findings from the research "fit" the data and are well grounded in the participants' experiences. This was confirmed by validation with participants, and the checking for the representativeness of the data by way of codes and categories (Guba & Lincoln, 1981; Sandelowski, 1986).

- Consistency - since the researcher was inexperienced, reliability was ensured with having the chair of the thesis committee review a section of the data to ensure there were consistencies in interpretations. The aim was that the chair arrived at the same or comparable conclusions (Guba & Lincoln, 1981; Sandelowski, 1986). Auditability was ensured by the researcher describing, explaining or justifying all steps of the research process in this final written report (Guba & Lincoln, 1981; Sandelowski, 1986).

- Neutrality - freedom of researcher bias in the data was ensured by way of the researcher carefully tracking and documenting all phases of the research. This is reflected in the research report (Guba & Lincoln, 1981;
Sandelowski, 1986).

**Ethical Considerations**

At the beginning of the interviews, the purpose of the research was again reviewed with participants. The researcher confirmed the eligibility criteria and asked participants if they had any questions or issues that had not been addressed. These were answered or resolved to the satisfaction of the participants.

At the beginning of the initial interviews, prior to any data collection, duplicate consent forms were signed by participants and the researcher (Appendix D, p. 198). The signing of the consent documents that participants had been informed about adequate information and were willing to participate in the research (Polit & Hungler, 1991; Swanson, 1986). Once the consent forms were signed, a copy was retained by participants and the duplicate was kept by the researcher (Polit & Hungler, 1991). There was not any financial remuneration for the participants of this research.

Participants were all informed that they were free to: withdraw from the study at any time without jeopardy and refuse to discuss any specific topics (Munhall, 1988). Participants were assured of confidentiality. This was attained through the use of codes known only to the researcher to identify participants on the interview audiottapes and any of the written materials for example transcripts and/or journal entries. Participant names and
specific work settings were not used at any time. Data was stored in a locked cupboard in the researcher’s home and accessible only to the researcher. Any resultant publications of this research will not identify participants either directly or indirectly. The data collected during all interviews was used only for the purposes of the research and upon completion of the study all audio-tapes will be erased. Participants were informed that for those interested a summary of the research findings would be made available.

Chapter Summary

This chapter has described the methodology that guided this study in its exploration of the definition of ANP and the relationship of ANP to CHO. Discussion was included that described the exploratory-descriptive research design, participant selection, data collection, data analysis and ethical considerations. In the next chapter, findings of the study are presented.
CHAPTER FOUR

FINDINGS

In this chapter, the research findings are presented. The research area of interest generated thoughtful and reflective discussions by participants. As nurses in ANP, participants attempted to define ANP as well as describe their practice in relation to CHO.

Although participants enthusiastically began discussions about the research phenomena of interest, it quickly became obvious that ANP was not a term that was easily and concisely definable. Initially, participants made comments such as "could you start with an easier question," "I really haven’t thought about this a lot" and "I should know this." Participants thought ANP was a term that was broad and vague in nature, however was able to be articulated through descriptors.

Participants found it challenging to describe their practice in relation to CHO. Initially, they focused on CHO, again as a term that needed a clearer understanding. This too presented challenges. Participants thought that the clinical focus for nurses in ANP was staff nurses. Therefore, participants believed that any influence they might have had on CHO would be of an indirect nature rather than a direct correlation. Participants chose interesting ways to articulate the possible relationship between their practice and CHO.
All participants confirmed confidently that they considered themselves to be advanced nursing practitioners. They were able to describe their practice from the perspective of their individual understanding of ANP. A common understanding was evidenced in that all participants cited, without prompting, indepth knowledge of Joy Calkin and Patricia Benner’s research, related to five levels of professional nursing competency in clinical practice, as well as ANP. Participants made reference to the wealth of literature that had been published over several years related to the CNS role and ANP. They also described how a CNS was formally acknowledged by nursing scholars and professional associations as being under the umbrella of ANP.

By way of setting the stage for reader consideration of research findings, information is presented now related to participant context of practice. All participants recognized that despite efforts to understand, define or describe ANP, abilities to enact their role and any influence they may have on CHO was strongly dependent upon the context of practice. They saw this as the single major determinant of how they practiced:

Context of practice is probably the major determiner of how we practice...it is the environment of your practice but not just the physical environment...it is the actual nature of the client population...a multidisciplinary setting. It is all those things that impinge on what I do, that are a feature of the social environment, the physical environment, the client populations...and then the context of the individual giving care....right from the micro to the macro.
Participants wanted the researcher to be clear that what they might have believed during this study about ANP may not continue to be realized due to many of the initiatives involved in health care reform. During the time of the research, many nursing positions were being examined and participants were being asked to justify their roles, and to take on more and more of what they considered to be administrative functions, as well as broader scopes of practice. For these reasons, they strongly believed that ANP was ever-changing and required a great deal of flexibility:

I have had to take on, at times, especially lately, duties and responsibilities that I normally would not take on. They would normally have gone to management people. What can I say? I mean in times of need, in times of crunch, if my boss or somebody says "I need somebody to do this and you're the only one I can call on right now to do it" what am I going to say but okay?

I am so flexible. I just go with the flow. Just watch how fast I can re-define my role.

My motto these days is "flexibility and insecurity is the future"...if I am inflexible I won't survive, I won't be employed in the agency first of all. Then I am not going to affect client* care if I am not employed first and foremost.

Participants recognized that health reform was significantly impacting all health care providers but believed that inherent in ANP was the consistent and ever-

NOTE:

* The term client will continue to be used throughout the presentation of research findings. The participants used terms of client, patient, resident and consumer in their discussions. However, for brevity, participant anonymity as well as consistency form the previous three chapters, client will be inserted wherever the participants spoke of the recipients of, or participants in nursing care.
changing context of practice. Thus, participants believed that they frequently needed to provide evidence of their value to nursing services and overall client care.

The researcher has chosen to present findings according to three broad categories, or descriptors, that resulted from the thematic analysis. The first broad category relates to difficulties in clearly defining ANP. This category of data consisted of two components: initial attempts at defining ANP and reasons for lack of clarity about ANP. Participants were not concerned about their lack of clarity around a term that was routinely linked with their practice. They identified many factors that influenced the vagueness associated with ANP.

The second broad category relates to descriptors of ANP. This category of data consisted of two components: minimal requirement triad of ANP and essential qualities of ANP. Participants built on their attempts to define ANP and were able to articulate what they considered to be the foundation for ANP, as well as essential qualities.

The third broad category relates to possible relationship between ANP and CHO. This category of data consisted of three components: problems in articulating CHO; communicating the relationship between ANP and CHO; and, theoretical problems in linking ANP with CHO. This data reflects participant attempts to describe their practice in relation to CHO. It builds on the previous categories by way
of exploration and description of how nurses in ANP roles influence CHO.

Together these three broad categories represent participant attempts to define ANP and to describe their practice in relation to CHO. Throughout the presentation, findings are illustrated with verbatim excerpts from participant accounts.

**Difficulties in Clearly Defining Advanced Nursing Practice**

In presenting these findings, it is important to again emphasize that participants were CNSs who addressed the research phenomena of interest from the perspective of their own roles. CNSs have been consistently identified in nursing literature and in nursing discussions as being advanced nursing practitioners. The assumption has been made for the purposes of this research, that since CNSs have been clearly linked with ANP, participants were able to speak from that perspective.

Participants had difficulty clearly defining ANP and initial attempts to do so reflected this. However, participants offered reasons for their lack of clarity about ANP. A description of their perceptions of what makes this difficult will provide a context within which their views about ANP and CHO can be understood.

**Initial Attempts at Defining Advanced Nursing Practice**

When participants initially tried to articulate a definition of ANP, they could not provide a clear or concise
one. The following accounts are reflective of participants' initial lack of clarity regarding a definition of ANP. They recognized that a definition of ANP was open to many interpretations:

_I don't know, I really don't know how (pause) how you define it._

_I am sure there is a basic core thing of what most people mean when they use that term. But everyone has a different idea._

_It is a concept that is not concrete nor easily defined (pause) there are not a lot of easy boundaries around that concept you know._

All participants recognized that their role as a CNS was directly associated with ANP. However, they also believed that ANP was a term that remained broad and vague in nature. They were not concerned about their lack of clarity about ANP, and as the data will show, cautioned the researcher in her attempts towards a clearer understanding of it.

**Broad and Vague Term**

All participants were familiar with nursing literature on ANP and cited various nursing scholars such as Calkin and Benner's efforts at defining and/or describing ANP. However, participants thought that these definitions and/or descriptions, although valuable and assistive in their roles, were not clear or consistently practiced.

Participants referred to Benner's work and believed that the lack of explicit linkage between expert and ANP added to the lack of clarity about ANP. They thought that Benner's work did not fully capture "ANP" although they knew she
referred to, and used the term along with "expert."

Participants believed that ANP was something more than the indepth clinical knowledge that was often associated with the expert nurse:

*I think that whole business around the experienced nurse is so baffling. I don't think we really understand a whole lot about it. I mean I meet people who do become experts by experience but I think they are limited. I mean one is limited by one's knowledge and experience generates, at least in Benner's terms, it generates clinical knowledge. But there is more to the practice of nursing than just clinical knowledge. That is where I think there is a problem with her work.*

Contributors to the overall lack of clarity around ANP were thought to include nursing language/rhetoric that was not easily understood and/or meaningful within nursing, let alone outside nursing. Participants also cited the overall sensitivity that nurses had towards the various levels of nursing education. The following account summarizes these contributors and reflects participant awareness of the influence of their practice related to CHO:

*Advanced practice is not easy to define without putting down colleagues with less education, because we do know that because we have more education, we make a bigger difference in the lives of our clientele. You know, when you take all that rhetoric aside, don't you find often that you're trying to tell people about what a clinical nurse specialist is? You try to tell your mother or a friend who has nothing to do with health care and you're at a loss, because the language that we use is not day-to-day language. We've got a lot of flowery or technical words or you know fluctuating language that we use to describe it. And yet the bottom line for me about advanced practice and client health outcomes has more to do with my willingness to really try my hardest to provide leadership and guide people in the right directions so they can find the client health outcomes that are meaningful for them....We haven't been using language that is meaningful.*
Thus, according to participants, ANP was a term that was broad and vague in nature. They cited nursing literature and work of nursing scholars such as Calkin and Benner but thought that current research did not adequately capture the differences between the expert nurse and the nurse in ANP. Participants believed that there is more to ANP than clinical knowledge and that providing leadership and guidance to others were an important part of influencing them to find meaningful CHO.

Lack of Concern

Not one of the participants was concerned about her lack of clarity around ANP. All were very willing to engage in discussion for the purposes of the research. However, it was obvious to the researcher that a clearer understanding of ANP was not a priority area for participant consideration. Overall, although gracious in taking part in this study, participants believed that in their day-to-day practice they had more important things, such as program planning and consultations to consider rather than trying to define ANP more clearly:

*I know that ANP is not a clear term but I have other more important things to think about.*

*It is not a burning issue. It’s interesting, all of this role confusion that people have and all this, all this angst I suppose with the role. I don’t have it...I don’t know (pause) I have too many other things on my desk to get done in terms of program planning, consultations and all that kind of stuff to really worry about how other people define my role or try to define my role or what it should be.*
All participants were comfortable with their own understanding of ANP and voiced confidence in how they defined it for themselves and how they enacted it. They were not concerned if their own understanding was not clear to others. In fact, as the following account demonstrates participants got "fed up" and "tired" of what they perceived to be exhaustive and futile efforts to more clearly define ANP:

So we have a hard time defining it. It doesn't bother me. I know how to define it for myself and for the people that I work with and I'm comfortable with my definition or with my perception of it. And this may sound sacrilegious but I don't really care how anyone else defines it. I use it as a framework as to how to interact with the client and the rest of the health care team. As long as I am comfortable in how I perform my role and define my role that is enough!...I get tired of it. I think that we work so hard at trying to define our role that we get carried away and our focus gets displaced.

Participants elaborated on their own lack of concern by pointing out that very credible and well known nursing scholars had made significant efforts toward trying to further understand ANP, as well as the individual roles in it, but without much success. Although participants valued these efforts, the lack of success reinforced their own ideas about not needing to be directly involved in these efforts:

How do you define advanced nursing practice or how do you define a CNS or a Nurse Practitioner or a Nurse Anesthetist? With a great deal of difficulty. And how many years have people been trying to do this? People with much better qualifications than you or I will ever have! How many years have they been trying to define what nursings' mission is? Some forty and we still haven't answered that question either. So why should I try?
Thus, participants were not concerned about their lack of clarity about ANP. From their own perspective, they understood it well enough to be able to enact it. Although participants supported the researcher in her efforts to define ANP, clearly they did not share this need. Day-to-day demands of practice were thought to be far more important areas for consideration. Participants recognized the exhaustive, but non-conclusive efforts of nursing leaders around various components of ANP. Although participants found these efforts worthy of applause, they believed that defining ANP was not something they needed to spend any more time with. In fact, they thought efforts to do so were tiring and futile.

Cautions Around Trying to Clearly Define

Not only were participants not concerned about the lack of clarity about ANP, they cautioned the researcher in efforts aimed at a clearer understanding. They believed that it was beneficial for ANP to remain broad and vague. This allowed for the flexibility required for ANP to continue to evolve, like the rest of nursing. Participants identified the risk of what they referred to as forcing a definition. Although recognizing that some nurses wanted things like definitions to be in "black and white," participants saw clarity as potentially resulting in negative consequences for nursing. Given the ever-changing health care environments and the resultant ambiguity in nursing, participants thought
ANP was understood well enough. The following account captures this most clearly:

I think we are in the process of evolution so to prematurely pin it down too tightly would be dangerous. I mean I think we are in the process of evolving that level of practice and that it is very difficult to do, so you don’t want to force it. The risk if you force a definition is that it will not serve us....And I worry that someone will force some definition onto the floor that actually won’t serve us because they have such a great need to have things in black and white. I think that nursing is in a state of great ambiguity right now...great greyness. So I think we have to be really cautious!

Participants reinforced that nurses knew enough about ANP yet may never know enough to have a clear definition. They thought ANP was something to be described and these descriptions allowed for ongoing changes and flexibility for the role. The descriptions also involved telling paradigm stories:

I mean I think we know something about it, it is just that we don’t know and we may never know enough to make it a clear definition. What you have to do is to talk in terms of "at this moment in time these are the kinds of things that advanced nurse practitioners are able to do"...it would probably be very descriptive and more told in paradigm stories and I don’t know that it will ever become more clear than that.

Thus, participants believed that nursing was evolving and ANP needed to be flexible to respond to these changes. Participants also believed that nurses understood ANP well enough and may never know enough to have a clear definition. They thought ANP was something to be described in paradigm stories, with the descriptions allowing for ongoing changes to the enactment of the role.
Reasons for Lack of Clarity About Advanced Nursing Practice

As has been mentioned, participants had difficulty with a clear definition of ANP. Besides not being concerned, participants could articulate valid explanations for their lack of clarity in attempting to define ANP. These included: role inconsistencies; imprecision regarding nursing; terminology changes; and, lack of time for reflection.

Role Inconsistencies

Participants recognized that nurses in ANP brought their individual focus and variation to the enactment of that practice. This was believed to result in overall inconsistencies related to ANP. Although recognized as a factor in lack of clarity about ANP, participants thought these very inconsistencies were valuable, as they supported the individuality of the nurse. Participants supported the unique personal and professional competencies* that each nurse brought to ANP:

We certainly do not have a singular view of life as a CNS....I think there is a real variation in how we all practice.

Every single one of us is very different, very, very different.

Participants believed that nurses who went in to ANP had very strong personalities. These strong personalities combined with advanced education and experience resulted in

NOTE:

*competencies - participants defined competencies as the knowledge, skills, attitudes and judgements that nurses brought to ANP.
unique, powerful competencies which had the potential to positively and significantly impact nursing and health care. Participants also believed that despite the varying personalities, nurses in ANP were very supportive of each other and would try hard to embrace nurses new to the role. The following account reflects participant attempts to explain why ANP was not clearly definable and how nurses in ANP would support and mentor others:

"I don't know if I even have a handle on why it is that it is not able to be defined clearly. I think it is just the amorphous operationalization of the role, of the roles. I mean we don't even have consistent terminology for the roles. And I think of it being kind of amoeba-like. You get someone coming in to the role, an advanced practice role and they've got qualifications you didn't expect or experience you didn't expect and all that kind of thing. So then the amoeba kind of reaches out and takes that person in to the fold.

Thus, participants believed that there were significant differences in how nurses in ANP enacted their roles. These differences were supported as participants thought that nurses who chose ANP brought some strong personalities, as well as professional competencies that had the potential to positively and significantly influence nursing and health care. Nurses in ANP valued supporting their peers.

**Imprecision Regarding Nursing**

Participants thought that ANP, similar to so many other terms in nursing, lacked clarity. They therefore questioned the focus within nursing on ANP. Participants believed that despite an apparent unclear understanding of specific terms, most nurses were competently able to practice nursing. In
other words, although most nurses could competently practice nursing, they couldn't clearly articulate it.

Participants recognized the controversy concerning clarity of nursing itself, let alone specific roles within it. As a result, participants thought many factors influenced attempts at clear definitions of ANP. They thought the variety of understandings of ANP were influenced by "hidden agendas" and "protecting turf" of those trying to develop definitions:

It is almost like everything else in professional nursing. There is so much controversy about nursing itself never mind specific roles within nursing. I think everybody has so many different perspectives as to what advanced practice is. Often it is people with very specific hidden agendas to define it one way, and other people define it another way. I think a lot of people are interested in protecting their turf when they are defining it or trying to define it as nursing practice.

The following account reflects these ideas as well as participant views that it was "the experts" who were most concerned about confusion associated with all of nursing practice. However, despite overall lack of clarity, participants thought ANP was a useful term:

I would ask well why should we be using the term nursing? Only experts have disagreement about what nursing truly is and what nurses do. How come we’ve had such difficulty truly defining what nurses do? It is a concept that is very broad and can mean a lot of things to a lot of different people. But it still represents a concept, represents an idea. So I think it is a useful term. But where I think it is problematic is whenever a specific group refers to themselves as advanced nursing practitioners without looking at how broad the role of an advanced nursing practitioner can be and how many people, how many types of nurses that could apply too.

Thus, according to participants, part of the lack of
clarity associated with ANP was reflective of the broader imprecision regarding nursing itself. Although participants believed that most nurses could quite competently practice nursing, these same nurses had difficulty trying to articulate their practice. Participants did believe that factors such as "hidden agendas" and "protecting turf" influenced the varying understandings of ANP. Despite expert disagreement on the definitions and practice of nursing, participants believed that ANP was a useful term.

**Terminology Changes**

Participants thought that ANP was a complex and "relatively new" yet ever-changing term. Participants believed that one possible influencing factor as to whether a nurse could talk about ANP in detail was whether or not it was a topic in the literature during attendance at graduate school. If it was, participants believed it would then have been included in their course work. Even though participants recognized the scope of nursing literature in circulation during the time of this research related to ANP, they thought that to truly understand ANP it might have been useful to have "the luxury of graduate student time" for indepth discussion. They believed that once nurses completed graduate education, they would be unlikely to have the time to fully explore terms such as ANP. This lack of time was thought to be primarily due to the extensive day-to-day demands of practice:
The term advanced nursing practice is new to me, having been out of graduate school for five years now...it was not tossed around in graduate school. So you are being exposed to a certain body of literature where you are at in this point and time. That is the beauty of being a student. It gets you right back into the current literature. The reality of practice for me is that it is impossible for me in my current position, I can't talk about the others, but to really keep abreast of all the literature on the CNS role and advanced practice and all that.

Thus, participants recognized the value of being able to fully explore terms such as ANP in graduate school. The extent that a nurse could discuss ANP was thought to be reflective of whether or not the term was in the literature, and therefore part of education, while the nurse was attending graduate school. If not, once the nurse was in day-to-day demands of practice, time required for full exploration of ANP was not available.

**Lack of Time for Reflection**

Participants believed that to understand terms such as ANP, critical thinking about practice was required. Participants referred to this as "reflective time." They defined reflective time as time when nurses in ANP could "step back" and spend quality time critically thinking about a variety of terms and/or concepts that were linked with their practice. This reflective time, although highly sought, was referred to as "a luxury" and basically unattainable due to workload pressures. However, participants identified that when reflective time is not built in to nursing practice, it could be an important factor
related to the overall lack of clarity about ANP:

One of the reasons that we might have difficulty doing that (defining ANP) is that we don't build in reflective time. We are very versed in front line work and it is very hard to do conceptual thinking of the order that you are asking us to do unless in fact we have done reflective thinking about our practice.

The following account further exemplifies that this reflective thinking would only be done when the nurse in ANP was involved in research. Otherwise participants thought that, in day-to-day practice, they were not required to be "practiced in articulating ANP":

No one ever asks me what it is I do or why it is that I am called this or you know, in terms of the people that I work with so maybe the opportunity to explain myself arises only in these settings, when someone is doing research. I am really not practiced in articulating it.

Thus, according to participants, reflective time was required for nurses in ANP to understand terms such as ANP. They realized that due to day-to-day workload pressures in their practice, they could not build reflective time in. So reflective time was thought to be a luxury that was usually only engaged in when participants were involved in research.

In summary, ANP was a term that did not allow for a clear or concise definition but rather was thought to be inherently broad and vague in nature. This nature was thought to be influenced by the lack of understanding that nursing scholars had between expert and ANP, nursing language/rhetoric and sensitivity of issues related to nursing education.

Participants were not concerned about their lack of
clarity about ANP and believed that their personal understanding was sufficient to adequately conduct their practice. Out of support to the researcher, participants attempted to address the phenomena of interest. However, they believed that if nursing scholars were not clear about ANP, then nurses in ANP had more important and pressing issues for consideration.

Although supportive of the research, participants were cautious around efforts to clearly define ANP. They believed that nurses in ANP could adequately describe their practice using paradigm stories that would allow for the flexibility required for on-going changes that influenced the evolvement of ANP.

Participants offered reasons for the general lack of clarity about ANP. Nurses in ANP were thought to have significant inconsistencies in how they enacted their role, although this variation was strongly supported and encouraged. The lack of precision or definition regarding nursing was another reason cited. Participants recognized that most nurses could competently practice nursing but could not clearly articulate their practice. Despite factors such as the general disagreement around many definitions associated with nursing and the influence that various agendas and turf issues had in trying to develop a clearer understanding about ANP, participants thought that ANP was a useful term especially to represent a concept or idea.
Participants also believed that graduate school was a setting where concepts or terms such as ANP could be fully explored. They believed that if a term such as ANP was not part of a nurse’s graduate education, then busy day-to-day practice would preclude time required to be able to clearly articulate a definition.

Finally, time for reflection in practice was thought to be a crucial factor for understanding ANP. Although believed to be crucial, participants recognized reflective time as a luxury that was usually only possible during the process of assisting others in research.

Descriptors of Advanced Nursing Practice

Although participants could not clearly and concisely define ANP, they believed it was a term that was amenable to description. Two main descriptors were identified. The first was what participants believed to be minimal requirements of ANP namely: graduate education, clinical specialty focus and research-based practice. The second was the essential qualities of ANP.

Minimal Requirement Triad of Advanced Nursing Practice

Participants outlined what they believed to be the basics, the foundation or minimal requirements of ANP. These have been categorized as the three minimal requirements of ANP, namely graduate education, clinical specialty focus and research-based practice. According to participants, each one of these requirements was thought to be equally crucial for
ANP. However, it was the combination of the three that formed a triad of minimal requirements for ANP.

**Graduate Education**

All participants strongly supported the need for graduate education. Graduate education formed the first element of the minimal requirement triad of ANP:

*The bottom line for me is that the person have advanced education, at least at the master’s level.*

*I say very simply that you must have a master’s degree...to me it is simple because I believe at the bachelor level we’re just beginning to provide that basic level of a liberal education.*

Graduate education was thought to contribute significantly and positively to ANP. Participants believed that, during graduate education, nurses developed many competencies that were vital for ANP. These competencies were thought to be influenced by an exposure to in-depth pertinent theories, research methodologies and interpersonal communication skills:

*Graduate learning...to learn pertinent theory to apply to situations, learn research methods that help me understand those things, learn interpersonal communication skills that help me as a Clinical Nurse Specialist.*

During graduate education, participants believed they developed: a broader knowledge base, enhanced problem solving skills, principles of research-based practice and a higher level of overall analysis of nursing practice:

*I suppose I have a much broader base of knowledge than I did. I know more about where to go to learn about things. I know more about setting up programs. I know more about utilizing research and in fact being active*
in research or knowing where I can’t do research. I think that it is as much knowing when you can’t do as knowing what you can do, that is so critical. So the master’s program really developed me in my specialization.

Advanced practice and the education that goes with that forces you to analyze what you do in a different way.

Participants believed that graduate education also provided a liberal education in domains of social sciences and the overall health care system. Participants thought this resulted in a foundation for ongoing learning related to practice:

Advanced practice rests on having been provided that liberal education in all domains of the social sciences plus a liberal in-depth knowledge of the health care system and the knowledge that you always need to know more about your health care system. You can’t sit still, you always have to keep on learning!

Graduate education also significantly enhanced critical thinking:

I think it is a combination of education as I do think you learn to think differently the more you go to school, learn to look at things differently. You learn more critical thinking and nurses in ANP are constantly engaged in critical thinking.

Although all participants clearly supported graduate education, they had strong and differing views on what faculty the graduate degree should be from. Participants were graduates of varying programs and had definite opinions on this matter. Graduate nursing education was strongly supported by those who had graduate degrees in nursing:

The graduate degree has to be in nursing. I know it may be contentious but if we really want to advance nursing, I mean really if we are talking about advanced nursing practice how do you get that advanced nursing
preparation in another faculty? I don't think you do. Those participants also understood why some nurses chose to undertake non-nursing graduate education. Reasons cited included proximity to a university and whether or not the nurse had respect for the nursing graduate program. Participants with nursing graduate degrees were sensitive to the issue of some of their colleagues having non-nursing graduate education. Obviously wanting to be supportive, these participants still questioned whether or not non-nursing graduate education contributed positively to ANP. They did not think it did:

I think the thing is the fallacy of people taking a master's degree outside of nursing is the fact that we don't really know what that contributes to advanced practice. We know why they do it, and that has nothing to do with advanced practice. It has a lot more to do with if there was a school close enough that they could go to or that they had any respect for. They often aren't decisions made about advanced practice.

Conversely, participants who had non-nursing graduate degrees vigorously questioned the ongoing support for nursing graduate education as a basic requirement for CNS practice and ANP:

There is a lot of discrepancy then over...what kind of degree that should be.

These participants seemed as sensitive as participants with nursing graduate degrees to the issue of education, yet believed they were making a significant and valuable contribution to ANP. They based some of their questioning about the support for nursing graduate education on the fact
that many of these nursing programs did not contain a clinical specialization focus:

*Now exactly what that master’s degree is in and what its focus is in is a real bone of contention as far as I am concerned. Many nursing master’s are not clinically focused anyway and why would we suddenly say that the person is an advanced nursing practitioner as opposed to somebody who might have a master’s degree in another area other than nursing but has really focused on a clinical speciality area.*

At the same time, occasionally these participants questioned if part of their difficulty related to addressing aspects of the research phenomena was due to their non-nursing graduate education:

*Some of us may have difficulty in defining client health outcomes because we don’t have a nursing master’s. I don’t know...*

Despite strongly identifying the need for graduate education, participants believed that this education alone did not result in ANP. Although recognized as a vital minimal requirement, they believed graduate education only formed the first element of what has been conceptualized as the minimal requirement triad of ANP. Although graduate education was thought to provide valuable competencies that led to ANP, participants thought most graduate nursing education programs did not significantly contribute to advanced clinical expertise:

*Why do we zero in on the advanced preparation? Because that in itself doesn’t make an expert does it? You can have someone who has all the degrees but they are not the advanced practice nurse that we want to know today.*

*I think the difficulty is in our graduate educational programs. They are not designed to define expertise.*
Thus, according to participants, graduate education was thought to be a crucial minimum requirement of ANP. During graduate education, nurses learned: indepth pertinent theories, research methodologies, interpersonal communication skills, a broader knowledge base, enhanced problem solving skills, research-based practice and a higher level of overall analysis in nursing practice. They also developed a constant questioning of, and learning, related to practice and the broader health care system, as well as enhanced critical thinking. All of these competencies were thought to contribute positively to ANP. The issue of whether graduate education needed to be in nursing or another faculty remained contentious. However, participants recognized that graduate education alone did not result in ANP.

**Clinical Specialty Focus**

Participants believed that nurses in ANP must combine graduate education with a clinical specialty focus. This focus formed the second element of the minimal requirement triad of ANP. Even those participants with non-nursing graduate education believed that, despite the graduate program, nurses who wanted to practice ANP needed to combine their graduate education with an indepth nursing clinical specialty focus:

*First of all that it would be in terms of the person, someone who had a particular education, master's degree I would define where in fact they specialized in a particular area of nursing. An area that you were most interested in and then become further educated in that focusing that practice to the specialty area and*
applying that specialty knowledge in a clinical setting.

It is a combination of graduate education plus clinical experience in the field, you know, your specialty. I think those are the two major components of what makes advanced practice.

Participants reflected on their own experience about their clinical practice prior to graduate education. They described themselves as having been "expert" clinical practitioners prior to their graduate work. They clearly described how they brought their individual specialty area of nursing to graduate education and then during their studies focused on more indepth clinical competencies. On completion of their programs, participants could easily describe how their practice had changed by way of personal growth and enhancement of their overall clinical specialization:

Until you attend graduate education, you really don't know how much more you can offer your clients, your profession and yourself. I was an expert in my field before I did my master's degree. Now I know I was an expert, yes, but a very limited expert. Now after going to graduate school and linking that education with significant clinical practicums in my field, I am capable of so much more. You grow in leaps and bounds and then can help others to grow as well.

Back when I was a diploma nurse in ICU, I was very good in my field. I had good practice skills and to some nurses they might have called it advanced practice. Maybe I was a expert practitioner as opposed to advanced practice. But at that point and time, I did not see the world of ICUs. I did not analyze why people were coming in or if they should be coming in or if they should not....Advanced practice is broader and you develop that ability to stand back and look at it from a systems perspective and what is the impact on a whole specific population.

Despite being an expert prior to graduate education,
participants thought that the clinical specialty focus of this education needed to include clinical practice that was mentored. They believed this to be critical if nurses were to really develop into ANP. Participants believed the mentor needed to be a role model that the nurse could respect and be challenged by. Again, participants believed that the mentoring system needed to include dedicated time so that reflective practice did occur:

The thing that advances nursing is education that contains within it a lot of clinical practice that is mentored. I don’t believe...I mean it is not just throwing people out. It is a reflective practice and it is done within a mentoring system.

Mentoring is necessary to have at some point in preparing for a role like this so that you can know what it is about and have as a group a shared vision of what it is you are trying to accomplish.

Participants believed that the clinical specialty focus combined with graduate education was beneficial for ANP for a couple of reasons. Firstly, they thought that it enhanced the ability of nurses in ANP to link academic experience with practice. This linkage was thought to enable nurses in ANP to draw from a number of valid theories whether in familiar or non-familiar scenarios related to client care. Participants believed this to be very effective in problem solving complex clinical practice challenges that nurses in ANP were presented with on a day-to-day basis:

The thing that differentiates me as an advanced nursing practitioner from the expert nurse is that pursuit of learning, experience being able to integrate a lot of my academic experience into practice. When I arrive into a situation that requires a particular theoretical
framework I can reflect on my academic experience. And even if the theoretical framework does not exist, it is easier for me, I think, to pull a number of theories together to form a framework for a particular situation or client.

I think that if I was strictly and advanced practitioner, an expert like Benner describes where my skills have been acquired strictly through clinical practice, I wouldn't have the theoretical background to be able to expand that practice into areas that might be unfamiliar. I think that is one of the things, even being an expert you always run into things that are a little unfamiliar, something that you haven't run into before and I think that my academic preparation and my way of approaching the problem solving process allows me to accommodate those strange situations a lot easier that if I focused strictly on clinical practice.

Secondly, participants thought the clinical specialty focus linked with graduate education was assistive in developing different approaches to the ongoing evaluation of actions:

Advanced clinical practice and the education that goes with that forces you to consistently analyze what you do in a different way.

This analysis began a process that developed into what participants described as a constant questioning of practice. They believed that the process of graduate education supported and encouraged behaviours inherent in critical thinking such as challenging colleagues and faculty, as well as questioning everything from basic clinical practice protocols to broad health policy. Participants believed that nurses in ANP had the confidence to question the practice of all levels of health care providers, as well as policy makers. Participants saw their level and frequency of questioning practice as being very different from that of
other nurses:

We are constantly questioning the practices that we have and whether we can do things differently.

We are the ones that are not afraid to ask the stupid questions. We are always questioning.

Participants also valued their ability to prompt others to begin to question practice more:

I have the luxury of questioning what it is that we do and then by doing that, then I expect the nurses will also begin to question. So I kind of trigger their questions.

Participants recognized that by asking questions of staff nurses, rather than providing answers, they could further develop competencies staff nurses might already possess:

The CNS is often the "what-if" person, not rushing in with all the answers but asking the questions. Because staff nurses can do it, they have a lot of knowledge, sometimes they need to hear the questions rather than the answers. To me that is one of the biggest roles of the CNS, to ask the questions.

Participants believed the confidence of nurses in ANP to consistently question practice, combined with other competencies noted above, enabled nurses in ANP to be "proactive" rather than "reactive" to clinical practice scenarios and overall health care:

As a profession, nursing can't actively participate and progress if we can only manage to keep up to day-to-day client needs. That is one big influence of advanced nursing practice. Those of us in the role can be proactive and try to influence overall health care.

The following account reflects a combination of the competencies of overall system analysis, questioning of practice and proactive approaches to care related to ANP:
What I am looking at...looking at identifying client populations within our agency that...by and large lack something in their care, that would improve their outcomes, that would get them out of here faster, that we would question why they are even here in the first place. And then what I try to do in that role is that I try to develop an overall approach to that particular group of clients. I do believe in looking at trends and with what is happening with the clients in the areas and filling gaps in care. As well I am trying to be proactive in looking at what are the gaps in care in our community.

Thus, according to participants, an indepth clinical specialty focus combined with nursing or non-nursing graduate education were minimal requirements for ANP. Participants described how they entered graduate education having been recognized as a clinical expert in their field. Once they focused their studies with more indepth clinical work, they thought they graduated being able to practice at a different and advanced level of nursing. Participants believed that inherent in graduate studies was the need for mentors and reflective time in order to fully develop as a nurse in ANP.

A clinical specialty focus combined with graduate education was believed to have many positive outcomes such as use of valid theories for decision making, ability to effectively problem solve complex clinical practice challenges, development of an awareness of and ability to influence the broad health care system and development of different approaches to analysis of practice which included a constant questioning of practice. Participants saw this questioning of practice as being different from that of other nurses. Participants also believed these competencies
enabled nurses in ANP to be proactive rather than reactive to clinical practice issues and overall health care. Of interest is the fact the participants were quite clear about what differentiated expert from ANP, yet they were unable to articulate that in response to being asked to define ANP.

**Research-Based Practice**

Participants believed that another vital requirement of ANP was research-based practice. This formed the third element of the minimal requirement triad of ANP. When participants referred to research-based practice, they meant the research competencies gained through graduate education linked with a clinical specialty focus. Participants cited research-based practice from the perspectives of consistently thinking about, participating in, and utilization of research as crucial for ANP:

*CNSs think critically in the research mode.*

*As CNSs, we have to constantly be thinking about practice and how the trends of practice fit or don’t fit with research that has been done. We also have to participate in research and consistently ensure research-based practice.*

Participants believed that research needed to be the foundation of all nursing practice when that was possible. They recognized that a great deal of nursing practice was not based on research. However, they strongly believed that when valid and reliable research related to practice had been done, nurses in ANP often led the way into incorporating it into practice:
I realize there is a great deal of what we do that is not based on research. But if valid and reliable research has been done, we need to examine how we can incorporate it into practice.

Participants believed that the wealth of information contained in research literature was extremely useful in learning about, understanding and influencing nursing practice. Participants thought that this literature assisted them to work with and educate staff about practice from a variety of perspectives. It was also thought to provide a strategy for nurses in ANP to get staff nurses to question their own practice:

CNSs regularly go to the literature, especially the research literature, to learn more about, understand and influence practice. The research is a way for us to assist other nurses. We may have to translate the findings or results but we can do that and put it into terms that the staff nurse will understand. The research also helps us to get the nurses to question why they are doing some of the things that they do regularly.

Participants clearly valued partnerships with colleagues, interdisciplinary professionals and university educators in the conduct of research and/or dissemination of findings:

Everything we do needs to be based on research. It is great when we can, yet it is vital that we do participate in research with either other CNSs and/or interdisciplinary professionals or when we link with the university faculty.

Although participants thought the conduct of research to be important and recognized the value of partnerships with others toward this aim, an important area of their consideration was whether the master’s prepared nurse in ANP
could adequately assume the principle investigator role in research. Participants believed they played a significant role in research-based practice but that really definitive research involved a partnership between a nurse in ANP and a doctorally prepared nurse. They believed the doctorally prepared nurse should be the principle investigator:

*I'm not actually committed to the master's level practitioner as the principle researcher.*

*The advanced practitioner is someone who in fact understands where there are not answers in research. And I am not at all convinced that advanced practice at the master's level means you should be able to do research. I think that you should certainly understand the research process and you can do some subtle research....I think that the really definitive research is done jointly between the CNS and a PhD researcher.*

Thus, according to participants, research-based practice by way of research competencies, gained through graduate education linked with a clinical specialty focus, was a critical minimum requirement of ANP. They saw research-based practice as inclusive of thinking about, participating in and utilization of research. Participants recognized that much of nursing practice was not based on research, however they believed that when valid and reliable research had been done, nurses in ANP needed to make strong efforts that it be incorporated into nursing practice. Information contained within research literature was thought to be useful for nurses in ANP, in order to assist them in efforts with staff nurses about overall examination of practice. Participants also valued partnerships with others for the conduct of
research and/or dissemination of findings. Participants questioned if master's prepared nurses in ANP could adequately assume the principle investigator role in research. According to participants, truly definitive research involved partnerships between a nurse in ANP and a doctorally prepared nurse.

Essential Qualities of Advanced Nursing Practice

Participants believed that there were a number of essential qualities that were characteristic of ANP. Participants thought that nurses in ANP incorporated the competencies mastered in relation to the minimal requirement triad and combined these with experience and time. This resulted in what participants believed were the essential qualities of ANP: global thinking; indirect clinical focus; assistive care delivery; effective leadership; and, interdisciplinary collaboration.

Global Thinking

All participants strongly believed that ANP involved an indelph ability to consistently think globally. This global thinking represented the first essential quality of ANP. It was mentioned frequently and thought to be part of the "world view" and "system" perspective. According to participants, global thinking included overall logical, analytical and global views of the nursing practice world:

I think you develop a lot more of a world view. I think that most people who have come through the advanced educational programs have developed some more logical, analytical, global views of the world, which I think
also has to be part of advanced practice.

Global thinking was believed by participants to be thinking about the "bigger picture."

It was frequently obvious to the researcher that participants were consistently translating information into a global perspective. In other words, they were frequently thinking and talking about how any particular individual client scenario had relevance for understanding the whole of client care. They believed their ability to think globally was extremely beneficial for nursing, as well as for interdisciplinary practice. Participants thought that nurses in ANP were aware of issues in the worlds of nursing and in health care and had made some personal stands about these. This was viewed as useful in interactions with staff, such as telling staff what was going on in other areas, as well as what kinds of things they should have been considering for their own areas of practice:

To be an advanced practitioner I believe that you need that global view and you need to know what is going on in the world of health care, you need to know what is going on in the world of nursing. You need to have made some stands, otherwise you can't get back down there with the bedside practice nurses and try and tell them what kinds of things are going on out there, and what kinds of things mean something or should mean something to them at the bedside.

Participants described how they never interacted with one client without thinking about the implications that the care of that particular client would have for other clients as well as overall practice:
Care is not just for one client but for other clients that will do better because of that one scenario.

The following accounts exemplify participants' abilities to translate individual client scenarios into a whole or pattern. The first demonstrates recognition of "patterns" related to practice and resultant analysis of practice:

Sometimes you end up dealing with the same problem over and over again and you suddenly realize that there is a pattern here....in order for us to nurse in the best way possible and the most effective way we have to analyze what it is we are doing, analyze our practice.

The second refers to recognition of patterns but assurance that decisions were not made because of one or two occurrences:

You are forced to look more broadly and you then start to look more broadly and I think that is part of it...you say okay this is happening here...but I am not making my decision based on my sample size of one or two. Lets see what has happened elsewhere, lets see if there are some commonalities here, lets see if other people have this problem and maybe they have even come up with some solutions.

At the same time, participants recognized the benefit of bringing "the whole" to any one client scenario for an improvement in clinical status of individuals/groups through working with staff:

In a complex clinical situation I look to the research, I look to trends, I consult with experts from the world of available information to try to determine how to assist any individual client or groups of clients via the staff.

This thinking was influenced by synthesis of competencies in nurses in ANP linked with their awareness of agency, community, provincial, national and international health care
trends, issues and initiatives. Participants believed this thinking could have an impact on their communities, as well as ethical decision making and policy formation:

As nursing practice is about broadening the way in which you practice such that it touches on a whole bunch of people rather than your clients for the day. So it is much more global and it can even have community effects and ethical decision making and policies and all that kind of thing.

During this research, all participants were available for consultation to their entire agency. This large geographical responsibility was believed to be useful in identifying and monitoring trends and sharing information between units, as well as allowing global thinking to influence and be a part of clinical practice:

Many of the client groups that I have dealt with are so diverse and in such diverse areas of the hospital, that if you worked in a specific clinical area you would not see the other groups throughout the hospital. Whereas, in my role travelling throughout the hospital and at the variety of sites, you pick up some things that other people may not see.

Participants believed there were many benefits of bringing global thinking to clinical nursing practice. Firstly, they thought it assisted in their efforts to positively influence the "bedside" or "staff" nurse and thus enhance overall practice:

The more global you can be, the more knowledgeable you can be, the more advanced your practice is going to be. Because you can pass all that, you can somehow pass all that, or have an impact if you’re lucky on some bedside nurse or a number of bedside nurses.

To positively influence staff nurses was thought to be extremely important. Overall, participants thought that the
majority of nurses traditionally practiced from a "narrow" focus and were subsequently generally "reactive" to client care and overall health care and thus were consistently managing crisis. They explained that, due to day-to-day pressures and responsibilities, most nurses were "barely able to keep up" during their shifts, and often ended up being only able to practice in the "reactive" mode. However, participants also recognized that, due to system restrictions, it may have been impossible for staff nurses to do anything but react:

In acute care in particular, nurses are so busy running around trying to meet individual client needs, they don’t have time to stand back and think of the meaning of what they are seeing. They can only focus on the clients that they are assigned to for any given day. The system does not allow them to be proactive.

Participants believed that one responsibility of nurses in ANP was to bring their global thinking to clinical practice and thus try to work with nurses in efforts to move them from a less reactive and crisis management mode to one of being proactive. However, participants recognized that their role enabled them to be "once removed" from the client, therefore able to see issues that many nurses saw, but with more objectivity. Participants believed this enhanced the ability of nurses in ANP to be proactive:

When you are in it you sometimes don’t know...you don’t generate as many questions as when you are once removed. The beauty of my job is that I am once removed from what is going on, from the actual work, the day-to-day work of the nurse. So I look at it through a nurse’s eyes but I look at it more objectively, not caught up in the emotion of the job, the stress and the pressure of the
Secondly, participants believed many client needs went un-met in an agency that did not have a nurse in ANP. The following account reflects participant attempts to explain the value they saw in bringing the global thinking to clinical practice in an agency:

Part of the difficulty that we often have with staff is, even expert staff out there that are terrific clinical practitioners, they are so focused on their clinical practice that they have a hard time seeing beyond that and beyond client needs except as related to their specific practice setting. There are a lot of client needs that would not get met unless you have a more global vision.

Thirdly, participants believed nurses in ANP utilized global thinking, proactive strategies and monitoring of trends to make changes to the health of clients in their agency and therefore improve client care:

I can also with advanced practice say that this will happen to the next person that comes in, and this will happen over here and I can almost predict what the problems are going to be over there....And to look at how the system is functioning here and what do we do.

As well as within their agency, participants also believed that nurses in ANP needed to expand/extend global thinking to outside agencies/groups:

I always try to see that big picture...whether it is within our system or I am being consulted from outside...you are coming from out there, the world view and helping people to solve the problem that they are trying to address.

Thus, according to participants, ANP involved an in-depth ability to think globally. Global thinking was believed to be the nurse’s ability to think broadly about the links
between individual clients and groups/populations as well as overall health care. Nurses in ANP were thought to have competencies to translate individual client scenarios into a whole or pattern as well as bringing that whole or pattern to any individual client. Participants identified a number of benefits of bringing their global thinking to clinical practice. It was believed to be a positive influence when working with staff. Participants recognized that staff nurses practiced in the reactive mode, primarily due to system constraints. Participants believed that nurses in ANP practiced from a proactive mode, and it was their responsibility to use their global thinking in efforts to move staff away from crisis management. Participants believed that if an agency did not have a nurse in ANP, many client needs would go un-met. Another benefit of global thinking, proactive strategies and monitoring of trends was that they were thought to be assistive for nurses in ANP to make changes to the health of clients within their agency, as well as external agencies.

**Indirect Clinical Focus**

Rather than focus on individual clients, as would most nurses, all but one of the participants identified that nurses in ANP had an indirect clinical focus on clients. This indirect clinical focus represented the second essential quality of ANP. Participants thought most nurses traditionally clinically focused directly on clients as
recipients of care, whereas nurses in ANP clinically focused directly on staff nurses and indirectly on clients. Participants thought that nurses in ANP used leadership and modelling with nurses to indirectly influence safe client care:

Our effect on client care comes sort of indirect. It is indirect because of where we try to influence. I believe who we do influence is the bedside nurse. We are trying to influence her/him in a leadership way, in a modelling way. We are trying to provide what is current, what the literature deems current, what is safe.

Participants believed that the anticipated outcome from directly clinically focusing on staff and indirectly on clients was improvement in practice and enhancement of health outcomes for both nurses and clients, as well as appropriate others involved in care. Participants spoke very highly of staff nurses and described them as the "most valuable nursing care practitioner":

I think what we really have to recognize as a group is that at least from my perception, the most valuable nursing care practitioner is the staff nurse, the practicing nurse at the bedside. We are here to support them, period, that is the end!

One participant had a somewhat different slant on her direct clinical focus in that she identified it as clients or groups of clients, rather than staff nurses. She believed she was somewhat unique in this approach. However, as the following account demonstrates, she still described working directly with the nursing staff to facilitate client care and outcomes:
I have or at least I think I might have a little
different perspective and it is often to the chagrin of
the nursing staff that I work with. My focus isn’t the
staff. My focus is the client. My sole reason for
being here, if I had one sole reason, would be to
enhance outcomes for that client. Now that often means
creating things or doing things that are not beneficial
to the staff, in their eyes. In other words, it might
create more of a workload, it might create more
complexity for them. I see that as being a secondary
focus and I try to modify that as much as possible and
try to facilitate that as much as possible, but my
primary focus is the client or groups of clients.

Participants very strongly valued their indirect
relationship with clients and had a great deal of personal
satisfaction in solving staff/client challenges through their
work with staff:

Well you see I have only ever wanted to work with
clients. It is the kind of situations that people need
help with in health care. These are the kinds of
situations that I am challenged to work with. I love
working with staff and clients in that they present me
with the kind of challenges that have great meaning to
me in solving.

Due to an indirect relationship, participants believed
that it was almost impossible to directly link their practice
to CHO. Due to their overall assistive care delivery
qualities, participants thought that their influence on CHO
was actually from the broader perspective, in other words,
from the second or third person down:

My personal perspective of the CNS role wasn’t so much
getting hands on involved in client care but in
teaching, in modelling and showing other people how to
carry out client care, how to look at nursing
practice....So if you are looking at advanced nursing
practice and nursing outcomes from my perspective, what
we are looking at is outcomes maybe two or third person
down.

Participants recognized that it would be advantageous to
be able to measure the influence of their practice on CHO, even in an associative type way. However, they saw that as being very difficult due to their indirect relationship with clients:

The only thing I wish, is that we could somehow develop some kind of system, some kind of method, some kind of tool that would be actually able to connect maybe not a cause and effect type of thing, but just an associative type of thing on our role with client outcomes. But I think that is going to be incredibly difficult.

All participants had made informed decisions to remain close to clinical practice thus close to staff nurses and clients, as opposed to pursuing careers in administration. Participants believed that all nurses in ANP were very clear about the personal value they placed on clinical practice:

Clinical Nurse Specialists have never wanted to move away from what is referred to as bedside care, client care or direct client contact. This has always been something that is highly prized.

Participants believed that although administrators were very important and played a key role, nurses in ANP found real meaning and challenge in working with staff nurses and clients. The following account demonstrates participant passion about nurses in ANP involvement in clinical practice:

I am grateful, immensely grateful to administrators because I think they are terribly important. I am bored to death by the problems that they encounter. But the situations of human beings and health and illness are situations that are very, very challenging and meaningful to me to work with and that has been true all my career.

An indirect clinical focus with clients was incredibly important to participants. So much so that, despite the
ongoing flexibility required in their roles, participants thought that if there was ever a significant threat to their focus, they would resign from their agency:

I would not be able to move away from direct care orientation because I think that is a distortion of the role. So if I was required to take on more and more management areas I would leave, I know that.

Participants believed that an issue associated with ANP was whether or not nurses in these roles should assume responsibility for direct client care. Participants believed that nurses in ANP should not assume responsibility for direct client care as this was contradictory to the very essence of ANP, as well as not being cost effective:

I would love to go in and solve the problem. It makes you feel good, you sleep good. But after a while you sense that something is missing here. I am not helping the staff to be able to do what they need to be able to do. And so I think the advanced practice role is to say how can I assist others to elevate their level of practice, move the standards above the basic level of what is required...it is too expensive to have this level of person (participant pointing to herself) dealing on a one to one in these economic times.

Participants occasionally had some minor personal struggles with this since they enjoyed direct client care. However, another reason they identified for nurses in ANP not assuming responsibility for direct client care was because one would get "buried" and then not be able to continue to see the global picture:

I think that is one of the biggest frustrations in the role. You spend a lot of time trying to help other people to either gain knowledge or expertise so that they can do something that you would probably rather like to do yourself...I don’t carry a caseload and I don’t really want to do that because then one gets
Participants also believed that if nurses in ANP did assume responsibility for direct client care, it would be counter-productive for nursing staff. Participants were very sensitive to the potential of giving the impression that they were "better than" staff. Instead they wanted to work with staff in order to assist them to continue to learn and to recognize their own competencies in solving clinical scenarios:

*I think that you do get into trouble as an advanced practitioner if you take on client care. Then you exclude the nurses who would normally look after that client because they are not going to learn anything new if you are going to do it. And you also then give the message that I am better than you and I can do it."

Thus, according to participants, since nurses in ANP worked directly with staff nurses and indirectly with clients, any influence that nurses in ANP had on CHO was of an indirect nature. Participants recognized the benefits of being able to measure this influence, even in an associative manner, but thought this to be difficult.

Participants believed that nurses in ANP had staff nurses as a direct clinical focus and worked with them to enhance CHO. Participants believed that nurses in ANP made very informed decisions to remain involved in clinical practice. This involvement was highly valued and participants found meaning and challenge working with staff nurses and clients. If this was ever seriously threatened, participants thought they would resign from their agency.
Participants thought that, although the temptation was strong, it was inappropriate for nurses in ANP to assume responsibility for direct client care. They believed this to be contradictory to the very essence of ANP as well as not being cost-effective. In addition, participants expressed sensitivity about staff nurses, in that it was important they continue to learn and recognize their own competencies to solve clinical scenarios.

**Assistive Care Delivery**

Closely aligned with the indirect clinical focus, participants believed that nurses in ANP had a primary responsibility to be of assistance to "others" in care delivery. Assistive care delivery represented the third essential quality of ANP. "Others" primarily referred to staff nurses but participants also spoke of assisting interdisciplinary professionals, as well as working with clients and families/significant others in order to enhance CHO. Participants believed this assistive role to be crucial for ANP and thus client care, as well as advancement of nursing and overall health care. Participants gained a great deal of personal and professional satisfaction by way of assisting others to deliver care:

> To me there is a lot of personal satisfaction seeing that staff nurses or even a physician, but anyone else that asks for my assistance in a difficult situation. They are not sure on how to progress. And then you come in and help the whole situation and then step out and let them take over. To me that is more of what I want to do. That is advanced nursing practice.
Participants cited indepth use of consultation and education as strategies to assist care delivery. The following account reflects participant descriptions of ANP via the assistive care delivery perspective. As is illustrated in the account, participants described being able to relate to and validate both client and staff experiences, being able to assist them to take action and to feel positive about their decisions and to use a particular experience as an opportunity to increase staff competencies. Participants strongly believed in the "use of self" with others rather than demonstrating advanced clinical expertise:

When staff or clients have an experience that I am somehow able to relate to it, that I am able to validate it, help them what to do next, help them with their reactions, help them feel good about themselves and where they are at, to help them to grow. That to me is advanced practice, what I am trying to give to people to work with. I see it as a giving up of myself much more than a giving out of some sort of expertise.

By way of assistive care delivery, participants were particularly intrigued and challenged by complex clinical practice scenarios. They believed nurses in ANP were predominantly involved in those scenarios. The following account illustrates how participants thought nurses in ANP, using Joy Calkin’s model as a reference, targeted complex, really unusual clinical scenarios and were able to be assistive to others to solve these:

Advanced Nursing Practice is working with people on the extreme ends of the curve. People who experience the unusual problems, both in terms of health and in terms of deficits. And that is where I see the differentiation in advanced practice. Advanced practice
to me is essentially that the scope of client situations, in whatever the target population is, whatever the person with advanced practice has chosen to specialize in, that population group that the advanced practitioner can work with is in fact much greater. It goes right across the whole spectrum, for instance all the populations.

Participants believed that nurses in ANP, through being involved in an assistive care delivery, utilized many strategies related to empowerment of staff. They also believed that these strategies needed to be so effective that often staff nurses would not remember who initiated an idea. Participants thought this was a true reflection of really effective empowerment. They thought that nurses in ANP "started things," "planted seeds," "initiated programs" and by their assistive care delivery could get the staff to the point where they owned the ideas and/or programs:

The nurses don’t attribute it or very seldom do they attribute an idea back to how it all got started.

You can help the nurses look at care delivery. I have had some come to me and say on one unit, they would like to look at their care delivery system. They are thinking that it is not very effective, the way they are doing it. I like to think I had planted some seeds.

Usually you go back in the area six or eight months later and there is a whole different perspective the staff have. They see that the client outcomes have been enhanced and they see eventually that their workload may have decreased because of these changes. Unfortunately, they often don’t recognize that it is because of something that you have pushed.

Participants were so committed to improving and/or enhancing staff competencies that they aimed towards working themselves out of a job:

It is getting better and better as time goes on. Now I
see staff have worked part way through it and need a little bit of help to get the rest of the way through it....In fact, I would be very happy to work myself out of a job because that would mean the staff have learned enough to do all that is needed for care.

I guess the best thing for us to do is in a sense to assist people to take on what it is that we start out doing....In a sense it is working yourself out of a job but there is always enough to do.

However, at the same time, particularly if participants had spent a great deal of time and effort on a complex clinical scenario, they occasionally had some personal challenges associated with not being given credit for it. These reactions were brief and participants were able to overcome their personal feelings and obtain satisfaction about the overall improvement in client care and outcomes:

It is pretty rough sometimes. I say you have to develop a thick skin....I just keep focusing on the client and take my pats on the back from knowing that client outcomes are going to improve....I get my strokes from seeing the staff recognize that client outcomes have changed for the better.

When working with others, participants believed that nurses in ANP also wanted to educate and empower clients at the same time as other health care providers. They described learning scenarios where education was aimed at both nurses and clients. The goal was that both nurses and clients actions/activities changed not only during that particular scenario but they would be able "to recall" the learning and use it effectively the next time. Participants consistently aimed at an increased level of knowledge, decision making and actions related to care for both staff and clients:
If the nurses learn, clicks will go off in their head the next time.

That client will have seen it happen...and clients will question next time and they will have a better experience the next time.

Thus, according to participants, nurses in ANP were assistive to staff nurses, interdisciplinary professionals, clients and families/significant others by way of care delivery. Participants extensively utilized consultation and education as strategies for this approach. They thought that nurses in ANP were particularly intrigued, challenged and satisfied by complex clinical scenarios that they were able to solve. Participants also believed that the empowerment of staff was crucial even to the point of willingness to work themselves out of their jobs. This empowerment was reflected by the fact that although nurses in ANP may have initiated an idea/program, they were fully able to allow other nurses to assume ownership of these. Often this resulted in staff not remembering that the nurse in ANP initiated these ideas/actions but participants were satisfied with obvious improvement in client care and outcomes. Participants also believed in education and empowering clients while working with nurses aiming for the overall goal of an increased level of care for both staff and clients.

Effective Leadership

Participants believed that nurses in ANP provided a high level of effective leadership. Effective leadership represented the fourth essential quality of ANP.
Participants believed that nurses in ANP had credibility, responsibility and authority to shape clinical practice. Participants valued the contribution that they made to their agencies. The following account reflects participant beliefs that nurses in ANP were on the "cutting edge" of clinical nursing practice:

*I think we are the cutting edge of the practice discipline and I think we are the clinical conscience of the organization...I think that is the greatest contribution that we make.*

Participants believed there were leadership traits inherent in ANP. These included providing direction and role modelling to staff that were based on nurses in ANP having an indepth, rich competency base:

*We are in a leadership role. We provide direction to bedside nurses and we do that because we have that knowledge base and practice base as well.*

*The CNS role is a leadership role mainly and therefore we are able to provide some modelling and some direction to nurses.*

Other leadership traits were being high achievers who strove for excellence in clinical practice and thus client care, educators who significantly wanted to positively influence health care, a bit perfectionistic and not wanting to maintain the status quo:

*I think we are people who are either high achievers or striving to be high achievers, who are wanting the best for client care. We want to teach, want to share, feel like if we weren't in that role or a role that is a teaching kind of role then we wouldn't be influencing health care enough...a little bit perfectionistic...not too crazy about the status quo.*

Other leadership traits were being interested in radical,
although appropriate change, demonstrated initiative and creativity, as well as possessing a high tolerance for conflict:

CNSs have opinions, they are well read, they speak for nursing, they are interested in change but not for change sake. They resent being boxed in or being told what to do. They tend to be creative....They are self starters and have initiative and a high tolerance for conflict.

Another trait was advanced group facilitation skills used to address problem solving and/or learning situations:

Being able to facilitate groups of people in problem solving or learning situations. You need to be able to collect information systematically and do something with it so you can show people and say hey we've got a problem here and it is not just what I think, look here is the data.

Other traits included being change agents, risk takers and extremely dedicated to nursing. For participants, there was a fine line from being dedicated to nursing to being consumed by nursing:

CNSs are change agents because that is a big part of the role. To be that you have to be a risk taker and CNSs are often pretty excited and dedicated about the kind of nursing they do, maybe to a fault....That is a quality that I see in Clinical Nurse Specialists. They become swallowed up by nursing.

Related to dedication, participants believed that nurses in ANP were "really hard workers." Participants thought that nurses in ANP put a great deal of time in over and above their regularly scheduled shifts:

Most CNSs have already caught fire, you know, they have the burning desire to be really hard workers and other kinds of things, you know, they don't want to go home until the work is done, a lot of work on their own time.
Related to effective leadership, participants recognized that nurses in ANP needed to work closely, in a complementary manner, with senior nursing administration. This resultant partnership was seen as critical for effective and thorough ANP:

Most of the senior administrative personnel in nursing right now see very much a complimentary thing between themselves and...the CNSs. We oversee practice, practice issues, issues in clinical practice, you name it but practice, practice, practice. They see us as the practice people, them as the management people and obviously the twain does meet.

The role should be lending the clinical voice, practising the clinical perspective and relating that to administration.

Participants also believed that nurses in ANP needed strong administrative support. They thought that if nurses in ANP did not have this support many of their efforts would be in vain:

There is organizational management support for the role. That is incredibly important.

Thus, according to participants, nurses in ANP provided a high level of effective leadership. Participants believed there were many leadership traits inherent in ANP which included providing direction and role modelling based on an advanced competency base. Participants thought nurses in ANP were high achievers who constantly strove for excellence in clinical practice and client care. They also saw ANP as inclusive of education aimed at positively influencing health care. Participants thought nurses in ANP were perfectionists who were interested in radical but appropriate change, had
demonstrated initiative and creativity as well as possessing a high tolerance for conflict. Other leadership traits included advanced group facilitation skills, change agents, risk takers and extremely dedicated to nursing. Participants believed that nurses in ANP were hard workers who put in very long hours. Finally, participants thought that for the successful continuation and effectiveness of ANP, nurses in ANP needed to have complementary relationships with, as well as strong support from senior nursing administration.

**Interdisciplinary Collaboration**

All participants had developed strong, highly valued interdisciplinary collaborative relationships and clearly recognized the merits of other members of the health care team. Interdisciplinary collaboration represented the fifth essential quality of ANP. Participants articulated the very significant contribution that nurses made to client care but seriously questioned a discipline specific approach. They recognized that "discipline specific" and "interdisciplinary practice" were issues of concern and debate for many health care providers. Providers were thought to be concerned about "unique" aspects of their discipline's practice and wanting to "protect turf." However, participants believed that as a result, health care was often disjointed which resulted in gaps, fragmentation and duplication particularly from the client's perspective.

Participants believed that they had much to offer
clinical practice and client care from a nursing perspective, but that nursing was usually not all that was required.

Participants valued approaching client care scenarios not from a singular nursing perspective, but instead from the context of interdisciplinary collaboration and practice. Participants recognized that when care was approached by specific disciplines, often decisions were made in isolation. Instead, participants thought that nurses in ANP approached client care recognizing that other disciplines had much to offer:

The fact that I am working within a multidisciplinary setting means that I don't run around saying oh well we will just do this and just do that.

Participants strongly believed that in order to enhance client care, all nurses needed to practice more closely and collaboratively with other disciplines. Although recognizing that staff nurses worked with other health care providers, participants thought staff nurses did not routinely collaborate with other disciplines, nor feel comfortable doing so. Participants believed that one contributing factor was that the majority of nurses were educated in non-university settings, therefore were not as articulate about, nor aware that they could benefit from, and thus value interdisciplinary collaboration;

The other disciplines are often more articulate and they have been educated at university, everyone except nurses. I think that nurses, at least many of them, have never had that experience. They don't know that they could value interdisciplinary collaboration.
Participants believed that their acceptance of, consultation with, and collaborative relationships with other disciplines was quite unique to ANP, as compared to other nurses. Participants thought nurses in ANP were more aware and able to actively participate in collaborative practice and research, as well as recognize that no one health care provider could "do it alone:"

An advanced practice nurse works differently with other disciplines. I think there is more of an awareness, more operationalization of the interdisciplinary collaborative practice, collaborative research, of knowing you can not do it alone.

Participants described a different "degree" or "matter of knowledge" related to interdisciplinary collaboration when comparing nurses in ANP with staff nurses. Participants believed that a major function of nurses in ANP was to be the link between staff nurses and other disciplines in order to enhance client care. They recognized that both staff nurses and nurses in ANP sought resources needed for client care, however these resources might be different based on levels of expertise. Participants believed that nurses in ANP had a higher level of expertise to draw from compared to staff nurses. Participants expressed hopes that staff nurses would be able to recognize their own limitations and call in nurses in ANP when they reached their personal limits:

I think that it might be a matter of degree or it might be a matter of knowledge as to when to involve other disciplines....I think nursing staff might not get involved to the same level. It might be all part of the degree. I would hope that nursing staff are seeking the resources they need for client care, and I hope I would
seek the resources I need for client care. Now the resources might be different based on our level of expertise but I hope we both recognize our limitations and hope we both recognize that we can help. My knowledge in some of the resources in especially my particular area are probably greater, so I can maybe call on some resources that the staff nurse may not and hopefully they will recognize that is when they call me in, when they see something is required.

Participants believed that nurses in ANP had a clear understanding of when to involve other disciplines and a freedom to then approach and communicate with them:

In my role there are no bounds to basically who I can communicate with.

I like working with other disciplines. I know spatterings of all the different areas to help my group of clients but there is lots of expertise that I don’t have. But I do know when to get it and that is important.

Participants believed that their education, demonstrated and recognized clinical expertise, confidence, ability to articulate and their title gave them additional credibility and legitimate access to and acceptance from other disciplines. This credibility, access and acceptance was thought to be enhanced by the fact that nurses in ANP usually had a broader competency base than solely from nursing. This base came from formal and informal education with and from other disciplines. This was thought to be assistive in appropriate consultation and prevention of turf issues between disciplines:

Our knowledge is not just strictly nursing knowledge. It draws from sociology, psychology or medicine or whatever but I feel strongly about that. I think nurses perhaps undervalue the other disciplines but...in advanced practice, you begin to really understand their
Participants believed that they routinely used their strong nursing competency base, along with information and resources from other disciplines to enhance client care through assistive care delivery:

*I draw on a lot of information and resources from other disciplines to focus on the client and I also use my nursing knowledge and expertise to enhance the nursing care of that client either through me directly or indirectly from or via the nursing staff.*

Participants believed that traditionally nurses had assumed a subservient role with other health care team members, particularly physicians. However, they thought that nurses in ANP were partners on equal footing with all health providers:

*Nurses in Advanced Nursing Practice are valued partners with other members of the health care team. I mean you just have to look at the number of referrals that we get from physicians. It is good, the consulting back and forth.*

Thus, according to participants, nurses in ANP developed strong and highly valued interdisciplinary collaborative relationships. Participants believed that although nurses in ANP clearly recognized the significant contribution that nurses make to client care, clinical issues could not be fully met with discipline specific approaches. To do so was thought to result in gaps, fragmentation and duplication particularly from client perspectives. Participants recognized that all nurses engaged in practice with other disciplines. However they believed that staff nurses did not
feel comfortable in routine collaboration with other disciplines. Participants explained this due to non-university education of most nurses who were thus not articulate about, nor aware of the benefits of interdisciplinary collaboration.

Participants thought there was a different degree or matter of knowledge between nurses in ANP and staff nurses related to interdisciplinary collaboration. Participants saw a role for nurses in ANP to be the linkage between staff nurses and other disciplines for the overall enhancement of client care. They recognized that nurses in ANP had a clear understanding and freedom of when to involve other disciplines. Participants identified their credibility, legitimate access and acceptance from other disciplines as factors related to their level of interdisciplinary collaboration. Finally, they believed that nurses in ANP were on "equal footing" with all health care providers, including physicians.

In summary, ANP was believed by participants to be a term that could be described. This description had as a basis or foundation what has been categorized as the minimal requirement triad of ANP. The first element of this triad was graduate education. During this education, participants believed that nurses were exposed to many important areas that resulted in the competencies required for ANP. Participants struggled with whether graduate education should
be in nursing and if the education was in another faculty how did that contribute to ANP.

The second element of the minimal requirement triad of ANP was thought to be a clinical specialty focus. According to participants, this focus needed to be combined with graduate education. All participants recognized themselves as "expert" nurses in their clinical area prior to graduate education. They all believed that once they focused their studies with more indepth clinical work, they graduated being able to practice at an advanced level. Strongly linked with the clinical speciality focus was the need for mentored practice and time for reflection in order to fully develop as a nurse in ANP. Participants described additional competencies that were acquired during graduate education linked with a clinical speciality focus. These competencies were believed by participants to enable nurses in ANP to be able to be proactive rather than reactive in all areas of practice.

The third element of the minimal requirement triad of ANP was thought to be research-based practice which was believed to be thinking about, participating in and utilization of research. Participants believed that nurses in ANP worked hard at trying to have practice based on research. Toward that end, participants were active partners in the conduct of research but believed that the principal investigator role could not be assumed by the master's
prepared nurse. They believed that truly definitive research involved a partnership between a nurse in ANP and a doctorally prepared nurse.

The five identified essential qualities of ANP were believed by participants to build on what has been categorized as the minimal requirement triad of ANP. Participants believed that nurses in ANP began development of these qualities while involved in the triad. In other words, while these nurses were attending graduate school, focusing on a clinical speciality and learning competencies related to research-based practice they were developing the essential qualities of ANP. These essential qualities were thought by participants to include an indepth ability to think globally, an indirect clinical focus on clients, a direct clinical focus on staff nurses, providing a high level of effective leadership and finally strong and highly valued interdisciplinary collaborative relationships.

Possible Relationship Between Advanced Nursing Practice and Client Health Outcomes

It was not easy for participants to clearly describe their practice in relation to CHO. As they had articulated, nurses in ANP had clients as their indirect clinical focus, whereas staff nurses were their direct clinical focus. Since clients were an indirect focus, participants recognized the difficulties in describing their practice, as representatives of ANP, in relation to CHO. They thought that nurses in ANP
were more the "conduit," in that CHO came through them but not necessarily from them independently:

In advanced nursing practice and in the preparation for that you are the conduit in a sense so the client outcomes come through you but not necessarily from you independently.

Participants again reiterated that trying to make a linkage between ANP and CHO was "new" and "foreign." They believed that nurses in ANP were just beginning to examine their input or contribution to CHO:

I think we are just learning to recognize what we, how we contribute to outcomes. I think deep down we thought we have, but I don't think we have really empirically looked at relating our input or our contribution and what effect it has on outcomes. It is just fairly new.

Once participants began to describe their practice in relation to CHO, they described problems in trying to articulate CHO. They identified ways in which nurses communicated the relationship between ANP and CHO, as well as theoretical problems in trying to do so.

Problems in Articulating Client Health Outcomes

Although participants knew that the researcher was interested in learning about their practice in relation to CHO, initially participants focused on CHO as a term that required further discussion. They believed that CHO were a more recent area of interest than was ANP. They thought that CHO meant different things to different populations, including nurses in ANP. Participants believed that CHO were difficult to define yet recognized that potentially many definitions were possible. They believed that there were
varying perceptions about CHO and there was difficulty in trying to get agreement among interested parties:

It is good to raise this. We need to be looking at outcomes but what outcomes do we expect and who has done any research?...And so I think the whole world has just begun to really zero in on outcomes and start asking okay what does outcome mean to which population? What does it mean to CNSs?

I guess there are a thousand definitions.

It is very, very difficult to define.

I think that at this point in time, there are so many perceptions out there as to what it is that it is pretty hard to get agreement.

Participants discussed their interpretations of CHO as not being clear cut but rather open to many interpretations and influenced by values such as "healthy," "negative," "positive," "successful," "curative," "intended," "unintended" and "end results of interventions." They thought that in nursing, it was "only nurses in ANP, researchers and academics" that were just beginning, and were therefore inexperienced, in trying to explain a relationship of nursing practice, let alone ANP, to CHO:

I don’t think that we as nursing practitioners have really looked at linking our practice to outcomes first of all so I think that very few of us have experience in it. I definitely think some of us are starting to look at outcomes more than others. I don’t think the staff nurse at all looks at outcomes by and large. They look at surviving their day and finding the energy in getting through the day. But I think we, we are starting to look at outcomes and I think it is a new area for us.

Participants thought that one reason for the lack of clarity around CHO was that they had not been a priority for nursing, policy makers or government up until recently. Participants
recognized that there was not solid evidence that nurses had any direct effect on CHO:

_It hasn’t been a priority for nursing. It hasn’t been a priority for government. There hasn’t been much work done in that area so I can’t say that nursing has an effect on long term outcomes that are specifically attributable to nursing._

Participants believed that it was important that clients be involved in looking at or measuring CHO. They thought that part of the difficulty in articulating CHO was that there had been very little involvement of clients in determining or measuring CHO. Participants thought that health care had been traditionally provider focused and that nurses and others had been tempted to define CHO. However, participants believed that all clients were different and had very different expectations from and with the health care system, let alone specific disciplines that may have been involved in their care. Participants believed that clients had the right to set goals or outcomes when interacting with health care providers as well as be involved in the measurement of this. It was however, a responsibility of the health care providers to ensure that clients had sufficient information in order to make decisions around their care:

_You’re looking at client health outcomes from whose perspective? Our perspective or from the clients’? I tend to go with what a client would see as a health outcome as I don’t necessarily think that my definition of a health outcome for a specific client has anything to do with that client. They are the ones that know what they want their health status to be and if they feel good, bad or in between._

_I believe really strongly that the person can define the_
health outcomes for themselves. But I believe then the obligation is to give them the information to make decisions. I don't know if I am doing that well. But I think that ideally that is what health outcomes are.

Thus, according to participants, CHO were thought to be a term that was not well understood and therefore open to a variety of definitions and interpretations that could be influenced by values. They believed that nurses in ANP, researchers and academics were the only nurses trying to make a link between ANP and CHO. Up until the time of the research, participants thought that interest in CHO had not been a priority for nursing, policy makers and/or government. Finally, participants believed that client non-involvement in looking at or measuring CHO was a factor related to problems in articulating what they were.

**Communicating the Relationship Between Advanced Nursing Practice and Client Health Outcomes**

While participants were describing their practice in relation to CHO, they spoke of their influence on CHO through the use of detailed clinical stories. They thought that nurses in ANP influenced CHO from an indirect and broad system perspective.

**Detailed Clinical Stories**

Throughout interviews, all participants frequently utilized detailed clinical stories as an inherent part of their discussions. These clinical stories were used most while participants were attempting to describe their practice in relation to CHO. The clinical stories were descriptions
of how nurses in ANP, through use of what had been
categorized as essential qualities, influenced or impacted
CHO. The following accounts are examples of these clinical
stories. The first illustrates participant introduction of a
controversial program where improvement in CHO resulted:

I have been working on a framework of care for a certain
client group and it is extremely controversial. It
really hits the heart of a lot of beliefs and attitudes
that nursing and medical staff have. It goes directly
against their grain. It is pain management in the
chemically dependent client and includes a framework of
care to recognize that you can't rescue or save that
person from their addiction. Only they can do it and
your focus should be on the pain management and comfort
and the prevention of withdrawal. So in other words,
you basically supply this person with a lot of drugs to
satisfy their habit and their pain management. A lot of
people have difficulty with that. But what is quite
rewarding is that once staff have a few patients where
this framework is implemented and they see the results
it is like night and day. It has been very interesting
because recently a number of staff have come to me and
said that they just can't believe the decreased stress
that they have surrounding working with those clients
and seeing the difference in client outcomes. There are
a lot less abusive interactions between the client and
the nursing staff. The clients are out of here earlier
and they appear to recover faster. The nurses are
letting go of their guilt about not being able to cure
the person of their addiction. They realize that they
are not contributing towards the addiction and realize
that they don't have to help them with the addiction.
So that kind of framework and I mean it is modelling in
some respects but it is also research utilization and
also client advocacy. But really, I have really fought
culture on that one and people are starting to see the
results and people, nursing staff in particular, really
see the value or see the effect on client outcomes that
a CNS has.

The second account refers to the general participant
recognition of their ongoing influence with staff to enhance
CHO:

The use of self is my philosophical underpinning of my
practice. You learn about the use of self with individuals and then as you develop you learn how to use yourself with groups of nurses as well. I know that the reason the Dementia Care Unit, not the only reason, but the fact that unit is a success and is maintained one year later as a thriving success, had to do with the relationship I have with the nursing staff. The encouragement that I give them as individuals and as groups that they are on the right track, they are doing the right thing, finding ways to celebrate the beauty of their work in making the end of life with Alzheimer’s disease good were important.

Although the above accounts are fairly broad in nature and refer to client groups, participants also described many other client-specific detailed clinical stories that consistently reflected their activities with staff to enhance CHO. The following account illustrates this:

We have a lady who is a long standing schizophrenic who is also diabetic and has multi-system problems. She developed severe gangrene on her feet. Of course, we did treat some of the gangrene but meanwhile there were some side effects. The gangrene on top of the diabetes and she developed septicemia and had refused for a long time any of her schizophrenic medications. The bottom line of it is that the Clinical Teacher tried to help the nurses with the skin care. I got involved because she was refusing any treatment on the foot or the leg, refusing to let them dress it at all, refusing to let them do anything, refusing to have surgery. The question is was she competent or not competent to make those decisions? I got involved in helping the staff make it through that one.

Participants believed that use of detailed clinical stories was a routine and valued component of ANP. They seemed proud and confident about their ability to make the stories meaningful. Participants were clearly able to articulate why nurses in ANP extensively used clinical stories throughout their practice, particularly for education of all levels of health care providers and public. In
keeping with their focus on clinical practice, they claimed that detailed clinical stories were the embodiment of their role:

That is the way the role has been historically enacted. I think that many CNSs feel that is the embodiment of their role. I think it is a natural learning....One of the reasons that we have clinical in front of our names is that it should be our focus. We represent the clinical area.

Participants believed that detailed clinical stories were useful as they reflected how nurses in ANP thought, learned and mentored:

That is exactly what the nature of our practice is....The only way I know how to talk about it is through clinical examples. Those are the things that make it real for me. I might make a generalization but then I will give you the stories to say well this is what it looks like. Because that is the very nature of the practice. I mean we tell paradigm cases, that is how we think, that is how we learn, that is how we mentor.

Participants believed that staff easily understood detailed clinical stories that were relevant and meaningful. Therefore, nurses in ANP found the stories to be very useful in education and practice to enhance CHO:

A sign of advanced nursing practice is being able to explain to people with a clinical example that they can fully understand. Logically speaking, you can help people understand what you are talking about a lot easier if you give them, and maybe that is a sign of advanced practice too, if you give them something to work with, something that they can understand.

Thus, according to participants, the use of detailed clinical stories was a way that nurses in ANP described their practice in relation to CHO. These clinical stories were client and program focused and reflected what was thought to
be a routine and valued component of ANP. Participants saw
the routine use of these detailed clinical stories as the
embodiment of ANP. They found them to be particularly useful
and meaningful when working with staff to enhance CHO.

**Broad System Perspective**

Participants also described their practice in relation
to CHO from a broad system perspective. Through this
description, they provided specific examples that they
believed were reflective of nurses in ANP positively
influencing CHO. They explained their influence on CHO as a
result of global thinking that related to clinical practice
both internal and external to their employing agency. They
believed that nurses in ANP influenced CHO by way of their
involvement in programs that reflected a faster turnover of
clients therefore decreased wait lists, clients were
discharged with an improved health status, and admissions and
bed utilization were more appropriate:

*Well I can demonstrate to you, in a number of cases that my involvement has resulted in faster turnover of clients through here so there are decreased wait lists for one thing. I can demonstrate very clearly and specifically that my interventions have caused people to be turned away from our doors. In other words, their care would be best met somewhere else than in an acute care setting so in terms of bed utilization, more appropriate bed utilization. I can fairly clearly demonstrate by some of the programs that I have been involved in, that I have coordinated or had probably the most significant input in. Those clients are out of here sooner, they are out of here healthier. They are not receiving some of the care that was inappropriately given to them before I was here.*

Participants believed that nurses in ANP developed and
distributed innovative programs that assisted in the advancement of nursing and interdisciplinary practice:

You can measure the effectiveness not only fiscally but in terms of client outcomes and staff outcomes and public relations. In terms of the programs that we have developed here, some of them have become well known in the province and sometimes in the country. And sure they haven't been big money makers but they have advanced nursing practice and interdisciplinary practice in care of the elderly. Well that is big payoffs. You know that the bedside nurses could never have done that.

Participants were confident that ANP positively influenced CHO in both the specific and general sense. They identified themselves as being the "common thread or person" who influenced many agency broad system decisions. However, participants recognized that these influences were not hard indicators related to ANP:

I think it is easy to demonstrate if you look at the various decisions that are made in an organization and identify the common person in all those decisions...that is the nurses in advanced nursing practice. But that is not a hard indicator.

Participants thought that nurses in ANP needed to be able to explain their practice in relation to financial issues around CHO. They thought that, due to current restraints, it was not enough to think about overall improvements in CHO without being able to demonstrate financial savings:

We are all increasingly looking at that, whether we are a CNS or not. How do we justify that we are here? It is really, really hard to quantify what you are doing....It is not enough to just be here, people need to know that you have helped to save perhaps this amount of money by your recommendations....I try every day and it is not every day but the ideal is that I am sort of thinking about what I am doing, should I be doing it, is it, is it?...You won't be here anymore if you are not asking those questions.
Participants thought that to date, nurses in ANP had not done well in terms of proving their financial worth via quantitative aspects of effectiveness related to CHO:

I think that we haven't done really well in terms of proving our financial worth...in dollars and cents and unfortunately planners like quantitative aspects of effectiveness.

However, participants believed that nurses in ANP were far more responsible fiscally than were staff nurses in terms of operational management:

Trying to make the most of the system which is what I think CNSs do. Trying to advance nursing, trying to advance the way in which we practice yet being fiscally responsible at the same time. You can't expect your bedside nurses, your people entrenched in client care, they are not going to do that. They are not going to analyze your system and find out that you are using too many drugs or you are calling in too many people or you know, making mistakes in time keeping or having too much sick time or whatever. Certainly management has some responsibility for that but Clinical Nurse Specialists can really assist in fiscal responsibility, in effective and efficient running of operations and that is where your best bang for your buck is.

Thus, according to participants, ANP was linked with CHO from a broad system perspective. Participants were able to illustrate this perspective through descriptions of their broad influences on care and CHO. These same influences were thought to advance nursing as well as interdisciplinary practice. Participants saw nurses in ANP as being the "common thread or person" that influenced many agency system decisions, however recognized that this did not represent a hard indicator. Nurses in ANP were thought to have not clearly demonstrated their effectiveness in terms of fiscal
issues. However, participants believed that nurses in ANP were fiscally responsible in terms of operational management.

**Theoretical Problems in Linking Advanced Nursing Practice With Client Health Outcomes**

Participants thought there were some theoretical issues that explained their difficulties in trying to describe their practice in relation to CHO. These issues included the differences in attempting to measure long term versus short term CHO and the strong influence of other variables.

**Long Term Versus Short Term**

Participants believed that there were major differences in trying to examine and potentially measure the influence of ANP on long term versus short term CHO. They believed that short term CHO were easier to measure and done on a limited basis particularly in acute care settings:

> I would think it is much easier for me to see client outcomes or demonstrate client outcomes in an acute care setting....It is easier to see the short term in an acute care setting.

Participants gave examples of why short term CHO were easier to measure in acute care settings. These were often related to specific interventions aimed at clinical problems such as pain or wound management. They thought that since acute care clients were generally quite ill, results of interventions aimed at keeping them out of crisis were easier to observe and measure:

> When I look at an outcome if I intervene with a client on a specific unit I can see that there is a better outcome say in terms of management of one of the
problems he or she is having whether it is pain or wound or whatever. So I can see an outcome there and that is great.

People come in here generally because they are quite sick or require fairly significant interventions both from medicine and nursing. Their problems are so serious and even small interventions are often able to be demonstrated in terms of client outcomes.... Acute care interventions are basically to help the client over a crisis, through a crisis situation.

Participants thought that nursing and medicine and other health care providers were not skilled at measuring long term CHO. Participants believed these to be the real indicators of health care provider involvement and/or effectiveness. Long term CHO described included coping strategies, improved health status and lifestyle changes. Participants recognized these measurements were unclear and difficult to identify and rate. They believed it was because of these difficulties that long term CHO had not been a focus of attention:

Long term outcomes I think are something that we haven’t looked at that much in nursing and in medicine too....But if we look at really what our role is, it is to help the client cope, improve health status, lifestyle and I mean that is all based on long term outcomes. Are they clear and identifiable? I don’t think so. That is probably part of the reason why we haven’t focused on them because they might be so difficult to measure.

Participants recognized that many long term CHO were associated with quality of life issues and that some early efforts to address these were appearing in the literature.

Participants from geriatric care environments were somewhat attuned to long term CHO and gave specific examples. These included aggressive client behaviours, psychosocial
outcomes of adaptation to environment or chronic illness, physical health outcomes such as skin break-down, infection rates, management of constipation and peaceful deaths:

In the long term care setting, I am very concerned about psychosocial outcomes of adaptation to the institutional environment or chronic illness care....I am particularly concerned about physical health outcomes like skin break-down, infection rates, management of constipation and the outcomes associated with that because that is such a big problem. The good deaths, I am very concerned about them too because 33 percent of our population die each year.

Thus, according to participants, there were major differences in trying to measure short term versus long term CHO. Short term CHO were thought to be easier to measure and done on a limited basis in acute care settings. Long term CHO were thought to be the real indicators of health care provider involvement with clients, however were thought to be vague and difficult to measure. Participants recognized that some early efforts to address these issues were appearing in the literature. Participants from geriatric care environments seemed to focus more on what they described as long term CHO than did those from acute care.

**Strong Influence of Other Variables**

Participants recognized that many other variables influenced how nurses in ANP could describe their practice in relation to CHO. To begin with, participants questioned how any CHO could be directly and conclusively linked back to any specific discipline, let alone nursing:

*If we want to get valid outcome measures, it is really hard to pull out what one person in a health care team*
has done, to contribute to whatever outcomes the client has had and has experienced.

Participants recognized that clients were exposed to a multitude of health care providers. In addition, participants believed that clients assumed varying levels of responsibility related to personal education around their health concerns. Participants thought that this client education was also a factor related to CHO:

Client health outcomes are just a neutral kind of thing that says whatever the outcome is of the interventions that any health professionals perform. And actually it doesn't even have to be health professionals, right? What about those clients that want to learn all they can about whatever it is that caused them to seek health care anyway? What about what they learn from friends and family let alone what they watch on television.

Participants believed that many other variables influenced CHO and attempts to link them back to nurses in ANP particularly in the era of interdisciplinary collaboration would be problematic:

If it is a true multidisciplinary approach and people are really, really administering care together with the client...it is harder to pull out what one person does....I think we are going to continue to struggle, even though we can focus on what we might call nursing outcomes or medical outcomes or occupational outcomes or social work outcomes. It is pretty blurry and I think we have a long way to go yet.

The following account reflects participant efforts to illustrate what they viewed as futility in trying to directly describe ANP in relation to CHO:

Unless you are in a situation where you are all by yourself with no other support systems, with nothing else going on and you are doing a laying on of hands and looking after this client in complete and total isolation. How would you know and I guess that is a
subject for researchers. How would you know that whatever outcome this client had was related to your intervention? And even at that, so you did do the laying on of hands and you did do a lot with this client, again how would you know that what you did wasn’t related to some change in this client or something this client did as opposed to all your good intentions.

The next account was a summary of a clinical program that was thought to have demonstrated positive CHO, however again the participant clearly questioned how these could be linked back to her:

*If there are good clinical outcomes, positive clinical outcomes, how would you relate those to me as opposed to the Clinical Teacher who set up the education plan or one of the staff members that we took out of the rotation so that she could work on it and conduct education. I was involved in all that stuff, very much involved as a mentor... I took a leadership role in the development in that but how would you relate the positive outcomes to me? With much difficulty!*

On the other hand, participants thought it sufficient to be able to describe the indirect relationship of their practice on CHO. They found it useful to differentiate how nurses in ANP influenced CHO as compared to nurses at the bedside. They thought nurses in ANP influenced CHO for populations of clients and staff from a broad perspective:

*I think that ANP is really toward influencing in a number of arenas. So that it is much different from bedside nursing where really what you are influencing is the health outcome of the client you are looking after that day... We are influencing health outcomes for a population of clients and health outcomes for staff.*

They described this perspective as "having a vision" and taking the time to develop it with significant input from interdisciplinary health care providers as well as clients.
and what they referred to as the appropriate "resource people." The participants described this ability to put a vision into action very rewarding:

Clinical Nurse Specialists can have the vision and then they can actually take the time to develop that vision with the resource people they need....It is a vision that comes through the staff to us but we can make it happen. It is a big payoff.

Participants believed that the holistic, caring practice of nurses did not allow for easy measurement of CHO. Participants believed that nursing practice included decision making based on intuition and ways of knowing. Nursing practice was thought to be very encompassing in relation to client care. It was also thought to overlap and complement other health care providers which created issues about separating out the influence of nursing, let alone nurses in ANP. Participants did not know how it would be possible to measure their own intuitive practice, ways of knowing and caring let alone that of other nurses:

How do you measure intuitiveness and nurses ways of knowing and caring and so on and so forth?

From a professional practice point of view, participants cited the importance of standards in relation to setting and measuring CHO. Linked with their support for client involvement in care and determining CHO, participants thought that if their professional standards did not provide direction, then clients should direct and determine their own outcomes:

I suppose there are specific health outcomes that you've
got to look at from a professional point of view. I mean we have standards and obviously we have to follow them. But I guess the only thing to me, the only things you would have to look at defining in my perspective, the only things that I look at when I look at defining outcomes is what is my professional role? And if there is none mandated for me, if I don't have a standard to meet then as far as I am concerned the definition comes from the client. Whatever that client defines is the outcome that she/he wants that she/he is going to be happy with then that is the outcome.

While discussing the relationship of ANP to CHO, participants identified their belief that outcome measures from other disciplines such as medicine had been traditionally more valued than those of nursing. Reasons cited for this included the power base that medicine had traditionally held and their focus on quantitative measures such as morbidity and mortality was much easier to capture. Participants thought that nursing played a major role in these indicators but this had not been acknowledged:

*It is easier to place emphasis on outcomes from other disciplines, medicine in particular, simply because that is the way we have always looked at outcomes....Nursing is still struggling with hard indicators, concrete indicators of client outcomes that can be directly linked to nursing alone. Even when we look at morbidity and mortality we all know that nursing plays a role in those outcomes, a major role!*

Participants recognized that medical outcome indicators were a factor in current initiatives such as the development of provincial clinical practice guidelines. However, they also believed that outcome measures related to CHO needed to be interdisciplinary in nature for all concerned particularly clients:

*Traditionally, we have been looking at medical care.*
But I think there needs to be a balance to include the kinds of things that nursing values and thinks is important for clients and for health parameters.

Thus, participants recognized that many other variables influenced the ability of a nurse in ANP describing her/his practice in relation to CHO. Participants questioned how any CHO could be clearly linked back to the involvement of any specific discipline. Participants believed that since clients were exposed to a multitude of health care providers, and assumed varying levels of responsibility towards personal education around their health concerns, attempts to link CHO to nurses in ANP was problematic.

Participants believed that nurses in ANP could describe an indirect relationship with CHO. Nurses in ANP were thought to broadly influence CHO from a population of client and staff perspectives. These perspectives included having a vision to meet populations of client needs and then taking all the required steps to ensure action.

Participants recognized that nurses were holistic and caring in their practice which again did not allow for ease in measuring their influence on CHO. Participants recognized that nursing practice was often based on "intuition" and "ways of knowing" that could not be easily explained let alone measured. Participants stressed the importance of client involvement in CHO but at the same time recognized the need to determine whether or not professional nursing standards were assistive.
Participants recognized that although nursing played a major role in CHO such as morbidity and mortality measures, this role had not been acknowledged. These measures had traditionally been associated with medicine and were fairly easy to capture quantitatively. Linked with this, participants believed that current emphasis on medical outcome measures such as clinical practice guidelines needed to be interdisciplinary in nature.

In summary, participant attempts to describe their practice in relation to CHO presented challenges. As participants did with ANP, they spent some time trying to define CHO. They believed that CHO were understood from many perspectives. They claimed that although it was valuable to examine CHO, only nurses in ANP, researchers and academics were doing so. This interest in CHO was thought to be recent and therefore explained some of the lack of clarity. Participants believed that the exclusion of clients in defining CHO was problematic.

In communicating the relationship between ANP and CHO, participants made extensive use of detailed clinical stories which reflected influences on broad client groups and specific clients. The use of detailed clinical stories was believed by participants to be a routine, useful and valued aspect of ANP. Participants also believed that nurses in ANP influenced CHO from a broad system perspective that included faster turnover of clients, decreased wait lists, discharges
with improved health status, more appropriate admissions and bed utilization, as well as development and distribution of innovative programs. Participants believed that nurses in ANP were often the "common thread or person" that influenced system changes. Participants recognized that nurses in ANP had not clearly demonstrated their financial worth, however believed that they were fiscally responsible in terms of operational management.

Participants believed that there were some fairly clear theoretical problems in linking ANP with CHO. These included short term CHO being easier to examine and potentially measure than were long term CHO. Participants also believed that other variables influenced how nurses in ANP could describe their practice in relation to CHO. Participants questioned how any CHO could be directly linked back to a specific health care provider, considering the multiplicity of providers and the knowledge base of clients. Participants did believe that nurses in ANP positively influenced populations of clients and staff.

In describing the nature of nursing practice and the overlapping scopes of nursing with other health care providers, participants believed that this nature would be difficult to measure. Inherent in the nature of nursing practice, participants believed it important to determine if nursing standards could assist in looking at CHO. However, if the standards did not provide direction, then participants
believed that nurses in ANP needed to take direction from clients.

Chapter Summary

In this chapter, participant attempts to define ANP and describe their practice in relation to CHO were presented. These definitions and descriptions were conceptualized from three broad categories.

The first broad category related to difficulties participants had in clearly defining ANP. This category consisted of two components: initial attempts at defining ANP and reasons for lack of clarity about ANP. During initial attempts to define ANP participants had difficulties in trying to articulate a clear and concise definition. Participants believed that ANP was a term that was inherently broad and vague in nature. Participants were not concerned that many nurses in ANP lacked clarity about ANP. In fact, participants supported this as they claimed it allowed for the continued flexibility required for ANP. Participants believed that there were several valid reasons related to the lack of clarity about ANP.

The second broad category related to the descriptors of ANP. This category consisted of two components: minimal requirement triad of ANP and essential qualities of ANP. Participants claimed that ANP had as its foundation three minimal requirements, namely graduate education, clinical specialty focus and research-based practice. Participants
also believed that ANP included five essential qualities that built on the minimal requirement triad. These were believed to be global thinking, indirect clinical focus, assistive care delivery, effective leadership and interdisciplinary collaboration.

The third broad category related to possible relationship between ANP and CHO. This category consisted of three components: problems in articulating CHO, communicating the relationship between ANP and CHO and theoretical problems in linking ANP with CHO. Problems in articulating CHO were evident. Participants believed that CHO were a fairly recent area of interest and were understood from many perspectives. Participants believed that the most effective way to communicate the relationship between ANP and CHO was through the use of detailed clinical stories. These stories reflected influences on CHO which ranged from an individual client to broad, system perspectives. Participants claimed there were some fairly clear theoretical problems in attempting to directly link ANP with CHO.

This chapter has presented the findings of this study. In the next chapter, major findings that contribute to the knowledge base of ANP are discussed.
CHAPTER FIVE

DISCUSSION of FINDINGS

Findings from this study reinforce many of the current views and research related to ANP. The exploration and description of how ANP influences CHO reflects an area of study that has not been well documented in the literature. Although a significant body of literature challenges nurses in ANP to recognize the impact of their practice on CHO, to date methodology to do so is unclear.

While participants in this study recognized the importance of being able to describe their practice in relation to CHO, they were not accustomed to doing so. Considering that all participants were employed in a major hospital society, hesitancy in being able to easily articulate ANP in relation to CHO reflects the "newness" of the overall general emphasis on outcomes throughout Canadian health care.

Despite the general consistency of this study with ideas in the available literature, there are three areas that may push us one step further in developing clarity and richness about a description of ANP. These areas are: issues related to a definition of ANP; graduate education and ANP; and, ANP and interdisciplinary collaboration. The following discussion will consider each of these within the context of existing knowledge.
Issues Related to a Definition of Advanced Nursing Practice

Participants were not able to articulate a clear and concise definition of ANP and were aware of the vagueness associated with it that was evident in nursing literature. At the same time, participants were very confident in their personal understanding of ANP and attempted to assist the researcher to build a common view of it.

Participant inability to provide a clear definition of ANP is not surprising. As was noted in chapter two, nursing literature frequently incorporates the term ANP but authors rarely define it. Extensive use of the term ANP continues with regular articles and/or editorials appearing in nursing journals that emphasize a strong push for clarity about it (eg. Forbes, 1995a). One justification for the movement toward a clearer understanding of ANP is the need to be able to articulate it to others. According to Giovannetti and Tenove (1995), this is particularly important during current times of economic constraint and health reform. Although authors still recognize the need for a clear definition of ANP, there is a growing trend to describe the characteristics, attributes, competencies and behaviours of nurses in ANP (eg. Davies & Hughes, 1995; Patterson & Haddad, 1992).

Three specific findings of this study have raised important points for consideration about issues related to a definition of ANP. These points are either non-existent or
well developed in the literature, or their treatment in the literature raises further questions. They are: support for ANP remaining a broad and vague term; global thinking as an essential quality; and, the minimal requirement triad as the foundation for ANP.

Support For Advanced Nursing Practice Remaining A Broad And Vague Term

Participants in this study were experienced CNSs who recognized that their role was labelled ANP by professional associations, colleagues and nursing scholars. Participants clearly considered themselves to be advanced nursing practitioners. They also cited, without prompting, an indepth knowledge of activities by nursing scholars related to the development of a clear definition of ANP. However, if there was any aspect related to a definition of ANP that participants emphasized above all others, it was that they had a lack of concern related to their inabilities to clearly and concisely define ANP and, in fact, cautioned the researcher in efforts to do so.

Initially, participants attempted to provide a definition of ANP and said things such as "I should know this..." This reaction can be typical of CNSs and is depicted in the literature as an element of the "imposter phenomenon" (eg. Arena & Page, 1992). The imposter phenomenon, according to Arena and Page, describes individuals who may feel that they are fooling everyone, that
is they are actually imposters in their chosen profession. The title of CNS which includes the term "specialist" implies extensive expertise and the CNS may develop unrealistic expectations about her/his performance. As a result, it is common for the CNS to think "I should know this..."

However, soon after beginning discussions, it became obvious that participants lacked concern about their inabilitys to articulate a clear and concise definition of ANP. Participants justified their personal lack of concern on the minimal progress that credible and well known nursing scholars had made related to further understanding ANP. Participants were willing to spend considerable time in support of the researcher's efforts. However, it was clearly evident that they did not feel that the phenomena of interest were priorities either for themselves or for ANP in general.

Participants were confident in how they individually understood ANP. They felt comfortable in their competencies related to ANP and considered these to be based on their personal and professional experiences, education and personality. Furthermore, participants thought that the requirements of busy day-to-day practice for nurses in ANP required energy and focus related to nurses, clients and interdisciplinary health care providers. Thus, this precluded interest in consideration of such issues as defining terms.

It is the researcher's opinion that nurses in ANP
understand their practice and each other very well. They almost have an ingrained, intuitive sense of it. In day-to-day activities, particularly where nurses in ANP are autonomous and strongly supported by senior nursing administration, they are not accustomed to articulating a description of their practice. Despite the participants' confidence about their own practice, they are not necessarily able to communicate clearly their understanding of it especially to others who may not be in an ANP role. It would be most useful to observe participants in their practice. The researcher is left with the questions: How do nurses in ANP compare to each other in the way they conduct their practice? Are some nurses "better" at ANP than others? What are the levels or stages of ANP?

Participants viewed ANP as a term that was broad and vague in nature. This nature was seen as beneficial as it allowed for unlimited flexibility associated with ANP. Participants highly valued this flexibility and believed it was instrumental in justifying the individual perspectives that nurses brought to ANP. In addition, participants recognized flexibility as allowing them to consistently respond to changes as nursing evolved, organizational restructuring occurred and health reform continued.

Literature generally reflects varying interpretations of the unlimited flexibility of ANP. Some nursing authors think that unlimited flexibility can result in the perception and
operationalization of ANP varying from nurse to nurse and from practice setting to practice setting (eg. Alcock, 1995; Langford, 1995; Russell & Hezel, 1994). As a result, some think this causes confusion about ANP (eg. Patterson & Haddad, 1992), and others view it as impeding implementation of ANP (eg. Davies & Eng, 1994). Confusion about ANP can result in the public and professional colleagues not being clear about specific roles associated with ANP, unlike other disciplines such as medicine where roles are clear (Alcock, 1995).

Vagueness about ANP leaves room for others to interpret the term based on their own needs, particularly during health reform discussions. In some of these discussions, nursing authors are questioning if senior nursing administrators, educators and researchers should also be called advanced nursing practitioners (eg. Ontario Ministry of Health, 1994; The Working Group for Registered Nurses in Advanced Nursing Practice in Rural/Remote Communities, 1994). The use of ANP within the context of these initiatives again raises questions about the lack of clarity regarding ANP and the resultant implications. The idea that flexibility could potentially result in practice inconsistencies with negative consequences for successful implementation of ANP was not a concern expressed by participants in this study.

Other nursing authors recognize that unlimited flexibility in ANP is beneficial as it allows nurses in the
role to be highly creative (e.g. Sparacino, 1992), and increase their marketability particularly during times of job insecurity (e.g. Prevost, 1995). Others see it as an essential characteristic of ANP if a goal of these nurses is the development and exploration of new approaches and avenues in an evolving health system (e.g. Patterson & Haddad, 1992). These views closely resemble those of the participants of this study.

Although participants supported the researcher in this study, they had strong cautions about efforts aimed at a clearer understanding of ANP. Participants were concerned about efforts to force a definition of ANP and believed it should remain broad and vague in nature. They thought a clear definition of ANP would potentially be restrictive and thereby prove to be more negative than positive.

This caution around efforts to more clearly understand ANP has not been documented by others. As the reader will recall from chapter two, the opposite is true. Although participants of this study had cautions, it may have been because they were secure and confident about their practice and supported to have unlimited flexibility in their roles. As a result, they viewed efforts towards developing a clear definition of ANP as negative. They did not support efforts that could restrict their practice.

For participants, ANP was "ever-changing" and therefore led to new areas of focus. Participants discussed the
increased administrative responsibilities that they were assuming and justified this due to changing organizational needs. Again, they stressed the flexibility they valued in ANP as a factor to legitimize an administrative focus. Participants understood the examination of various nursing roles as being an element of health reform. For these reasons, participants believed that to be able to continue employment, they needed to be open to an increasing administrative focus.

A trend for CNSs to take on more administrative functions is not surprising. In current times of fiscal restraint, nursing administrators and nurses in ANP are often having to re-examine ANP roles (eg. Brunk, 1992; Houston & Green, 1993). With the elimination of many head nurse positions, often nurses in ANP take on more administrative functions that are required for organizational efficiency. Until recently, administrative functions have generally not been associated with ANP. However, this is changing. For example, a survey done by Davies and Eng (1995) related to CNS role implementation demonstrated that, "surprisingly, 19% of time was spent on administrative activities" (p. 26). Although the actual data collection time-frame is not clearly outlined in the article by Davies and Eng, the reader can assume that this figure probably reflects the situation prior to many recent eliminations of head nurse positions.

Thus, participants as nurses in ANP were confident in
how they conducted their practice and valued the unlimited flexibility inherent in their roles. This legitimized changing role foci such as an increased administrative one. Participants believed that a clear definition of ANP would be restrictive for nurses in the role. However, while participants of this study did not feel that a definition of ANP was a priority, definitions continue to play an important role in the health reform discourse.

**Global Thinking as an Essential Quality**

Participants valued global thinking that they believed was an essential quality of ANP. Although global thinking is only one of the essential qualities of ANP identified by participants, it is discussed here since this quality is not well developed in the literature.

Global thinking was consistently evident in the accounts and reflected participants' knowledge of their agency and community, as well as provincial, national and international initiatives and trends. Participants could focus on an individual client but would be consistently thinking about how that client related to the whole of client care. At the same time, participants would bring their competencies related to the health care system to any individual client scenario.

Participants stressed that global thinking enabled nurses in ANP to be proactive so that they could participate in planning for programs/strategies prior to occurrence of a
crisis. According to participants, nurses in ANP practiced in a proactive manner, as opposed to staff nurses who generally practiced in a reactive manner. This reactive approach of staff nurses was due to busy day-to-day demands of practice that precluded any long term planning or proactive strategies. Based on a proactive approach to client care, nurses in ANP assume a leadership role in the improvement of client care within their agency, as well as external agencies/groups.

As noted above, the notion of global thinking as an essential quality of ANP is not prominent in the literature. A linkage with this quality is apparent, for example, in the phrases "broad context" (Benner, Tanner & Chelsa, 1992), "broad perspective" (Davies & Hughes, 1995) and "whole picture" (Schaefer & Lucke, 1990). Although these phrases may reflect the same dimensions of practice, what is not clearly described in the literature is how this global thinking is useful for nurses in ANP to be proactive. This finding is important and worthy of future attention as traditionally health care providers continue to be reactive and to "practice in response to both the historical and current social demands" (Patterson & Haddad, 1992, p. 18). In the era of health reform, the competencies of nurses in ANP to articulate global thinking to health policy decision makers could be very effective not only for ensuring survival of ANP, but also for improving overall health care.
Inherent in their focus on global thinking, participants were able to describe through the use of detailed clinical stories, how they improved client care, nursing satisfaction with care, interdisciplinary collaboration and CHO. They also clearly articulated broad improvements in care within their organizations. Participants stressed that staff nurses were their clients and consistently described ANP through clinical stories within this context.

Literature often reflects how nurses in ANP focus on staff nurses in order to meet professional and client needs (eg. Langford, 1995; Schaefer & Lucke, 1990). What is not well developed in the literature is how nurses in ANP clearly improve CHO and overall health care within an organization. Literature is beginning to appear that challenges nurses in ANP to consider an organization as their client (eg. Forbes, 1995b), rather than focusing directly on staff nurses. This approach is believed to be advantageous for ensuring the survival of the CNS position.

Thus, according to participants, global thinking represented an essential quality of ANP. Global thinking allowed nurses in ANP to be proactive in their practice and therefore assume a leadership role within their agency/organization to improve client care. The ability of nurses in ANP to articulate how global thinking and a proactive approach to care can benefit both the survival of ANP and improvements in overall health care can be
Participants cited three minimum requirements as foundational for ANP. These have been conceptualized into the minimal requirement triad of ANP, namely: graduate education, clinical specialty focus, and research-based practice. Reasons why each element of the minimum requirement triad was considered by participants as crucial for ANP were outlined in chapter four. The purpose of discussion at this point is to focus on the minimal requirement triad of ANP in its entirety. It is not just the three required elements of ANP, but rather the combination and interaction of them that provides the foundation of ANP.

Within the literature, a baseline foundation of ANP remains contentious and nurses have not come to a consensus about it. Authors of nursing literature related to CNS practice do not consistently focus on the above elements as providing a baseline or foundation for ANP. Although the elements are written about frequently, it is usually within the context of need for, implications and inconsistencies of one or more of these elements in combination with others (eg. Calkin, 1994; Registered Nurses Association of British Columbia, 1994), and/or role functions and practice areas (eg. Patterson & Haddad, 1992). Is it important to articulate the need for a combination of minimum requirements as a foundation for ANP? How would the minimal requirement
triat assist with a definition of ANP? Although the minimal requirement triad discussed by participants in this study is not apparent in the literature, elements within the triad have been discussed at length and can contribute to our interpretations of this finding.

The need for graduate education, at least at the master's level, was believed by participants to be required in order to develop the competencies that contribute positively to ANP. This view is well documented in the literature (eg. Montemuro, 1987; Ray & Hardin, 1995; Synder, 1989) and more issues specific to graduate education are discussed later in this chapter.

According to participants, a clinical specialty focus in graduate education, despite the faculty of study, was mandatory for ANP. Participants described themselves as expert practitioners prior to their graduate education. They believed that the combination of their expert practice in a specialty area of nursing combined with graduate education resulted in being to conduct ANP at a competent level. Davies and Hughes (1994) also note that ANP "builds upon clinical expertise" and "experiential knowledge" (p. 158).

This finding may be explained by the knowledge that participants of this study do not necessarily reflect the average nurse entering graduate education. That is, many nurses entering graduate education may not be clinical experts as were participants. When nurses enter graduate
studies, even if they wish to focus on nursing clinical practice, they may change the area in which they have previously been practising. For example, a nurse with previous experience in pediatrics may focus on community health in her or his graduate studies.

Participants viewed research-based practice as critical for ANP and thought it was developed through research competencies gained through graduate education linked with a clinical specialty focus. Participants referred to research-based practice as consistently thinking about, participating in, and utilizing research. Participants thought that nurses in ANP assumed a lead role in relation to research-based practice within an organization.

Participants viewed valid and reliable research as a useful strategy for nurses in ANP to prompt staff nurses to examine their individual and overall practice. This finding concurs with that of Nuccio and colleagues (1993), in their study involving staff nurse perceptions of the CNS role. The convenience sample consisted of 636 registered nurses employed in staff positions in three campuses of two affiliated medical centres in the United States. Staff nurses believed that research-based nursing practice was important but thought they had insufficient time, knowledge and experience with it themselves. Staff nurses reported a need for CNSs to be involved in all aspects of the research process.
CNS literature regularly includes research as an important subrole of ANP (e.g. Beecroft, 1992; Lusis, 1995; Montemuro, 1987; Sparacino, 1992). Nurses in ANP are often seen as leaders in the identification of research questions and the initiation of studies in order to advance nursing and interdisciplinary practice within an agency (e.g. Fitzpatrick et al., 1991). However, there is evidence that CNSs spend less time on research than on other nursing functions associated with the role (e.g. Davies & Eng, 1995; Lusis, 1995; Williams & Valdivieso, 1994). Participants of this study did not comment on the amount of time spent on research but, as the detailed clinical stories reflected, they were in various stages of being actively involved in conducting research and all identified research utilization in their practice.

Participants recognized their own limitations related to research and clearly valued partnerships with colleagues, interdisciplinary professionals and university faculty for the conduct of research. Participants thought that truly definitive research involved a partnership between nurses in ANP and doctorally prepared nurses. They believed that the doctorally prepared nurse should assume the principle investigator role.

The nursing literature supports this finding. Some authors hypothesize that nurses in ANP spend limited time on research due to their graduate education. Some view a
master's level research course and the conduct of a thesis as preparing nurses to be consumers of research only (eg. Collins, 1992), to function as a research associate (eg. Stinson, Field & Thibaudeau, 1988), or take "an active collaborative role in such research activities as data collection and analysis" (Sharp & Hart, 1987, p. 38). Due to these factors, many support master's prepared nurses to partner with doctorally prepared nurses in order to advance the science of nursing (eg. Arena & Page, 1992; Collins, 1992; Stinson, Field & Thibaudeau, 1988).

Thus, participants thought that ANP is built on a minimal requirement foundation. This foundation included a triad with the elements of graduate education, clinical specialty focus and research-based practice.

In summary, participants discussed important points related to efforts towards a definition of ANP. Overall, participants were not concerned about the general lack of clarity about ANP. They valued aspects of ANP that could be developed due to the broad and vague nature of it. Global thinking represents one essential quality of ANP that enables nurses in the role to be proactive in their practice which can result in overall improvements to all levels of health care. Participants believed that there are three minimum requirements of ANP. These aspects of ANP are of assistance in understanding the complexities in attempting to develop a definition of ANP.
Graduate Education and Advanced Nursing Practice

According to participants, graduate education was a minimal requirement for ANP and provided a strong basis for many of the required competencies. A critical concern for participants was whether graduate education should be in nursing or in another faculty. While recognizing reasons why some nurses in ANP undertook non-nursing degrees, participants with nursing graduate education questioned if this contributed positively to ANP. Participants with non-nursing graduate education were also sensitive and somewhat defensive about their preparation. They questioned the Registered Nurses Association of British Columbia (1994) support for nursing graduate education, related to ANP, when so many university programs do not offer an associated clinical specialization.

This diversity about graduate education for nursing, and for ANP, remains contentious amongst nurses. As participants identified and literature confirms, arguments centre around what education will make the ultimate difference in advancing and perfecting nursing knowledge, as well as nursing practice, education and research (eg. Stinson, Field & Thibaudeau, 1988).

It is not surprising to find that some participants undertook non-nursing graduate education. Non-nursing graduate education was the norm until recently in Canada since there were very limited opportunities for graduate
education in nursing (Kerr, 1991; Stinson, Field & Thibaudeau, 1988). According to Kerr (1991), many nurses wishing to undertake non-nursing graduate education, did so due to a lack of: available programs, respect for nursing programs, and qualified faculty to teach these programs. By 1985, the majority of nurses who held master’s degrees obtained non-nursing degrees although the precise breakdown is not available (Stinson, Field & Thibaudeau, 1988).

Participants with non-nursing graduate education believed they were making valuable and significant contributions to ANP, despite the focus of their graduate studies. Although graduate education in other faculties may have served a purpose at one time, it is creating some problems now for nurses in ANP. For example, during this study, participants with non-nursing graduate education wondered colloquially if some of the difficulties related to addressing the phenomena of interest was due to their educational preparation. However, from the researcher’s perspective, there were no noticeable differences in participant accounts that could be explained the faculty of their graduate educational preparation.

Despite many nursing authors "best guess" that nursing graduate education is required for ANP, what is not clear is how this preparation clearly impacts practice and CHO. It is not known for example, if nurses are convinced that graduate education in nursing is mandatory for ANP particularly in an
era of interdisciplinary collaboration. It is also not clear what differences there are in the activities and outcomes of nurses in ANP despite the faculty of their graduate studies.

At the present time, nursing professional bodies, although formally recognizing why some nurses in ANP previously undertook non-nursing graduate education, are making it clear that the preferred education for ANP is a master's degree in nursing (eg. Canadian Clinical Nurse Specialist Interest Group, 1994; Registered Nurses Association of British Columbia, 1994). This information can explain the sensitivity and defensiveness that participants with non-nursing graduate education are experiencing about their preparation for ANP. It also explains the support that participants with nursing graduate education have for this specific preparation being a minimum requirement for ANP.

Participants who had nursing graduate education viewed this as critically important in order to advance the science of nursing, and more specifically ANP. Indeed, nursing graduate education is often depicted in the literature as being mandatory for ANP (eg. Bednash, Wulff & Haux, 1989; Canadian Clinical Nurse Specialist Interest Group, 1994; Hunsberger et al, 1992; United States Department of Health and Human Services, 1990). Given this knowledge, the strong support that these participants had for nursing graduate education related to ANP is made more evident.

All participants recognized the benefits of a strong
mented clinical specialty focus during graduate education, despite the faculty. A number of authors have specifically reinforced the need for indepth mentored, clinical experiences by way of practicums during graduate education in order to develop competencies required for ANP (eg. Arena & Page, 1992; Bass, Rabbett & Siskind, 1993; Forbes, 1994; Hamric & Taylor, 1989). All participants of this study were clinical experts prior to graduate education and experienced in their ANP roles. In addition, all participants had obviously made significant efforts to be informed about ANP as evidenced by their indepth knowledge, cited without prompting, related to nursing scholars who had written extensively about ANP.

There is no description in the literature as to how a mentored, clinical specialty focus can be included in non-nursing graduate education. The two participants with non-nursing graduate education took the initiative during graduate studies to ensure a mentored, clinical specialty focus, despite the faculty of their studies. It is the researcher's opinion that this approach may not be reflective of the majority of nurses undertaking non-nursing graduate education.

At the same time, participants with non-nursing graduate education questioned the increased support for nursing graduate education related to ANP, when many nursing programs did not contain a clinical specialization focus. They thought
this represented one justification that non-nursing graduate education was still very appropriate for ANP, particularly in an era of interdisciplinary collaborative practice.

Participants recognized the importance of a strong clinical background of the nurse prior to graduate studies. These participants believed that a creative and motivated clinical expert can maximize the benefits of non-nursing graduate education through strong linkages with nursing faculty.

These findings were reinforced in the literature in the diversity that exists regarding clinical specialization requirements for graduate nursing programs in Canada (eg. Synder, 1989), as well as internationally (eg. Starck, 1987). Although a specialized clinical focus for ANP is available at some universities, others offer a focus on administration or education in nursing programs. Programs also differ in entrance requirements and course work related to clinical experiences. Some programs require that the student have a defined number of years of clinical practice in a specialty area while others do not require clinical experience (Synder, 1989). Programs that do offer clinical specialization also differ in the amount and effectiveness of mentored clinical practice that is available (Anderson, 1994; Forbes, 1994). A lack of mentored clinical practice was reported by Davies and Eng (1995). In their survey, 38 CNSs completed a self administered questionnaire related to role implementation in various health care agencies in the Lower Mainland, B.C.
Participants of their study suggested the strong value of mentoring, particularly for novice CNSs, however few CNSs reported having had the opportunity for this experience. This may be a reflection of the number of CNSs available for the purposes of mentoring and not an indication of the interest of experienced CNSs in this activity.

This information explains why participants with non-nursing graduate education questioned the focus on nursing graduate education as mandatory for ANP. They questioned nursing graduate education being so strongly advocated as mandatory for ANP given the inconsistencies of graduate preparation of nurses.

Thus, although participants agreed that graduate education was a requirement for ANP, they had concerns related to whether or not this education should be in nursing. Those participants with nursing graduate education believed it was critical in order to advance nursing science and ANP. Participants with non-nursing graduate education questioned the support for nursing graduate education when so many inconsistencies and a lack of a clinical speciality focus existed in nursing programs in Canada. However, what is not clear is how varying graduate education influences the practice and outcomes of nurses in ANP particularly within an interdisciplinary collaborative care environment.

**Advanced Nursing Practice and Interdisciplinary Collaboration**

As nurses in ANP, participants clearly valued
interdisciplinary collaborative practice (ICP) that actively encouraged client involvement. Participants thought that nurses in ANP were more confident about ICP than were staff nurses, and therefore promoted its benefits. According to participants, when nurses in ANP embraced ICP, the ability to determine any one health care provider’s direct influence on CHO was challenging, and perhaps not possible. Recognition of the complexities related to trying to isolate the influence of any one provider, or the providers of any one discipline on CHO is a theme in the literature (eg. Bond & Thomas, 1991; Hamric, 1983; Higgins, McCaughan, Griffiths & Carr-Hill, 1992; Hoeman, 1995; Pike et al, 1993).

Findings from this study about ANP within the context of ICP warrant further consideration. Limited literature is available that clearly demonstrates the influence of ANP on CHO within the context of ICP. Government health policy decision makers and authors are touting ICP as a potential answer to current gaps and fragmentation in health care, as well as to reducing costs of care (eg. Hastings, O’Keefe & Buckley, 1992; Seaton, 1991; Sebas, 1994; Velianoff, Neely & Hall, 1993).

Literature related to ICP has often focused on physician-nurse interactions or what was coined by Stein as early as 1967 as the "doctor-nurse game." Literature has focused on improving nurse-physician relationships (eg. Fagin, 1992; Kirchnoff, 1987; Prescott & Bowen, 1985; Sebas,
1994), and has maintained that collaboration is essential for client care (eg. Michelson, 1988), and does lead to improved CHO (Baggs, Ryan, Phelps, Richeson & Johnson, 1992). Despite this, the literature continues to reflect the difficulty that nurses and physicians have in achieving true collaboration (eg. Wandel, 1991). Relations with other health care providers are less frequently mentioned in the literature and are usually in the context of an interdisciplinary team approach to care of specific populations of clients.

Articles are appearing that describe the benefits of physicians working in collaborative relationships with nurses in ANP (eg. Mundinger, 1994), however, literature related to CNS/physician collaboration is minimal. According to Sparacino (1994), some physicians continue to view ANP as a true encroachment on the practice of medicine. Participants of this study recognized the merits of all health care providers and did not isolate out physicians in their discussions of ICP. In addition, they discussed positive relationships with all health care providers and did not refer to difficulties in achieving collaboration.

Participants highly valued and promoted ICP. They were confident in their own competencies and therefore felt on equal footing with all members of the health care team. Participants saw nurses in ANP as "partners" with other health care providers. Yet, participants also recognized that nursing offered unique perspectives to client care.
Participants clearly saw effective and efficient client care as a priority for their practice. They were clear about when to involve other disciplines in client care and who to consult. Participants recognized they had credibility with other health care providers. They attributed this to: their broad university education, knowledge of other disciplines’ competencies, demonstrated and recognized clinical expertise, well-developed abilities to articulate and their role within the organization.

Literature reflects the strong emphasis that nurses in ANP place on ICP and some see it as an integral part of ANP (eg. Hawkins & Thibodeau, 1989; Nugent, 1992; Spross, 1989). The notion of partnerships between nurses in ANP and other health care providers is viewed as ensuring successful ICP (eg. Fenton, 1995). According to Arslanian-Engoren (1995), nurses in ANP are prepared by experience, education and role interpretation to advance ICP and will enact very creative strategies to meet needs of staff and clients. Literature reflects the strong influence of graduate level university education in terms of nurses in ANP being accepted by other disciplines, particularly physicians (eg. Alcock, 1995; Arslanian-Engoren, 1995). It is understandable, therefore, that participants highly valued ICP and felt they had to be active, contributory members and promoters of it.

Participants viewed nurses in ANP as interacting more frequently, directly, appropriately and collaboratively with
interdisciplinary health care providers than did staff nurses. They saw staff nurses as hesitant and lacking confidence about ICP. This view concurs with that of Wise (1995) who recognized that staff nurses lack confidence in their nursing knowledge base despite their assessments of client needs. Participants of this study believed a contributing factor to this was that many staff nurses were educated in non-university settings. This limited staff nurses' knowledge about the benefits of ICP.

Staff nurse subservience with respect to ICP is noted in the literature and considered to be the result of basic nursing curricula encouraging this approach (eg. Larson, 1995). Another noted trend is that staff nurses often defer clinical decisions to other disciplines and as a result imply that their knowledge is less important than that of other disciplines (eg. Wise, 1995). Therefore, it appears that staff nurse hesitancy and lack of confidence related to ICP is common practice. Participants saw a key role for nurses in ANP as that of assisting staff nurses to increase their competencies about the benefits of ICP and to recognize their own limits in regard to client care.

For participants, the description of their practice in relation to CHO proved to be problematic. This was due to complexities inherent in their role, such as being assistive to others, as well as being active members of ICP. Therefore, according to participants, nurses in ANP have an
important but indirect influence on CHO. Participants viewed nurses in ANP as "the conduit" in that many CHO came "through them" rather than "from them" directly. The fact that measuring CHO was a relatively new emphasis in health care in B.C. further complicated participants' attempts to make this linkage explicit. The trend demonstrated by participants to not isolate out their activities in relation to CHO is supported in a study by Schaefer and Lucke (1990). Findings from that study indicated that CNSs consistently report that they perceive their work as part of a team and not occurring independent of others.

Participants easily articulated the strong emphasis in their practice related to client involvement in their own care. Participants worked with others to ensure a client focus of care. The value and support that nurses in ANP place on client directed care is evident in the literature. For example, in her discussion of the CNS as case manager in a collaborative practice model, Nugent (1992) thinks that a CNS is best suited to assume the case manager role on an interdisciplinary collaborative team. Nugent thinks that the CNS has the competencies required that ensure a truly collaborative practice that keeps the client as the focal point. Others discuss how CHO should be viewed in light of professional actions but also "viewed in the light of individual patients' needs and wishes" (Bond & Thomas, 1991, p. 1498). Therefore, the findings related to nurses in ANP
promoting clients being actively involved in their own care are consistent with the theoretical descriptions of it in the literature.

Participants recognized the significance of being able to articulate a justification for their roles. Despite all of the influencing variables, participants recognized that for many reasons it would be advantageous to be able to quantitatively measure the influence of nurses in ANP on CHO. The ANP literature continues to stress the importance of outcomes in relation to ANP (eg. Harris & Warren, 1995; Sparacino, 1995; Spross, 1995; Waltz & Sylvia, 1991; Williams & Valdivieso, 1994). However, methodology to make the link between ANP and CHO is not well developed. Waltz and Sylvia (1991) word these challenges most accurately when they say "much remains to be accomplished with the thorny issues that still challenge those who seek to measure nursing outcomes" (p. 202).

Participants thought that a tool that could measure an association between ANP and CHO would be useful but a real challenge to develop. Literature reflects the need for research related to the development of tools to measure CNS outcomes (eg. Harris & Warren, 1995) in order to substantiate credibility and worth of providers (eg. Moore, 1995; Waltz & Sylvia, 1991). How to do so remains unclear. For example, Munro (1993) asks "what [outcome] measures should we use? Certainly, if we could agree on some, we would be able to
compare and contrast results across studies" (p. 246). Therefore, it appears that the challenges associated with being able to quantify measures of the influence of ANP on CHO present common problems.

Using detailed clinical stories, participants described how they positively influenced CHO as well as staff and organizational outcomes within an ICP environment. Their abilities to be visionary and proactive about client care were viewed as positive influences on overall CHO. Literature occasionally reflects the need for nurses in ANP to describe their practice through the use of clinical examples (eg. Mantle, 1993; Mason et al, 1992). Some authors are capitalizing on this approach (eg. Davies & Hughes, 1995). Their discussion indicates that nurses in ANP describing their practice in relation to CHO through the use of detailed clinical stories might be very useful. Through this process, nurses in ANP may be able to more clearly articulate which CHO they are in a key position to influence.

Thus, nurses in ANP highly value and strongly promote ICP that includes an emphasis on active client involvement in their own care. Given this approach to care, methodology to make explicit the influence of ANP on CHO is difficult. Nurses in ANP are often the "linkage" between staff nurses and other health care providers in order to enhance CHO. The use of detailed clinical stories, although perhaps not providing a quantifiable influence of ANP on CHO, may be the
avenue for these nurses to accurately describe their practice within an ICP environment.

**Chapter Summary**

In this chapter, the findings of this research were discussed in relation to the findings of other researchers and views of nursing authors. The discussion was presented from three areas which relate to major findings from chapter four that contribute to the knowledge base of ANP. These findings are of assistance in efforts to more clearly understand ANP and include: issues related to a definition of ANP, graduate education and ANP, and ANP and interdisciplinary collaboration.

Participants of this study were not able to articulate a clear and concise definition of ANP. This finding is consistent with that found in the literature. Participants valued ANP being a broad and vague term and believed the unlimited flexibility associated with it allowed nurses in ANP to adapt to ever-changing needs inherent in health reform. Participants believed they understood their own practice well and were not concerned about the general lack of clarity about ANP. Participants cautioned the researcher in efforts to more clearly define ANP. This finding is not reflected in the literature but may be explained by current autonomy and senior nursing administrative support enjoyed by participants.

Participants viewed global thinking as an essential
quality of ANP. Although nursing authors discuss similar qualities, the literature does not clearly identify how nurses in ANP are proactive in their practice within the competency of global thinking.

Participants also identified some minimal requirements of ANP that were conceptualized later as the minimal requirement triad of ANP, namely: the combination of graduate education, clinical specialty focus and research-based practice. In the literature, the combining of these three elements are not specifically identified as a baseline or foundation but individually have been discussed at length.

The need for graduate education as a critical requirement for ANP was described by all participants. What is not clear from participant accounts and from the literature is how graduate education from various faculties influences the process and outcomes related to ANP.

Participants raised many questions about the influence of ANP on CHO within an ICP environment. Participants highly valued and promoted ICP that included clients having active involvement in their own care. Since this was how participants approached their practice, they viewed isolating out the influence of ANP on CHO as being problematic. This finding was supported in the literature by the multitude of factors that influence CHO within an ICP environment. Although participants saw their role as working with staff nurses and other health care providers to enhance CHO, they
were able to describe detailed clinical stories that illustrated how they did so. These clinical stories are believed by some nursing authors to be a useful strategy for nurses in ANP to be able to articulate which CHO they can influence within an ICP environment.

In this chapter, a discussion of the research findings were presented. In the next chapter, the summary, conclusions and implications for nursing graduate education, policy and administration as well as research are presented.
This study was designed to gain an understanding of how CNSs define ANP and describe their practice in relation to CHO. The CNS participants were recognized as practising under the umbrella of ANP. The term ANP has been utilized in nursing literature and discussions for many years. However, ANP remains a term that is not clearly defined nor consistently enacted. Although literature exists encouraging nurses in ANP to be able to describe the impact of their practice on CHO, methodology to do so is not clear. Any direct linkage between ANP and CHO is difficult to measure due to the broad, global and assistive role that these nurses assume within an interdisciplinary collaborative environment.

The efforts of nursing scholars to date have reflected a genuine urgency in being able to attain further clarity about ANP and its influence on CHO. Although a wealth of literature exists that relates to the phenomena of interest, minimal research-based literature is available. In the push for clarity about ANP, literature reflects attempts at definitions, descriptions, characteristics, attributes and subroles. Literature related to ANP and its influence on CHO reflects the early stages of nurses' attempts to link their practice to outcomes of care. This approach is further complicated by an era of ICP. Nurses and other health care
providers are questioning how any CHO can be directly linked to a specific provider and/or discipline. No research-based literature asking nurses in ANP to define and describe ANP in relation to CHO was found.

The exploratory descriptive method of qualitative research was used for this study. This method was particularly suited to the question since there have not been indepth studies of the phenomena of interest (Brink & Wood, 1989), particularly from a Canadian perspective. The researcher wanted to understand the definition of ANP and the relationship of ANP on CHO from the perspectives of nurses in ANP, within the B.C. health care environment. A purposive sample of Vancouver Island CNSs, employed in a large hospital society, was chosen to participate in this study. All participants who were approached for inclusion consented to participate.

Seven participants of this study, who met specific eligibility criteria, participated in semi-structured interviews. All of the interviews, which were two to three one hour sessions with each participant, were audio-tape recorded and subsequently transcribed verbatim. Data analysis occurred concurrently with data collection. This qualitative thematic analysis was done based on analytical techniques and procedures identified by Strauss and Corbin (1990). Findings were clarified, elaborated upon and/or validated with participants to ensure accuracy, as well as
adding to the depth and richness of the data.

There was not an available specific theory that could be linked with the phenomena of interest and utilized as a guide. The work of nursing scholars such as Fenton (1985), Benner (1984) and Calkin (1984), provided some conceptual background for this study. All participants were very familiar with, and cited without prompting, the work of these nurses. Findings of this study were presented according to three broad categories that resulted from thematic analysis.

The first broad category related to difficulties in clearly defining ANP. This category of data consisted of two components: initial attempts at defining ANP and reasons for lack of clarity about it. While participants were not able to provide a clear and concise definition of ANP, they were not at all concerned about this and believed that they personally understood how their practice was that of ANP. They perceived the apparent lack of clarity about ANP as advantageous in that it allowed for the continued flexibility that was required for ANP. They offered several reasons to explain the current vagueness associated with ANP such as role inconsistencies, imprecision regarding nursing, terminology changes and lack of time for reflection about practice in general.

The second broad category related to the descriptors of ANP. This category consisted of two components: minimal requirement triad of ANP and essential qualities of ANP.
Participants believed that there were three minimal requirements that were combined to provide the foundation for ANP: graduate education, clinical specialty focus and research-based practice. Participants also identified five essential qualities present in ANP: global thinking, indirect clinical focus, assistive care delivery, effective leadership and interdisciplinary collaboration.

The third broad category related to participants' ideas about a possible relationship between ANP and CHO. This category consisted of three components: problems in articulating CHO, communicating the relationship between ANP and CHO, and the theoretical problems in linking ANP with CHO. Participants recognized that measuring CHO was a fairly new area of focus for health care providers in B.C. They also recognized that the term CHO was understood from many perspectives and often did not involve the client in an active manner. Participants believed that nurses in ANP influenced CHO in an indirect manner that was best explained through the use of detailed clinical stories. Such stories provided detailed client-specific illustrations of the application of ANP using a broad system perspective. Participants also identified theoretical problems in attempting to link ANP with CHO, such as the indirect relationship that nurses in ANP had with clients, the differences in trying to measure short term versus long term CHO, and the strong influence of other variables. In
particular, participants wondered how any CHO could be directly linked to any discipline, let alone a specific provider, in the current era of interdisciplinary collaboration. Participants valued ICP highly and thought that they had more direct access to and interacted with their colleagues in other disciplines very differently than did staff nurses.

**Conclusions**

The research findings led to a number of conclusions about a definition of ANP and the relationship of ANP on CHO. These include:

- ANP remains a term that is not amenable to a clear and concise definition;
- nurses communicate about ANP through the use of detailed clinical stories rather than definitions;
- the broad and vague nature of ANP is valued in that it allows for unlimited flexibility of the role as currently required in health reform;
- the ability of nurses in ANP to enact their roles is strongly dependent upon the context of their practice;
- an explicit definition of ANP is not a priority for nurses in ANP. In fact, some believe that efforts to create such definitions could be counter-productive;
- the significant inconsistencies in how nurses in ANP enact their roles are viewed positively, as they allow for the unique personal and professional competencies
that nurses bring to ANP;

• some nurses in ANP tend not to have reflective time to think about terms such as ANP and CHO;

• some nurses in ANP believe that graduate education is mandatory for ANP;

• some nurses in ANP believe that a nurse should be a clinical expert prior to graduate education for ANP;

• some nurses in ANP believe that graduate education for ANP should include a strong clinical specialty focus;

• some nurses in ANP believe that research is an important component of their role;

• while there is no consensus about the need for nursing or non-nursing graduate education for ANP, mentored clinical experience in graduate education is thought to be crucial for nurses to develop into ANP;

• some nurses in ANP believe that ANP requires the ability to think globally, that is the ability to translate individual client scenarios into a whole or pattern, as well as bringing that whole or pattern to any individual client;

• some nurses in ANP believe that their ability to think globally allow them to be proactive rather than reactive in their practice;

• some nurses in ANP see their role as assistive to others in order to enhance client care;

• some nurses in ANP strongly support active involvement
of clients in determining meaningful CHO;

- given current cost constraints, some nurses in ANP are taking on more functions typically associated with senior nursing administrators;
- some nurses in ANP strongly value interdisciplinary collaborative practice and recognize the contributions of all health care providers; and,
- it may not be possible to articulate a direct relationship between ANP and CHO in an interdisciplinary collaborative practice environment.

**Nursing Implications**

The findings of this study have implications for graduate education, policy and administration as well as research. These will now be presented.

**Graduate Education**

Participants of this study believed that graduate education is mandatory for ANP. However, as participants discussed and literature confirms, nurses in ANP vary in their support about the need for graduate education to be in nursing. To date, this issue remains contentious despite a lack of evidence that there are any differences in the practice and outcomes of nurses in ANP despite the faculty focus of their graduate studies. Of note, in the interviews for this study, although recognizing that there were only two participants with non-nursing graduate education, there were no noticeable differences in how participants were able to
discuss ANP and describe their practice in relation to CHO.

Given the current era of ICP, discussions about the need for nursing versus non-nursing graduate education are very appropriate. Nurses, professional regulatory bodies and university educators need to consider how to best prepare nurses to assume responsibilities for ANP and its influence on CHO. This is particularly important during health care reform. The above stakeholders need to determine and/or confirm concerns about the faculty of graduate study for ANP, particularly if a strong clinical specialty focus and research expertise could be assured. Further dialogue about these issues will assist in determining whether current acceptance of non-nursing graduate education will result in negative consequences for ANP and the science of nursing. Perhaps a primary graduate focus in another faculty may be very useful in an ICP environment especially if there was a strong link with the nursing program to ensure some nursing courses as well as a mentored clinical specialization. These issues need to be debated, and if required, appropriate changes should be made to graduate education.

Nurses in ANP believe that graduate education should include a strong clinical specialty focus. Participants of this study believed that nurses should be clinical experts prior to graduate education. The nursing community and educational institutions have addressed the question of whether a nurse should be a clinical expert prior to graduate
education. However, as was noted in chapter five, nursing graduate educational programs vary in this requirement. If this is to continue, potential students need to make careful decisions about their selections for graduate education. They need to recognize that class discussions, assignments and other activities in programs that do require clinical experts may be very challenging to students without clinical expertise. However, educators and students can further develop creative individual ways to meet personal education goals. The individual student may require considerable additional efforts.

Nurses in ANP recognize the benefits of a mentored clinical specialty focus during graduate education. Students and educators need to examine how clinical practicums are structured and monitored in order to ensure a mentored experience. Careful selection of preceptors who are keenly interested in active participation and partnership with students and educators is critical. Strategies to ensure effective communication between educators and preceptors can be strengthened, such as orientation, mentoring the mentor by faculty, and joint evaluation of students.

Nurses in ANP seem to communicate about their practice, not through definitions, but through the use of detailed clinical stories. This approach can be further developed during graduate education through incorporation of clinical stories into assignments and class discussions. Students can
question preceptors about how they articulate their practice with administrators and peers in order to change and advance nursing practice. They can also engage in discussions about articulating the relationship of ANP on CHO. Outcomes from these can assist novice nurses in ANP to become more articulate about their practice and its influence on CHO.

Nurses in ANP value the flexibility associated with their role. This flexibility was believed to be a factor that allowed nurses in ANP to respond to changes inherent in health reform. During graduate education, students should be exposed to a variety of nurses in ANP and observe and question them about this aspect of their practice. They could discuss the positive and negative effects of the diversity and flexibility. Students could then have discussions with others about whether flexibility was a positive aspect of ANP.

Participants in this study believe that reflective time is required for discussing terms like ANP and CHO. However, in busy day-to-day practice this reflective time is not readily available. During graduate education, students regularly engage in reflective time in order to prepare for class discussions and assignments. Graduate studies could be a platform to ensure that reflective time is built into practicums. Graduate nursing students and preceptors often engage in reflective thinking and discussions but perhaps other nurses could also participate. Educators and students
could also promote the overall benefits of the proactive approach of ANP which can be further developed by taking time for reflection of practice. These strategies could provide a foundation for nurses in ANP to believe that reflective time is mandatory for ANP and not a luxury.

Nurses in ANP strongly value research as an important component of their role. Many nursing graduate programs do include a research course and the conduct of a thesis as a requirement. Others do not. Non-nursing faculties also vary in their offerings of research courses. These inconsistencies influence the competencies of nurses in ANP related to research. Nurses, professional regulatory bodies and educators need to examine the appropriate role for master’s prepared nurses in the conduct of research. The question as to whether clinically based graduate education should include a research thesis experience also needs to be addressed.

Although research is generally recognized as an important component of ANP, participants of this study believed they could best contribute to research by partnering with doctorally prepared nurses. Participants also believed that doing research accounted for the smallest proportion of their time in their overall practice, although research utilization permeated their practice. It is important to revisit the general expectation of independent research on the part of a master’s prepared nurse in ANP.
Finally, nurses in ANP highly value and interact differently with colleagues from other disciplines than do staff nurses. Currently, many nursing graduate programs are solely focused on nursing and rarely involve other disciplines through readings or class participation. Students and educators need to question a faculty specific approach to graduate education. This is particularly important when all levels of health policy decision makers are suggesting ICP as a potential answer to current fragmentation, gaps and duplication in health care. Students and educators could experiment with interdisciplinary education for courses early in programs and at various stages throughout graduate education. During clinical practicums, students need to observe and discuss how preceptors encourage ICP and how they perceive that influences CHO. Students could also involve clients in these discussions.

**Policy And Administration**

Nurses, health policy decision makers and administrators need to be more cognizant of the valuable contribution that nurses in ANP can make to health reform. Participants of this study described significant contributions that they were making to individual, as well as overall client care within their organizations. Although participants alluded to being involved in care with external agencies, this seemed to be a minor focus.

Findings from this study reinforce that nurses in ANP
have many of the competencies that could positively contribute to the enhancements of outcomes for clients, interdisciplinary health care providers, as well as organizations. However, this potential contribution does not seem to be promoted, recognized or sought. For example, in current debates between "hospital and community" there is a strong effort to determine "what nurses" should be providing care and in "what context." Community nurses actively discourage hospital nurses from practising "outside" the hospital walls and vice-versa. However, in the case of ANP, the health care community needs to ask if this is appropriate. In many instances, nurses in ANP should monitor and influence care across delivery settings more directly. Although isolated examples of this are occurring, it is not consistently encouraged and/or sanctioned. Nurses in ANP could make significant contributions in discussions with health policy decision makers, including representatives from Community Health Councils and Regional Health Boards, concerning local and regional health care needs/plans.

Participants of this study described their increasing administrative focus. The outcomes of increased administrative responsibilities for nurses in ANP need further study. In the meantime, administrators need to carefully consider reasons for this practice. If nurses in ANP are educated to actively participate with others in order to improve client care within an organization, administrators
need to determine if that goal will be met with nurses in ANP taking on more of an administrative role. It is recognized that this action may be the result of a "fill the gap" measure due to cost constraints and down-sizing of middle nursing management. However, administrators and nurses in ANP need to carefully monitor how a decreasing focus on client care will impact clinical practice within the organization. On the other hand, perhaps this increased administrative focus could be viewed as an appropriate compromise that keeps ANP alive during current times of economic restraint.

Lastly, the nurse participants in this study positively view and encourage ICP. At the present time, there is a heightened interest in ICP with many disciplines fearing yet others supporting it. Nurses in ANP can make use of this interest and model to others how to actively participate in ICP. Nurses in ANP can more fully communicate their practice with others and encourage discussions about new and creative ways to improve CHO with an integrated care delivery mechanism.

Research

Findings from this study can be used to identify further research topics related to ANP. The on-going exhaustive efforts to clearly define ANP need to be questioned. Nursing scholars strive for clarity about ANP because they know that these nurses make significant and valuable contributions to
client care, nursing practice and overall health care. The nurse participants in this study share these views. However, definitions of ANP may not prove fruitful in furthering the cause of ANP.

Instead of trying to define ANP, efforts can be put toward applying current vision statements about it toward meeting organizational, regional and provincial health reform goals. Because nurses in ANP do not find it important to spend energy trying to define a term equated with their practice, they caution against such efforts. Perhaps the above approach, related to vision statements, would enable nursing scholars and nurses in ANP to be able to effectively communicate the valuable contribution they know nurses in ANP make. There needs to be a clear and concise way to describe ANP so policy makers, government, other disciplines and even nurses come to understand what ANP is and are able to more fully value it.

Participants identified some minimal requirements for ANP. Currently there are many nurses using a title linked with ANP from a variety of programs and backgrounds. Although others are actively exploring this, it may be useful to come to a consensus on minimal requirements for ANP. Research related to minimal requirements could explore any differences, and the resultant implications of how nurses in ANP enact their roles, dependent upon whether they have nursing or non-nursing graduate education. Another question
worthy of further study relates to any differences between nurses who are clinical experts versus those with minimal clinical experiences prior to graduate education.

In this study, participants were all from one major hospital society. Participants were quite consistent in their approaches to the phenomena of interest. It would be beneficial to investigate how nurses in ANP in other Canadian facilities and cities describe their practice. A study of nurses in ANP in other centres might illuminate further the issues in trying to define ANP and describe this practice in relation to CHO.

Only two participants of this study had undertaken non-nursing graduate education. Although generalizations cannot be made on the basis of these accounts, it was obvious that both of these participants had made concerted efforts to ensure a clinical specialty focus during their graduate studies. It would be useful to determine why nurses undertake non-nursing graduate education particularly if they wish to be actively involved in nursing. Another question is to determine the implications for ANP if a nurse is a graduate of a non-nursing graduate program that did not include a clinical specialty focus.

Participants of this study attempted to define ANP and describe their practice in relation to CHO. It would be most useful to follow these descriptions by observing nurses in ANP as they conduct their practice. These observations would
shed more light on ANP.

Nurses in ANP strongly support client active involvement in decision making about their own care. These nurses also recognize the need for clients to identify meaningful CHO from their own perspectives. Further research related to these areas could be of assistance in the debates about health reform and evaluation of services both specifically and generally. Perhaps asking clients to articulate the influence of nurses and nursing care on their CHO could assist in our understanding of how to separate out the influence of nursing on CHO in an ICP environment. It may also assist health policy decision makers, health care providers and nurses in ANP to determine, justify and/or eliminate programs that either result in positive or negative CHO.

Lastly, the whole issue of the relationship of ANP to CHO requires further research. Participants described the complexities that they had in trying to make a theoretical linkage between their practice and CHO explicit. Although participants were not accustomed to doing so, they described indirect relationships between ANP and CHO. Although there is general support for ANP, failure to more clearly articulate it in relation to CHO could prove to be problematic. Further questions need to be asked about the contribution that nurses in ANP make to CHO, particularly in ICP environment. Perhaps the emphasis on clients as
individuals has been problematic. Participants described the proactive, global perspective they brought to client and overall health care. An expansion on the contribution that nurses in ANP make to an organization or to populations as client could assist in further understanding of how this positively, albeit indirectly, influences CHO. Finally, how other nurses in ANP eg., nurse practitioners address these issues could be useful in efforts to further develop this role in Canada.

Concluding Remarks

In conclusion, this report has outlined how CNSs define ANP and describe their practice in relation to CHO. At the beginning of this study, the researcher assumed that nurses whose role fell under the umbrella of ANP would be able to fairly easily assist in articulating a definition of ANP as well as have an accurate sense of how their practice influenced CHO. This study has be an illuminating experience that may have raised more questions than answers to the phenomena of interest. However, it is the researcher’s hope that despite the complexities associated with understanding ANP, nurses and others will continue to recognize the valuable and significant contributions that these nurses make to health care. Nurses, educators and researchers need to reassess the approach to understanding and describing ANP. Nurses in ANP also need to take further opportunities to be proactive and actively communicate how their practice
enhances outcomes for clients, health care providers and organizations.
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APPENDIX A

LETTER OF INVITATION TO PARTICIPANTS

Address of Researcher

Date...

Specific name,
title and
address of potential participant

Dear (name of CNS);

As you may know, I am a student in the Master's of Nursing Program at the University of British Columbia (UBC). I would like to enlist your help as a participant in my proposed research that will be conducted for the purposes of completing thesis research.

The proposed research is a qualitative study related to advanced nursing practice and client health outcomes. As you are aware, during times of economic restraint as is facing our health care system now, health policy and economic decision makers may question your role as a Clinical Nurse Specialist. The outcome of this study will contribute to a knowledge base related to a clear definition of advanced nursing practice and how this practice relates or contributes to client health outcomes.

I would like to invite you to participate in this research. Your involvement would include time for interviews, estimated to be a maximum of three, one hour interviews. This timing and frequency will be determined based on our discussions and the subsequent findings of the interviews.

The location and timing of these interviews can be mutually determined to accommodate your busy work schedule. Your privacy and confidentiality would be maintained. You would of course be free to withdraw from the proposed research at any time without jeopardy and would be free to refuse to discuss any specific topics.
If you have any questions and/or if you would like to volunteer to participate in the proposed research please contact me at home xxx-xxxx (machine), at work xxx-xxxx (phone) or by fax (xxx-xxxx). If I have not heard from you in two weeks I will give you a phone call to ask you about your participation decision and to answer any questions or issues that you may have.

Dr. Sally Thorne, Chair of my Thesis Committee, is available to answer any questions as well, and she can be contacted at UBC, telephone # xxx-xxxx. Thank you for your consideration and I look forward to hearing from you.

Sincerely,

Katherine Cox.
APPENDIX B

ELIGIBILITY CRITERIA AND DEMOGRAPHICS

1. Are you currently employed as a CNS? yes ___ no ___

2. Have you been employed as a CNS for a minimum of one year? yes ___ no ___

3. Do you have a Master's degree? yes ___ no ___

4. What faculty is your degree in? ____________________________

5. Demographics:
   Age____ Gender F___ M___
   Years employed as CNS____
   Specialty___________________________
APPENDIX C

Research Question:

"How do Clinical Nurse Specialists define advanced nursing practice and how do they describe their practice in relation to client health outcomes?"

PROMPTS

1. Demographics, previous professional history, length of time employed as a Clinical Nurse Specialist and in what department or area, what faculty master’s degree is in.

2. Please tell me something about your practice.

3. So it sounds like this could be called "advanced" practice in nursing.

4. It sounds like you are differentiating between expert practice and advanced nursing practice.

5. What you just noted there is a client health outcome, so to speak. I am interested in that...

6. How do you define client health outcomes? So you seem to be making a link to the immediate effect of your care on the client? Is there any benefit to examining or exploring long term effects?

7. You seem to be making a link between advanced nursing practice and client health outcomes. Can you elaborate on that...?

8. How do you see your practice as influencing client health outcomes?

9. It sounds like you think that things you do affect the client...(pause).

Adapted from Patterson and Haddad, 1992.
APPENDIX D
CONSENT FOR INTERVIEW

In signing this document, I am giving my consent to be interviewed by Katherine Cox, a Master of Science in Nursing student from the University of British Columbia. I understand that I will participate in data collection for research in a nursing thesis. The research area of interest is advanced nursing practice and client health outcomes and will involve one to three audio-taped interviews of approximately one hour in length. There will not be any financial renumeration for any of the participants.

I am aware that the tapes used during the interview will be transcribed for the purposes of analysis by Katherine. The tape may be transcribed by a typist but the only other person (other than Katherine and the typist) who may listen to them will be three of Katherine’s professors. I am assured of my confidentiality, in that the tape and transcriptions will not identify me personally.

I understand that I was selected to participate in this study because of my interest in advanced nursing practice and the fact that I am employed as a Clinical Nurse Specialist. I have met the participant eligibility criteria as they have been explained to me by Katherine. I have been informed that the interview is entirely voluntary, and that at any point during the interview I can refuse to discuss any specific topics, and in fact, can terminate the interview without jeopardy.

This study has the potential to contribute to a definition of advanced nursing practice and the evaluation of how this practice affects client health outcomes, which to date is lacking. I am aware that I am free to contact Katherine for any questions related to this process or study and her telephone number is on the bottom of this consent. I understand that Dr. Sally Thorne (Thesis Committee Chair: xxx-xxxx) or Dr. Anita Molzahn (xxx-xxxx), are the nursing faculty to contact if I have any questions about this process or study. I also understand that Katherine may contact me for more information in the future. In addition, Katherine will share the findings of this study with me if I am interested.

Date

Acknowledgement that the participant has been given a copy of the consent form (will be signed by both the participant and researcher and a copy given to the participant).