

AN EXPLORATORY DESCRIPTIVE STUDY OF ADVANCED PRACTICE NURSES
AS NURSE LEADERS

by

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DEDICATION

This thesis is dedicated to my family and fellow nurses. To my husband, Darryl and his continual support in my personal and professional goals. To my son, William who is a constant source of happiness and pride. To my parents, whose continual support never wavers, especially my mother who has always encouraged and supported me to pursue my dreams. To my nursing colleagues and friends who have supported, motivated and inspired me to pursue my passion for nursing.

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ABSTRACT

Healthcare is provided in a complex dynamic system that requires leadership at all levels and positions in order to achieve the goal of safe, efficient, high quality care to all Canadians. Advanced practice nurses (APNs) are expected to demonstrate leadership. The purpose of this study was to explore APNs' perceptions of their leadership and how it contributes to positive healthcare outcomes.

A qualitative descriptive methodology informed by a leadership framework was used to explore participants' perceptions. Fourteen APNs participated in semi-structured interviews. Content analysis was used and two themes were identified from the data: *Patient-focused leadership* and *Organization and system-focused leadership*. These two themes are further described through leadership domains that house leadership capabilities and outcomes. The findings of this study can be used to clearly articulate APN leadership and its contribution to patients and families, nurses and other health care providers, organizations and the healthcare system.

LIST OF ABBREVIATIONS USED

APN	Advanced Practice Nurse
AACN	American Association of Colleges of Nursing
AMP	Advanced Nurse Midwife
ANP	Advanced Nurse Practitioner
CDHA	Capital District Health Authority
CNA	Canadian Nurses Association
CNS	Clinical Nurse Specialist
CRNNS	College of Registered Nurses of Nova Scotia
ICN	International Council of Nurses
LEADS	The LEADS in a Caring Environment Leadership Capability Framework
MHA	Master of Health Administration
MN	Master of Nursing
NCPDNM	National Council of the Professional Development of Nursing and Midwifery
NICU	Neonatal Intensive Care Unit
NP	Nurse Practitioner
REB	Research Ethics Board
RN	Registered Nurse

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Chapter One: Introduction

Healthcare in Canada is in the midst of major change, stimulated by the current economic challenges facing Canada and the world, the shifting demographics of Canada's population and the growing number of people living with chronic illness. These variables have led to increased and focused attention being paid to the effectiveness, quality and efficiency of healthcare services. As a result, healthcare providers are being asked to examine their roles and scopes of practice to ensure optimal utilization of these resources. Nurses comprise one-third of all healthcare professionals in Canada and therefore are the largest group of healthcare professionals that interface between patients and the healthcare system (Health Canada, 2007). This places nurses in a position to not only continue to improve patient outcomes through direct care but also to initiate, manage, and lead system changes to improve patient and family, nursing and healthcare provider, and healthcare system outcomes (Cummings, 2010).

Within the diverse profession of nursing there is a distinct area of nursing known as advanced nursing practice. In Canada, the Canadian Nurses Association (CNA), which is the national professional association representing registered nurses (RN) in Canada and consists of 11 provincial nursing federations and colleges, provides national leadership and policy guidance. The CNA defines advanced nursing practice as an "umbrella term that described an advanced level of clinical nursing practice that maximizes the use of graduate education preparation, in-depth nursing knowledge and expertise in meeting the health needs of individuals, families, groups, communities and populations" (2008, p.9). Two types of roles are engaged in advanced nursing practice in Canada; these include the Clinical Nurses Specialist (CNS) and the Nurse Practitioner (NP). These two roles are

collectively referred to as Advanced Practice Nurses (APNs). As defined by the CNA (2008), APNs include NPs and CNSs and “they have the education, clinical expertise, leadership skills and understanding of organizations, health policy and decision-making to play an important role in client and healthcare system outcomes now and in the future” (p. 7).

CNSs are defined as “registered nurses who hold a masters or doctoral degree in nursing. CNSs have advanced knowledge and clinical expertise in a nursing specialty. They provide leadership in the development of clinical guidelines and protocols. They also promote the use of evidence, provide expert support, consultation, education, and facilitate system change” (CNA, 2011, para. 1). CNSs have traditionally worked in acute care settings as their role developed in hospitals in the 1950s when a need for more experienced nurses was required to provide clinical leadership at the bedside (Kaaslainen et al., 2010). Today, CNSs remain mostly in acute care settings, but have also expanded to other outpatient, community and long term care settings (Kilpatrick et al., 2013).

In comparison, the role of NPs are defined by the CNA as “registered nurses with additional educational preparation and experience who possess and demonstrate the competences to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform specific procedures within a legislated scope of practice” (CNA, 2008, p.1). NPs in Canada must successfully complete an NP licensing exam and meet all necessary competencies before using the title NP, as it is a legally protected title in all Canadian provinces and territories.

The NP role can be further divided into acute care and primary care foci. Primary healthcare NPs have traditionally worked in the community and their focus is health

promotion, primary prevention care, diagnosis of acute common illnesses, and chronic disease management (Donald et al., 2010). Acute care NPs have worked mostly in tertiary or community hospitals. Their advanced nursing practice focuses on providing care to critically ill patients with complex acute and or chronic medical diagnoses often accompanied by multiple co-morbidities (Kilpatrick et al., 2010). This study focused on NPs and CNSs working in acute care.

NP and CNS roles are distinct in their licensing requirements and scopes of practice yet both are advanced nursing practice roles. In other countries the term APN is not limited to CNSs and NPs, but also includes midwives, nurse anesthetists and others (International Council of Nurses [ICN], 2009). The term APN is recognized internationally as referring to “a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A masters degree is recommended for entry level” (ICN, 2009, para. 3).

Healthcare in Canada and specifically in Nova Scotia is experiencing an unprecedented level of change. APNs are in a position as healthcare professionals in advanced nursing practice roles to be leaders and make a substantial contribution to positively influence the direction of healthcare at a provincial and national level.

Location as a researcher

I am a RN having completed my Bachelor of Science in Nursing from the University of Toronto in 2005. I have been employed as an RN in Halifax, Nova Scotia for the past eight years. My nursing experience is mainly in acute care, most recently as a

Quality and Patient Safety Leader. I have also worked in critical care, medicine and surgery areas as well as in a youth healthcare clinic focused on sexual health.

I am currently a graduate student at Dalhousie University completing my Master of Nursing (MN)/Master of Health Administration (MHA) and I am passionate about nursing leadership. I had the opportunity as part of my MHA course requirements to work with APNs on a pilot project that focused on measuring outcomes associated with APN practice. This experience stimulated my interest in leadership as it related to advanced nursing practice because many of the APNs I worked with struggled to define their role as a nurse leader and the impact of their leadership on healthcare outcomes.

My location as a researcher is also influenced by my knowledge of health administration and my experience as an acute care RN. My health administration educational background encourages me to take a system-based perspective in which I acknowledge the complexity and inter-related relationships that exist within the healthcare system. For example, I have the basic skills and theoretical knowledge to analyze the financial, economic, and clinical impact of decisions as well as the desire to optimize the effectiveness and efficiency of each component of the system in order to result in better healthcare system. As an RN, and health administration student, I have had the opportunity to work with many APNs in acute care settings. As an RN at the bedside in acute care, I have experienced the positive contribution APNs bring to the clinical team as clinicians, and leaders in nursing. From a graduate student (health administration) perspective, I have first-hand experience working with APNs as they attempt to define outcomes relevant to their practice and to both qualify and quantify their contribution to patients and families as well as the broader healthcare system.

As a practitioner, my nursing practice is influenced by the empirical paradigm and the biomedical model that dominates patient care in the acute care. I often rely on my senses through observation and concrete measurements such as mean arterial blood pressure, vital signs, volumes of intake and output to guide my nursing interventions (Weaver & Olson, 2006). However, my beliefs also align with the interpretive/constructivist paradigm (Monti & Tingen, 1999). I strongly believe that as a nurse I must understand health and illness in the context of the person who experiences it. I recognize that there are multiple truths and realities and not one single reality is true when considering the human experience and the social world. I also view the patient as a whole, whole in the sense they are not simply a diagnosis, but rather a person who has a history, a family, a community and a reality that is their lived experience and it is unique to them.

Background to the study

Canadian healthcare.

Healthcare in Canada is clearly under increasing pressure to meet the needs of an older, sicker population. The 2006 Canadian census data showed the median age of Canadians is 39.5 years, but by 2031 this is expected to exceed 44 years (Statistics Canada, 2009). This means that the number of older people is growing and the number of children is declining, with the average life expectancy for Canadian women reaching 86.0 years in 2030 (Statistics Canada, 2008). This is in part due to the advances in clean water, readily available food sources and medical technologies. These advances have led to a dramatic difference in the causes of death of Canadians. Up until the later part of the last century, Canadians commonly died from infectious disease and malnutrition. Now the

leading cause of death for adult Canadians is chronic disease related to the circulatory system and cancer (Statistics Canada, 2008). As a result of technological and medical advances people are not only living longer, they are living with chronic diseases, and medical challenges that would have previously been fatal. Therefore when people need acute care services the complexity of care they require in hospitals is greater than in previous decades.

Technological, medical, and pharmaceutical advancements are evolving at a rate never experienced before. There are constantly new products and information being made available. As the healthcare system continues to stress the importance of evidence-based decision-making, being able to appraise and select the most appropriate, efficient, and effective information or new technology and apply it in healthcare settings is essential (Buonocore, 2004).

Finally, healthcare budgets have risen to a proportionately high amount of governments' overall budgets and have caused all healthcare leaders and governments to consider how healthcare is delivered. One of the focuses in Nova Scotia and in other parts of Canada has been to optimize the roles and utilization of healthcare providers. In Nova Scotia, the Models of Care Initiative was instrumental in initiating this work in acute care facilities (Province of Nova Scotia, 2013). Optimizing roles and utilization requires healthcare providers to change current practice patterns to enhance the utilization of their knowledge and skills to provide high quality patient care (Dalhousie University/World Health Organization Collaborating Centre on Health Workforce Planning & Research, 2010).

Healthcare and leadership.

The combination of increasing complex patient populations, the tremendous growth in the access to new technologies and information, and the optimal utilization of all healthcare resources is stimulating a need for leaders who can provide guidance and direction through continuous change. Dickson, Briscoe, Fenwick, MacLead and Romilly state, “the Canadian healthcare system needs strong leadership if it is to be sustainable and responsive to the health needs of Canadian now and in the future” (2007, p. 1).

Leadership is a set of skills and abilities that a person embodies (Kouzes & Posner, 2007). The person who embodies and uses these abilities and skills to create a vision, and engage others to share that vision and accomplish changes to realize that vision, is a leader (Kouzes & Posner, 2007). Leadership is also defined as “the process through which an individual attempts to intentionally influence another individual or a group to accomplish a goal” (Shortell & Kaluzny, 2006, p. 109).

Historically, many forms of leadership and types of leaders have been discussed. Most recently transformational leadership has been commonly cited as an effective leadership style (Carmicheal, Collins, Emsell & Haydon, 2011). Transformational leadership is a means by which leaders are able to influence their followers and together they are able to achieve a shared vision (Burns, 1978; Carmicheal et al., 2011).

Nurses and leadership.

Nurses are expected to be leaders within the healthcare system. Leadership in nursing is considered a shared responsibility and as such it is assumed that all nurses regardless of position or title optimize their leadership potential for the betterment of

patients, families and the profession (CNA, n.d.). The College of Registered Nurses of Nova Scotia (CRNNS) recognizes leadership as one of the five standards of practice that all RNs must adhere to when practicing in Nova Scotia (CRNNS, 2012).

All nurses, regardless of their position, need to maximize their leadership potential (CNA, n.d.; CRNNS, 2012). Leadership in this context is considered to be shared leadership, where leadership is not associated with a title or position, rather it is an attribute shared by all RNs (Martin, 2007). Although leadership is an expected attribute of all RNs, leadership within the profession is often considered to be dependent on role (Scott & Miles, 2013). For example, those in administrative and management roles are considered formal leaders, while nurses at the bedside or in clinical practice are often defined as informal or clinical leaders. Both classifications of leaders need to demonstrate important attributes of leadership, however more is understood in reference to formal leadership roles.

As a result of nursing governing bodies acknowledgment of the importance of nursing leadership there is a growing body of evidence. This evidence supports the relationship between formal nursing leadership (nurse managers, senior health administrators and policy makers) and nursing outcomes (nurse job satisfaction, retention, etc.) and patient outcomes (patient satisfaction and reduced adverse events) is growing (Wong & Cummings, 2007). However, the evidence supporting the impact of leadership demonstrated by less formally recognized nurse leaders on patients, fellow nurses and the broader system is less abundant (Cummings, 2011).

The impact of leadership in healthcare can be conceptualized using Berwick's (2002, p. 81-82) model of the components of the healthcare system. In the model,

leadership is the base and it supports the rest of the system. Leadership holds up the organizational components that include the microsystem (care team units), followed by the components of patient and family care. Leadership also interacts and shapes the surrounding environment (regulation, accreditation, funding, etc.). This model was developed to assist in using the Institute of Medicine's Quality Chasm report, which is noted to be the impetus of quality improvement in American healthcare (Leatt & Porter, 2003).

Leadership is the ability to influence others to achieve a vision, a vision of a preferred future (Cummings, 2011). In healthcare the ultimate preferred future is optimal health outcomes for individual patients and the population. However, simple as this goal may seem, it is actually tremendously complicated. There is a multitude of complex and convoluted variables and systems to be considered. This may in part be the reason literature documenting the impact of leadership on patient and other healthcare outcomes is sparse.

As the healthcare system restructures and decision are made to increase efficiencies and reduce costs without impacting patient care, formal leadership roles are often the first to be removed. Between 1997 and 2002, 7000 nursing administrative positions were eliminated from the Canadian healthcare system (Cummings & Estabrooks, 2003). The current governing party in Nova Scotia has promised to reduce the number of healthcare executives and decrease the number of district health authorities to streamline access to healthcare (Nova Scotia Liberal Party, 2014). Decreasing the number of formal leadership roles creates an environment where managers and administrators who remain have increasing spans of control and increasing workloads.

Research has shown that increasing workload and span of control (the number of direct reports) directly affects a formal leader's capacity to lead and positively impact staff and patient outcomes (Cummings & Estabrooks, 2003; McCutcheon, Doran, Evans, McGillis Hall, & Pringle, 2009).

Advanced nursing practice and leadership.

Given that formal nursing leadership positions are being eliminated, it is crucial to better understand the factors influencing less recognized or informal nursing leadership, such as that provided by APNs. APNs are traditionally considered frontline healthcare providers and not formal leaders because the majority of their time is spent providing direct patient care. Sidani et al. (2000) studied the practice patterns of acute care NPs in Ontario and concluded that on average 70% to 80% of acute care NP time is spent in clinical care. Mayo et al. (2010) studied the practice patterns of CNSs in the United States. They surveyed 1500 CNSs practicing in a variety of roles across California. Their work illustrated the range of time CNSs spend providing clinical care is between 0 to 100%, but on average CNSs spend 38.3% of the time providing direct clinical care and over 50% when collaboration and consultation related to clinical care is included in that time. In Canada, a national survey conducted by Kilpatrick et al. (2013) investigating CNS practice patterns found that on average CNSs spend 22.35% of their time providing clinical care, however the reported range of time spent was between 0-75% of their time. Spending the majority of their time in the clinical area limits the time spent on other dimensions of advanced nursing practice but also provides an opportunity to provide leadership at the frontline (Mayo et al., 2010).

The CNA, in 2008, published a *National Framework for Advanced Nursing Practice in Canada*. The intention of this document was to provide a common and standard definition, educational requirements, and competencies that all APNs across Canada could use as a guide. The document outlines the “specific skills, knowledge and attributes RNs of advanced nursing practice the following four core competencies: clinical, consultation/collaboration, research, and leadership” (CNA, 2008, p. 22). The role of an APN is complex as they are expected to be competent clinical practitioners, researchers, consultants, collaborators, and leaders (DiCenso et al., 2010).

NP and CNS roles are relatively new, dating back approximately 40 years in the Canadian healthcare system (Kaasalainen et al., 2010). In the 1990s, healthcare budgets were being stringently controlled and skeptically reviewed, similar to today’s reality in healthcare. APNs at that time were in their relatively early stages of development in many countries. The need for APNs to clearly articulate and quantify their contribution to patient care, nursing practice and the impact they yielded on the respective organizations and systems in which they worked was imperative (Kleinpell, 2002; Irvine, Sidani, & McGillis Hall, 1998).

Research investigating the impact of healthcare personal or services is known as outcomes research. This type of research aims to assess the results of health services that are important to the people experiencing the service (Clancy & Eisenberg, 1997). The majority of outcomes evaluated related to APNs focuses on their clinical, consultation/collaboration and education dimensions of practice. This body of research has substantiated the claim that APNs provide safe and effective health care (DiCenso et al., 2010). Several literature reviews (Kleinpell, 2002; Newhouse et al., 2011) have been

completed focusing on the impact of APNs in acute care settings. The outcomes in these studies included readmission rates, length of stay, symptom management, cost of care, patient satisfaction, patient education, all of which focus on the clinical, consultation/ collaboration, and educational competencies of APNs (Kleinpell, 2002; Newhouse et al., 2011). Ingersoll, McIntosh and Williams (2000) surveyed APNs to determine what outcomes they felt would be relevant indicators of their practice, “the ten highest ranking indicators were satisfaction with care delivery, symptom resolution/reduction, perception of being well cared for, compliance with treatment plan, knowledge of patient and families, trust in the care provided, collaboration among care providers, frequency and type of procedures ordered and quality of life” (p. 1279). These outcomes illustrate very important aspects of NP and CNS roles, however, these outcomes do not capture the entire role or practice of the APN.

One of the key findings of DiCenso et al.’s (2010) *Advanced Practice Nursing in Canada: Overview of a Decision Support Synthesis* was “ the unfulfilled or unrealized contributions of APNs that could be made to address important gaps in maximizing the health of Canadians through equitable access to high quality healthcare service” (p. 32). To date research has not fully captured all of the contributions APNs make to the healthcare system. Specifically there is a lack of research focusing on APN leadership. Studies are needed to better understand how APNs perceive themselves as leaders and how their leadership impacts patients and families as well as other nurses and healthcare providers and the larger healthcare system.

Purpose and Significance of the Study

The goal of this qualitative research study was to explore advanced practice nursing leadership from the perspective of CNSs and NPs in the acute care setting in Nova Scotia. The approach used aimed to describe and to understand APN leadership from the perspective of CNSs and NPs and compare the descriptions of their leadership to the five domains of the LEADS framework. The research findings enhance our understanding of how APNs enact leadership and have informed the development of recommendations that are intended to optimize the scope of practice of APNs in acute care settings.

Being able to clearly define what APNs see as their purpose and impact as a nursing leader enables administrators, policy makers and others to better align their concept of APN leadership with that of APNs. This will ensure accurate expectations around leadership can be developed. Identifying and understanding the factors that influence APNs from engaging as nurse leaders may assist in resource development, implementation and structural changes to occur that better support APNs in engaging as nurse leaders within acute care settings. The following three research questions were used to describe APN leadership, how their leadership compares with the domains of the LEADS framework and the factors that influence APN as leaders.

Research Questions

Three research questions were used to explore APN leadership from the perspectives of APNs. They are as follows:

- 1) How do NPs and CNSs working in an acute care setting perceive they provide leadership to improve patient, healthcare providers and healthcare system outcomes?

- 2) How do CNSs' and NPs' descriptions of their leadership compare with the five activity domains of the LEADS framework?
- 3) What factors influence the engagement of acute care-based NPs and CNSs as nurse leaders within healthcare organizations?

Summary

This chapter outlined a rationale for the importance of leadership at all levels within healthcare. Leaders are needed to guide and create a sustainable healthcare system now and in the future (Dickson, 2010). Formally recognized leadership positions are declining within the healthcare system, thus it is even more important for others to step up and be leaders (Wong & Cummings, 2007). One of the core competencies of CNSs and NPs is leadership (CNA, 2008). This study aimed to address three research questions, to provide a rich description of APN leadership within the context of acute care. In the next chapter, I discuss the literature related to leadership in nursing and in advanced practice nursing.

Chapter Two: Literature Review

Advanced practice nursing

The following section highlights the literature that is relevant to advanced practice nursing, leadership in nursing and more specifically APNs as leaders. The methods used to collecting the literature included database searches of three databases: CINAHL, PubMed and Google Scholar using the search terms APN, CNS, NP nursing leadership, leadership and nurse leader. Grey literature was also searched and documents relevant to APN leadership were reviewed.

The purpose of the literature review was to provide a rationale for this study and a familiarization with the current body literature focused on advanced nursing practice leadership. The literature review is organized in the following manner: an introduction to advanced nursing practice; leadership in the context of healthcare; nursing leadership; and finally, APN leadership is discussed.

Origins of advanced nursing practice.

The evolution of advanced practice nursing in Canada began approximately forty years ago (CNA, 2008). The CNS role and the NP role emerged from changes in healthcare during the 1970s. For instance, in the 1970s it was recognized that hospital patients were becoming more complex with respect to technological developments and science contributing to complexity of diagnoses and healthcare (Donald et al., 2010). The need for experienced nurses to take a leadership role at the bedside was identified and “the role of CNS was created to provide clinical guidance and leadership to nursing staff managing complex care and to improve the quality of care and to promote evidence based practice” (CNA, 2008, p. 6).

The origin of the NP role in Canada dates back to the care provided by registered nurses (RNs) in remote communities and underserved, isolated populations. The NP role began to be formally recognized in the 1970s (CNA, 2008; Kaasalainen et al., 2010). It took until the 1990s for NPs to make gains beyond primary care. In the 1990s specialist physicians providing services in hospitals were declining in number and medical residents were experiencing tighter regulations around the number of hours residents could work and what they were allowed to do. Combined with the increasing complexity of care as a result of expanding technology, treatments, and pharmaceutical advancements led to physicians being overworked and gaps in care being identified in acute care settings. This was particularly evident in the neonatal intensive care (NICU) areas where NPs were first introduced into acute care (Kilpatrick et al., 2010). This led to the development of acute care NPs.

APN terminology.

The role of an acute care NP has expanded to all areas of the acute care sector in Canada (Kilpatrick et al., 2010). “Acute care NP” is not an official title used for licensing purposes (protected and legally recognized title), rather it is a title of convenience that identifies an NP who is working in an acute care setting.

The use of the umbrella term Advance Practice Nurse in which NPs and CNSs are recognized under is ambiguous to many and causes confusion for patients, healthcare professional and others (Donald et al., 2010). Not only do NPs and CNSs share the same umbrella title, they also share the same general advanced nursing practice competencies (CNA, 2008) and this further contributes to confusion and makes it difficult to differentiate the two roles. The essential difference between the respective roles is that

CNSs are authorized to perform the same acts as RNs and NPs have expanded clinical functions and legislated authority to perform acts such as diagnosing and prescribing, which were previously reserved for physicians (Donald et al., 2010).

The essence of advanced nursing practice is complex, thus in thinking about APNs' practice one must consider the nature and function of their roles (Calkin, 1984). APNs integrate their advanced knowledge and expertise "to deal with human responses that cut across health problems, or with a cluster of human responses to identifiable actual or potential problem, or a cluster of age-specific human responses to health problems or a combination of these" (Calkin, 1984, p. 27).

To clearly articulate the value of NPs and CNSs to the healthcare system, APNs must be able to define their practice. Often the roles and activities APNs engage in are used to describe their practice as these activities can then be measured. Being able to quantify the impact of these activities demonstrates the value of the clinical care, consultation and collaboration, research and leadership provided by the APN; this is important in acute care settings where many healthcare professionals contribute to the overall care of a patient and family (Kleinpell, 2002).

APN outcomes.

Outcomes commonly measured that demonstrate the impact of APN practice in acute care include; "length of stay, mortality rates, readmission rates, number of consultations, time spent with patient, patient educations, quality of care, patient satisfaction, time spent on role components, job satisfaction, and procedure complications rates" (Kleinpell, 2002, p. 271). There are numerous international studies, however, to date there are few Canadian studies that demonstrate the effectiveness of acute care-based

APN practice and the associated impact on Canadian healthcare outcomes (Newhouse et al., 2011). One Canadian study by Mitchell-DiCenso et al. (1996) found that the care NPs provide was equivalent to the care pediatric residents provide with respect to neonatal mortality/ morbidity and length of stay. There is a need for more Canadian research supporting the role of acute care-based APNs in Canada in order to contribute to the development of future roles and substantiate their integration to the Canadian healthcare system. Research must focus on the value of all domains of APN practice, including leadership.

Leadership

“Leadership is one of the world’s most sought-after and valued skills” (Leatt & Porter, 2003, p.15). It is often defined as “the process through which an individual attempts to intentionally influence human systems in order to accomplish a goal” (Pointer, 2006. p. 128). Leadership is an evolutionary concept that continues to develop with time and study (Vance & Larson, 2002). The concept of leadership has evolved from identifying leadership traits starting in the 1940s, followed by a behavioral approach to leadership in the 1960s. Leadership theory then developed to include theories linking types of leadership to certain situations, known as situational leadership. Burns (1978) identified two types of leaders: transactional and transformational. Transactional leaders attempt to maintain and work within the status quo. Transactional leadership is based on a transaction between a leader and a follower; leaders provide reward when those being led achieve what is agreed to. In contrast, the transformational leadership style is defined by the need to create change, a transformation of values, beliefs, and attitudes as the leader and follower interact (Burns, 1978; Yammarino, Spangler, & Dubinsky, 1998).

Transformational leadership is the ability of a leader to “appeal to a follower’s sense of values, help them see a higher vision, and help them to exert themselves to achieve that vision” (Burns, 1978). Kouzes and Pozner (2007) identified five practices of transformational leadership including: modeling the way, inspiring a shared vision, challenging the process, enabling others to act, and leading with the heart. These five practices combine both personal and relationship attributes that when enacted can effectively engage and motivate people to work towards a shared vision (Lyon, 2010). Transformational leadership has been adopted by most organizations in the 20th century as a model of leadership (Leatt & Porter, 2003). In the context, of healthcare several elements must be considered when modeling transformational leadership.

Healthcare leadership.

Within the healthcare sector there are seven elements of service delivery that make leadership in healthcare different from other sectors (Leatt & Porter, 2003). The seven elements include: “the client-provider relationship which is characterized by trust; multiple complex variables must be considered in decision-making at the patient care level; new technologies are continuously evolving; consequences of error can lead to serious injury or death; autonomous professional workforces; the combination of public/private sources of funding; and the goal of healthcare delivery is frequently ambiguous and conflicting” (Leatt & Porter, 2003, p.22).

The challenges facing healthcare are daunting and hence why leaders must be able to reframe those challenges into manageable and solvable problems while keeping focused on the future; this requires strong leadership (Dickson & Tholl, 2011). A leadership capabilities framework was developed for the healthcare sector in Canada to

address developing strong leadership within healthcare personnel. The leadership capabilities in the framework outline the capabilities required for leaders to be effective in healthcare (Dickson & Tholl, 2011). The framework is discussed in detail in Chapter Three.

Healthcare is a challenging and dynamic environment that requires leadership at many levels of the system to ensure high quality care is delivered and positive health systems outcomes are achieved (Huston, 2008; CNA, 2009). It is expected that nurses regardless of position, will optimize their leadership potential to improve patient care and nursing practice (CNA, n.d.).

Nursing Leadership.

Registered nurses are the largest autonomous healthcare professional body and their roles span across the entire spectrum of healthcare services, from bedside nursing to policy makers and senior administrators. For the majority of Canadians, the most recognized RN role is the nurse who provides direct care to patients (Cummings, 2010). Many RN roles necessitate the application of leadership skills to facilitate the interface between patients and the healthcare system. APNs make up a small fraction of the total number of RNs. As RNs working in advanced nursing practice roles they are expected to demonstrate leadership as part of their core competencies (CNA, 2008). The leadership RNs are expected to contribute to the healthcare system is just beginning to be of interest to health services researchers.

Formal nursing leadership. Much of the research to date has focused on nursing leadership in the context of formal nursing leaders. Germain and Cummings (2010) conducted a systematic review of the literature that focused on the relationship between

nursing leadership and staff RNs' performance from the staff RNs' perspective. The goal was to determine what motivated RNs to perform on the job. Seven studies met the inclusion criteria of the review. The studies sampled RNs working as staff RNs in acute care facilities in Canada and the United States. The majority of the studies defined leadership in a hierarchical manner and therefore the studies researched the types of behaviors or qualities that nursing supervisors, nursing managers or nursing executives possessed that motivated positive RN job performance. Germain and Cummings (2010) concluded that there is an important relationship between nursing leadership and staff RN performance. A nursing leader's ability to guide, mentor, coach, foster autonomy, build trusting relationships, and manage unit resources all affects RNs' ability to perform effectively.

Nursing leadership and outcomes. Nursing leadership also significantly influences patient outcomes. Wong and Cummings (2007) examined the relationship between nursing leadership and patient outcomes through a systematic review process. The studies included in the review defined a nurse leader as an RN in a formal leadership position at any level in the healthcare organization. Studies that looked at clinical leadership of staff nurses were excluded. As well, the studies had to focus on the impact of leadership on patient outcomes (patient satisfaction, functional status, incidence of adverse events). Seven quantitative studies conducted in North American in a variety of settings including community hospitals, teaching hospitals, and long-term care facilities met the inclusion criteria. In all seven studies leadership was related to patient outcomes through indirect processes influencing aspects of nurse behaviour that facilitated patient care. Two of the seven studies found that a significant increase in patient satisfaction was

associated with positive leadership behaviours. Three of the seven studies found a strong relationship between positive leadership practice (open communication, participative decision making, relationship oriented leadership) and reducing adverse events such as patient falls and medication errors (Wong & Cummings, 2007). The authors concluded that “leadership as it related to patient outcomes is a relatively new area of research, however there is evidence to support a positive relationship between transformational leadership and improved patient outcomes such as increased patient satisfaction and a reduction in adverse events” (Wong & Cummings, 2007, p. 520).

Nurses in formal leadership roles have experienced many changes in recent years. Restructuring of acute healthcare services has led to a reduced number of formal leadership roles. Therefore those who remain in formal leadership roles have an increased span of control, which means they have more employees reporting to them. Sanchez McCutcheon et al. (2009) explored the relationship between formal nursing leaders’ (front-line nursing managers) leadership style, span of control and nurses’ job satisfaction and patient satisfaction. A descriptive correlational survey design was used; 717 nurses (RNs and Registered Practical Nurses), 680 patients and 41 managers were surveyed. Staff nurses completed the Multifactor Leadership Questionnaire Form 5X and the McCloskey-Mueller Satisfaction Scale, patients completed the Patient Judgment of Hospital Quality Questionnaire and nurse managers completed the Managers’ SOC Questionnaire. Multiple regression analysis was conducted to analyze the data. Sanchez McCutcheon et al. (2009) concluded that nursing leaders’ span of control was not a good predictor of nurses’ job satisfaction, however it was a significant predictor of patient satisfaction. Managers with larger spans of control were associated with lower patient

satisfaction. The leadership style of a manager was a predictor of nurses' job satisfaction. Nursing managers who demonstrated transformational and or transactional leadership styles had nursing staff with higher job satisfaction than managers who demonstrated management by exception or a laissez-faire style of leadership. However, the authors did note, "the positive effects of transactional and transformational leadership styles on nurses' job satisfaction were significantly reduced in units where managers have wide spans of control" (Sanchez McCutcheon et al., 2009, p. 61). However, a nursing leader's span of control acts as a moderator in the relationship between leadership style and nurses' job satisfaction. Sanchez McCutcheon et al. (2009) suggest that managers with more direct reports have less time to spend developing high quality relationships with staff, as well as less time to implement and evaluate processes that improve patient care, hence the negative association between span of control on impact of leadership style and patient satisfaction.

Nursing leadership in the future. As healthcare continues to restructure, and formal nursing leadership positions are less common, the concept of leadership in nursing must evolve. It is no longer acceptable to assume that leadership is strictly the responsibility of those in traditional and formal nursing leadership roles. In a position statement released by the CNA (2009) on nursing leadership, the CNA states "leadership is essential and it is needed in every nursing positions across all domains of practice, it is a shared responsibility, that leadership and management skills co-exist, it is an essential determinant of vibrant professional work environments, it encompasses mentoring, coaching, supporting, rewarding and advocacy as well as the ability to develop, test and

implement effective and innovative and fiscally responsible policy solutions” (2009, p. 3-4).

To prepare for the future in health care, Huston (2008) suggests eight essential competencies for nursing leadership for 2020. The following competencies are directed at “formal nursing leadership: (a) a global perspective regarding healthcare and professional nursing issues; (b) technology skills which facilitate mobility and portability of relationships, interactions, and operational processes; (c) expert decision-making skills rooted in empirical science; (d) the ability to create organizational cultures that permeate quality health care and patient/ worker safety; (e) understanding and appropriately intervening in political processes; (f) highly developed collaborative and team building skills; (g) the ability to balance authenticity and performance expectations; and (h) being able to envision and proactively adapt to a health system characterized by rapid change and chaos” (Huston, 2008, p. 906). When considering the competencies and role of APNs in the context of the competencies suggested by Huston (2008) for nursing leaders, APNs are well positioned to meet these challenges of leadership in the future.

APN leadership

Leadership is a core competency of advanced nursing practice. Hanson and Spross (2005) explored the clinical and professional leadership of APNs in Chapter Nine of *Advanced Practice Nursing An Integrative Approach*. Hanson and Spross (2005) state, “Not all APNs are comfortable with the idea of being a leader, but leadership is not an optional activity” (p. 303). This statement clearly emphasizes the importance these authors place on APN leadership.

Leadership as a core competency.

Leadership is commonly cited in the advanced nursing practice literature as a generic feature of an advanced practice role (Mantzoukas & Watkinson, 2007).

Leadership is one of the four categories of advanced nursing competencies as defined by CNA (2008). “Advanced practice nurses are leaders in the organizations and communities where they work. They are agents of change, consistently seeking new ways of practice, to improve the delivery of care, to shape their organizations, to benefit the public and to influence health policy. An APN demonstrates leadership by:

- Advocating for individuals, families, groups and other members in relation to treatment, the healthcare system and policy decisions that affect health and quality of life;
- Identifying the learning needs of nurses and other members of the healthcare team and finding or developing programs and resources to meet those needs;
- Mentoring and coaching nursing colleagues, other members of the healthcare team and students;
- Advocating for and promoting the importance of healthcare access and advanced nursing practice to nurses and other health professionals, the public, legislators and policy-makers;
- Contributing to and advocating for an organizational culture that supports professional growth, continuous learning and collaborative practice;
- Evaluating programs in the organization and the community and developing innovative approaches to complex issues;

- Understanding and integrating the principles of resource allocation and cost-effectiveness in organizational and system level decision-making;
- Identifying gaps in the healthcare system and developing partnerships to facilitate and manage change;
- Developing and clearly articulating a vision for nursing practice, influencing and contributing to the organization's and the healthcare system's vision and implementing approaches to realize that vision;
- Advising clients, colleagues, the community, healthcare institutions and policy-makers on issues related to nursing, health and healthcare;
- Identifying problems and initiating change to address challenges at the individual, organizational and system level; and

Understanding legislative and socio-political issues that influence health policy, and building strategies to improve health, health care access and healthy public policy” (CNA, 2008, p. 23-24).

Leadership is a core competency for APNs not only in Canada but in other countries as well. The American Association of Colleges of Nursing (AACN) (2006) indicated that because of the complexity of the healthcare system, APNs must have the skills, knowledge and competencies in clinical practice and in leadership. Mantzoukas and Watkinson (2007) critically reviewed the concept of advanced nursing practice as it was portrayed in the literature. Seven generic features of advanced nursing practice emerged from their review of peer-reviewed articles, grey literature and book chapters: the use of knowledge in practice; critical thinking and analytical skills; clinical judgment and decision-making skills; professional leadership and clinical inquiry; coaching and

mentoring skills; research skills; and changing practice. Mantzoukas and Watkinson (2007, p. 33) emphasize the importance for APNs to have transformation leadership skills, “the necessity for practice knowledge in clinical reality that enables both collaboration with others, and the development of others knowledge and practice by utilizing transformational leadership skills is a reoccurring theme that threads throughout the literature on advanced nursing practice”.

Understanding APN leadership.

Donnelly (2006) used a hermeneutic phenomenological approach to understand and ascribe meaning to the advanced practice nursing role. Eight APNs working in CNS and NP roles, all holding masters degree in advanced practice nursing, participated in the study. A discovery-orientated approach (van Manen, 1997) was used to analyze taped conversational interviews conducted by the researcher. Three themes emerged from this study: leading the development of nursing practice; grounding practice in nursing values and perspectives; and using emerging evidence to guide practice (Donnelly, 2006). The most relevant theme supporting the concept of APNs as nurse leaders was the theme: leading the development of nursing practice (Donnelly, 2006). APNs are leaders in developing nursing practice, acting as a catalyst of change expanding the boundaries of professional nursing practice. They engage in leadership as leaders, role-models, mentors, expert clinicians and decision-makers (Donnelly, 2006).

Leadership is included in a variety of advanced practice nursing frameworks as well. At the University Health Network in 2004, APNs from across the organization developed a framework for advanced practice. It was noted within the framework that leadership permeated every aspect of their role. Specifically, APNs felt they

demonstrated leadership “in complex clinical settings, developing and evaluating patient care programs and articulating a local, national and international vision for nursing practice and care” (Micevski et al., 2004, p. 58). APNs at The Hospital for Sick Children (SickKids) created a vision statement and conceptual framework that is used to guide advanced nursing practice. Leadership again resonates throughout the framework, and is emphasized in the vision statement. “Advanced practice nurses at SickKids are leaders who deliver expert pediatric healthcare. We strive to build diverse partnerships, foster innovation and push boundaries to help children and families be the best they can be” (LeGrow, Hubley, & McAllister, 2010, p. 38).

Leadership activities were identified as a significant part of advanced nursing practice in a large multiple case study conducted in Ireland. The Specialist Clinical and Advanced Practice Evaluation (SCAPE) study was conducted by Elliot et al. (2012) as a national evaluation of advanced practitioners in nursing and midwifery, for the purposes of informing policy-makers decision-making about development of the role in Ireland (Elliot et al., 2012). The study included 23 cases from all regions in Ireland and all sectors of healthcare. The study used non-participant observation, interviews with key stakeholders and documents to collect data. The authors identified seven clinical leadership activities and three professional leadership activities as part of advanced nursing practice. The clinical leadership activities included: 1) guide and co-ordinate the activities of the multidisciplinary team; 2) initiate and change patient/client care through practice development; 3) take responsibility for policy and guideline development and implementation; 4) introduces and develops patient/client care services; 5) changes clinical practice through formal education of the multidisciplinary team; 6) mentors and

coaches the multidisciplinary team in clinical practice; and 7) acts as a positive role model for autonomous clinical decision-making and ongoing professional development. The three professional leadership activities included: 1) develops policy at national and international level; 2) engages in education outside the service at national and international level; and 3) engages in professional organizations at the national and international level (Elliot et al., 2012, p. 1042-1046).

To further explore the impact of advanced practice nursing and midwifery leadership the data set from the SCAPE study related to leadership was put through a secondary analysis (Elliot, Begley, Kleinpell & Higgins, 2013). The purpose of the secondary analysis was to identify leadership specific outcomes and outcome indicators. The authors identified four categories of leadership outcome indicators: “1) capacity and capability building of multidisciplinary teams; 2) measure of esteem; 3) new initiatives for clinical practice and service delivery; and 4) clinical practice based on evidence” (Elliot et al., 2013, p.5). Each outcomes category contained three to four outcomes and then indicators associated with the outcomes were identified. For example, for the outcomes category measures of esteem, one of the outcomes was multidisciplinary team satisfaction and the indicators of this included: member of the team highly valued the expert level of clinical decision-making, diagnosis and clinical care; efficient management of clinics; and ability to identify service needs (Elliot et al., 2013). This work provides an initial understanding of advanced nursing practice leadership activities and the outcomes associated with those activities.

Factors influencing APNs’ operationalizing their leadership.

Similar to the concept of leadership, the concept of advanced nursing practice is

evolving as more APNs enter into practice, and more research is done to further an understanding of the roles. As the roles change and develop, so do the competencies required to practice in those roles. Wessel Krejci and Marlin (2010) state, “We believe that understanding and mastering this context, and developing the competencies to lead in complex health environments is as, or more, important for APNs than any other clinical competency they might develop. Additionally, we propose that at present this competency is, at best, not effectively nurtured in either education or practice settings and, at worst, it is undermined” (p. 79). Wessel Krejci and Marlin are making this argument in the context of the current changes in entry to practice for APNs in the United States. It is expected that by 2015, in many parts of the United States APNs will require a doctoral level of education known as a Doctorate of Nursing Practice (DNP) to enter into practice. It is the authors’ opinion the current masters level does not include enough education and experience facilitating the development of leadership skills necessary for nurse leaders to lead in today’s complex healthcare system. They postulate that a doctoral level of education will address the challenges APNs face as nurse leaders and better prepare APNs to be nurse leaders (Wessel Krejci & Marlin, 2010).

Developing the appropriate skills to effectively practice as an APN in an acute care setting goes beyond the educational preparation required to become an APN. Lloyd Jones (2005) completed an integrative literature review and meta-synthesis focused on identifying the barriers and facilitators related to the development and effective practice of advanced practice roles in acute hospital setting care in the United Kingdom. Of the studies reviewed, 14 met the inclusion criteria. The barriers to full integration of APNs into acute care practice as they relate to leadership included the following: role

ambiguity, unclear expectations of the role, unrealistic expectations of the role, increasing workloads, lack of administrative support, and lack of autonomy. Facilitators to full integration of the APN roles identified in this meta-synthesis included: clear role definitions and boundaries; collaborative relationships with key stakeholders; and support from colleagues, managers, physicians and nurses (Lloyd Jones, 2005).

In another literature review focused on the challenges experienced by APNs integrating onto pediatric acute care settings, the authors concluded that “there is a need to better define and integrate the APN role into the pre-existing healthcare team in a fashion that facilitates and includes them in direct patient care while utilizing their skills as leaders in the realm of nursing” (Verger, Trimarchi, & Barnsteiner, 2002, p. 320). They also suggest that integrating APNs into the unit leadership enhances the APN’s feeling of being valued. Ways of integrating APNs into unit leadership were the following: including APNs in unit leadership meetings, assigning them to mentor staff, organizing journal clubs, and leading quality improvement. This type of involvement requires clearly defined reporting lines and formalized scheduling that allocates time for leadership activities (Verger et al., 2002).

Several obstacles to APN leadership development and effective operationlization of their leadership are discussed in the Hanson and Spross’s (2005) these include: conflict or competition between individuals, groups or organizations. This competition can be between APNs, nurses or other healthcare professionals and often is the result of a lack of communication. As well, obstacles to effective leadership often stem from the nursing mentality of historically being powerless. This feeling of powerlessness can lead to APNs detaching themselves from the nursing professional identity. Others may hoard or misuse

the newly gained power and authority they have gained as an APN. Finally, the third obstacle as it relates to leadership effectiveness is the failure to mentor. As APNs advanced in their careers they may forget to provide guidance and mentorship to younger nurses (Hanson & Spross, 2005).

Although many obstacles may exist to APN leadership development and effectiveness, Hanson and Spross (2005) suggest some facilitators to counterbalance and overcome the obstacles. These include: developing a leadership portfolio; collaborating with other APNs to form a united voice; motivating and empowering others; networking; and understanding change theory allowing for planning and implementing change (Hanson & Spross, 2005). APNs must challenge themselves to capitalize on the opportunities to develop and operationalize their leadership.

APNs have also noted that their ability to practice to full scope in all dimensions of their role, which includes leadership, is often challenging. Factors that impede practicing to full scope include: limited job descriptions, competing expectations from stakeholders, an organizational culture that does not promote the use of nursing skills in their entirety and lack of planning and preparation on introduction of roles (Pauly et al., 2004; Bryant-Lukosius, DiCenso, Browne & Pinelli, 2004). These factors are not unique to preventing APNs in engaging as leaders, rather they are factors that influence their ability to practice to their fullest potential in all dimensions of their practice.

Leadership is an expectation, generic feature and core competency of advanced nursing practice (Hanson & Spross, 2005; Miceviski et al., 2004, LeGrow et al., 2010; Mantzoukas & Watkinson, 2007; CNA, 2008; AACN, 2006). APNs provide leadership by being change agents, seeking to improve the delivery of patient care and influencing

public and health policy (CNA, 2008). APN leadership activities are often categorized into clinical leadership and professional leadership activities to assist APNs with defining, measuring and developing these activities (Elliot et al., 2012; Elliot et al., 2013). Many factors exist that influence APNs ability to operationalize their leadership (Wessel Krejci & Marlin, 2010; Lloyd Jones, 2005; Hanson & Spross, 2005; Pauly et al., 2004). However, both CNSs and NPs are expected to demonstrate leadership as part of their core competencies (CNA, 2008).

CNS leadership.

When comparing Canada's two recognized APN roles, the CNS is more overtly associated with leadership. Lyons (2010) states, "Leadership is the hallmark of CNS practice. ... The transformational leadership work of the CNS is principally focused on transforming patient care by closing the gap between what is known and what is done in practice and by resolving system level problems that impede effective patient care" (p. 149). Mayo et al. (2010) used a cross-sectional study design and surveyed 500 CNSs to better understand their role components, activities, and outcomes. The survey results identified that CNSs spend the most time on the clinical practice component of their role, followed by education, consultation, clinical leadership, and finally, research. CNSs' perceived that they spent 13.7% of their time on leadership activities. The survey used components traditionally associated with CNS practice, however Mayo et al. (2010, p. 65) noted, "CNSs were involved in a variety of discrete and different activity categories, with consultation, leadership, patient education, clinical practice and staff development comprising the majority of activities". This suggests that although only a small portion of CNS time is spent in what is traditionally considered leadership activities, there may be a

variety of other activities that CNSs do that could also be considered under the leadership umbrella.

The findings from Mayo et al.'s (2010) study are similar to those found by Kilpatrick et al. (2013) after completing a national CNS practice pattern survey in Canada. The number of CNSs in Canada is unknown as it is not a protected title. However, the survey was sent to 2431 provincial nursing college registry-identified CNSs, with 804 CNSs responding to the survey. The survey included 50 questions, one which asked the amount of time CNSs spent on the traditionally recognized dimensions of CNS practice which include: clinical care, education, research, scholarly/ professional development, consultation, and organizational leadership. CNSs perceived they spent 18.80% of their working hours on organizational leadership activities (Kilpatrick et al., 2013).

As a follow-up to the Canadian CNS practice pattern survey conducted by Kilpatrick et al. (2013), they surveyed those participants from the initial study who indicated they were not in or no longer in a CNS role. The purpose of this study was to determine why RNs who had the education, knowledge and expertise were no practicing as CNSs (Kilpatrick et al., 2014). Approximately 25% (196) of those that responded to the initial practice pattern survey indicated they were not working as a CNS. Of those approximately 50% had never worked as a CNS and the other half had worked as a CNS but were no longer in a CNS role. The top three reasons for not working as a CNS were: role confusion, could not find employment as a CNS, and unable to implement full dimensions of the CNS role (Kilpatrick et al., 2014). The inability for CNSs to implement

all role dimensions (including leadership) negatively influences their ability to work as a CNS (Kilpatrick et al., 2014).

Conceptualizing CNS practice. The CNS role is conceptualized to have three spheres of influence in practice. In the first sphere, the patient sphere of influence, which is considered the core of CNS practice, CNSs provide clinical expertise, continuity of care, and advocacy for patients (MacNeil & MacKinnon, 2011). The second sphere is nursing; CNSs are responsible for improving nursing practice to improve patient outcomes and provide cost-effective care, mentoring staff, and role modeling. Their role as a clinical nursing leader often fills the clinical leadership void left behind by healthcare restructuring (MacNeil & MacKinnon, 2011). Finally, the third sphere includes; organizations and systems. In this sphere CNSs are expected to identify gaps in care at an organizational or systems level and work collaboratively with other healthcare providers to bridge the gaps and enable a high quality of care to be provided (Lyon, 2010; MacNeil & MacKinnon, 2011).

Recognizing CNS leadership. The role of a CNS is not usually considered a formal leadership role, but leadership is an expectation of their role (Hanson & Spross, 2005; CNA, 2008). Not being considered a formal leader can cause CNSs' capacity and contributions as a leader to be unrecognized and underutilized (Pauly et al., 2004). One method of promoting the leadership capabilities of CNSs is for a formal partnership to be developed between a Nurse Manager (NM) and a CNS. This CNS-NM partnership is often referred to as a leadership dyad. Muller, McCauley, Harrington, Jablonski and Strauss (2011) piloted the dyad model of nursing leadership and unit management at an academic hospital in the United States. The purpose of the dyad was to fully utilize the

leadership skills of both the CNS and the NM to produce high quality outcomes for patients. The CNS role was a “clinical leader, disseminator of knowledge at the unit, divisional and organizational level, initiator of quality improvement efforts” (Muller et al., 2011, p. 142). As a formal leader the CNS was also accountable for achieving clinical outcomes. This model enabled the CNS to work to their full capacity and to engage in systematic change that led to a higher quality of care being provided and clinical outcomes being achieved (Muller et al., 2011).

The act of recognizing a CNS as a formal nurse leader was also explored in a study by LaSala, Connors, Pedro and Phipps (2007). LaSala et al. (2007) described the effect of recognizing the CNS role as a formal nurse leader position in a large urban acute care hospital. In the setting described in this article, the CNS was considered to be in a leadership position that was part of a triad model involving the CNS, nurse director and operation coordinator for the purpose of advancing quality care. LaSala et al. (2007) stated CNSs described the benefits of this leadership position as “empowering them to act as leaders, role models, practice experts and supporters and participants of research in their area or expertise” (p. 263).

Evidence-based practice is one of many ways research is used in practice. CNSs are considered leaders in implementing, promoting and sustaining evidence-based practices. Their use of leadership skills to translate knowledge, collaborate with other healthcare providers and act as an agent of change are instrumental in making evidence-based practice a reality (LaSala et al., 2007; Campbell & Profetto-McGrath, 2013; Profetto-McGrath, Negrin, Hugo & Bulmer Smith, 2010; Gerrish et al., 2012; Jones Charachi, Williams & McCormack, 2012).

Muller, Hujcs, Dubendorf and Harrington (2010) state, “CNS practice is essential in providing clinical expertise, leadership and organizational influence for attaining excellence in care” (p. 252). Muller et al. (2010) specifically focused on the role CNSs had as nurse leaders in hospitals attaining the American Nursing Credentialing Centre’s Magnet designation. Hospitals in the United States receiving and or retaining Magnet designation utilized the CNSs clinical expertise and leadership abilities to engage nurses and work towards evidence-based practice changes that directly and indirectly led to improved patient outcomes (Muller et al., 2010).

CNSs are able to successfully implement change such as evidence-based practice through their ability to influence others. Lyon (2010) describes CNS leadership as the capacity to influence others to achieve a common vision. This capacity to positively influence others and the larger system comes from both personal and relationship-oriented attributes that the CNS possesses. These attributes enable the CNS to develop positive influential relationships with others in which they can utilize their transformational leadership skills to make changes and transform the system to ultimately achieve higher quality patient care and better health outcomes for patients (Lyon, 2010).

Developing CNS leadership. Like other skills CNSs are expected to be competent in as they enter practice, leadership must be developed, specifically leadership at a system level. The National Association of Clinical Nurse Specialists (2010) defines systems leadership as “the ability to manage change and empower others to influence clinical practice and political processes both within and across systems” (p.6). Thompson and Nelson-Martin (2011) described how the integration of system leadership into CNS

education enables students to feel competent in leading system wide change when they graduate and begin to practice as an APN.

CNSs are expected to be leaders within the healthcare system (Hanson & Spross, 2005; CNA, 2008). Their practice is framed as three spheres of influence: patient/client, nurses/nursing, and health system (MacNeil & MacKinnon, 2011). The ability to influence and facilitate the attainment of a common goal defines leadership. Leadership is the hallmark of CNS practice (Lyons, 2010). The CNS role is one of the two advanced nursing practice roles recognized in Canada, the other is the NP role, which will be discussed next. Both roles share leadership as a core competency (CNA, 2008).

NP leadership.

Research related to the acute care NP role is more commonly associated with the safe and effective clinical care NPs provide to patients (Kilpatrick et al., 2010). This can be linked to the reality that NPs working in an acute care setting spend on average 80% of their practice time providing direct clinical care and coordination (Kilpatrick et al., 2010; Kleinpell, 2005; Sidani et al., 2000). A mixed methods study completed by van Soeren, Hurlock-Chorostecki and Reeves (2011) used role tracking via direct observations based on the four role competencies of advanced nursing practice (CNA, 2008). In this study, NPs were observed to spend 8% of their time on leadership activities, 46% of their time on clinical care, and 30% of their time on collaboration and 7% on the research domain (van Soeren et al., 2011). NPs were observed completing the following leadership activities: advocating for patients, mentoring team members, initiating evaluation of programs, representing NPs on committees, organizing

educational rounds, and preparing for accreditation (van Soeren et al., 2011). This study also concluded NPs positively contributed to the function of the healthcare team.

NPs as part of the team. Healthcare teams are interprofessional involving a variety of healthcare disciplines. The functionality of healthcare teams is important for patient care. Van Soeren et al. (2011) completed a mixed methods study that included 46 NPs, who worked in nine different hospital regions in Ontario. A total of 243 interprofessional people participated in the focus groups. The study also included role tracking, and self-reporting. From their findings the authors concluded NPs were key members to the healthcare team, they were described by participants as being the ‘hub’ or ‘glue’ of the team. NPs enhanced team communication, and were seen as approachable which lead to increased contributions by team members and increased collaboration amongst providers (van Soeren et al., 2011).

The role of NPs on teams was the focus of another study. Kilpatrick et al. (2012) completed a descriptive multiple case study to understand the healthcare team’s perceptions of team effectiveness after an acute care NP was introduced onto the team. Two cases were used in this study, both cases were acute care hospital cardiology units. A total of 59 participants, including 6 NPs participated in the study. Interviews, focus groups, time and motions studies, non-participant observation, document analysis and field notes were used in collecting data. The authors concluded that teams perceived their effectiveness to increase after the introduction of NPs. NPs were seen to improve communication between team members, fill the gap in patient follow-up, provide a big picture view of patient care, support other teams members practice, and collaborate well

with other providers. These elements were key to teams being able to function more efficiently in meeting patient care need (Kilpatrick et al., 2012).

NP-led clinics. NP-led clinics are an example of NP leadership. Watts et al. (2009) described the leadership role NPs played in implementing the group visits or shared medical appointments (SMA) based on the chronic care model (CCM). Watts et al. used a qualitative case analysis approach to analyzing three SMAs. Interviews were conducted with SMA staff and patients in regards to their experience with each component of the CCM in a SMA setting. Watts et al. concluded that NPs played a leadership role in implementing and managing the SMAs. NPs led the process of establishing patient criteria for participation, arranging the multiple providers required to be present at the SMA to see patients and facilitating continuous quality improvement debriefings (Watts et al., 2009).

In Canada the first NP-led clinic opened in Ontario in 2007 (Heale & Butcher, 2010). The opening of this clinic was a product of primary care NP nursing leadership. This innovative idea received funding after much lobbying and pressure from the NPs and the community to provide primary healthcare service to 30, 000 patients/clients in a small city who were without access to a primary healthcare provider. The clinic is NP-led in that NPs are the primary healthcare providers to the patients, the clinic director is an NP, and there is strong NP representation on the community board of directors (Heale & Butcher, 2010). This innovative example of NP leadership has made a significant impact on the community by providing primary healthcare services to many residents of the community (Heale & Butcher, 2010).

Understanding NP leadership. There are several peer-reviewed articles illustrating examples of NP leadership but few have actually explored how NPs perceive themselves as leaders. Joyce (2001) used a phenomenological research design to explore the leadership experiences of eight masters level prepared NPs, all females who had been working as NPs for more than one year. These NPs worked across a variety of populations (adult, family, geriatric and midwifery); it is unclear if they worked in acute care or primary care settings. The interviews lasted 30-60 minutes and the questions asked related to the NPs' perceptions and experiences as leaders. In this study, NPs defined leadership as "facilitating and assisting individuals to get their work done" (Joyce, 2001, p. 25). The participants used examples of role-modeling, professionalism, visioning, and facilitating in their definitions of leadership (Joyce, 2001).

In Joyce's (2001) study described above, the NPs who participated in the study viewed their leadership role as an informal type of leadership role within their organizations. Therefore they did not visualize themselves as leaders or in a management (traditional formal leader) capacity. Joyce (2001) identified the following four key themes of NPs' perceptions of their leadership in their client relationships, practice settings and communities: professional, role model, facilitator, and visionist. The theme of professional included an integrity component and confidence in client relationships and practice settings. As a role model, NPs described mentoring coworkers, motivating others, and teaching. The theme of facilitator described the importance of communication, effective listening, collaboration and the ability to make holistic decisions (Joyce, 2001). Their role of a visionist included "the ability to see the whole person, organizations and the ability to take risks and reach for future goals. NPs saw

leadership as taking risks in their profession and the need to challenge themselves on a daily basis” (Joyce, 2001, p. 28).

To better understand the NP role, Carryer, Gardner, Dunn, and Gardner (2007) explored the core role of NPs in New Zealand and Australia through an interpretive study using multiple data sources (grey literature, policy documents, NP curriculum) and interviewing 15 NPs. They identified three core components of NP practice: dynamic practice; professional efficacy; and clinical leadership. Participants of the study identified that they were expected to provide clinical leadership at an individual level and broader systems level because of their “clinical experience, education and extensive and expanded clinical skills” (Carryer et al., 2007, p. 1823). However, the authors concluded many of the NPs interviewed indicated their clinical leadership was still developing and reaching their full potential as leaders had yet to be achieved (Carryer et al., 2007).

Carryer et al. (2007) extrapolate that NPs are relatively new to Australia and New Zealand and the newness of the role and the stage of the NPs’ role development may explain why many of the NPs stated their leadership was only in developmental stages.

Leadership is a core competency of NP practice (CNA, 2008). The literature provides several of examples of the indirect and direct contribution to patient care NPs make as leaders including NP-led clinics, improved healthcare team functions and enhanced interprofessional relationships when NPs are present on teams (Heale & Butcher, 2010; Watts et al., 2009; Kilpatrick et al., 2012; van Soeren et al., 2011). NPs described their leadership as informal or clinical and leading through mentorship, visioning, facilitating, and collaborating (Joyce, 2001; Carryer et al., 2007).

Summary

Both the CNS and NP roles emerged from a need within healthcare for nurses with advanced knowledge, skill and expertise (Kilpatrick et al., 2010; Donald et al., 2010). Currently there is a significant leadership gap within today's healthcare system.

Healthcare is considered to be a dynamic and unpredictable environment that requires effective leaders to deliver high quality, safe patient care, and achieve positive healthcare systems outcomes (Huston, 2008; CNA, 2009). Leaders are people who have leadership abilities that allow them to succeed in such an environment (Dickson & Tholl, 2011). They succeed by creating an environment where others are able to see the goal and work together to achieve a shared vision (Burns, 1978).

The gap in leadership in healthcare is a result of a complicated set of variables, one of which is the significant reduction in formal nursing leadership positions that has occurred over the past few decades (Wong & Cummings, 2007). This has created an opportunity for less formally recognized leaders to operationalize their leadership capabilities and become recognized leaders.

Leadership is a core competency of advanced nursing practice (CNA, 2008). Research has explored the other competencies of CNS and NP practice that include clinical care, collaboration/consultation, and research. Particular focus has been given to the competency of clinical care. Research has provided significant evidence to support the notion that APNs provide safe and effective care to patients (Kleinpell, 2005; Newhouse et al., 2011, Mitchell-DiCenso et al., 1996). This research has helped to validate the safety and effectiveness of APNs and support the implementation of more APNs roles within the healthcare system. Clinical care is the central core of advanced

practice nursing, but it is only one of several dimensions that make NPs and CNSs advanced roles. Research describing dimensions other than clinical practice is needed if those aspects of the role are to be integrated and supported in CNS and NP practice (Pauly et al., 2004; Byrant-Lukosius et al., 2004). Research has shown that when APNs are unable to fulfill all dimensions of their role, they are less satisfied, and more likely to leave the role (Bryant-Lukosius et al., 2007; Kilpatrick et al., 2014).

Specifically, research in the area of APN leadership is limited. Exploring APN leadership is rarely the primary purpose of research studies. The exception is research that described clinical and professional leadership activities and associated outcomes of clinical specialist and midwives in advanced nursing practice in Ireland (Elliot et al., 2012; Elliot et al., 2013). The remainder of the research focused on elements that are related to or attributed to leadership such as team effectiveness and implementation of evidence-based practice (Kilpatrick et al., 2013; van Soeren et al., 2011; Campbell & Profetto-McGrath, 2013).

It is evident from the literature review that there is an opportunity to better understand how APNs perceive their role as nurse leaders and the impact their leadership has on patients, families and healthcare system outcomes. The ability to clearly articulate APN leadership and its contribution to the healthcare system is important in closing the current leadership gap that exists.

Chapter Three: Methodology and Methods

The following section defines the methodology and methods used in this qualitative descriptive research study. The conceptual framework used in the study is also described in the section.

Conceptual Framework

The LEADS Caring Environment: Leadership Capabilities Framework (LEADS) was used to guide the exploration of APN leadership. Developed through collaborative qualitative, action-based research, the LEADS framework is a leadership capabilities framework for Canadian healthcare. This purpose of the LEADS framework was to create a common and coordinated approach to developing high quality healthcare leaders across the Canadian healthcare system (Dickson et al., 2007). In 2009, LEADS was adopted as the standard for development of healthcare leadership by the Canadian Health Leadership Network, Health Care Leaders Association of BC Leader's for Life program and the Canadian College of Health Leaders. Organizations have begun to use the LEADS framework as best practice in developing their leaders (Dickson, 2010).

The qualitative, action-based research approach taken to develop the LEADS framework included: in-depth interviews with key informants and 10 focus groups consisting of health leaders from across Canada (health authority decision-makers, policy-makers, clinical leaders and professional organization leaders); an extensive review of peer-reviewed and grey literature; and analysis of leadership competency/capability frameworks from the United States, Britain, Scotland, British Columbia, Alberta, Canadian Colleges of Health Leaders, and the Canadian Medical Association (Dickson et al., 2007).

The research study led to the development of the LEADS framework. The framework includes three fundamental elements: caring, being and doing. Caring, refers to the common thread that binds all healthcare professionals and providers. Being, is essential for identifying who the leader is as a person, the individual knowledge, values and personality the leader possesses. Finally, doing, is the “how” of leadership, the behaviors that reflect the leader’s commitment, beliefs and attributes (Dickson, 2010).

The LEADS framework is further defined by five capability domains that include: lead self; engage others; achieve results; develop coalitions; and systems transformation (Dickson, 2010). Each of the domains begins with an action oriented word. As Dickson (2010) states, “leadership as a construct is a set of individual actions aimed at creating a larger action in a collective context” (para. 9). Four of the five domains are process domains, which include processes required to create change. The fifth domain is an outcome domain, the four process domains work together to *achieve results*, which is the outcome domain. Each of the five domains includes a set of four capabilities. The first domain, leads self, includes: being self-aware; managing oneself; developing oneself; and demonstrating character. The second domain, engaging others focuses on the capabilities of: being able to develop others; communicating effectively; and building teams. The third domain, achieves results, is about: having the capacity to set the direction; aligning decisions and actions with the organization’s vision, values and evidence; taking actions to implement the decisions; and assessing and evaluating the implementation. The fourth of the five domains is developing coalitions and it includes: working collaboratively with others to develop partnerships; demonstrating a commitment to clients and services; mobilizing knowledge; and being able to navigate socio-political environments. The fifth

and final domain, systems transformation includes the capabilities of: critically thinking and taking a systems perspective; encouraging and supporting innovation; orientating self and others to the future and being a champion of change (Dickson, 2010).

LEADS is a capabilities framework that is intended to be used to develop effective leaders in healthcare regardless of position or title (Dickson et al., 2007). The framework uses leadership capabilities instead of leadership competencies. Competencies are described as skills necessary to be effective in stable environment, such as a training environment (Dickson et al., 2007). Competencies are often associated with entry level to practice and are the minimum level that a professional must achieve to safely practice (CNA, 2005; 2007; Dickson et al., 2007). In comparison, capabilities are defined as abilities an individual has that enable them to be effective in dynamic and unpredictable settings, such as healthcare (Dickson et al., 2007).

The LEADS Caring Environment: Leadership Capabilities Framework was developed using a qualitative research approach. Similarly, this study used a qualitative approach incorporating the LEADS framework as a conceptual lens to studying APN leadership.

Philosophical and Theoretical Perspective of Qualitative Descriptive Approach

Paradigm.

The philosophical underpinnings of the *constructivist paradigm* are interchangeable with the term *naturalist paradigm*, because research conducted using the constructivist paradigm is conducted in natural settings, for example, the places where people live and work (Lincoln, 1992). This paradigm is founded in the philosophy of relativism. The ontological principles of relativism include truth being made up of

multiple local and contextual realities that may only be subjectively perceived (Weaver & Olson, 2006; Guba & Lincoln, 2005). These realities can be co-constructed. For example, as described by Lincoln (1992), the findings of research are created by the interactions of the researcher and the researched.

Epistemology.

The epistemology of constructivism is *subjectivity*. Subjectivity can be understood as the origin of knowledge and observation. Subjectivity and therefore constructivism values are relative to the context in which they are developed and used (Lincoln & Guba, 1985). Furthermore, the phenomenon viewed through the constructivist paradigm is analyzed as a *whole being* and as part of their natural environment, hence the use of qualitative research “which attempts to grasp a phenomenon in some holistic way” (Lincoln, 1992, p. 376).

In an attempt to grasp the phenomenon in a holistic manner, constructivists use a hermeneutic methodology (Guba & Lincoln, 1985). By definition, the Greek meaning of hermeneutics is “to interpret or translate” (Dombro, 2007, p. 111). The hermeneutic methodology is an iterative process between the researcher and the participants. This process involves interactions that allow the participant to share their reality of the phenomenon; the reality is then refined and compared to other constructions of the phenomenon in an attempt to establish a consensus in understanding the phenomenon (Lincoln, 1992, p. 380). This constructivist paradigm is also very similar and often referred to interchangeably with the interpretivist paradigm that maintains that knowledge has multiple meanings; “the ontological assumptions include reality that is complex, holistic, and context-dependent” (Lincoln & Guba, 1985, p. 37).

Qualitative descriptive methodology.

Qualitative research is used to study the meaning of a phenomenon. Specifically, it is the meaning of the phenomenon held by the participants. In this study it was the meaning of leadership from the perspectives of APNs.

Employing a qualitative methodology, research is conducted in a natural setting where the phenomenon is experienced, such as a hospital. The researcher is used as an instrument in the research process as they are intimately involved in the collection of the data, often conducting the interviews and analyzing the data. Moreover, the data gathered can be collected from multiple sources including personal interviews, focus groups, documents and observations. Furthermore, the analysis of the data is conducted through an inductive process with an aim of understanding the meaning of the phenomenon from the participants' view. In qualitative research the researcher must acknowledge that as an instrument of the research that they do not enter into the research as a void container; the researcher's background, history and personal experience will be part of the interpretation and the understanding of the meaning of the studied phenomena (Creswell, 2007).

Qualitative description is one of many forms of qualitative research. It is used to answer questions such as "why", "how" and "what" and to explore human behavior, motives, views and barriers (Neergaard, Olesen, Andersen, & Sondergarrd, 2009). It is a method that provides a "comprehensive summary of human experience without an in-depth level of interpretation, [and] this description is a summary of the collected data that is organized in a manner most relevant to the target audience" (Sandelowski, 2000, p. 339). Qualitative description uses the tenets of naturalistic inquiry, "in which there is a

commitment to study the phenomenon in its natural setting, with no manipulation of variables, nor a prior commitment to a theoretical view” (Sandelowski, 2000, p. 337).

The researcher’s intention in qualitative description is to produce findings as close to the data as possible (Sandelowski, 2010). The findings are presented as themes that are detailed and compiled through interpretation. However, this interpretation happens through reading and rereading transcripts of interviews or focus groups and content of the documents analyzed. Unlike other methodologies that require researchers to read between the lines or into the lines, the purpose of qualitative descriptive research is to describe the phenomenon, as it has meaning to the participants (Sandelowski, 2010). The aim of qualitative description is a “rich, straight description of the event or experience” (Neergaard et al., 2009, p. 2). In this research study, I described and gained an understanding of APN leadership, as APNs described their experiences as leaders.

The use of existing knowledge, thoughtful linkages to the work of others in the field and clinical experiences of the research group are essential to qualitative research (Neergaard et al., 2009). In the past decade there has been a body of knowledge developed describing APN, as well as leadership in nursing. However, there is a paucity of literature that exists describing APNs as nurse leaders. I have drawn on the bodies of existing literature, as well as the expert knowledge of my research committee and the experience of the APNs themselves to provide the linkages necessary to provide a rich description of APN leadership. The study ultimately accomplished its goal of developing an understanding of APN leadership that can be appreciated by APNs and the health service sector (Neergaard et al., 2009; Sandelowski, 2010).

Using language that is amenable and understood by the target audience that includes APNs and administrators is a strength of the qualitative descriptive approach. To do this, the researcher had to stay near to the data and use descriptions of the phenomenon similar to the language used by the participants (Neergaard et al., 2009). The descriptions, however, as Sandelowski (2000) states, “always depend on the perceptions, inclinations, sensitivities and the sensibilities of the describer” (p. 335). For instance, as the researcher, I sought to describe leadership as the acute care NP and CNS participants had experienced it. However, in the process of describing APN leadership I emphasized certain key features and in doing so I too was an instrument of the research and consequently this transformed the descriptions of APN leadership (Sandelowski, 2000, p. 335).

Study Setting

Nova Scotia is part of the three Maritime provinces in Canada. The provincial population is approximately 925, 000 (Government of Nova Scotia, 2011). The capital city, Halifax has a population of approximately 413, 000 (Statistics Canada, 2012), which is home to two large tertiary acute care facilities, one specializing in care of adults and the other specialized in care of women and children, both have academic affiliation. Study recruitment was conducted at these two facilities.

There were 10, 249 active-practicing licensed registered nurses in Nova Scotia in 2013, this number included CNSs (CRNNS, 2013). At the time recruitment started for the study there were 111 NPs licensed to practice in Nova Scotia, 51 of who were practicing as specialized NPs in acute care settings (CRNNS, 2012). There were 3 NPs practicing in acute care settings outside of Halifax, Nova Scotia. The number of CNSs practicing in

Nova Scotia was less clear, as the title CNS is not protected and CNSs are licensed under the RN designation. Kilpatrick et al. (2013) conducted a national study focused on CNS practice in Canada. The findings of the study indicate there are approximately 10 CNSs practicing in Nova Scotia; it can be assumed that the majority of these CNSs are practicing in acute care settings (Kilpatrick et al., 2013).

Participant Selection

Inclusion and exclusion criteria.

The following inclusion and exclusion criteria were used to assist in the selection of an appropriate sample. The first inclusion criterion was that only APNs who were working in tertiary acute care facilities in Halifax, Nova Scotia were selected. Acute care facilities, as defined by Canadian Institute of Health Information (2011, paragraph 3-4), encompass hospital-based acute inpatient, emergency and ambulatory care services. Acute care NPs focus their practice on a specific population of patients/clients and have acquired specialized competencies, training and/or certification to care for that population of patients/clients (CRNNS, 2012). This excluded all APNs who practice in community-based primary healthcare practice settings such as community health centers, long-term care and family practice offices.

Secondly, the APN had to be actively working in a role that was designated as a master's-prepared CNS or NP because the research questions were specific to how CNSs and NPs in acute care perceived their leadership. Therefore, this excluded RNs who have graduate education but were not working in recognized APN roles, for example, managers and educators. Acute care NPs whose name appeared on the CRNNS NP Licensing Roster indicating they have completed the requirements necessary to be

licensed to practice as an NP in Nova Scotia were selected (CRNNS, 2012). CNSs included in this study had to be practicing in active and recognized CNS roles. They were RNs who have masters or doctoral level education in nursing with advanced knowledge and expertise in a specialty area (CNA, 2011).

The third inclusion criterion was participants had to have a minimum of one-year experience in the APN role. It is recognized that in the first one to two years of practice the APN is establishing and defining the role and commonly not all competency areas, for example, leadership, have been well established in their practice (Baker, 1987; Hamric & Spross, 1983).

Recruitment of participants.

I, as the researcher, contacted the Chief of Nursing and Executive Director of Professional Practice at the one of the two tertiary acute care facilities in Halifax, Nova Scotia and the Executive Director of Learning and Chief of Nursing at the second of two tertiary acute care facilities in Halifax that employ NPs and CNSs. The initial contact with the Chief of Nursing/Executive Directors explained the study and requested they send out an email letter to the APNs working in their organizations by the way of APN email distribution lists. The email recruitment letter was sent to APNs via email distribution lists by way of Health Service Directors at one facility as they had access to the APN email distribution lists and the Executive Director of Learning and Chief of Nursing at the other facility. The invitation letter contained information briefly outlining the study and invited the APNs to contact the researcher if they were interested in participating in the study. A maximum of three reminder emails were sent to the APNs

requesting their participation in the study. Recruitment posters were also placed in the two acute care facilities where APNs are practicing in Halifax, Nova Scotia.

Sample size.

Purposeful sampling was used to select 14 APNs who participated in this study (Patton, 2002). APNs were selected purposefully to enable thorough understanding and in-depth insight into the issues central to the phenomenon (Patton, 2002). Unlike other forms of sampling where the average case is the standard, in qualitative research learning more from studying exemplar cases is fundamental to purposeful sampling (Patton, 2002). A sampling strategy of purposeful sampling is maximum variation. Maximum variation was used in this study as it allowed for the investigation of the phenomenon from a variety of diverse cases (Sandelowski, 1995). Both NPs and CNSs were recruited and selected to participate in this study. Selecting both NPs and CNSs provided both breadth and diversity in the APN role. As well, APNs were selected from two different acute care facilities in Halifax, Nova Scotia to provide organizational variation (Patton, 2002). APNs selected had a range of years of experience, age, APN specialty and APN patient population; this also provided further opportunity to achieve maximum variation in the sample (Sandelowski, 2000; Neergaard et al., 2009). The intent of using purposeful sampling was to sample information rich sources and maximize the information provided by each participant; therefore sampling was terminated when no new information came forth (Lincoln & Guba, 1985). To achieve such redundancy of information, several variables were considered such as: “the quality of the data, the scope of the study the nature of the topic, the amount of useful information obtained from each participant, the number of interviews per participant, the qualitative method and study design” (Morse,

2000, p.3). Finally, study recruitment ceased when the researcher was able to complete a deep analysis of the data. This was achieved with 11 participant interviews completed, however an additional three interviews were conducted to ensure no new themes emerged from the data. The sample size of 14 was adequate for deep analysis and information redundancy was achieved (Sandelowski, 1995).

Eight of the participants selected were NPs and six were CNSs; this established fair representation of the two roles that are recognized under the term APN (CNA, 2008). Five of the participants were employed at one acute care facility and nine participants were employed at the other facility.

Data Collection Procedures

Data collection techniques in qualitative description are traditionally semi-structured interviews using open-ended questions and or focus groups and in some cases direct observation and document analysis (Sandelowski, 2000, p. 338). Both semi-structured interviews and document analysis were used to collect data for this study.

Interviews.

Semi-structured interviews. Semi-structured interviews were conducted at a time and location of the participant's choice. All initial interviews were face-to-face. The location of the interviews were relatively free of distractions and noise, to allow for ease of hearing, listening and audio-recording. The environment was comfortable and allowed the interviewee to have privacy to freely discuss their thoughts and feelings related to APN leadership (Patton, 2002). Creating an environment that was neutral and judgment free increased the interviewee's comfort; this occurred by starting the interview with

more general questions before moving into questions that could evoke more emotional responses (Patton, 2002).

As the interviewer, it was my responsibility to explain the risks of the research and to minimize those risks before the interview began. I established a rapport with each person I interviewed. This rapport was established by showing respect for the person, listening intently to what they were saying, acknowledging that their knowledge, experience and feelings were important, and not judging the content of what they said.

After the interview was completed each participant completed a brief demographic questionnaire (Appendix A). This information provided a basic demographic profile of the sample.

The semi-structured interviews were conducted using an interview guide developed by the researcher (Appendix B). The LEADS framework (HealthCare Leaders, 2010), whose components include five domains of leadership: leads self, engages others, achieve results, develops coalitions, and systems transformation and which was discussed earlier in this chapter, helped guide the development of the interview questions. The interview guide consisted of a set of questions that were asked of each participant. The guide included strategically placed probes that were used to prompt the participant if needed (Patton, 2002). The interview guide allowed for the same basic line of questioning to be pursued, however, the guide also gave the interviewer the flexibility to build conversation and spontaneously develop questions to gain a more in-depth understanding of a topic, thought, feeling that arose during the interview (Patton, 2002). The initial face-to-face interviews lasted 60 to 90 minutes and were audio-recorded to capture the data verbatim. Audio-recorded data were then transcribed verbatim.

Follow-up interview. After an interview was analyzed, a follow-up 15 to 45 minute interview was conducted over the telephone or face-to-face with the participant (participant's choice). These interviews used an informal conversational interview style, using three broad questions to guide the discussion (Appendix C). The purpose of the follow-up interviews was to revisit previous responses and probe deeper into areas requiring clarification or more detail to enhance understanding (Patton, 2002).

Follow-up interviews were also used as a means of member-checking. Member-checking was used to enhance the credibility of the research (Graneheim & Lundman, 2003). Member-checking, means checking with the participant to ensure their voice was heard and their perceptions were accurately represented in the data that was collected (Milne & Oberle, 2005).

Each participant received a small honorarium and a note of appreciation after completing the follow-up interview. The honorarium and note were given to show my gratitude and appreciation for sharing their time and experiences which allowed this study to take place.

Document collection and analysis.

Document analysis is a systematic procedure of reviewing and evaluating documents (Bowen, 2009). Documents collected and analyzed during the study included two APN practice job profiles and three APN job postings. The purpose of document analysis was twofold. The first reason was to gather, select, appraise, synthesize and interpret data contained in the documents to provide context within which the APNs work and enhance the researcher's understanding of the research topic (Bowen, 2009; Hall & Rist, 1999). The second rationale for conducting document analysis was to enhance the

credibility of the research. Data from interviews and documents were analyzed along with reflective journal data to create a means of triangulation (Denzin, 1970). Bowen (2009) states, “Triangulation requires the researcher using a combination (minimum of two) methods to research the same phenomenon; that is to seek convergence and corroboration through the use of different data sources and methods” (p. 28). This process was used to reduce the potential risk of biases inherent in using a single method or single source of data.

Reflective journaling and field notes.

Reflective journaling was done and field notes were recorded following each interview. Journaling was used as a form of reflection and reflexivity for the researcher to critically reflect on the interviews and document analysis. Journaling included reflecting on how the interview went, what the researcher’s feelings and thoughts were during the collection of data, and what biases may have been present and how they may have affected the interview (Patton, 2002). The process of critical reflection increased the integrity of the research (Milne & Oberle, 2005). Field notes included observations of the interview setting, the conditions present during the interview, for example, the overall mood of the location of the interview. As well, observations of the participant’s reaction to questions and the interactions between the interviewer and interviewee provided context for the interview. Journals and field notes were used as a way to enhance the trustworthiness of the research as they provided a record of decisions made through the data collection and analysis process (Milne & Oberle, 2005).

Data Analysis

Content analysis.

Qualitative content analysis is commonly used in qualitative descriptive studies and was used in this study (Sandelowski, 2000). “Qualitative content analysis is a dynamic form of analysis of verbal and visual data that is oriented toward summarizing the informational contents of the data” (Sandelowski, 2000, p. 338). In this study, data analysis was dynamic in the sense that the researcher collected and analyzed the data simultaneously and therefore the analysis was continuously being modified to accommodate new data and new insights about the data that were gained from the reflexive and interactive actions of the researcher with the data (Sandelowski, 2000, p. 338).

The process of qualitative content analysis involved six analytical steps:

1. Coding of data from notes, observations or interviews;
2. Recording insights and reflections on the data;
3. Sorting through the data to identify similar phrases, themes, sequences, and important features;
4. Looking for commonalities and differences among the data and extracting them for further consideration and analysis;
5. Gradually deciding on a small group of generalization that hold true for the data;
6. Examining these generalizations in the light of existing knowledge (Miles & Huberman, 1994).

These six steps generally outlined what data were analyzed and how they were analyzed to develop the themes that provided a rich description of APN leadership (Neergaard et al., 2009; Attride-Stirling, 2001).

Graneheim and Lundman (2004) further elaborate the steps involved in qualitative content analysis including: content and latent content; unit of analysis; meaning unit; condensing; abstracting; content area; code; category and theme. A researcher must first decide if their focus will be on manifest or latent analysis. Manifest analysis deals with describing the obvious and visible aspects of the data whereas latent analysis is focused on “relationship aspects and involves an interpretation of the underlying meaning of the text” (Graneheim & Lundman, 2004, p. 106). For the purposes of this study and staying true to qualitative descriptive methodology, I focused on manifest analysis, staying close to the data and defining and describing leadership as close to what the APNs intended.

When analyzing the content in this study, the *unit of analysis* was defined as a whole interview or section of documents with relevant content (Graneheim & Lundman, 2004). Within the unit of analysis, the *meaning unit* entailed “words, sentences or paragraphs containing aspects related to each other through their content and context” that were relevant to the research questions (Graneheim & Lundman, 2004, p. 106). During the analysis process, steps were taken to *condense* the text into more manageable units while preserving the core meaning of the meaning unit (Graneheim & Lundman, 2004). These condensed meaning units were labeled with *codes*. “Codes allow the data to be looked at in new and different ways” (Graneheim & Lundman, 2004, p. 107).

The process of analysis continued with identifying areas of the text that focused on certain topics; these are known as *content areas* (Graneheim & Lundman, 2004). *Categories* were then created from groups of content that shared common meaning and features. “A category answers the “*what*”, identifying the threads between codes” (Graneheim & Lundman, 2004, p. 107). Finally, *themes* were created; themes answer the

“*how*”. Themes linked the shared meanings between meaning units, codes and categories (Graneheim & Lundman, 2004).

Data management

Data were managed in a confidential and secure manner. Electronic audiotapes were used to record all face-to-face interviews. Interviews were identified by alphanumeric codes not names. All interviews were transcribed by a professional transcriber who signed a confidentiality agreement. Data collected in electronic forms were stored in password-protected files. All other data (documents, reflecting journaling, and field notes) were stored in a secure locked filing cabinet.

Data management and analysis was facilitated through NVivo 10 (QSR International Pty Ltd, 2009) computer software. This computer software was designed to manage data collected through interviews and assisted in organizing and analyzing the data collected. Organized and analyzed data were stored in password-protected files.

Establishing Trustworthiness

Trustworthiness is the way in which the researcher convinces the audience that the findings of the research are worth paying attention to (Lincoln & Guba, 1985). Four main criteria were used to establish the truth-value of the research; these include *credibility, confirmability, dependability, and transferability*. All four criteria have processes that were included in this research study (Lincoln & Guba, 1985; Graneheim & Lundman, 2004).

Credibility.

Credibility focuses on taking the appropriate steps and following due process to increase the probability that the findings of the study are credible (Lincoln & Guba, 1985). *Credibility* was established in the study by firstly choosing to interview APNs to understand how APNs perceive their own nursing leadership. Selecting both NPs and CNSs from two tertiary acute care settings in Halifax, Nova Scotia shed light on the phenomena from different perspectives (Graneheim & Lundman, 2004). Other methods that were used to establish credibility were *triangulation* and *member checking*. Specifically source *triangulation* was used, as data were collected from interviews, documents and reflective journaling (Denzin, 1970). As well, once the data were collected and analyzed the main themes from the interviews were presented to participants to ensure that the reconstruction of leadership was recognizable and representative of what the participants' (APNs) descriptions of their reality (leadership) were; this is known as *member checking* (Lincoln & Guba, 1985).

Dependability.

The second criterion for trustworthiness is *dependability*. Dependability accounts for changes that occur in the data as a result of research design (Lincoln & Guba, 1985). This concept looks at how much data changes over time and the alterations made to the analysis process (Graneheim & Lundman, 2004). Lincoln and Guba (1985) state “one of the most notable ways to establish dependability is to establish credibility as you cannot have one without the other” (p. 311). For example, one method used in establishing dependability was the overlapping methods, which is essentially the use of triangulation that is also used to establish credibility (Lincoln & Guba, 1985). A second method used

to establish *dependability* suggested by Lincoln and Guba (1985) is to have the study audited. The auditor reviews the data collection processes, analysis processes and products to determine if the findings are authentic. For this study, my thesis supervisor acted as the auditor and reviewed the interview transcripts and coding framework to ensure the findings were dependable and authentic. In determining the findings were representative of the data, *confirmability* was also established (Lincoln & Guba, 1985).

Confirmability.

Confirmability is the third component of establishing trustworthiness. A confirmability audit can be created, which essentially includes “a trail of raw data, the data reconstruction and analysis products, the process notes, the material that related the research such as proposal, personal notes, and any pilot forms, observation formats and surveys used throughout the research process” (Lincoln & Guba, 1985, p. 320). In this study, I ensured all raw data, documents, field notes and journaling as well as analysis methods and products were kept as per ethical requirements. Therefore an audit could have been conducted to ensure the study findings reflect the data. Triangulation and reflective journaling are also means of establishing *confirmability*; both of these methods were also used in this study as indicated earlier (Lincoln & Guba, 1985).

Transferability.

The final aspect of trustworthiness is *transferability*. Polit and Hungler (1999, p.717) state “transferability refers to the extent to which the findings can be transferred to another setting or group”. To establish transferability the findings are presented in a format that clearly describes the process used for participant selection, data collection and analysis processes. Graneheim and Lundman state “A rich and vigorous presentation of

the findings together with the appropriate quotations will also enhance transferability” (2004, p. 110).

The data of this qualitative descriptive study are presented in a straightforward way that organizes, the data in a manner that best fits the data and that illustrates the credibility, confirmability, dependability, and transferability of the findings (Sandelowski, 2000). This allows the intended audience to understand the findings, see their applicability to practice and be able to argue their trustworthiness.

Ethical Consideration

Ethical process.

The ethics of the research were considered through the entirety of the study. Ramcharan and Cutcliffe (2001, p. 363) define “ethics as a process” which means with each aspect of the research the ethical impact of each element must be considered. Ethics is part of the entire research process not one simple step in the research process. Utilizing this model means the researcher must continually assess the ethical implications of their research (Miller & Bell, 2002).

In using the ‘ethics as a process’ model in this study, as the researcher I needed to build trust with the participants (APNs); this was achieved using the core principles of ethical research. The core principles included *respect for the person*, *beneficence* and *justice* (Dalhousie University, 2008). Respect for the person meant treating each individual as an autonomous being, ensuring that consent to the research was informed and voluntary. In respecting the APNs, I protected their confidentiality; interviews were coded with an alphanumeric code, names and identifying information was removed from all data and data excerpts and participation was kept confidential from the employer and

others. I protected their privacy by limiting access to the data using password-protected files; only the researcher, transcriber and supervisor had access to the interview data. The research complied with the provincial and federal laws regarding handling of personal information and Dalhousie University's Policy of Conflict interest and integrity of scholarly activity (Dalhousie University, 2008; Government of Canada, 2011) and the Tri-Council (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada and Social Sciences and Humanities Research Council of Canada, 2010).

The second core principle is beneficence, meaning the researcher aimed to maximize benefit and minimize harm done to participants (Dalhousie University, 2008). The benefits and harms as discussed below. Finally, the third core principle justice, was achieved through spreading the benefits and burdens of the research equitably across all participants (Dalhousie University, 2008). This was achieved by spending the same amount of time interviewing and reviewing documents with all APNs who participated in the study. I ensured each participant was provided the same level of protection and anonymity throughout the study and published results. Findings from the study were disseminated and shared with each participant through a summary of results report.

Ethical approval.

Ethical approval for this study was obtained from the Capital District Health Authority (CDHA) Research Ethics Board (REB), which as a result of reciprocal agreements is accepted, by Dalhousie University Social Sciences and Humanities Research Ethics Board. As well ethical approval was obtained from IWK Health Centre REB.

Informed consent.

The concept of informed, voluntary consent was considered as part of ethical research. Miller and Bell state “consent should be ongoing and renegotiated between the researcher and researched throughout the research process” (2002, p. 53). Informed meaning the participants in this study had access to all the necessary information to understand the type and the intention of the research, the expected harms and benefits for each APN and all the details required when they consented to participate. The process of consent was voluntary, void of both subtle and obvious coercion (Miller & Bell, 2002).

Confidentiality.

Confidentiality was maintained throughout the study. Only the researcher and the thesis supervisor had access to study records. The transcriptionist used to transcribe the study data signed a confidentiality waiver and had access to interview data for the purposes of transcription only. All other documents related to the study were in a locked cabinet in the researcher’s office. All interviews were given an alphanumeric code and all identifying information was removed from the transcribed interviews. All electronic files were password-protected and kept on a password-protected computer. All published work related to the study will not contain identifiable information.

Potential risks and benefits.

Potential risks included subtle less visible coercion. Subtle coercion can lie with the power structures that exist within institutions (Miller & Bell, 2002). Hence, this study used recruitment strategies that enabled participants to make voluntary decisions to participate. Recruitment occurred through posters and mass emails sent through APN email distributions lists not individual email invitations via the Chief of Nursing offices

and Health Service Directors. As well, the rationale for decisions made in regards to choice of participants was noted in the reflexive journal; this made the process more transparent (Miller & Bell, 2002). Participants were informed that participation was totally voluntary and that their decision to participate did not influence their relationship with the researcher or employer, as their employer was not informed who participated in the study and the participation was confidential and private. Participants had the opportunity to ask to have their data withdrawn from the study up until the time analysis occurred after which it was not be possible. All participants' data were included in the study as none of the participants asked for their data to be removed from the study.

The potential benefits of this research included developing a better understanding of the NP and CNS leadership; the impact of this leadership on patients, healthcare providers and the larger healthcare system; the facilitators that enable NPs and CNSs to be leaders; the barriers that prevent them from enacting their leadership.

Summary

A qualitative descriptive methodology was employed, using a naturalistic perspective to explore APNs' descriptions of their leadership and the contribution as nurse leaders they make to patient, nursing, and healthcare system outcomes. The theoretical perspective of naturalism informed the qualitative descriptive methodological approach that addressed the research questions. APNs were recruited from two tertiary, acute care facilities in Halifax. Purposeful sampling, in combination with maximum variation and detailed inclusion criteria were used as sampling methods. Data were collected through face-to-face, audio-recorded interviews, documents, reflective

journaling and field notes. Using content analysis, all data were analyzed. The methods used enabled the findings to be ethical and trustworthy.

Chapter Four: Findings and Interpretation

APN leadership is not a well understood or researched area of advanced nursing practice. A qualitative descriptive study was conducted to explore how APNs describe their leadership and its impact on patients and organizations. The study also explored factors that influence leadership and how APNs' descriptions of their leadership capabilities compare with those of the LEADS leadership framework.

The study was designed for a sample size of 12-15 participants. A total of 14 APNs participated in the study. All 14 APNs participated in the initial semi-structured interview, and 13 in the follow-up interview. All participants completed the demographic questionnaire, however, some chose not to answer all of the questions. Of the 14 APNs who participated in the study, eight were NPs and six were CNSs. Five of the fourteen APNs were employed at a women and children's tertiary acute care facility and nine at an adult tertiary acute care facility in Halifax, Nova Scotia. All participants were female, seven were 49 years of age or less, and six were 50 years of age or more. All 14 participants had attained master's level education or higher. Four APNs had been nursing between six and 25 years, and nine for more than 25 years. Five participants had been in an APN role for 10 or less years and nine participants had been in an APN role for 11 or more years. See Appendix F for complete details of the demographic questionnaire.

The remaining study findings are organized in the following manner. The first section summarizes the data related to research question one: How do NPs and CNSs working in an acute care setting perceive they provide leadership to improve patient, healthcare provider and healthcare system outcomes? This is followed by findings for the second research question: How do CNSs' and NPs' descriptions of their leadership

compare with the five capability domains of the LEADS framework? Finally, the third research question is addressed: What factors influence the engagement of acute care-based NPs and CNSs as nurse leaders within the healthcare system?

For the purposes of this study, leadership is defined as an individual's ability to influence others to achieve a shared vision or common goal (Pointer, 2006). As well, the term capability is defined as "the individual abilities required in the unpredictable and dynamic contexts in which leadership is required" (Dickson et al., 2007, p.2).

APN leadership

The findings related to research question one consist of two main themes; each of the two themes are further described through subthemes which are capability domains that capture APN leadership capabilities described by the APNs. The leadership capabilities are the leadership skills and abilities APNs described as being required for demonstrating leadership. Finally, the perceived outcomes of APN leadership are described. Outcomes have traditionally focused on three aspects of healthcare; the patient, the providers and the healthcare system (Donabedian, 2005). Patient outcomes are activities that result in a direct change in the patient. Nursing and healthcare provider outcomes are changes in the healthcare professional practice, mindset or actions as a result of action that directly affects them. Finally, system outcomes focus on changes that occur in the larger system as a result of some action. APNs' perceptions of the impact of their leadership were categorized into patient and family, nurse and healthcare provider, and healthcare system outcomes (Donabedian, 2005). Tables that map each of the leadership capability domains, capabilities, perceived outcomes and examples from the

data are included in Appendix D (patient-focused leadership) and Appendix E (organization and system-focused leadership).

Leadership was perceived by all 14 participants to be an expected part of their role as an APN. Two main themes described APNs' perceptions of their leadership and the impact of that leadership on patient and families, nurses and other healthcare providers and the larger healthcare system. *Patient-focused leadership* as described by APNs includes capabilities that are intended to directly impact patients and families. *Organization and system-focused leadership* includes capabilities that are intended to directly impact nurses and other healthcare providers, the organization or larger healthcare system.

The first theme, *patient-focused leadership*, includes four capability domains: 1) managing patient-centred care 2) coaching and educating; 3) advocating; 4) initiating meaningful communication. The second theme is *organization and system-focused leadership*, which includes seven capability domains: 1) improving the quality of care provided; 2) enhancing professional nursing practice; 3) being an expert clinician; 4) communicating effectively; 5) mentoring and coaching; 6) providing leadership on internal and external committees; and 7) facilitating collaboration.

The main findings related to APN leadership are summarized in Figures 1, 2 and 3 below, and in the following text. As Figure 1 shows, there are similarities between some of the capabilities domains of *patient-focused leadership* and *organization or system-focused leadership*. For example, coaching and educating is a domain of *patient-focused leadership* and mentoring and coaching is a domain of *organization and system-focused leadership*. However, as the following analysis will show, the capabilities,

beneficiary and outcomes for these domains are different and this is the reason they appear as separate domains in two different themes. This is also true for communication as initiating meaningful communication is a domain of *patient-focused leadership* and communicating effectively is a domain of *organization and system-focused leadership*.

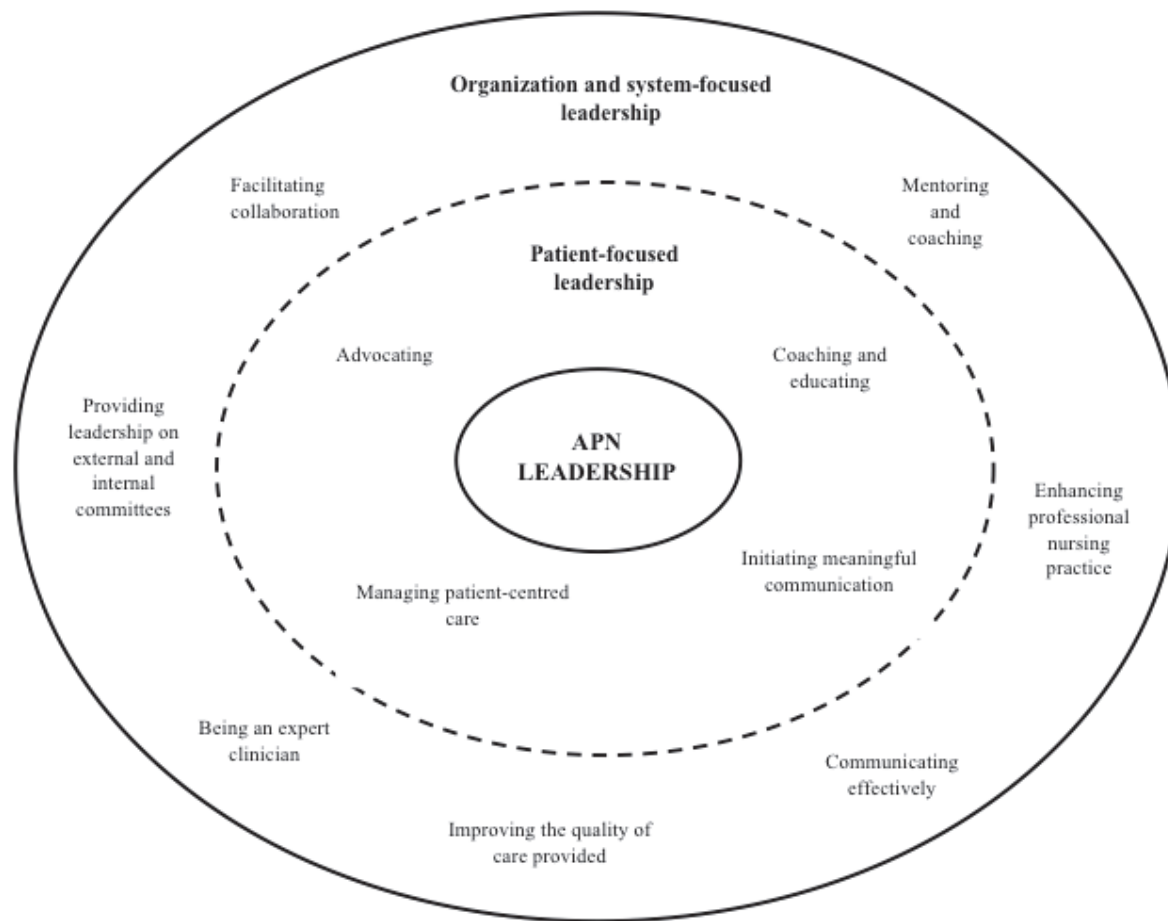


Figure 1: Advanced practice nurses (APNs) leadership capability domains.



Figure 2. APN patient-focused leadership capability domains, capabilities and perceived outcomes.



Figure 3. APN organization and system-focused leadership capability domains, capabilities and perceived outcomes.

Patient-focused leadership.

APNs described part of their leadership to be focused on patients and families. This leadership directly impacted patient and family outcomes (see Table 1 below). *Patient-focused leadership* includes four capability domains. These capability domains include a minimum of one leadership capability and several perceived outcomes of this leadership as described by the APNs. To illustrate each leadership capability, an example from the data is included. The four capability domains of *patient-focused leadership* are: 1) managing patient-centred care 2) coaching and educating; 3) advocating; 4) initiating meaningful communication. See Appendix D, Table D1 through D4 for patient-focused leadership capability domains, capabilities, perceived outcomes and more quotes of supporting data.

Leadership capability domain:	Leadership capabilities:
<i>Managing patient-centred care</i>	Providing clinical expertise in a specialty area Leading teams Promoting goal-oriented care Utilizing system level knowledge
<i>Coaching and educating</i>	Facilitating independence and autonomy Listening and explaining
<i>Advocating</i>	Being a strong voice, negotiating on their behalf
<i>Initiating meaningful communication</i>	Addressing the uncomfortable topics

Patient-focused leadership capability domain 1: Managing patient-centred care.

All participants described their ability to use clinical expertise in combination with advanced nursing knowledge to directly provide appropriate, high quality patient-centred care to patients and families. The capabilities necessary to enact this element of APN

leadership include; providing clinical expertise in a specialty area, leading teams, promoting goal-oriented care and utilizing system level knowledge. In addition to what is described below, Table D1 in Appendix D provides more examples of supporting quotes.

Providing clinical expertise in specialty area. All APNs described their practice based on their clinical expertise in a defined specialty area. These areas of clinical expertise are refined to meet the needs of the population they serve. APNs described being accountable for a roster or panel of patients (group of patients selected to be cared for with the scope of practice of an APN); this accountability included providing enhanced holistic assessments, changes to medications, referrals, care coordination, and the overall care for the patient and their family within that specialty area. Common patient and family outcomes as described by the APNs which result from their clinical expertise in a specialty area are improved access to specialty care for patients (in person or via telephone), management of complex patients, close patient follow-up, and individualized or tailored care (intensity and frequency of monitoring). The following example illustrates this leadership capability that all the APNs described. It describes how patient access to the APN expertise reduces unnecessary tests, as APNs have the knowledge and expertise in the specialty to assess the patient and make clinical decisions:

We have urgent access every day. We know that when patients with this diagnosis have to go to the ER with this symptom, they often get sent for a test. With urgent access to the APN, not only have we avoided ... most likely avoided a test. And on occasion, they do need to a test but we reduced the cost related to that. And we reduce the insult of a test to the patient.

APNs described decreased hospital admissions and readmissions, reduced numbers of tests ordered, and improved patient flow as health system outcomes attributable to this leadership capability.

Leading teams. A team of practitioners is often responsible for managing patient-centred care for patients and families and APNs described taking on a leading role within the healthcare team. This leadership role is perceived to improve the effectiveness of the team's function. As one participant described, the team lead role is how the APN is able to identify other providers' strengths and weaknesses and build a collegial environment:

In the clinical arena one of the ways which you have a lot of leadership is you are making some pretty big decisions. It's being able to work collaboratively with the team, recognizing everyone's skills and contributions. For 99% of the time you are taking the time to take in everyone's input, because at the end of the day the patient's outcomes are the best with the whole team's input. But there is the small percentage of the time when it's acute ... and you need to step up and say I'm in charge and this is what we are doing. ...

Leading teams is also described as the ability to identify the need to bring a variety of different healthcare professionals together to form a team to address the needs of a patient.

Promoting goal-oriented care. The capability domain of providing patients and families with high quality patient-centred care requires APNs, the healthcare team and patients and families to identify and work towards the overall goal of care. Promoting goal-oriented care is focused on achieving the healthiest outcomes for patients and families such as better symptom management and satisfaction with care. One APN described being focused on the healthiest outcome for the patient and family facilitates a better care experience for the patient:

From the perspective of complex patients, you're sort of always looking at the healthiest outcomes. Usually when I sit and talk with them, most times there are big issues going on anyway. And I always say to them, one of the goals is that from a system of care, we don't create more issues than you already have. And that becomes... So controlling all those variables just from team. Again, team knowledge, competencies, the system and the structure. That somebody with this diagnosis how do we navigate them through what care be a very scary and puzzling care experience? To come through and have the best possible outcome.

The above example is representative of what several of the APNs described as being goal-oriented, an essential leadership capability to achieve the healthiest outcomes for patients. Accomplishing the healthiest outcomes for patients is made easier when APNs have in-depth knowledge of the health system.

Utilizing system level knowledge. Having an understanding of how the healthcare system operates, who and what is involved at different levels and moving patients through the system was described by all the APNs interviewed as necessary for creating a seamless care experience for patients. APNs described their system knowledge as positively impacting patient outcomes by improving the integration of services across the spectrum of care, providing continuity through transitions in care, and increasing efficient navigation through the system, resulting in an improved flow of patients from a health system perspective. One APN described how system knowledge and providing a view of the larger picture assists patients in moving through the trajectory of care:

We have the ability to recognize the gaps because we have a full sense of how the whole system integrates. And we're not the only profession who has that but we have a very good sense of how to navigate the entire health system. We speak the language of every discipline. We understand how to get what patients need. ... I understand that in order for the patient to seamlessly move through the system, they need somebody who understands the entire system and just not the clinical care. ... I help patients with any particular issue related to their disease conditions. But also I help them with the bigger picture.

Patient-focused leadership capability domain 2: Coaching and educating. This leadership capability domain is described by the APNs as fostering trusting relationships and capitalizing on teachable moments. The two capabilities of this domain are facilitating independence and autonomy, and listening and explaining. Patient outcomes associated with APNs' *coaching and educating* are that patients and families feel safe, develop new skills and increase their knowledge, and become more comfortable and competent with self-care management. See Appendix D, Table D2.

Facilitating independence and autonomy. Several APNs described a core component of their leadership as capitalizing on opportunities that may only require a few short moments to educate patients and families about disease processes, medications, and new therapies. Coaching patients and families can help to develop the skills to manage their own care. The following quote from an APN illustrates this capability.

It's really about empowering and the focus is always on facilitating as much independence and autonomy as possible ... because that's what you need. You need the person to sort of be at a point to take charge.

Listening and explaining. Many of the APNs described how their ability to coach and educate patients is based on their ability to listen and explain. Taking the time to listen to patients and clearly explain a diagnosis or a new treatment is crucial for patient acquisition of skills to self-manage, as illustrated in the following quote.

Well I think part of my leadership is say on an in-patient unit is taking care a step beyond routine standard level of care. And so explaining things a bit more, listening a bit more, advocating for them a bit more. ... Hopefully it improves their outcomes or at least their satisfaction. ... But I hope that they're more informed and more pleased with the experience and comfortable with caring for themselves.

Patient-focused leadership capability domain 3: Advocating. As registered nurses, advocating for patients is a core competency. As an APN, advocacy is not only a core competency but also an essential leadership capability as APNs advocate for patients on a larger population scale. This capability domain includes one capability: being a strong voice and negotiating on patients and families behalf. Appendix D, Table D3 displays this capability domain, capability, perceived outcomes and supporting data.

Being a strong voice and negotiating on patients and families behalf. Advocating is perceived by many of the APNs to impact on patients in several ways. APNs represent and voice patient and family needs at different forums. Secondly, through advocating, APNs assist patients and families to feel safe and feel that the system is meeting their needs. The following quotes illustrate the advocating described by many of the APNs.

I want advocacy for my individual patient but I also advocate for the bigger community group. For example, we brought a few new drugs for the treatment of this disease. The provincial government was going to put them on the formulary but they needed help. So I help them, because I know what I want for these patients and what would be best for them without any boundaries.

Another APN describes keeping the attention of the patient population she serves by consistently raising their profile.

One of the challenges also is to keep the population in the eyes of the administration because it becomes nebulous. ... care for this population, care for that population is a little different then another population. And so part of this is, we don't always have leadership now that have an understanding, even in the population. Like it's not necessarily a criteria for an administrator. And part of that is to be always communicating and talking and, making sure all of the needs and perspectives of the population come forward to the different forms.

Patient-focused leadership capability domain 4: Initiating meaningful communication. Being able to effectively communicate is fundamental to being a strong

leader. All of the APNs interviewed described effective communication skills as important to their *patient-focused leadership*. This domain has one capability: initiating tough conversations. Appendix D, Table D4 displays this capability domain, capability, perceived outcomes and supporting data.

Initiating the tough conversations. Specifically, the capability of effective communication during the challenging moments in the care spectrum was described by several APNs. Initiating and addressing the more challenging topics and the tough conversations is perceived to positively impact patients and families, because patients and families are able to talk about uncomfortable, difficult, and challenging elements of their care. This often increases their overall satisfaction with the care they receive. The following example provided by one APN illustrates what several APNs described as their communication capabilities as a leader.

There was a complex patient that we had followed for a bit. We met with the team and they noted we weren't needed anymore. I am trying to get our team to go and meet with the patient and family and say this is why we are no longer involved in your care. We need to document it on the chart why we're no longer involved, and we need to communicate that with the patient and family because that's not fair to the them... they deserves to understand from us why we're no longer involved ... But we made a commitment to the family that, you know, we are here to provide the care that's needed. And if its not needed at this point in time, they need to hear from us. Because who knows what's going on in their mind. They could think we've abandoned them. And we said we would be back but we never came back. You know, I think there is an accountability I feel is important.

Summary of theme one, patient-focused leadership. *Patient-focused leadership* is described by the APNs as a fundamental component of their practice and a significant proportion of the APNs described spending the majority of their time providing clinical care. APNs' descriptions of their *patient-focused leadership* illustrate the leadership

capabilities APNs operationalize in their daily practice and the perceived outcomes of this leadership. APNs are also engaged in leadership capabilities that more broadly impact patient care and these will be described in the following section, under the theme *organization and system-focused leadership*.

Organization and system-focused leadership.

The second theme that describes how APNs perceived their leadership is *organization and system-focused leadership*. This theme describes leadership activities that are focused on the broader healthcare team, program, organization, community or health system. *Organization and system-focused leadership* includes seven leadership capability domains. These capability domains include a minimum of one leadership capability and several perceived outcomes as described by the APNs. To illustrate each leadership capability, an example from the data is included. The seven capability domains of *organization and system-focused leadership* are: 1) improving the quality of care provided; 2) enhancing professional nursing practice; 3) being an expert clinician; 4) communicating effectively; 5) mentoring and coaching; 6) providing leadership on internal or external committees; and 7) facilitating collaboration. See Table 2 for the leadership capability domains and capabilities. See Tables E1 through E7 in Appendix E for more examples of supporting quotes for each capability domain, capabilities and perceived outcomes.

Table 2: Organization and system-focused leadership capability domains, capabilities	
Leadership capability domain	Leadership capability
<i>Improving the quality of care provided</i>	Identifying gaps and integrating knowledge of the patient population, team and system to find solution Leading by example Scanning the environment for best practices and ideas, creating and implementing change Generating and using evidence in practice
<i>Enhancing professional nursing practice</i>	Advocating for nurses Modeling professionalism Informal bedside teaching Visioning
<i>Mentoring and coaching</i>	Engaging others Being a mentor
<i>Being an expert clinician</i>	Establishing clinical credibility Formal teaching of nursing and health professional students Having confidence in one's self and as a practitioner
<i>Communicating effectively</i>	Demonstrating effective communication Understanding your audience
<i>Providing leadership on internal and external committees</i>	Chairing or holding an executive position
<i>Facilitating collaboration</i>	Engaging other people and or organizations to purposefully work as a team

Organization and system-focused leadership capability domain 1: Improving the quality of care provided. This leadership capability domain is described as using advanced nursing knowledge and clinical expertise to facilitate changes, to improve the quality of care provided to patients and families. The leadership capabilities that facilitate improving the quality of care provided include: 1) identifying gaps and integrating knowledge of the patient population, team and system to find solutions; 2) leading by example; 3) scanning the environment for best practices and ideas, creating and

implementing change; and 4) generating and using evidence in practice. Appendix E, Table E1 provides examples of supporting quotes from the data of the capabilities and outcomes of this capability domain.

Identifying gaps and integrating knowledge of the patient population, team and system to find solutions. Many of the APNs described being able to see the larger picture to acknowledge the gaps in care and services and by using their knowledge of and access to resources across the spectrum of healthcare to minimize the gaps. APNs perceived nursing and healthcare provider outcomes arising from this capability to be improve communication amongst healthcare providers and collaboration between providers. Healthcare system level outcomes were identified as efficient use of health resources, and safer local healthcare. The following example illustrates what many of the APNs described.

I started this working group with this group of nurses. ... They were very much working in silos, they had never changed. So by bringing them all together and now we meet, once every couple of months, and I chair it, we just talk and we just have like informal discussions and share ideas. I'm bringing them together, and making the agenda and enabling them to talk and get ideas from one another and now they are working on project together. That's making change ...

Identifying the gaps and assimilating knowledge of people and systems to minimize the gaps in care and services is one of the leadership capabilities APNs described as they improve patient care. Another capability described by several of the APNs is leading by example.

Leading by example. Several APNs described the purpose of leading by example as showing others how to see things differently and how to respond professionally to challenging patient or team situations. Over time leading by example creates a positive

change in work culture. APNs perceive this change in work culture ultimately provides safer, higher quality of care to patients and healthcare providers are able to see a high standard of care in action. One APN's description of leading by example captures what several other APNs described.

I think I've been able to change people's minds, like, we can send this person home yes. Or no, that person can't go home for all these reasons because they're just going to be back here. ... One of the quality things I do is follow up with people who leave without being seen. It's like a safety net. ... I have caught a few significant things and brought them back in. ... And this has really changed people's perceptions of if this person has come in for 3 days in a row, there's something wrong with them. ...

Scanning the environment for best practices and new ideas, creating and implementing change. A third capability of *improving patient care*, is focused on APNs' ability to be current and connected in order to facilitate practice improvements which lead to safe, timely, high quality patient care. The following example describes the development and implementation of a new APN role.

I knew that I wanted that role developed somehow, some way, before I even got into the program. I think I had the discussion with the key people at the time. So there was an awareness of my plans. And the director and physician lead, were just incredibly supportive and knew that it was going to happen. And just the right people at the right time knew it needed to happen. I used the PEPPA framework to develop the role. We had a multidisciplinary collaborative approach to deciding what the role could look like, ensuring people were educated on what an APN could and couldn't do and where they could and couldn't work. It was a methodical, well strategized roll out of the role.

Scanning the environment for best practices and being able to make changes to implement best practices is a key aspect of improving patient care. Best practices are evidence based; when scanning the environment does not provide the necessary evidence APNs have the ability to conduct and or apply research findings to improve patient care.

Generating and or using evidence in practice. All the APNs described the importance of using evidence in their practice. Several APNs described leading research and quality assurance projects resulting in the generation of new evidence. All the APNs described applying evidence to practice for the purposes of optimal patient care. The following APN's description of generating evidence illustrates what several of the APNs described as the part of their leadership that was bringing evidence to the bedside.

Research, it's working with our professional practice groups within each area to kind of develop research questions that we look at trying to change practice, which could be policies and procedures, it could be changes in routines or guidelines. ... It's getting staff interested in that fact that research can be a simply a good clinical question which you look at the evidence. Are we doing best practice? If we're not doing best practice, how can we get to best practice and make a difference?

All APNs described one or more of the above leadership capabilities as being fundamental to improving patient care. These capabilities enable APNs to facilitate the provision of high quality, timely, evidence informed and safe patient care.

Organization and system-focused leadership capability domain 2: Enhancing professional nursing practice. The second capability domain of *organization and system-focused leadership* as described by many of the APNs is their responsibility to always bring a high level of professionalism to their nursing practice. The leadership capabilities exhibited by APNs to enhance professional nursing practice included: advocating for nurses; modeling professionalism; providing informal bedside teaching; and visioning. Appendix E, Table E2 provides examples of supporting quotes from the data of the capabilities and outcomes of this capability domain.

Advocating for nurses. This capability is described by several of the APNs interviewed as being a strong and supportive voice for all nurses. The nursing outcomes are an increased visibility of nursing, nurses working to full scope and an increased awareness of advanced nursing practice. One APN succinctly describes what several APNs said in reference to this capability.

I think as a leader in a leadership role, that advocating for nursing has to be part of my role, I want those nurses to be fully functioning and safe and good practitioners. ... so a larger part of my role is promoting and supporting nurses.

Modeling professionalism. The second capability of enhancing professional nursing practice is demonstrating professionalism. A few APNs described that as a leader others are watching them and there is a need to role model professionalism in practice, so those that are watching are able to learn and understand what is expected of them as a professional. The following quote from one of the APNs illustrates this capability.

Leadership for me is active. It's demonstrating constantly what it means to be a professional nurse. ... I think it's giving those new nurses grounding and giving those new nurses a sense of, we care about them and their professional development, and our expectations as an organization. ... So that they're coming in and they're knowing that at our organization, we're expected to practice in a certain way. And there's a high standard for that practice.

Providing informal bedside teaching. All of the APNs described this capability as taking every opportunity to share their knowledge and teach nurses as well as other healthcare providers new skills. The nursing and healthcare provider outcomes of this are real-time teaching and skill development. The following is a description of this capability provided by one of the APNs that illustrates what all the APNs described.

They look to me every day for answers to questions, clinical questions. I think that being an APN, you have a level of knowledge that nurses acknowledge, appreciate and want to learn from.

Visioning. The capability of visioning is described by many of the APNs as seeing what nursing can be and helping nurses and the profession grow and advance. The nursing outcome of this capability is advancing nursing practice. A couple of the APNs spoke passionately about their vision for nursing and how they as APNs played an important role in advancing nursing. The following quote from one APN illustrates this capability.

You know it's very much to lead nursing. ... I think you need to be able to stimulate passion, stimulate excellence, stimulate ongoing learning, stimulate the desire to grow as a nurse, provide holistic care

Organization and system-focused leadership capability domain 3: Being an expert clinician. Several APNs described this capability domain as having extensive knowledge of the patient population and a proven ability to translate that knowledge to improve care. This knowledge and experience is illustrated in the capabilities of establishing clinical credibility, formal teaching of nursing and health professional students, and having confidence in one's self and as a practitioner. Appendix E, Table E3 provides examples of supporting quotes from the data of the capabilities and outcomes of this capability domain.

Establishing clinical credibility. This capability is described by APNs as being respected for their knowledge of the patient population and nursing. Being a respected clinician with clinical credibility enables APNs to be considered an expert within their organizations and be invited to share their expertise to inform policy, collaborate on research and practice beyond the organization. The nursing outcome of this capability is that a nursing perspective is represented in a variety of settings, forums or decision-

making tables. APNs perceived their ability to be respected and credible clinician enables them to have a voice at a variety of decision-making table and inform organization and system programs and policies as a result. The following example provided by an APN describes the capability of having establishing clinical credibility.

I think that from a system perspective, as advanced practice nurses bring their population specific knowledge to other professional organizations, they have the ability to impact the health of that population at a larger level, a larger scale than they would within their organization. For example, right now I'm taking my knowledge of the disease and population and I'm working with a national foundation to create a document to send out to governments and hospitals, looking at the fact that the disease is not a preventable disease but it is a chronic illness and needs to be looked at in that perspective and needs to be funded and supported. ... So its bringing together that knowledge, clinical leadership, respect and ability to broker with others, and build capacity so that you help other organizations, governments, national bodies, funding agencies, all of that, understand the importance of the work you do with a particular population.

Having the clinical expertise and knowledge is laden with the responsibility of sharing that knowledge with novice practitioners. The second capability of being an expert clinician is formal teaching of nurses and other healthcare providers.

Formal teaching of nurses and other healthcare providers. Several of the APNs who participated in the study described their leadership as having the opportunity to teach others in a formal setting. The nursing/ healthcare provider outcomes as perceived by the APNs are learning from experts, and sharing of knowledge and skill development. The following description of this capability illustrates what several of the APNs said during their interviews. This description refers to teaching nurses and physicians entering practice in a specialty area.

With respect to formal teaching ... I still do, I would say 95% of all the nursing care orientation to the nursing staff coming into our area with respect to my area

of expertise. I continue some formal teaching on sort of my research findings but also teach in the fellowship program through the department

In order to impart one's knowledge on a variety of audiences, an APN must have confidence in himself or herself and as a practitioner.

Having confidence in one's self as a person and a practitioner. A couple of APNs spoke to the importance of being confident in one's self as a person and as a nurse in order to lead. This APN's quote is an example of what other APNs described as well.

You know, the leadership that you have in clinical arena, I mean it still is about helping others and that whole senior role in mentoring and being able to step back and really work with other people to improve their clinical skills and their clinical expertise. And you can't do that in the same way when you yourself are not comfortable ... it's the novice to expert theory, you need to feel confident and comfortable before you can lead others.

Being an expert clinician as described by the APNs is being confident and being able to use one's clinical and nursing knowledge to improve patient care. One of the essential elements of being able to use this knowledge is being an effective communicator.

Organization and system-focused leadership capability domain 4:

Communicating effectively. All of the APNs described the importance of communication skills as a leader. They described the need to be able to listen and express one's opinions and ideas in a constructive and productive way. The leadership capabilities required to be an effective communicator are demonstrating effective communication and understanding your audience. Appendix E, Table E4 provides examples of supporting quotes from the data of the capabilities and outcomes of this capability domain. The nursing and healthcare provider outcomes of this domain were perceived to be conflict management,

relationship building and establishing buy-in. The health system outcomes are perceived to be improving practice.

Demonstrating effective communication. All APNs stated effective communication skills are fundamental to their leadership in advanced nursing practice. The capability of demonstrating effective communication is described by the APNs as the ability to actively listen and engage in conversations with purpose. One example provided by an APN described effective communication skills when dealing with conflict.

And it's having the skill set to have conversations. Conflict is good, and conflict can be good in good conversations. But a lot of people don't like conflict. So it's knowing how can you have a difficult conversations in a respectful way? You know, we don't need to agree, and we may choose to disagree. But listening is a skill. ... I'm all about conflict, but in a positive way. Like let's talk about this.

To be an effective communicator you must have effective communication skills and be able to understand the audience.

Understanding the audience. Many of the APNs interviewed described that when they were communicating their ideas and thoughts they had to understand who they were speaking with, and their goals or agenda. This skill of understanding who the APN was conversing with, was necessary so they could adapt their message so that the target audience could understand and see the value and purpose of the message and buy into the idea. There are many examples of this capability in the data but the following quote from one of the APNs exemplifies understanding the audience. The APN described understanding the barriers that could arise in the audience and tailoring the message to minimize resistance and gain buy-in.

Feeling like an informal nurse leader and breaking through the physician barrier, I need your buy in but it's going to happen, but I still need your buy in. Just knowing the right way to go up the ladder. Sometimes I would change little things. You have to be careful with how you talk, and you have to be careful with what your message is. Your intended message, your intended audience. You have to be very political in how that's delivered.

Organization and system-focused leadership capability domain 5: Mentoring

and coaching. This capability domain is described by many APNs as fostering trusting relationships with the goal of building capacity within others. This leadership capability includes the following two leadership capabilities, engaging others and being a mentor. The APNs perceived nursing/healthcare provider outcomes associated with the leadership capability domain of mentoring and coaching were creating a safe learning environment and enabling nurses and other healthcare professionals to work to full scope. Appendix E, Table E5 provides examples of supporting quotes from the data of the capabilities and outcomes of this capability domain.

Engaging others. Having an encouraging approach and a demeanor that other people can respect and learn from is how a few APNs described the capability of engaging others. This is illustrated in the following example provided by one of the APNs.

Leadership is not just being at the forefront of teaching and leading and showing by example. It's encouraging other staff members. It doesn't necessarily have to be nursing. It could be OT, it could be physio, and it could be social work. That you can take the lead, you can be a leader, and here's how you can do it. And I'm right behind you. You are working under the same principles that I am. You know, you can make you're way and form a bit of an autonomous practice for yourself if you take these things on. But in a very diplomatic way and make sure you've got all the team on side and you follow your principles and you don't go outside your scope.

The capability of engaging others is part of mentoring and coaching.

Being a mentor. APNs described being a mentor to other nurses and healthcare providers to assist them in developing new skills and inspiring them to work towards their professional goals. One APN described her ability to mentor staff to be competent and capable in their roles.

A couple of years ago myself and another APN worked with a team, to help the nurses work to full scope. I see leadership as a way that you're kind of guiding and mentoring other nurses and healthcare providers to push the practice forward and feel confident and able.

Organization and system-focused leadership capability domain 6: Providing leadership on internal and external committees. Many APNs described taking an active leadership role as chair, co-chair or executive position on committees within the organization where they work as well as external organizations they are professionally associated with as an APN. The leadership capability of this domain is chairing or holding an executive position. The nursing/ healthcare provider outcomes are creating professional networks, nursing representation on different committees and bringing new evidence back to practice. The healthcare system outcomes are the organizational representation on committees external to the organization and advancing nursing practice at a local, provincial and national level. Appendix E, Table E6 provides examples of supporting quotes from the data of the capabilities and outcomes of this capability domain.

Chairing or holding an executive position. The majority of the APNs who participated in the study describe having a leadership role on an internal and or external committee. There were many examples of APNs chairing committees within their organizations as well as at provincial and national special interest organizations or sub-

committees. The following example illustrates the productivity of the APN chairpersonships.

I sit on the Canadian Association of (specialty) Nurses. And in the last few years have helped write standards because there were never any. I first wrote competencies. Then we wrote standards for population. ... That will be the end of my mandate co-chairing and chairing it. The competencies are being used by an academic centre as a credit course. It's specifically for this population of patients. It's interdisciplinary. It was really exciting they took that work and created a course.

Taking on leadership roles on committees is beneficial for APNs, the organization and the broader healthcare system.

Organization and system-focused leadership capability domain 7: Facilitating collaboration. The ability to work together for a common goal, through the development of effective partnerships was described by a few APNs as an important leadership capability domain. Building effective partnerships requires APNs to engage other people and or organizations to purposefully work as a team to ultimately achieve a common goal. The perceived patient outcome of facilitating collaboration is increasing continuity of care. The healthcare system outcomes of collaboration are productive partnerships across the spectrum of care to improve patient care, safer healthcare processes, and team effectiveness. Appendix E, Table E7 provides examples of supporting quotes from the data of the capabilities and outcomes of this capability domain.

Engaging other people and or organizations to purposefully work as a team. A few APNs described bringing people together to tackle an issue and improve patient care. For example, the following quotes depict an APN's ability to build effective partnerships with a variety of groups.

I collaborate really well. I have formed really good relationships with people in the community as well. Certain family doctors, the health team, the Community Centre. I think it's really important to, even in acute care, to build these important community partnerships.

Summary of theme two. APNs described enacting *organization and system-focused leadership*. The leadership capabilities the APNs described are perceived by APNs to be instrumental in achieving positive impacts on the organization, which includes nurses and healthcare providers, as well as the healthcare system.

Summary of research question one findings.

In summary, APNs described their leadership as having two main focuses, *patient-focused leadership* and the *organization and system-focused leadership*. Their leadership is further described through leadership capabilities that are grouped into capabilities domains. There are four capabilities domains that are included in *patient-focused leadership* and seven capability domains described as part of *organization and system-focused leadership*. These domains are associated with perceived outcomes that APNs described as being the impact of their leadership on patients and families, nurses and other healthcare providers and the larger healthcare system.

Comparison of APNs' perspective of their leadership with the *LEADS framework*

The comparison of APN leadership capabilities to those capabilities outlined in *The LEADS in a Caring Environment Leadership Capabilities Framework* (LEADS) are the findings related to research question two: How do CNSs' and NPs' descriptions of their leadership compare with the five capability domains of the LEADS framework? The LEADS in a Caring Environment Leadership Capabilities Framework is founded on the principles of caring, being and doing and is a Canadian action based framework which is

intended to guide the development of effective leaders regardless of title or position within healthcare. The framework is based on the three pillars: caring, being and doing, “Caring is to care about oneself and others. For the provider it means delivering the best service with compassion, respect and empathy. ... Being, is who the leader is; his/her values, beliefs, and personality. ... Doing, is the how of leadership; the ability to give expression of one’s character and one’s commitment to caring in behaviour that truly reflects who the leader is” (2010, p. 2). Caring, being and doing were reflected in the interviews with APNs in the context of their leadership. The following quote from one of the APNs who participated in the study illustrates this congruence with the caring, being and doing concept. This quote reflects what all the APNs described as what makes them leaders.

Leadership to me is having a passion an interest in promoting the betterment of yourself and others. And in our business, it’s improving the health of people who have this disease and working together with others to build capacity around that vision of improving health for these people. And the leadership component is enacting that. So putting that into action.

The LEADS framework was used as a lens to analyze the data collected from interviews with APNs regarding their descriptions of their leadership.

The capability domains of the LEADS framework are briefly reviewed here. Four of the five are process domains and the fifth, achieve results, and is the outcome domain. *Leads self* is the first capability domain. It is defined as being a self-motivated leader and involves the capabilities of self-awareness, managing self, developing oneself, and being able to demonstrate character. The second capability domain of effective leadership is *engage others*, and is described as being able to draw people in and share your vision and

desire for change. It includes the capabilities of fostering development of others, contributing to the creation of healthy organizations, communicating effectively, and building teams. Being a collaborative leader is fundamental to *developing coalitions*, the third domain of LEADS. The four capabilities of develop coalitions are purposefully building partnerships and networks to create results, demonstrating a commitment to customers and service, mobilizing knowledge, and navigating socio-political environments. The final process domain of the LEADS framework is *systems transformation*. This domain emphasizes that effective leaders make significant changes to the system; these changes can be small or large. To facilitate such transformational change, leaders: demonstrate systems/critical thinking, encourage and support innovation, orient themselves strategically to the future, and champion and orchestrate change. The outcome domain is *achieve results* which includes the following four capabilities: setting direction; strategically aligning decisions with vision, values and evidence; taking action to implement decisions and assessing and evaluating (Dickson, 2010).

APNs described their leadership as *patient-focused leadership* and *organization and system-focused leadership*. These two themes have been further detailed into leadership capability domains. The domains included in *patient-focused leadership* were: managing patient-centred care, coaching and educating, advocating, and initiating meaningful communication. The leadership capability domains of *organization and system-focused leadership* included: improving the quality of care provided, communicating effectively, mentoring and coaching, enhancing professional nursing practice, being an expert clinician, providing leadership on internal and external

committees, and facilitating collaboration. These leadership capability domains are founded on leadership capabilities as described by the APNs.

The following section will compare the capability domains and capabilities of APN leadership as described by the APNs with the leadership capabilities domains and capabilities outlined in the five domains of the *LEADS* framework. This comparison will illustrate the similarities and discrepancies that exist between a commonly used leadership capabilities framework and leadership capabilities described by APNs.

Similarities.

The LEADS leadership capabilities framework is intended to develop effective leaders who are capable of effecting change and achieving results. Similarly, APNs described engaging in leadership with the purpose to achieve results. The perceived results of their leadership are described through patient/family outcomes with respect to *patient-focused leadership* and nursing/healthcare provider and healthcare system outcomes with respect to *organization and system-focused leadership*. There are similarities between LEADS and APN leadership capability domains that extend beyond the capability of achieving results. Table 3 compares APN leadership capability domains and capabilities with those of the LEADS framework. On the surface it may not appear that there are similarities in the two sets of capability domains, however the similarities are evident in the descriptions of the capabilities domains and capabilities and these are discussed in the following section.

<i>Patient-focused leadership</i>		<i>Organization or system-focused leadership</i>	
APN capability domains	LEADS capability domains	APN capability domains	LEADS capability domains
Managing patient-centred care	<i>Lead Self Engage Others Achieve Results Systems Transformation</i>	Improving the quality of care provided	<i>Lead Self Achieve Results Systems Transformation</i>
Coaching and educating	<i>Engage Others</i>	Mentoring and coaching	<i>Engage Others</i>
Advocating		Being an expert clinician	<i>Lead Self Develop Coalitions</i>
Initiating meaningful communication	<i>Engage Others</i>	Communicating effectively	<i>Engage Others Develop Coalitions</i>
		Enhancing professional nursing practice	<i>Lead Self Engage Others Systems Transformation</i>
		Providing leadership on internal and external committees	<i>Lead Self Systems Transformation</i>
		Facilitating collaboration	<i>Engage Others Develop Coalitions</i>

Patient-focused leadership. The capability domains and capabilities of patient-focused leadership illustrate many of the actions involved in lead self, engage others, systems transformation, and achieve results as outlined in the following section.

The leadership capabilities in the LEADS domain of *engages others* are the most commonly described aspects of APN leadership in the *patient-focused leadership* theme. For example, APNs described coaching and educating patients and families, fostering trusting relationships, and capitalizing on teachable moments with the intent of patients and families learning and developing the skills necessary to self-manage their own care.

The ability for a patient to better self-manage their care through, enhanced education. The ability to spend more time with the client or the patient enables the patient to learn more about their illness.

All of the APNs described good communication skills as being an essential part of their leadership. The LEADS framework describes *effectively communicate* as a capability of the domain *engages others*. To effectively communicate, leaders must be able to listen and explain. APNs described listening and explaining as a capability necessary for coaching and educating patients. The ability to *effectively communicate* to *engage others* is elements of coaching and educating and is illustrated in the following example.

Well I think part of my leadership is say on an in-patient unit is taking care a step beyond routine standard level of care. And so explaining things a bit more, listening a bit more, advocating for them a bit more. ... So hopefully is improves their outcomes or at least their satisfaction. ... But I hope that they're more informed and more pleased with the experience and comfortable with caring for themselves.

Finally, APNs described how they *engage others* as part of managing patient-centred care when leading teams. APNs described facilitating collaboration and cooperation amongst the healthcare team. This is illustrated in the following quote by one of the APNs.

Part of leadership is being central in the teams, working side by side with the nurses and the physicians, and building credibility and respect, and understanding where they're coming from as well as the patients.

The domain of managing patient-centred care is described by APNs as using clinical expertise in combination with advanced nursing practice knowledge to directly provide appropriate, high quality patient-centred care to patients and families. APNs described their leadership in this area as providing clinical expertise in a specialty area,

leading teams, promoting goal-oriented care, and utilizing system level knowledge to be effective in managing patient-centred care. Leading teams is similar to the capability of *build teams* in the LEADS domain of *engages others* as described above. The capability of providing clinical expertise in a specialty area is reflective of the *leads self* domain. Part of providing clinical expertise in a specialty area as described by the APNs includes being life-long learners and developing themselves to be clinical leaders.

I think a leader knows when they don't know something but puts mechanisms in place to learn and recognize their own strengths and weaknesses.

The third similarity to LEADS in the capabilities involved in managing patient-centred care is promoting goal-oriented care, which is similar to the capability of *set direction*, a capability of the outcome domain of LEADS, which is *achieves results*. APNs described being goal-oriented in the care they provide to patients and families. These goals are established through communicating with patients, families, and the healthcare team to establish the goals of care. These conversations are led by APNs; as they set the direction, align care decisions with best practice and current evidence, they implement, assess and evaluate goals of care. This is demonstrated in the following quote.

From the perspective of complex patients, you're sort of always looking at the healthiest outcomes. Usually when I sit and talk with them, most times there are big issues going on anyway. And I always say to them, one of the goals is that from a system of care, we don't create more issues than you already have. And that becomes... So controlling all those variables just from team. ... That somebody with this diagnosis, how do we navigate them through what care be a very scary and puzzling care experience? To come through and have the best possible outcome.

As illustrated in the above example of *achieve results* through promoting goal-oriented care, APNs must have a breadth of knowledge that they use to accomplish positive change for patients. Utilizing system level knowledge has similarities to the LEADS capability domain of *systems transformation*. Managing patient-centred care requires APNs to utilize the knowledge of the healthcare system to facilitate change to transform the system so patients can seamlessly move through the system. One APN eloquently describes utilizing systems level knowledge in relations to *systems transformation*.

So we have the ability to recognize the gaps because we have a full sense of how the whole system integrates. And we're not the only profession who has that but we have a very good sense of how to navigate the entire health system. We speak the language of every discipline. So we understand how to get what patients need. ... So I understand that in order for the patient to seamlessly move through the system, they need somebody who understands the entire system and just not the clinical care. ... I help patients with any particular issue related to their disease conditions. But also I help them with the bigger picture.

Organization and system-focused leadership. All five leadership capability domains of the LEADS framework are demonstrated by APNs with respect to their descriptions of *organizational and system-focused leadership*. Similar to *patient-focused leadership* APNs' ability to *engage others* is emphasized in their descriptions as is the ability to develop coalitions as collaborative partners in healthcare. The capabilities of the LEADS domain *systems transformation* domain are also strongly reflected in the leadership APNs described as part of *organization and system-focused leadership*.

Improving the quality of care provided is described by APNs as using their advanced knowledge and clinical expertise to facilitate changes, resulting in patients and families receiving higher quality care. APNs enacted this leadership capability with the

intent to *achieve results* or high quality health service delivery. They achieve these results, by generating and using evidence in practice; this capability is similar to the *achieve results* capability of *strategically align decisions with visions, values and evidence*. The following is an example of how APNs are using evidence in practice to achieve the result of improving healthcare delivery.

With our screening program I wanted to ensure we were meeting the benchmarks, there are no Canadian stats so we had to look to the US, the largest provider. We should at least be equal to the largest provider in the US, but we're actually better than them.

The second similarity between the LEADS domains and the APN leadership domain of improving the quality of care provided, is the capability of leading by example. To lead by example in a positive and effective manner, APNs described having to know themselves, and be aware others were watching these are similar to the capabilities of the LEADS domain *lead self*. Therefore they needed to consistently demonstrate themselves in a respectable and professional manner. This was described by many of the APNs and is illustrated in the following quote.

A lot of it is role-modeling. Going out and modeling how would I do clinical care, how would I respond to this family, how would I respond to this patient? Because role-modeling at this point is bigger than nursing. It's role-modeling within the whole healthcare team.

APNs also described identifying gaps and integrating knowledge of the patient population, team and system to find solutions and scanning the environment for best practices and ideas, creating and implementing change as a means of enacting the leadership activity of improving the quality of patient care. These two capabilities as described by the APNs exhibit similarities to the four capabilities outlined in the LEADS

domain of *systems transformation*: *demonstrate systems/critical thinking, encourage and support innovation, orient themselves strategically to the future and champion and orchestrate change*. The following quote exemplifies APNs ability to transform an aspect of the system and improve the quality of care provided to patients and families.

Our patients, when I started, it was there's no place to transition them to, there's no place ... I spoke with the managers, the directors. I spoke with the clinic. And we develop a committee. We met on a regular basis. Developed a plan and developed a program. So it's identifying that gap, getting all the players together and hopefully moving forward and achieving the outcome we want. So now we have a successful program.

APNs also described that a significant portion of their leadership is mentoring and coaching staff. The purpose of mentoring and coaching staff is to build capacity within them to function to their fullest scope. This is comparable to the *fostering the development of others* a capability of the LEADS domain *engage others*. When APNs described coaching and mentoring staff they also spoke to being a resource for staff and creating an environment where staff could learn and grow, similar to the capability within the LEADS domain of *engage others* which is *contributing to the creation of a healthy organizations*. The following quote represents these capabilities.

From a clinical perspective, I lead and guide and sort of hope to work myself out of a job by building competence and building skills, and developing that in other nurses and other healthcare providers. ... A couple of years ago myself and another APN worked with a team, to help the nurses work to full scope. I see leadership as a way that you're kind of guiding and mentoring other nurses and healthcare providers to push the practice forward and feel confident and able.

The leadership capabilities used to *engage others* as effective leaders are also demonstrated in two other APN described leadership capability domains: communicating effectively and facilitating collaboration.

Communicating effectively is described by APNs as listening and expressing your opinions and ideas in a constructive and productive way. The capability of demonstrating effective communication is very similar to the capability of *communicate effectively* in the LEADS *engage others* capability domain. APNs purposefully and effectively communicate to influence change, as demonstrated by the following quote.

I think its really being able to step out of your comfort zone, you know, do the hard work or ask the hard questions that everybody in the room is thinking and nobody wants to say. Being willing to put your head above the parapet and say, but this is not acceptable.

Communicating effectively as described by APNs includes the capability of understanding the audience you are communicating with and the importance of this skill in gaining buy-in, influencing change, improving practice and establishing relationships. Understanding the audience as described by APNs is a means of being able to *purposefully build partnerships and networks to create results and navigate socio-political environments*, which are capabilities included in the LEADS domain of *develops coalitions*. The following description summarizes what many of the APNs stated.

Feeling like an informal nurse leader and breaking through the physician barrier of like, I need your buy in but its going to happen, but I still need your buy in. Just knowing the right way to go up the ladder, I think. Sometimes like the little things I would change. You have to be careful with how you talk, and you have to be careful with what your message is. So your intended message, your intended audience. Sometimes you have to be very political in how that's delivered.

Another leadership capability domain described by APNs that includes the same LEADS domains as communicating effectively is facilitating collaboration.

Facilitating collaboration as defined by APNs is about building effective partnerships. This includes the capability of engaging other people or organizations to

work together as a team. This APN capability domain is similar to the LEADS domains of *engage others* and *develop coalitions*. APNs described engaging others, to purposefully build relationships and partnerships to facilitate better care for patients.

The following example illustrates what many APNs described.

So I collaborate really well. I have formed really good relationships with people in the community as well. So certain family doctors, the health team, the Community Centre. I think it's really important to, even in acute care, to build these important community partnerships.

The capabilities of the LEADS *developing coalitions* domain are also illustrated in the APN leadership activity of being an expert clinician.

APNs described being an expert clinician as having an extensive knowledge of the population and a proven ability to translate that knowledge to improve patient care. Part of what APNs described as being an expert clinician was the formal teaching of nursing and health professional students. This capability has similarities to those included in the LEADS domain of *developing coalitions*. Formal teaching of nursing and health professional students is an opportunity to *mobilize knowledge*. *Mobilizing knowledge* is one of the four capabilities of *developing coalitions*. APNs spoke to teaching students and providers, and how this enables them to share their knowledge and learn from students and encourage students and providers to use evidence to improve patient care.

I've gone off to do a lot of education. People have called a lot of its with certain communities ... Then the next thing I find myself driving to the community to give a half day workshop... The word gets out. And I would never say I am an expert. I never grew up in this. But again, but you do work in it because you have to because that's part of the role. So much of my leadership very much depends on the networks that I make.

The other elements of being an expert clinician is having confidence in one's self as a person and as a practitioner and establishing clinical credibility, both of these are representative of the capabilities found in LEADS domain *lead self*. APNs described being aware of their strengths and weakness, being accountable for their actions, seeking new learning opportunities and modeling professionalism. The following APN example of being an expert clinician illustrates *lead self*.

The only thing I do know is people call me. Somebody thinks I know something, and they're willing to listen. People do respect us (APNs) when I come up with a comment, whether it be ... we do work with industry and how we want to go about doing things and we work with the lab on how we want to change process. They do ask. They do listen.

APNs also enact the actions of *lead self* in the APN described leadership activity of enhancing professional nursing practice. APNs describe demonstrating professionalism as a leader, which requires them to be self-aware, manage themselves and demonstrate character. The following example demonstrates APN modeling professionalism.

So leadership for me is active. It's demonstrating constantly what it means to be a professional nurse. ... So I think it's to give those new nurses grounding and give those new nurses a sense of, you know, that we care about them and their professional development, and our expectations as an organization. ... So that they're coming in and they're knowing that at our organization, we're expected to practice in a certain way. And there's a high standard for that practice.

Beyond *lead self* the LEADS capability domains of *systems transformation* and *engage others* are similarly represented in the enhancing professional nursing practice leadership activity. APNs described visioning as a necessary leadership capability. The ability to have a vision is to *orient themselves strategically to the future* to identify new

ideas and best practices to improve nursing practice and patient care is demonstrated in the quotes from one of the APNs.

I think so much of it is facilitating, seeing where we are, where do we need to go, and then what do we do to get there? And it's either me or who else that would do that.

The final comparison between the APN capability domain of enhancing professional nursing practice and the capability of formal teaching and the LEADS domain of *engage others*, is the capability of *fosters the development of others*. APNs described continuously teaching nurses at the bedside. This informal bedside teaching is invaluable to nurses as it real-time learning, where concepts can be learned and applied simultaneously. One APN explained this capability in the following quote.

They look to me every day for answers to questions, clinical questions. So I think that being an APN, you have a level of knowledge that nurses acknowledge, appreciate and want to learn from.

The last set of similarities identified between the LEADS capability domains and the APN leadership capability domains and capabilities described by the APNs is the leadership activity of providing leadership on internal and external committees; the capabilities of this domain are similar to some of the capabilities in the domain of *lead self* and *systems transformation*.

Taking on a chairperson or executive position on a committee is a form of developing oneself, which is a capability of the *lead self* domain in LEADS. The committee may be internal to the organization or external to it meaning at the professional association, provincial, national or international level; both require the leader to take on the opportunity and challenge of learning and building new skills as a leader.

Being part of a committee, particularly in the capacity of a recognized leadership role, gives APNs the opportunity to make system level changes in how patient care is delivered. Making system level change can be considered to be similar to *systems transformation*. The following quote illustrates an APN having a leadership role on an international committee and making changes that impact a system.

I am part of an international group which is developing population specific nurse competencies. So I try to provide leadership here but also on a broader scale, but everything you learn elsewhere, you bring back here.

APNs described enacting many of the capabilities in the LEADS framework.

When comparing the leadership capabilities APNs described as part of *patient-focused leadership* and *organization and system-focused leadership* to the leadership capabilities of the LEADS framework many similarities exist as demonstrated above. However there are several discrepancies that have been noted between the two sets of leadership capability domains and capabilities, which will be described in the following section.

Discrepancies.

This first discrepancy noted is that much of the nursing literature and language refers to competencies and or skills in leadership not capabilities. The documents analyzed in this study as well as the CNA (2008) *National Framework for Advanced Nursing Practice* used the term leadership competency as does the College of Registered Nurses of Nova Scotia *Nurse Practitioner Competency Framework* (CRNNS, 2011). These documents have been influential in the guiding the development of CNS and NP roles within Nova Scotia, therefore the term competency was used regularly by APNs when describing their leadership. The term competency is defined as the knowledge,

skills, judgment and attributes that registered nurse need to practice safely and ethically in a designated role and setting (CNA, 2005). APNs are described as having the ability to integrate and utilize an advanced knowledge and skill in complex and unpredictable practice settings (Calkin, 1984). As a nurse leader in unpredictable and dynamic environments, APNs must possess abilities that allow them to not only be safe and ethical leaders but also effective leaders. The LEADS framework is founded on the concept of leadership capabilities, and not competencies. Capabilities are the individual abilities required to be effective leaders in unpredictable and dynamic environments (Dickson et al., 2007).

Secondly, APNs are clinicians and a large part of their practice is spent directly caring for patients and families and because of this they often consider themselves clinical leader or frontline leaders. When they describe their leadership it is in the context of making change at the level of the patient, nurse, healthcare provider or program, and less frequently at the level of the entire healthcare system. The language used to describe the leadership capabilities in LEADS often refers to system level change and does not fully capture APN leadership.

Finally, the capability of advocacy is not reflected in the LEADS framework. APNs described *advocating* as an activity of both *patient-focused leadership* and *organizational or system-focused leadership*. Advocacy is described by APNs as a fundamental element of nursing, as APNs moved from being competent patient advocates, to capable and effective advocates for populations of patients and nurses.

Summary of research question two findings.

APNs described many of the leadership capabilities listed in the *LEADS in a Caring Environment Leadership Capabilities Framework* as they described their leadership and its impact on patients and families, nurses and healthcare providers and the healthcare system. The language used in LEADS does not fully capture the participants' descriptions of APN leadership in its entirety, however, there are far more similarities in the terminology than discrepancies.

Factors influencing engagement of APNs as nurse leaders

Advanced practice nurses have described their leadership and the impact of their leadership on patient, nurse and healthcare provider and healthcare system outcomes. They exhibit all the capabilities of effective leadership, when their descriptions of their leadership are compared to the capabilities of the LEADS framework. The opportunity to engage as nurse leaders or be recognized for their leadership varied for all APNs. The following section addresses research question three: What factors influence the engagement of acute care-based NPs and CNSs as nurse leaders within the healthcare system? APNs described many factors that influenced their ability to engage as nurse leaders.

APNs described factors that challenged their engagement as nurse leaders, and in some cases, these factors were barriers they were able overcome with time, perseverance and creativity. In other situations, the factors prevented the APNs enacting leadership and created an environment where APNs felt underutilized and frustrated. The following

quote by an APN described what several APNs described as the impact of factors that slowed or prevented their practice.

I do believe that we've been significantly and seriously underutilized within the organization from a clinical knowledge, clinical leadership and system-wide leadership perspective. Some of its our own fault because we haven't pursued it. And I think some of it is people just haven't really thought about us.

APNs described factors that facilitated and encouraged their engagement as nurse leaders. These factors positively contributed to the APNs' leadership experiences and enabled them to fulfill the leadership dimension of their practice. The factors as described by the APNs have been categorized as organizational factors or healthcare system factors and are discussed in the following section.

Organizational factors.

Organizational factors are those factors that exist within the organization where the APN is employed and influence their engagement as a nurse leader. These factors included: *workload and structure of APN practice, formally recognized leadership team, APN reporting structure, culture of the organization, unionization, formalized APN group, outcome measurement, knowledge of the APN role, leadership experience, comprehensive orientation, and mentorship.*

Workload and structure of APN practice. All of the APNs described the workload and structure of their practice as influencing their ability to engage as a leader. Specifically, APNs described having heavy workloads with respect to clinical care and this was the biggest factor influencing their engagement as a nurse leader. Many of the APNs described their practices to be ideally 75% clinical and 25% for other domains of practice. However, most APNs noted that clinical care consumes the majority of their

time and non-direct patient care activities are squeezed in after hours or on their own time. The following quote from one APN illustrates the clinical care demands that all the APNs described.

... It's very difficult because the clinical demands will always be so huge and they will always take precedence if we let them.

Another APN described wanting to take on a leadership role on a committee, but clinical demands prevented that from happening because there was no clinical coverage,

And if you wanted to try to do something, and you had to take time off the work day, you had to rebook all those patients. So nothing changed. And in fact, it was more added to the workload.

Formally recognized leadership team. Administrators and physicians who are supportive and embrace the APN role in its entirety are the most commonly described facilitators of APN leadership. Many of the APNs described managers, directors and physicians (formal leadership team) who understood the role and were supportive of the role. These people created working environments where the APNs could flourish as leaders, through providing leadership opportunities, resources to engage in leadership activities, clear expectations for APN leadership and trusting relationships. The following two quotes describe administrators' and physicians' support.

So I think when new APNs are working in roles, managers are so important in relation to their leadership. Is this just something the manager put in as a political thing because it's good to have an APN? Or is this somebody I really want to work with my teams, and my program and make sure that we get where we need to go? And if you have that passionate person to say, this is my change agent, this is somebody I ... Then it's a whole different embracement. And that's, what I have been so blessed to have.

The next description is in reference to the support physicians have provided to support APNs in engaging as leaders.

The vast majority of physicians are extremely supportive of what I do, and are not only supportive but also encouraging and they're willing to take me under their wing, and let me fly when I need to, and they bring me back to the nest when I need to come back to the nest. And it's done in a very informal, comfortable way.

APNs also described how not being considered part of the formal leadership team of a program or patient care area challenged their ability to lead and operationalize their leadership capabilities. They described how administrators regarded them as clinical staff because the focus of their practice is mainly clinical. As a result, APNs were not being considered part of the formal leadership team in their organizations. A consequence of being regarded as clinical staff was that APNs were not regarded as having managerial responsibilities and therefore were not invited to decision-making tables. This factor is described in the following quote provided by one APN.

Because we are labeled clinical, very clinical, we get siloed. Or as a leader I have. So I sit on clinical care groups, but so does everyone else. But in those real leadership circles, those decisions that affect ... we are not there.

Another APN described making suggestions and recommendations and trying to lead but because APNs are seen as clinical their efforts went unheard.

I think sometimes we can have the actions that are very articulate to the leaders that have to make the changes but nothing happens. So we recommend, suggestion, try to lead and it doesn't happen, we aren't successful.

Another group of APNs described that when they are considered as part of this leadership team, it facilitated their engagement in leadership activities.

I think ideally what you need is a manager onboard with you if you're going to make changes in an area. Because in my mind, it's the manager or administrator who set the standards and expectations. As an APN I can only do that in an informal way. So ideally you work together, that's the best bang for your buck.

Being considered as part of or an extension of the formally recognized leadership team is important for APNs. Several APNs described the benefits of regular communication with their management team. This communication often came in the form of regularly scheduled meetings and it facilitated knowledge sharing and assisted the APNs with being aware of leadership opportunities.

We met on a regular basis with the director of our program, so that we could get updated on what key things were happening in the program, so we felt informed and could say “hey, I can do that”. It was all about trying to make sure the right person is in the right place. Because at the end of the day, you do want to be efficient.

Another APN noted that having regular communication with administrators facilitates a broader perspective for APNs, engaging them in leadership activities outside direct patient care.

So I think having that kind of guidance and lens from a director level has been helpful in kind of building skills and competence, and having a broader focus.

Reporting structure. Many of the APNs described having a dual reporting structure, meaning the APN reports to both a physician lead and a health service/program administrator. This can cause confusion in regards to APN priorities and where their time and energies should be spent, as described by this APN.

It can be a facilitator but it can also be a barrier in terms of the fact that the dual reporting. ... We’re employed by the institution, and the physicians aren’t. So the physicians don’t understand. They see you as a colleague but they don’t understand the idea that you are not “their” APN, I am an APN who works for the organization.

Culture of the organization. The culture within the institution can be an influential factor for APNs attempting to engage as nurse leaders. A couple of APNs described having a culture within their organizations that lacked a clear vision for

nursing. Thus engaging as a nurse leader to advance practice and move nursing forward was very challenging. One APN's description illustrates what a few other APNs referenced as a barrier to engaging as an APN.

I think that's what is missing, that formally recognized nursing leaders in our organization and that sense of nursing; we've lost that nursing identity.

Unionization. The majority of nurses including APNs are unionized in the two organizations where recruitment for this study occurred. Several APNs described how the label of being a unionized employee can prevent APNs from being invited to participate in discussions related to staffing, budget, and human resources. The following quote illustrates what a few APNs described.

There's almost that point that you're allowed to be part of the conversations but yet when it gets to the nitty gritty, sometimes it's just the administrators that are going to make the decision.

As well, if union contract obligations are strictly enforced, the opportunity to be engaged as a leader in professional associations external to the organization can become challenging as professional development hours are limited. This is described by a few APNs.

You go to meetings and conferences for education and to network. I fund my own travel, I don't get money from the institution. I just want time. However, because I am a unionized employee I only get 2 days. So I have to use vacation and eventually you get tired of using your vacation time to go and learn new things from people.

Formal APN group. APNs described APN colleagues as supporting and encouraging them to pursue leadership endeavors. The following quote from an APN illustrates the influence of peers and was described by several APNs.

I think having peers. I think having like advanced practice peers. Because I am thinking when I started in the role, someone else started at the same time in another APN role. So we kind of went through, the first bit together. I think having that peer support made a huge difference.

APNs also described how not having a collective APN voice was a barrier to engaging as a nurse leader. The variation and diversity in APN practice creates challenges to forming a cohesive group. The lack of a collective voice limits APNs' ability to be a powerful voice supporting, promoting and advancing nursing practice. The following quote summarized what several of the APNs described.

I've seen it in another hospital. I mean nursing was a powerful force at that hospital. ... it's okay here but I saw it be way more powerful and can promote advanced nursing roles and now sort of succumb to government decisions or administrative decisions or medicine.

Measuring outcomes. The lack of means to measure outcomes associated with APN practice presents challenges at several different levels. Many of the APNs described not being able to measure the impact of clinical activities or leadership activities in a meaningful way. The following quote by one APN illustrates what the others said.

The challenge with advanced practice roles within this organization is that outcome measurement was not built into the role.

The lack of collective voice for APNs and means by which to measure outcomes of their practice creates challenges for APNs to overcome. The following quote from one APN uniquely ties these two factors together.

As a group, we ourselves are not exerting an effort to come together collectively to work on things to promote advanced practice and the contribution of advanced practice within the organization.

Knowledge of the APN role. APNs described people's lack of knowledge about the diversity and complexity of APNs' practice as a factor that influences their

engagement as a leader. APNs described people as being familiar with only a small fraction of the clinical aspect the role. The lack of knowledge and understanding, particularly by administrators (manager, directors, system leaders), creates an environment of underutilization of APN leadership skills. This APN's quote describes what others also said.

If you don't have strong leadership, they don't understand your role and they don't use you, you can have zero impact on the system.

Lack of knowledge and understanding of the APN role by physicians and other healthcare providers also can impede APNs' engagement as nurse leaders. One APN notes,

It's not just physicians, but it's other healthcare providers like insurance companies, other professionals, who just don't get, know about or understand the roles.

And finally, when there is a perception that the APN role is not understood or valued, APNs are less likely to attempt to engage as a leader.

One of the barriers is that when people don't value your work, you tend to work more independently. It's hard to work in a team that doesn't value the APN contribution.

Experience. Many of the APNs described the value of experience as influencing their ability to engage as a leader. Many of the APNs described having experiences within their professional and personal lives that allowed them to have the capacity to be a leader. The APNs described an innate desire to be challenged and grow as a person that allowed them to gain valuable experiences that contributed to the ability to feel confident and facilitate their desire to be a leader.

I think advanced practice nurses, need experience for sure. And that comes with time. They need to have confidence in their ability to be a leader, confidence in their ability to make decisions that are, you know, what is right for the patient, the staff, the department, whatever it is. So confidence, knowledge. So you obviously need to have a strong knowledge base as well. It just can't be in name only. It has to be in action as well.

Comprehensive orientation. A comprehensive orientation is as important as it is the foundation from which practice is built. Several APNs described the need to have a comprehensive orientation to the APN role in both their specialty area and to the organization. The following quote by one APN described what several others referred to in their interviews.

I think it bodes well during orientation to spend time with a few different APNs so that you can mold into what you think needs to be why you are going to practice the way you're going to practice.

Along with orientation, practitioners need mentorship, as noted in the following quote.

It's so important to be mentored properly, to have time to learn properly with a very good orientation.

Mentorship. APNs described mentors as being fundamental to being an effective leader. One APN's description represents the emphasis many of the APNs placed on mentorship as a facilitator.

I had great mentorship, opportunities to work with great people on the forefront of nursing and practice. And really challenging us all to see how to maximize our scope.

Another APN described how mentors assisted in her development as a leader.

"... You need a mentor. You really need a knowledgeable ... somebody. They don't have to be an APN but just somebody who is a leader role that really embraces what you do and knows it's hard to be a leader and sort of helps you along."

Finally, this description by one APN depicts the importance of mentorship for APNs in facilitating their leadership.

... In my various roles, I've worked with some amazing visionary women who, you know, knew how to work the system and get things done.

Mentorship is an ongoing process and changes and develops over time and as needs change.

In summary, APNs described many *organizational factors* that facilitated or challenged their ability to engage as nurse leaders. Factors that APNs have described as positively influencing their leadership engagement are opportunities to exploit and increase APN engagement as leaders. Those factors that negatively influence APN engagement as leaders are areas or opportunities for improvement as the mitigation of these barriers could optimize APNs' ability to successfully engage as nurse leaders and operationalize their leadership capabilities.

Healthcare system factors.

Healthcare system factors are those factors that exist outside the APNs' organization of employment that influence either positively or negatively their engagement as a nurse leader. These factors include: *regulatory bodies* and *professional organizations*.

Regulatory bodies. The College of Registered Nurses of Nova Scotia provides APNs with support and also with the opportunity to be involved at the provincial level in committees. A few APNs described the regulatory body as a factor influencing their engagement as a leader and it is summarized in this statement by an APN.

The legislation and the Colleges are facilitators; they provide access to education sessions, a practice consultant ...

Another APN describes how the College recognizes the clinical expertise and advanced nursing knowledge of APNs and engages APNs as leaders.

The College totally includes advanced practice nurses in any sort of policy change that's even being considered or coming up. So there's a lot of respect at that level too.

Professional organizations. APNs described being involved in professional/specialty organizations as serving several purposes. Involvement in professional/specialty organizations facilitates leadership as it enables APNs to stay current, network with other professionals and places an ownership on APNs to bring the knowledge back to their own practice. This is described by an APN in the following quote.

I think it's really important to stay involved in your specialty association. It keeps you honest. You need to be leaders in the working groups. You need to be at conferences and doing things. ...

APNs described a couple of healthcare system factors that influenced their ability to succeed and flourish as nurse leaders. Capitalizing on those factors that support and enable APNs to engage as nurse leaders at both the system and organization level is essential for patients and families, nursing and other healthcare providers and the healthcare system to benefit fully from APN leadership.

Summary of research question three findings.

The factors that influenced APN engagement in leadership as described by participants of this study range from organizational level factors to system levels factors. Several of the factors facilitated APNs' ability to engage as nurse leaders and to operationalize their leadership capabilities such as being provided mentorship from other

nursing leaders. Other factors were described by the APNs as inhibiting or challenging their ability to engage as nurse leader such as their dual reporting structure which leads to conflicting priorities being expected of APNs. Some factors both positively and negatively influence APN ability to engage for example, the unionization.

APN document analysis findings

Content analysis was used to analyze the five documents collected during the study. Three of the five documents were APN job postings, and two were APN job profiles.

The APN job postings briefly outlined the qualifications required for the job and the responsibilities involved in the APN roles being advertised. All postings required a graduate level education and clinical experience. Two of the three postings listed leadership skills in combination with organizational skills as a qualification. The third job posting did not include leadership as a necessary qualification.

The two job profiles, both outlined leadership as a core component of the APN role. One of the two job profiles, categorized leadership as a major responsibility of the role and described APN leadership as clinical leadership, allotting 25% to leadership. The responsibilities described as part of clinical leadership included: application and evaluation of best practices; design and evaluate programs and initiatives that align with organizational and program goals; develop and implement quality improvement initiatives; mentor nursing staff; advocate for patients, families and communities; provide nursing expertise to colleagues, interest groups, healthcare institutions and policymakers; guide changes; be a resources to administrations; demonstrate clinical leadership on

internal and external committees; provide clinical leadership and vision in planning, collaborate with stakeholders; and engage in professional development.

The second job profile described leadership as a core competency of the APN role. Leadership was described in this profile as: an advocate for the health of populations; being accountable for relationships, decisions, and actions; pursuing excellence, in care, teaching and research; taking a leadership role in complex, clinical situations; develop and evaluate patient programs; articulate a vision for nursing practice and patient care; acting as a resources, facilitator, mentor, coordinator and role-model to build and maintain teams; and possessing leadership attributes to work with stakeholders to achieve optimal quality outcomes.

Four of the five documents collected in this study included leadership as part of the APN role. The extent to which leadership was described varied between the documents.

Summary

Using a qualitative descriptive approach framed by a leadership capabilities development framework to guide the study, APNs described themselves as effective leaders within the healthcare system. APNs described leadership as an expectation of their employment, within acute care. APNs described their leadership to be focused on two broad areas of practice (two themes): *patient-focused leadership* and *organization and system-focused leadership*. The first, *patient-focused leadership* is described as leadership capabilities they employ to directly influence the patient. These capability domains included: 1) managing patient-centred care; 2) coaching and educating; 3)

advocating; 4) initiating meaningful conversations. The leadership capabilities included in these domains are often demonstrated while APNs are providing clinical care. *Patient-focused leadership* contributed to patients and families experiencing high quality, patient-centred healthcare.

The second focus of APN leadership is *organization and system-focused leadership*. APNs' leadership focused on the organization and system included the following leadership capability domains: 1) improving the quality of care provided; 2) enhancing professional nursing practice; 3) being an expert clinician; 4) communicating effectively; 5) mentoring and coaching; 6) providing leadership on internal and external committees; and 7) facilitating collaboration. These capabilities directly impacted nurses, other healthcare providers and the healthcare system and indirectly impacted patients through improved care delivery.

APNs described possessing an array of leadership abilities that make them capable of leading change that positively impacted patients, organizations and the healthcare system. These descriptions of APN leadership and perceived outcomes illustrate the breadth and depth of leadership demonstrated by APNs.

When comparing the capability domains and capabilities of APN *patient-focused leadership* and *organization and system-focused leadership* to the LEADS leadership domains and capabilities, there are many similarities. In their descriptions of their leadership, APNs described many of the leadership capabilities outlined in the *LEADS in a Caring Environment Leadership Capabilities Framework*. APNs described being self-aware, engaged in life-long learning, and being accountable for their performance, all

capabilities of the LEADS *lead self* domain. The APNs interviewed emphasized the importance of demonstrating capabilities included in the *engage others* and *develop coalitions* domains. All the APNs described the ability to communicate effectively, foster the development of patients, nurses and other healthcare providers and build purposeful productive partnerships, and lead healthcare teams while negotiating the complex and dynamic environment that is healthcare.

APNs demonstrated, through their descriptions of their leadership, that they are being successful leaders who are transforming the system. They described utilizing knowledge of the entire system that enables them to navigate the system for patients and practitioners. As defined in LEADS, leaders need to be innovators and champions of change APNs in this study described continuously seeking out best practices and generating research to better patient care. The purpose of APNs engaging others is to achieve results, the third set of capabilities detailed in the LEADS framework. APNs described being goal-oriented, taking action to implement evidence based/ informed decisions to enhance patient care and continuously assessing and evaluating their practice.

APNs provided detailed descriptions of perceived leadership outcomes as evidence of the capabilities required to be effective leaders in the healthcare system. Outcomes are results, and *achieving results* is the final domain of the LEADS framework. APNs described a plethora of outcomes that illustrate their effectiveness as leaders such as improved patient flow, increased patient skill and knowledge, increased continuity of care, improved team communication, improved team functions, evidence

based practice implements, healthcare professionals working to full scope and advancing practice.

Being effective leaders within the healthcare system can often be challenging for APNs; there are several factors as described by APNs that influenced their ability to engage and be effective leaders. These factors are described as either organizational or system factors. These factors can positively or negatively influence APNs' engagement as leaders.

APNs described being effective leaders within the healthcare system. They exhibit leadership capabilities unique to advanced practice nursing as well as many capabilities which are comparable to those outlined in the LEADS framework for effective leadership. The leadership provided by APNs is perceived to positively impact patients and families, nurses and healthcare providers, and the overall healthcare system. Factors supporting and encouraging the engagement and development of APNs as leaders need to be expanded to ensure all APNs can flourish as leaders.

Chapter Five: Discussion, Conclusions and Knowledge Translation

The following chapter will discuss the findings in the context of current literature. This section highlights how the findings can be used to describe APN leadership, the effectiveness of APN leadership as well as APN engagement as leaders. The implications for practice, policy, education and research are also discussed. The implications are followed by an explanation of the limitations of the study. Finally, avenues that will be used to translate and exchange the knowledge that has been generated from this study are explored.

Discussion

Healthcare in Canada is experiencing tremendous pressure from an increased patient acuity and complexity of care associated with an aging population, treatment advancements and use of technologies. In concert with the above challenges healthcare is also struggling with the need to contain the rising costs of delivering healthcare and the increasing expectation for accessible, high quality healthcare provision to all Canadians. These pressures have created the need for innovative, courageous, and knowledgeable people to lead changes to ensure the healthcare system adapts to meet the needs of Canadians now and in the future (Dickson, 2010). Leaders are often considered to be people who hold formal and recognized leadership positions, such as senior hospital executives, and nursing administrators, such as managers and directors. As healthcare has restructured over the past several decades many of these formal nursing leadership roles have been removed, resulting in a significant gap in formally recognized nursing

leadership at the frontline (Wong & Cummings, 2007; Gottlieb, Gottlieb, & Shamian, 2012).

People in all positions within healthcare can develop leadership capabilities and lead change (Dickson, 2010). The *LEADS in a Caring Environment: Leadership Capabilities Framework* was the result of a Canadian participatory action based research study. The framework can be used to develop leaders at all levels and positions in healthcare (Dickson & Tholl, 2011).

APNs are graduate educated RNs who are expected to demonstrate leadership as part of their core competencies (CNA, 2008). However this leadership has not been well understood. APNs have not traditionally been considered formal leaders because of the significant clinical focus of their roles (Sidani et al., 2000; Mayo et al., 2010; Kilpatrick et al., 2013). Research has mainly focused on the development and utilization of APNs' clinical expertise and less emphasis has been given to other dimensions of their role, such as leadership (Bryant-Lukosius et al., 2007; Bryant-Lukosius, 2010; Elliot et al., 2012; MacNeil & MacKinnon, 2011; Pauly et al., 2004). APNs are clinical experts with advanced nursing knowledge. Their roles heavily favour direct clinical care and this ideally positions them to be leaders and to provide leadership to patients and families, nurses and other healthcare providers and the healthcare system. There is a need to better understand this leadership.

This current qualitative descriptive study informed by the *LEADS in a Caring Environment: Leadership Capabilities Framework* was conducted to address the following three research questions: 1) How do NPs and CNSs working in an acute care

setting perceive they provide leadership to improve patient and family, nurses and healthcare providers and healthcare system outcomes?; 2) How do CNSs' and NPs' descriptions of their leadership compare with the five domains of the LEADS framework? 3) What factors influence the engagement of acute care-based NPs and CNSs as nurse leaders within healthcare organizations?

Describing APN leadership.

The study data were analyzed and two overarching themes describing APNs' leadership were identified, the first being *patient-focused leadership* and the second being *organization and system-focused leadership*. *Patient-focused leadership* included the following leadership capability domains: 1) managing patient-centred care; 2) coaching and educating; 3) advocating and; 4) initiating meaningful communication. *Organization and system-focused leadership* included these leadership capability domains: 1) improving the quality of care provided; 2) enhancing professional nursing practice; 3) being an expert clinician; 4) communicating effectively; 5) mentoring and coaching; 6) providing leadership on internal and external committees; and 7) facilitating collaboration. These leadership capability domains as described by the APNs illustrate nature of APN leadership and complexity of their roles. Each domain includes one or more capabilities described by APNs. The capabilities are linked with perceived outcomes that were described by the APNs to be the impact of their leadership. Organizing APNs' descriptions of their leadership in such a manner creates a language and a road map from which APNs and others can begin to articulate and better understand APN leadership. Nurses in advanced nursing practice must be able to clearly

articulate their role as it is an antecedent to the role being understood and utilized to its fullest scope (Jones Charbachi, Williams & McCormack, 2012; Calkin, 1984).

Varying definitions of leadership in the context of advanced nursing practice exist. These definitions differentiate the leadership provided by nurses in advanced nursing practice as clinical or professional (Hanson & Spross, 2005; Elliot et al., 2012; Gardner, Chang, & Duffield, 2007; Mantzoukas & Watkinson, 2007). Clinical leadership often focuses on influencing, directing, supporting or developing patient care at the individual, team, department and organization level (Elliot et al., 2012; Fealy et al., 2011; Carryer et al., 2007). This is similar to the definition Hanson and Spross (2005) provide for clinical leadership that involves patients and colleagues and includes roles such as advocate, group leader and change agent. Professional leadership is referred to less frequently in the literature, but is defined as leadership in a wider context of national or international organizations (Elliot et al., 2012) or formally elected or appointed positions of power within defined organizations or groups (Hanson & Spross, 2005).

Categorizing APN leadership activities into clinical and professional emphasizes the leadership APNs provide as part of clinical care, which is important as APNs tend to spend the majority of their time providing direct clinical care. A disadvantage of this categorization is that it overshadows the important contribution professional leadership makes to professional nursing practice and patient care. Non-clinical role dimensions such as those associated with professional leadership are less understood, not as well developed and less likely to be fully implemented (Bryant-Lukosius et al., 2007; Bryant-Lukosius, 2010). APNs in this study described the need to be actively involved as leaders

in professional and specialty organizations to stay abreast on the latest evidence, and network with colleagues nationally and internationally. Both of which allow APNs to bring new knowledge and ideas back to their practice to benefit patients and the organization. Finally, they described what is traditionally considered professional leadership, the involvement in national or international organizations, as a means of advancing nursing practice and influencing policy.

APNs in this study described their leadership using two main themes. The leadership capabilities included in each theme were grouped based on the focus or main beneficiary of their leadership. APNs described their leadership as *patient-focused* and *organization and system-focused*. The categorization of clinical and professional leadership did not adequately capture the descriptions APNs provided of their leadership or the impact of their leadership. *Patient-focused* and *organization and system-focused leadership* resonated with the APNs as the themes captured what they described as their leadership and provided descriptive language to the breadth and scope of APN leadership. For example, many of the *patient-focused leadership* capabilities that APNs described were articulated as being part of their daily practice. Leadership capabilities such as; being a team lead, coaching patients, directing and facilitating care were all part of what they considered to be clinical practice. However, this is valuable leadership that is directed at improving outcomes for patients. As such, this leadership needs to be articulated clearly, so the impact of this leadership can be understood and measured (Lowe, Plummer, O'Brien, & Boyd, 2011; Kleinpell, 2013; Kilpatrick et al., 2014; MacNeil & MacKinnon, 2011). Unfortunately, when abilities of professionals such as

APNs are not understood, they are often underutilized and talent can be wasted and the potential benefits to patients, nurses, healthcare providers and the larger health system can be lost.

There are several *organization and system-focused leadership* capabilities that APNs described in their interviews. Many APNs reported that clinical responsibilities consumed the majority of their time. However, as they provided clinical care, they also described developing purposeful partnerships with healthcare providers across the healthcare system to minimize gaps in care and to enhance continuity of care for patients. APNs also described impromptu teaching of RNs and other healthcare providers at the bedside, advocating for their patient population to administrators, and being consulted as an expert on a topic as part of the daily clinical practice. These are examples of APN *organization and system-focused leadership* capabilities in action. The focus of *organization and system-focused leadership* is nurses and healthcare providers and the organization or healthcare system.

The APNs described spending the majority of their practice time providing and facilitating patient care. It is apparent through their descriptions that while facilitating patients' care, APNs are being leaders. They described demonstrating leadership capabilities necessary for *managing patient-centred care* and *improving the quality of care provided*. Both of these capabilities improve patients' outcomes as well as align with the foundation of most organization's strategic priorities of improving the quality of patient care. For example, APNs perceived *managing patient-centred care* and *improving the quality of care provided* to have improved patient access to specialty care, enhanced

care management of complex patients, decreased hospital admission and readmissions, reduced the number of tests for patients, improved patient flow, improved team communication, enhanced collaboration between staff and increased the efficient use of healthcare resources. Leadership is also embedded in a series of complex actions in care delivery and may not be apparent or tangible (Calkin, 1984). As a result, the value of this work and the contribution APNs make to the healthcare system is often lost because it is considered clinical practice and not leadership. This work may also be invisible to others as APN outcomes are not systematically evaluated. Beginning to use the language provided in *patient-focused leadership* and *organization and system-focused leadership* will assist APNs in describing their leadership. This will also allow those in decision-making roles to better understand the valuable resource that is APN leadership. The road map also makes the contribution APN leadership makes to organizational and system goals, as well as patient goals visible.

Leadership activities and capabilities.

Recently research has been conducted to empirically review leadership in the context of advanced nursing practice. Elliot et al. (2012) published results identifying clinical and professional leadership activities from a national case study conducted in Ireland focusing on advanced nursing practice. In their results they described several leadership activities that are similar to leadership capability domains described in this study. For example, Elliot et al. (2012) described the following clinical leadership activities: *initiates and changes patient/client care through practice development; changes clinical practice through formal education; guides and co-ordinates the*

activities of the multidisciplinary team; and mentors and coaching the multidisciplinary team in clinical practice. These activities are comparable to the following capability domains in this study: *improving the quality of care provided; managing patient-centred care; and mentoring and coaching.* Elliot et al. (2012) also described professional leadership activities that are similar to the leadership capabilities domains described by APNs in this study such as: *engages in professional organizations at a national or international level.* These activities are relevant to the *organization and system-focused leadership* capability domain of providing leadership on external committees. This study also highlights several new leadership capabilities not reported in the study by Elliot et al. (2012) including: coaching and educating patients and families, advocating for patient populations, communicating effectively, enhancing professional nursing practice, facilitating collaboration, and being an expert clinician. Differences in the results between the two studies may arise from methodology. Elliot et al. (2012) used a case study method which included non-participant observation, key stakeholder, and participant interviews, and document analysis from across the spectrum of the Irish healthcare system and included nurse midwives and nurses in advanced practice. This study included only acute care NPs and CNSs, and used participant interviews, and document analysis only. Differences may also potentially be related to contextual differences in country healthcare systems and or role expectations of APNs.

Effective leadership.

APNs demonstrate effective leadership in their practice according to the LEADS framework. This effectiveness is substantiated by the similarities between the leadership

capabilities described by the APNs and those articulated as necessary for effective leadership in the *LEADS in a Caring Environment: Leadership Capabilities Framework*. The five domains of leadership capabilities in LEADS were reflected in the capability domains of both *patient-focused leadership* and *organization and system-focused leadership* capability domains.

To be an effective leader you must demonstrate leadership capabilities (Dickson et al., 2007). Much of the nursing literature and language refers to competencies and or skills in leadership not capabilities. *The National Framework for Advanced Nursing Practice* (CNA, 2008) uses the term leadership competency, as does the College of Registered Nurses of Nova Scotia *Nurse Practitioner Competency Framework* (CRNNS, 2011). These two documents have been influential in guiding the development of CNS and NP roles within Nova Scotia, and may account for why the term competency was used regularly by APNs to describe their leadership. However, when describing their leadership and providing examples of their leadership, APNs identified themselves as being experienced, efficient and effective leaders. These descriptions extend beyond being only competent. Competency defines the standards required to practice to a minimum, safe standard in a predictable environment (CNA, 2005; Dickson et al., 2007). Rather the APNs were describing being leaders in dynamic, unpredictable settings which required their advanced nursing knowledge and expertise, therefore APNs were demonstrating leadership beyond competency expectations.

The LEADS framework is founded on the concept that leadership capabilities are required to be an effective leader and therefore leaders should be striving beyond the

achievement of competence (Dickson, 2010). Capabilities are the abilities individuals require to be effective in unpredictable and dynamic environments, such as those described by the APNs in this study (Dickson et al., 2007). There is an opportunity for nursing to reconsider and reframe leadership as a set of capabilities to enable APNs to develop the level of skills necessary to be considered effective leaders within healthcare.

APNs are clinicians and a large part of their practice is spent directly caring for patients and families and because of this they consider themselves to be clinical or frontline leaders. Therefore, when they described their leadership, it was often in the context of making change at the level of the patient, nurse, healthcare provider or program, and less frequently at the level of the healthcare system. The LEADS framework was founded on the presumption that regardless of position or title, any person can be an effective leader if they develop the leadership capabilities outlined in LEADS. However, the language used to describe the leadership capabilities in LEADS is ‘grande’ and refers to system level change. The references to change, at the systems level can make it challenging for leaders, whose practice largely consists of delivering direct patient care, to see themselves as effective leaders. LEADS provided a lens from which to analyze APN leadership. The framework developed in this study describes APN leadership through the themes of *patient-focused leadership* and *organization and system-focused leadership* and is informed by the LEADS framework. This framework is intended to be more relatable and meaningful to APNs, other healthcare providers and decision-makers as it uses the descriptions and meaning APNs used when they described their leadership.

APNs identified many of the leadership capabilities listed in the *LEADS in a Caring Environment: Leadership Capabilities Framework* as they described their leadership and its impact on patients and families, nurses and healthcare providers and the healthcare system. Although there were some discrepancies between APNs' descriptions of their leadership and the LEADS framework, the overlap in leadership capabilities was significant and supports the fact that APNs are effective leaders within the healthcare system. The effectiveness of leadership is often measured through outcomes.

Outcomes. Part of being an effective leader is *achieving results* (Dickson, 2010). Results are often measured through outcomes, which are a measure of APNs' effectiveness (Brooten et al., 2012). Outcomes are traditionally considered to be changes in patient's health status that can be attributed to the care they receive (Donabedian, 1980). For example, outcomes commonly used to measure the effectiveness of APNs' practice are patient reported outcomes (patient satisfaction, functional status, quality of life), nursing and healthcare provider outcomes (colleague satisfaction, increasing staff adherence to protocol) and finally, healthcare system outcomes (patient length of stay, readmissions rates, emergency room visits) (Kleinpell, 2013; Newhouse et al., 2012). The APNs noted that they were not regularly measuring outcomes associated with their practice for a variety of reasons, mainly the lack of easily accessible and meaningful data collection methods and resources to measure quantifiable outcomes.

APNs described what they perceived to be the impact of their leadership on patients and families, nurses and other healthcare providers as well as the healthcare

system. They reported, for example, how their leadership positively impacted patient experiences, increased patient flow, decreased emergency room admissions, increased nursing knowledge, enhanced team function, created a seamless care experience for patients and contributed to evidence based healthcare policy development. The challenge is to now find practical and meaningful ways of measuring these outcomes.

Considering outcomes in the three traditional domains (patient, provider, healthcare system) emphasizes the clinical and organizational benefit of the APN leadership. It is necessary to begin to consistently and accurately measure these outcomes. More recently, leadership outcomes have been created, and are defined as “initiating, developing and integrating new initiatives into the healthcare organization” (Elliot et al., 2013, p.6). In a secondary analysis of 23 case studies identifying leadership activities of nurses in advanced practice, Elliot et al. (2013) defined several outcome measures of leadership. For example: training and mentoring the multi-disciplinary team; formal knowledge transfer to clinicians and public, expression of respect by multidisciplinary team members, expression of respect by an external body, a new service, a new practice support initiative, advanced practitioner-led clinical practice guidelines development, review and implementation, increased use/application of research evidence in clinical practice, and knowledge generation to inform clinical practice (Elliot et al., 2013). APNs in this study described the impact of their leadership on patients and the organization (nurses/ healthcare providers and the healthcare system), not as leadership outcomes as defined by Elliot et al. (2013). While no new leadership

outcomes were identified in this study, this could be the result of differences in study methods or contextual factors.

The contextual factors that exist between Canada and Ireland in relation to the implementation of advanced nursing practice roles are significant. In Ireland, advanced practice roles in the context of nursing include advanced nurse practitioners (ANP), clinical specialists and advanced midwife practitioners (AMP). As well, Ireland has a national healthcare system and is geographically much smaller and is more densely populated than Canada. In Canada, NPs and CNSs are the only two recognized roles, the healthcare system in Canada is made up of 11 provincial and 3 territorial healthcare systems that spread across a very large land mass. The implementation of APN roles in Canada has not been governed by a national strategy, roles are implemented on an as needed basis. The CNA (2008) *National Framework on Advanced Nursing Practice* is used as a guide in outlining the educational requirements and core competencies for advanced nursing practice. In Ireland, implementation of ANP/AMP positions is strategic and all roles approved by the National Council before implementation of the roles occurs (National Council for the Professional Development of Nursing and Midwifery [NCPDNW], 2008). The process for approval is rigorous and is outlined in detail in the *Framework for Establishment of Advanced Nurse Practitioner and Advanced Midwife Practitioner Posts* (NCPDNW, 2008). The population service needs for the ANP/AMP post must initially be established and evidence supporting the need provided. A job description containing a detailed list of the role and responsibilities including the core concepts and definition of the ANP/AMP is required. The core concepts of ANP/AMP

include autonomy in clinical practice, expert practice, research, and professional and clinical leadership. As well, the preparation of the site and resources; financial, structural, educational and human that have been put in place to support the role must be outlined. The application is then submitted to two levels of national committees for review and approval (NCPDNW, 2008). If the application does not meet the committees' criteria then the application can be sent back for revisions. The application must be approved before a site can actively recruit for an ANP/AMP position (NCPDNW, 2008).

As part of the job description the core concepts of ANP/AMP that must be included in the application for an ANP/AMP post (NCPDNW, 2008). Professional and clinical leadership are part of the core concepts. This leadership is defined as clinical leaders who initiate change, have a vision of nursing/midwifery practice development, provide new services, and participate in educating staff through role-modeling, mentoring, sharing and facilitating knowledge exchange (NCPDNW, 2008). The above highlights only one of the core concepts of ANP/AMP practice. The core concepts clearly define what is expected of the ANP/AMP in each domain of practice. These concepts in combination with the rigorous application process and strategic implementation provide very detailed criteria and expectations of ANP/AMPs in demonstrating the impact of each domain and provide a potential model for making the effectiveness of APN role more visible in Canada.

Identifying a means of more efficiently and effectively measuring patient, organization and system outcomes attributable to APN leadership is important. In

additions, there are several other factors beyond measuring outcomes that contribute to the potential effectiveness of APN leadership that warrant discussion.

APNs' engagement as effective leaders.

APNs described several factors that influenced their engagement as nurse leaders. They also described these factors as influencing their ability operationalize their leadership capabilities and therefore their effectiveness as a leader.

Unionization. APNs in this study described the benefits and challenges to being part of a union. The benefits as unionized APNs included job security and adequate hourly wages. However, unionization also presented challenges to their engagement as leaders. Some of the challenges included inflexible contract obligations and being classified as unionized. APNs indicated that rigid interpretation of union contracts by their supervisors challenged APNs' engagement as a leader. For example, several APNs noted that by union contract they only have two education days per year. This limits their ability to take on leadership roles outside of their organization as these roles require more time commitment than two working days as provided for in the union contract. Engaging in leadership is an expectation of their roles as described by the APNs, applying for education time to gain clinical coverage and administrative support to fulfill an expectation of the job is counter-intuitive. Reframing how APNs and administrators understand APN roles and leadership is necessary to ensure APNs can fulfill all dimensions of their role in a unionized environment.

The second challenge associated with being unionized was how it often excluded the APNs from decision-making or management tables. Being excluded from

management tables prevented APNs from actively engaging as a leader and being able to contribute their knowledge and expertise to changes and decisions.

Like most nurses in Canada, the majority of RNs and APNs working in acute care facilities in Nova Scotia are unionized employees (Briskin, 2012; Nova Scotia Nurses Union [NSNU], 2013; Nova Scotia Government Employee Union [NSGEU], 2014; CRNNS, 2013), however, APNs make up a very small proportion (less than 3%) of the unionized nurses in Nova Scotia (NSNU, 2013; NSGEU, 2014; CRNNS, 2013). It is less clear what percentage of APNs in Canada is unionized. Kilpatrick et al. (2013), completed a national survey on practice patterns of CNSs and noted 44.5% of Canadian CNSs were in unionized positions; statistics for Canadian NPs are not currently available. There is little in the literature regarding the advantages and disadvantages of unionization in the context of APN roles, let alone research identifying the influence unionization has on APN engagement as nurse leaders.

Collective voice. Although unionization is a form of a collective voice for APNs, many of the APNs described needing a collective APN voice within their organizations. Approximately half the participants were part of an organization based APN group and the other half was not. The APNs who did not participate in an APN group felt the lack of collective voice. They also reported feeling underutilized as leaders. Underutilized because healthcare providers and decision-makers lacked awareness of their existence and or lacked understanding either of the scope and capacity of their roles. Those with the opportunity to participate in an APN collective group felt this as facilitating their engagement as leaders. Being part of an APN group gave them an

opportunity to collectively speak as APNs. The group also acted as a single point of contact for others in the organization to contact and learn more about APNs. Finally, having a collective APN group gave APNs the opportunity to problem solve and strategically plan and work as a group towards common goals.

A few APN groups in large acute care centres in Canada have published the benefits of APNs across their organizations working collaboratively as a group. APNs at the University Health Network (UHN) in Ontario developed the UHN APN network for the purposes of collegial support and to address challenges of implementing and evaluating APNs roles. They developed the UHN Framework for Advanced Nursing Practice in the late 1990s. This conceptual framework provided role clarity and guided the development and implementation of APN roles (Micevski et al., 2004). Also in Ontario, APNs at SickKids have a collaborative APN group, known as the SickKids APN council. This council collectively developed an evidence-based vision and practice model for APNs working at SickKids. The purpose of the vision and framework was to guide and sustain APN roles. It provides a common language for APNs to use when discussing their role across specialties, settings and with stakeholders. APNs at SickKids noted the framework has resulted in a consistent and commonly held understanding and expectations of the APN roles within the organization (LeGrow et al., 2010).

Organization-wide APN groups are valuable resources in facilitating APNs to engage as leaders. Working collaboratively as a collective group of APNs to develop a common vision for advanced nursing practice in their organizations could be a positive contribution to the overall culture of nursing within an organization.

A nursing culture. A culture within organizations that is supportive and values APNs optimizing all dimensions of their role is important (Carter et al., 2010; Pauly et al., 2004). Several APNs noted the culture within their organization presented challenges to engaging as a nurse leader. The dominant culture of medicine with its disease/illness model of care obscures the nursing vision of holistic care. Gottlieb et al. (2012) challenges nursing leaders of all kinds to adopt a *Strengths-based Nursing Leadership* approach, which is “founded on nursing values of holism and restoring the centrality of the nurse-patient relationship as expressed through a strengths-based approach” (p. 43). This challenge is an opportunity for APNs to transform the culture within their organizations. APNs in this study described some of their leadership capabilities as enhancing professional nursing practice, mentoring and coaching, and facilitating collaboration. Specifically, they described demonstrating professionalism, advocating for nurses, providing informal bedside teaching, and visioning as part of enhancing professional nursing practice. These capabilities are the foundation for APNs to engage other nurses and collaborate with them to transform their organizations from a disease/illness model to a strengths-based nursing culture that values interprofessional collaboration, mobilizes and develops people’s strengths to promote health and healing (Gottlieb et al., 2012).

APNs described how RNs are struggling with a lack of nursing identity within their organizations. APNs described how they promote and support a vision for nursing where nurses have a strong, positive presence within their organizations and work to optimal scope of practice in an environment that appreciates the value of nursing.

Utilizing the principles of strengths-based nursing, APNs could further actualize this vision. Adopting a strengths-based nursing culture would redefine nursing within organizations and allow nurses to regain their identity and purpose within a rapidly changing healthcare system. APNs, in collaboration with other nursing leaders, have the capabilities to create this change and build a strong nursing culture within organizations.

Experience. Many of the APNs who participated in the study noted that experience was an influential factor for engaging as a leader. Previous life and work experiences enabled them to develop leadership skills and build confidence as a leader. All APNs who participated in the study had a minimum of one year experience as an APN, but the majority had six or more years of APN experience, and all had more than five years of nursing experience. Therefore this was a relatively experienced sample of APNs. Their experience enabled them to have confidence in themselves as a person and as a practitioner to engage as a leader. Benner (1984, p. 36) defines experience in the context of clinical practice, not as the passing of time, but rather as the “refinement of preconceived notions and theory through encounters with many actual practical situations that add nuances or shades of difference to theory.” Although Benner’s (1984) work focused on development of clinical expertise, her theory suggests that APN experience with leadership influences development of their leadership capabilities.

Minimal research has been done linking experience to leadership ability in the context of APNs. Ferrara (2008) completed a doctoral study to determine if there was a relationship between prior RN experience and leadership or clinical competence in APNs. Ferrara (2008) concluded experience as a RN was not a significant factor in predicting

leadership competence. However age was a significant factor in predicting leadership competence. Age often is associated with experience; in many cases, the older a person is the more opportunities they have had to develop and practice leadership skills (Ferrara, 2008). Experience, not necessarily in the context of bedside nursing, but rather experience with engaging as a leader is the important factor. Acknowledging experience as a factor that influences APN engagement as leader provides an opportunity for educators to include leadership development opportunities within APN education programs. Healthcare and professional organizations should consider offering APN leadership and development opportunities. More research is needed to further understand the role of experience in leadership.

Implications for Practice

APNs are continuously engaging in *patient-focused* and *organization and system-focused* leadership when providing clinical care to patients. The challenge now is for APNs to recognize these activities of daily clinical practice as functions of their leadership and begin to articulate these capabilities as leadership not simply part of clinical practice and patient care. The ability to clearly articulate APN leadership capabilities is necessary for APNs and administrators to fully understand and optimize the role.

Full engagement.

To fully engage in all dimensions and optimize the use of the APN role, clear expectations for the role must be established (Bryant-Lukosius et al., 2007; Carter et al., 2010, Kilpatrick et al., 2014). APNs described having a dual reporting structure,

reporting to a nursing or health service administrator as well as a physician lead. APNs described experiencing competing priorities in relation to their clinical and non-clinical responsibilities. Lack of consistency in expectations between the nursing and physician administrators and between groups of administrators can cause confusion and challenges to APNs' practicing with optimal capacity in all their role dimensions. These reasons have been cited before as contributing to the underutilization of APN roles, role structure and poor APN job satisfaction (Bryant-Lukosius, 2004; Bryant-Lukosius, 2007; Sangster-Gormley, Martin-Misener, Wamboldt & DiCenso, 2011; MacNiel & MacKinnon, 2011). Creating detailed job descriptions, clear role expectations and having a vision for the role that is agreed upon by APNs, physicians and nursing administrators can facilitate APNs to engage as leaders (Carter et al., 2010).

Job descriptions and expectations should also include the amount of time in percentage or hours allotted to each dimension in the role. Heavy patient care demands and workloads are commonly described by APNs a barrier to engaging in all dimensions of their practice (Kilpatrick et al., 2013; Sidani et al., 2000; Mayo et al., 2010). All the APNs interviewed in this study reported spending a minimum of 75%, and in many cases 95% to 100% of their working hours, providing clinical care to patients. Ideally a minimum of 25% of the APN workload should be protected for research, education and leadership. Only one document collected during the study outlined the amount of time to be spent in each dimension of practice. Role overload and heavy workloads have been described in the literature as a barrier to optimal utilization and effectiveness of APN roles (Gerrish et al., 2012; Bryant-Lukosius et al., 2004; Faris et al., 2010). APNs must

begin to address role overload and workload concerns in constructive ways with physician collaborators and administrators to ensure optimal role utilization and their own job satisfaction (Bryant-Lukosius et al., 2004).

Although APN roles have been in place for several decades now, many physicians and administrators are unfamiliar with and or lack a comprehensive understanding of all dimensions of the NP and CNS role (DiCenso et al., 2010; Donald et al., 2010; Carter et al., 2013). Specifically, hospital decision-makers (directors, managers, senior administrators and physicians) acknowledge they have limited knowledge about the value-added elements of APN roles, such as leadership (Carter et al., 2013). Many hospital decision-makers described the most common avenue to receive information about APNs' roles is through APNs within their organization (Carter et al., 2013). Therefore it is incumbent on APNs to educate key stakeholders about APN roles. Having a collaborative, evidence-based APN vision and or framework specific to the organization would facilitate consistency in communication of APN roles and could assist physicians and administrators to better appreciate the complexity and value-added of APN roles. It is equally important for administrators and other stakeholders to educate themselves about the APN role. The findings of this study provide a descriptive APN leadership framework that could contribute to an overall vision and road map for APN practice within an organization. Supportive administrators (nursing and medical) are integral to implementing and sustaining APN roles, therefore the more consistent and evidence-based the information that decision-makers receive about APNs' roles, the more

likely they are to understand and support these roles (Carter et al., 2013; Carter et al., 2010; DiCenso, et al., 2010).

Having administrators understand and support all dimensions of the APN role was identified by APNs as a factor that positively influences their engagement as leaders. Many of the APNs articulated how they implemented leadership capabilities such as generating and using evidence in practice, leading by example and identifying gaps and assimilating knowledge to find solutions with the purpose of *improving the quality care provided to patients*. High quality, safe and efficient patient care is an organizational priority for most healthcare organizations. This is just one of the areas APNs can make a significant contribution to when administrators fully understand, support and engage APNs as leaders.

Teams.

Healthcare is provided in a team environment. When teams function well, effective and efficient use of healthcare resources are utilized to provide high quality, safe healthcare. APNs described having an integral role as a member of the healthcare team. They described themselves as leading teams and as being the consistent core of the healthcare team. The perceived impact of the APN leadership capability of leading teams was multipronged affecting; patients, nurses and healthcare providers as well as the healthcare system. APNs perceived their ability to be team leaders enhanced the teams functioning and allowed patients with complex diagnoses to receive better management of their care and APNs increased the continuity of care for patients. APNs ability to lead teams was perceived to impact the healthcare team by improving team communication,

and increasing the efficiency and effectiveness of team functioning. This in turn led to healthcare system outcomes of improved patient flow and efficient use of healthcare resources. These findings are consistent with those of other studies.

APNs have been described and observed to be essential for effective communication and collaboration within the interprofessional team (van Soeren et al., 2011). As well, NPs in acute care have been perceived to improve the effectiveness of team function, ultimately enabling healthcare teams to better meet patient needs (Kilpatrick et al., 2012). APNs play an important role in leading teams by improving their team functioning in healthcare. The value of this role is just beginning to be appreciated.

Implications for Policy

Evidence from this study shows that policy in the context of advanced nursing practice needs to clearly articulate and emphasize the significance of APN leadership for patients and families, nurses and healthcare providers and the healthcare system. Currently many policy documents clearly define the clinical expectations of advanced nursing practice, but are less descriptive with respect to the leadership qualities APNs require. The CNA (2008) *National Framework for Advanced Nursing Practice* is an exception to this as it defines each core competency area of advanced nursing practice.

In the CNA *National framework* (2008), leadership is referred to as a competency, indicating the minimum level of knowledge one must have to practice safely. Being competent ensures patients safety, but as a leader, one must be able to go beyond the minimum requirements to effect change (CNA, 2008; Dickson, 2010). To be an effective leader in an environment that is as unpredictable and as dynamic as healthcare, leadership

capabilities are required (Dickson et al., 2007). Therefore policies and documents outlining APN expectations and skills should identify leadership capabilities of APNs not just entry-level competencies. Ensuring that position papers and policy documents clearly and consistently articulate the leadership capabilities and the impact of APN leadership will elevate the profile of APNs as leaders within healthcare and enable optimal use of their leadership capital.

Implications for Education

Leadership as described by the APNs in this study is a set of capabilities that can be developed through experience and education (Dickson, 2010; Hanson & Spross, 2005). Many of the APNs described the desire to be a leader as an innate part of who they were, but the opportunity to practice their leadership skills and engage as a leader came through professional and life experience and education. In a systematic review of factors that contribute to nursing leadership, Cummings et al. (2008) determined that leadership can be developed through educational activities and the opportunity to model and practice leadership competencies. Ideally graduate education provides an opportunity for APNs to develop and refine their leadership skills, through practice, reflective learning and interactions with nurse leaders and mentors (Hanson & Spross, 2005, p. 303).

Graduate level education is recommended for entry level to practice for advanced practice roles (ICN, 2009; CNA, 2008). The CNA (2008) *National Framework for Advanced Nursing Practice* details leadership as a core competency to enter practice. It is therefore incumbent on graduate program educators to prepare APNs with the necessary leadership capabilities required to engage as nurse leaders and to operationalize their

leadership capabilities. Leadership must be considered an integral dimension across the continuum of nursing education if nurses are to consider leadership as a dimension of practice and a core competency to enter practice (Scott & Miles, 2013).

Literature is sparse about to how leadership is taught at the graduate level of nursing. At the undergraduate level a variety of means of teaching and developing leadership skills exist. In some undergraduate nursing programs leadership is taught in the final year as a transition into practice and in others it is integrated through the baccalaureate curriculum, with little evidence to support one method as superior to another (Curtis, de Vries, & Sheerin, 2011). Leadership needs to be seen as part of practice not as a responsibility of only those who hold formal leadership positions (Scott & Miles, 2013). Strategies to develop and practice leadership capabilities should be incorporated through both the theoretical and clinical elements of graduate education.

Nurses need practice opportunities in combination with theoretical and experiential knowledge through formal education and professional development (Hanson & Spross, 2005). Currently, APNs' education varies between graduate programs and there are not best practices established as to how leadership capabilities should be incorporated into APN education (Martin-Misener et al., 2010; Hamric & Hanson, 2003). The LEADS capabilities framework is an evidence-based framework intended to be a guide for developing leadership capabilities to be an effective leader, regardless of position or title within healthcare (Dickson, 2010). LEADS has informed the framework of APN leadership that was generated from the results of the study. Educators could adopt the APN leadership framework as a guide to developing leadership capabilities in

APNs. These capabilities could be integrated and practiced throughout the curriculum. For example, Thompson and Nelson-Marten (2011) explore one method of developing leadership competency at a systems level in CNS education. The theories and skills required for leadership are taught and practiced over three courses. Leadership is practiced in the clinical setting over the span of the course, where students identify a gap in care, plan and implement a project that is evidence-based to address the gap and finally evaluate the intervention (Thompson & Nelson-Marten, 2011). Students need to be provided an opportunity to participate in successful leadership experiences, to build confidence and experience the positive outcomes of engaging as a leader (Scott & Miles, 2013; Hanson & Spross, 2005).

Leadership development is a life long journey and therefore it is the responsibility of nurses, specifically APNs to continue to seek out learning opportunities to refine and enhance their leadership capabilities. It is also the responsibility of employers (healthcare organizations), professional colleges and specialty nursing organizations to offer professional development and ongoing leadership training opportunities. Employers must create work environments that promote and maintain leadership development as well as the other dimensions of APN practice to retain APNs and positively impact patient outcomes (Curtis et al., 2011; Bryant-Lukosius et al., 2004; Kilpatrick et al., 2014). One way for healthcare organizations to support leadership development of their nurses is through mentorship.

Mentorship is a form of leadership and mentoring can help develop leaders (Curtis et al., 2011). Many of the APNs who participated in the study described mentors

and mentorship as factors positively influencing their engagement as a leader. They reported feeling supported and encouraged by their mentor to practice their leadership capabilities. The mentorship relationships APNs experienced were informal and existed within their organizations and through professional networks external to their employer. There may be benefits to establishing formalized mentorship programs for new APNs entering practice and formalizing one of the more commonly described facilitators of leadership engagement as described by the APNs. Creating mentorships within organizations and across organizations would assist APNs to tap into leadership expertise and help accelerate their leadership development (van DeVelde-Coke & Velji, 2011).

Further research is necessary to establish the most effective means of developing leadership capabilities in APNs. It is a combination of formal education, ongoing training and the opportunity to successfully practice leadership capabilities through mentorship and other experiences that enable APNs and other nurses to develop and enact effective leadership capabilities. The importance of establishing an effective means of developing leadership in nurses is emphasized by Miller and Cummings “leadership development is key to improving nurses’ work life and advancing the profession” (2012, p. 22).

Implications for Research

There is tremendous opportunity for further research in the area of APN leadership. Firstly, a qualitative descriptive study investigating the perceptions of APN working in long-term care and primary care settings of their leadership would allow for a comparison between leadership capabilities described by APNs in other care areas. This information would deepen the overall understanding of APN leadership.

Secondly, the findings of this study could be validated through a time in motion study. The leadership capabilities described by APNs could be developed into an observational tracking tool (Kilpatrick et al., 2012; van Soeren et al., 2011). The tool could then be used to track the leadership capabilities of APNs. This would provide empirical evidence of APNs' leadership capabilities.

Further to the descriptions provided by APNs of their leadership, other team members (allied health professionals, physicians, nurses) as well as administrators could be included in a qualitative descriptive study exploring their perceptions of APN leadership. A comparison could then be completed to determine the similarities and differences between APN descriptions of their leadership and how others who work with them perceive APN leadership capabilities and the contribution of APN leadership.

Finally, this study could be replicated with a sample that includes APNs with a minimal amount of experience, such as APNs with less than a year of experience in an APN role, and as a more experienced cohort, such as those with more than five years of experience in an APN role. The comparison of experience in years could provide valuable insight into the relationship between experience and APN leadership.

Limitation of the Study

This study was successful in generating relevant information to address the posed questions for the purpose of this study: 1) How do NPs and CNSs working in an acute care setting perceive they provide leadership to improve patient, healthcare providers and healthcare system outcomes? 2) How do CNSs' and NPs' descriptions of their leadership compare with the five capability domains of the LEADS framework? 3) What factors

influence the engagement of acute-care based NPs and CNSs as nurse leaders within healthcare organizations? However, there were some limitations to the study that must be considered when interpreting the data and conclusions of this study. Leadership is considered a potentially sensitive topic and social desirability bias and selection bias must be taken into account. Several strategies were taken to prevent this bias: a) the participants were asked to describe their leadership in general terms; b) the issue of confidentiality was discussed with each participant prior to the interview; c) each participant was informed they had the right to refuse to answer any question; d) the researcher was not a APN, nor had any authority in the context of advancing nursing practice; and e) the invitation letter clearly explained the researchers genuine interest in APN leadership.

Secondly, this study addresses only the perceptions of acute care APNs employed in academic tertiary centres, and consideration must be given to the context from which the data was generated. The same descriptions of leadership capabilities, outcomes, and influencing factors may not apply to the primary care, community and long-term care settings where APNs are also employed. Further research will need to be conducted to determine the leadership perceptions of APNs as nurse leaders in the primary care and long term care settings.

Finally, there is a relatively small population of APNs in the province of Nova Scotia, particularly in APNs working in acute care. As a result the privacy and confidentiality of the 14 APNs who participated in the study had to be protected. As such the level of detail in the findings reflects this limitation.

Concluding Remarks and Knowledge Translation and Exchange

This qualitative descriptive study has provided evidence to better understand and utilize a lesser-known dimension of APN practice, leadership. APN leadership is described by APNs as encompassing *patient-focused leadership* and *organization and system-focused leadership*. Both leadership themes consist of leadership capabilities which, when enacted, positively contribute to patient, nursing and healthcare provider, and healthcare system outcomes. This study's findings have created a descriptive language and framework of APN leadership using the words of APNs. It is a means to begin to articulate what APN leadership is and how it contributes to patients and families, nurses and healthcare providers and the health system. As Benner (1984) stated "... clinical expertise has not been adequately described or contemplated and the lag in description contributes to the lag in recognition and reward" (p.11). These findings provide a description of APN leadership.

Having a language that describes APN leadership using the words of APNs will enable APNs to recognize the leadership capabilities they demonstrate as part of their daily practice. The ability to recognize and then describe their leadership will allow APNs to clearly articulate their leadership to decision-makers, other healthcare professionals and the public. This will enhance people's understanding of the APN role and they can begin to appreciate and optimize the contributions APNs make through their leadership.

Increasing knowledge of the APN role is important. Specifically decision-makers such as healthcare administrators, government officials, and policy makers need to fully

understand the leadership capabilities APNs possess to fully engage them as leaders within healthcare organizations. The current state of healthcare is one of continuous change where leaders at all levels and positions are needed to lead changes to create positive results. Those recognized as formal leaders such as hospital decision-makers and government officials can no longer fail to recognize the valuable resource APNs are within the system. APNs have the knowledge, expertise and capabilities to be recognized and engaged as effective leaders.

The results of this study also provide educators with new insight into the leadership capabilities APNs should be prepared with upon entrance to practice. APNs described leadership experience as an important factor influencing their ability to engage as a leader. Providing leadership experiences through graduate education and professional development opportunities is instrumental in building APN confidence and experience as a leader and increasing the likelihood of APNs being prepared to successfully engage as leaders.

APNs' descriptions of their leadership capabilities compared favorably to those outlined in the LEADS framework. LEADS is intended to develop leadership capabilities, so a person regardless of position or title can be an effective leader. There is an opportunity to adopt the APN leadership framework described in this study that is informed by the LEADS framework to guide the development of APN leadership capabilities in education settings.

Moving forward within organizations, APNs and healthcare decision-makers and policy makers need to collaborate to address factors that are prevent APNs engaging to

their fullest capacity as leaders. By mitigating prohibitive factors and capitalizing on the factors APNs described as facilitating their engagement as leaders the benefits of APN leadership can be felt across the healthcare system.

As I am very passionate about this work, there are plans to disseminate the results of this study using the following mechanisms: 1) an executive summary of the results will be shared with all APNs who participated in the study; 2) an executive summary of the results will be distributed to the Chiefs of Nursing offices at both acute care facilities in Halifax involved in the study; 3) an executive brief outlining the findings of the study will be submitted to the CRNNS for publication in their quarterly journal; 4) a briefing note will be submitted for posting on the Canadian Centre for Advanced Practice Nursing Research; 5) presentations of the findings will take place at regional and national conferences. I will also submit papers for publication to scholarly and professional journals.

APNs' descriptions of their *patient-focused leadership* and *organization or system-focused leadership* capabilities provide a framework to guide the development and optimal utilization of APNs as leaders. Their leadership capabilities positively impact patient and family, nurse and healthcare provider, and healthcare system outcomes. Our healthcare system is in need of healthcare leaders across the spectrum of the system. APNs are effective leaders as evidenced by this study's findings, and as such need to be supported to fully engage as leaders for the benefit of patients and the system.

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Appendix A Demographic Questionnaire: APNs

1. What is your sex?
Female Male
2. What is your age?
20-29
30-39
40-49
50-59
60-69
3. Location of employment?
Capital Health IWK Health Centre
4. Employment title?
Clinical Nurse Specialist Nurse Practitioner
5. Highest level of education achieved?
Graduate Degree Doctoral Degree
6. Number of years in nursing practice?
1-5 years
6-10 years
11-15 years
16-20 years
21-25 years
25+ years
7. Number of years as an APN?
1-5 years
6-10 years
11-15 years
16-20 years
21-25 years
25+ years
8. Are you employed
a. Part-time
b. Full-time
9. Is leadership part of the APN job description within your organization?
Yes
No
Unsure
10. Please indicate what leadership roles you have if any within your practice?

Thank you for completing the above questions.

Appendix B Interview Guide: APNs

The purpose of this study is to better understand how APNs perceive themselves as leaders and how their leadership impacts patients and families as well as other healthcare team members and the larger health care system.

Participation is voluntary. You can refuse to answer any question or stop at any point.

1. To begin, can you please briefly describe your practice to me?
 - a. What type of patient population do you care for?
 - b. How is your practice organized? (inpatient, ambulatory, community)
 - c. What other team members do you work with on a daily basis?
2. Can you briefly walk me through your typical day?
 - a. What is your usual routine?
 - b. How is your day scheduled? (appointments, clinical time or meetings)
 - c. What responsibilities do you typically have to patients and families, team members, healthcare system?
 - d. What activities or functions do you commonly perform?
 - e. How much time allotted to each activity?
 - f. How do you manage to meet all the demands?
3. When describing your APN practice what roles and activities would best describe your role as an APN?
 - a. Are these similar to the four competencies used by CNA as defining advanced nursing practice?
 - b. How much time do you spend on each competency?
 - c. Is your comfort level different today with certain roles and activities then when you started as an APN?
4. Leadership is often considered a key role dimension of advanced nursing practice, can you describe in your own words what leadership means to you?
 - a. Can you provide examples of APN leadership?
5. How do you as an APN demonstrate leadership? Examples?
6. When thinking about leadership what are the most important capabilities for an APN leader to demonstrate?
 - a. How do leaders learn and develop leadership capabilities?
 - b. What makes a leader successful?
7. How does your leadership improve healthcare outcomes at a patient, healthcare providers and system levels?
 - a. Patient outcomes (functionality, pain management, patient/ family satisfaction, length of stay, compliance with treatment regimen, etc.)
 - b. Healthcare team outcomes (health provider retention, work life satisfaction, health provider level of knowledge, recruitment, compliance with best practice)
 - c. Healthcare system outcomes (improved population outcomes, decrease wait times, etc.)

8. As a CNS or NP can you explain how your leadership role is similar or different compared to other nursing leadership roles?
 - a. Are APNs expected to provide the same leadership that is expected of nursing managers, nurse educators, etc?
 - b. What are the similarities between “formal” nursing leaders and “informal” nursing leaders?
 - c. What are the differences?
9. In your role as a CNS or NP what has assisted you in engaging as a nurse leader?
 - a. Were you provided with leadership courses?
 - b. Did you have a mentor or group of peers that encouraged and supported you?
 - c. Were you provided with time to focus on leadership development?
 - d. Have you been encouraged to take on formal leadership positions?
 - e. What partnership have you developed that have helped you be a leader?
10. Can you describe some of the challenges you face engaging as a nurse leader?
 - a. What challenges have you faced in creating change within your organization?
 - b. Have you experienced resistance or encouragement when you have shown interest in further developing your leadership skills?
11. Tell me what you would like to have said about CNSs or NPs as a nurse leader that we did not cover.

Appendix C Follow-up Interview Guide: APNs

1. Please take a few minutes to review the summary transcript from your first interview:
 - a) Is there anything that you would like to modify in the transcription?
 - b) Is there anything in your responses that identifies you as an individual that you would like to modify to enhance the confidentiality and privacy of the data?

2. Here is a summary of what I understood you were conveying about your leadership as an APN (Insert participant's interview summary here...), is my understanding of what you said what you intended to convey?

3. Is there anything you would like to add or feel the research has not captured with research to APN leadership?

Appendix D Patient-focused leadership Capability Domains, Capabilities, Perceived Outcomes and Supporting Quotes

Table D1: Patient-focused leadership capability domain 1: Managing patient-centred care			
Leadership capability domain with definition	Leadership capabilities (ALX### is a participant identifier)	Perceived outcomes PF = Patient/ Family NH = Nursing/ Health Provider HS = Healthcare System	Examples of supporting data
Managing patient centred care = Using clinical expertise in combination with advanced nursing knowledge to directly provide appropriate, high quality patient centred care to patients and families.	Providing clinical expertise in specialty area ALX 232, 214, 234, 341, 412, 332, 423, 312, 242, 321, 431, 424, 412, 413, 421	PF-Improved access to specialty care for patients (in person or via phone) PF-Management of complex patients closely followed, tailored care (intensity and frequency of monitoring) HS - decreased hospital admissions and readmissions HS - reduction in number of test HS - improve patient flow	ALX 332 – “I hope that by seeing some of the patients that don’t need specialty services, that’s freeing the physician to see patients in a more timely fashion.” ALX 424 – “You’re accountable to the patient. You’re accountable to the team.” ALX332 – “NP-led specialty clinic. I mean I am getting referrals from across the Maritimes. Before I had the NP-led specialty clinic patients were getting seen in a timely fashion because we identified those patients had to be seen. What the collaborating physician will say is now he’s not seeing as many. And this is very pragmatic but we are not seeing as many late presentations. Because 1) we’ve done education with family docs to say this is why we should be getting these referrals. We’re screening much more. And we are seeing them much earlier, which is what we want to see. And we’re not seeing these patient with late diagnosis because they’re

		<p>already be screened and if needed assessed.”</p> <p>ALX234 – “I collected some data for 4 months, and I see way less patients that physicians see. And my patients are generally sicker on average. My bounce back rates are lower, so fewer patients come back. Satisfaction rates are high, patients really appreciate the care.”</p> <p>ALX 214 – “And basically the function of the specialty clinic is so that they could be rapidly assessed and managed more frequently. So the wait time for a specialist physician is 6 months or above. And so they can’t see patients on a return basis every week and every 2 weeks. Whereas in the specialty clinic as an APN, you can. So if you’re worried about a patient, if you make a change, you can see them back in a week. And the goal is to prevent admission to hospital.”</p> <p>ALX 312 – “We have urgent access every day. We know that when patients with this diagnosis have to go to the ER with symptoms, they often get a scan. With urgent access to the APN, not only have we avoided ... most likely avoided a scan. And on occasion, they do need a scan but we reduced the cost related to that. And we reduce the insult to the patient of a scan.”</p> <p>ALX 423 – “So patients call me with concerns and I arrange to see them in clinic. So we definitely keep some patients out of emerg. ... Sometimes they are admitted from clinic, but at least they haven’t had to sit in emerg and be seen by several healthcare</p>
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	<p>Leading teams ALX214, 232, 423, 234, 242, 321, 424, 412, 413</p>	<p>NH - Team functioning PS - Better patient outcomes</p>	<p>professionals before seeing the specialist.”</p> <p>ALX 413 – “In the clinical arena one of the ways which you have a lot of leadership is you are making some pretty big decisions. And it’s being able to work collaboratively with the team, recognizing everyone’s skills and contributions. For 99% of the time you taking the time to take in everyone’s input, because at the end of the day the patient’s outcomes are the best with the whole team’s input. But there is the small percentage of the time when its acute ... and you need to step up and say “I’m in charge and this is what we are doing. ...”</p> <p>ALX413 – “So I would say my leadership is really around role modeling and also just being able to have the skills to help a team move forward to actually get the job done. ...”</p> <p>ALX424 – “One of our patients lives outside the HRM and has multiple healthcare providers and we have our healthcare providers here. We’ve identified the patient and family is struggling. And is there a way we can bring the whole team together. So its organizing and brining all these community providers and acute care providers together via telehealth to support this patient and family.”</p> <p>ALX234 - “And I think the cool part of what I do is bring the players in, and I’m like we need to play on the same team, everybody. And people are so keen to do it. ...”</p> <p>ALX242 – “And with our interdisciplinary team. Its</p>
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	<p>Promoting goal-oriented care ALX 232, 234, 214, 332, 412, 413, 421</p>	<p>PF - Improved symptom management PF - Patients feel they are part of the team PF - Holistic care provided to patients and families</p>	<p>bringing others onboard, whether its OT, PT, medicine or pharmacy, and helping lead in that way.” ALX232 – “Part of leadership is being central in the teams, working side by side with the nurses and the physicians, and building credibility and respect, and understanding where they’re coming from as well as the patients.” ALX 423 – “ I think I contribute to the functioning of that team, and I’m another cog in the wheel of the team. I think I have an expertise not only from a clinical point of view but also from a broader nursing point of view. ... I can kind of bring people together because I know a lot of different people and I know how to bring people together. So when then team needs to be brought together, I can bring them together.”</p> <p>ALX 312 – “Leadership is how you improve the care for the people you’re serving.” ALX 413 – “I think if you can always be looking at the common goal versus a particular situation, always seems to be able to make things move forward.” ALX412 – “... I will admit I actually engineered for somebody within the group to make the recommendation of monthly team meetings ... But its interesting because the meetings give people like social work an opportunity to inform the team around issues related to the patient’s social circumstances and they have never really had an opportunity to do</p>
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	<p>Utilizing system level knowledge ALX 312, 232, 214, 423, 242, 321, 431, 341, 413-</p>	<p>PF - Integration of health care services for patient across the spectrum of care PF - Efficient system navigation for patients</p>	<p>that before ... And I have to say without that sort of APN view of what needed to happen, we could have had the review and nothing would have happened differently from it.” ALX421 – “... We’re all trying to do the same thing, we have the same goals, is to make sure that the patient goes to the right place, at the right time, have the right resources in place, if possible.” ALX232- “From the perspective of complex patients, you’re sort of always looking at the healthiest outcomes. Usually when I sit and talk with them, most times there are big issues going on anyway. And I always say to them, you know, one of the goals is that from a system of care, we don’t create more issues than you already have. And that becomes... So controlling all those variables just from team. Again, team knowledge, competencies, the system and the structure. That somebody with this diagnosis, how do we navigate them through what care be a very scary and puzzling care experience? To come through and have the best possible outcome.”</p> <p>ALX 413 – “People report we (APNs) approach things a little bit differently – systems, big global picture, better communication, better ability to sort of understand where everyone is coming from.” ALX332 – “Even though this is a great place. The outcome is better at home. You know there are little blips that come up. But even if they get home for a</p>
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		<p>PF - Continuity during transitions of care HS - Improve patient flow</p>	<p>day or a night or whatever, its better then being here continuously, I think, for the whole family unit. I advocate for them to get home in a timely fashion but also that they feel comfortable going home. So when they're home, they're not, you know, so confused as to what they should be doing. ”</p> <p>ALX431 – “Advocating for a drug to be put on the formulary is like ... So I look at leadership as opportunity. The drug doesn't come out of the hospital budget. In fact it hospital's budget because we're going to have more use and more ability. But in the overall thing, you know, I know its better for all the patients because eventually in 20 years, if they don't get treated, the hospital is going to look after them anyway.”</p> <p>ALX 431 – “And we work with this group. There's this huge thing where we work with them to try and ensure that the conversation that we have here is the conversation that they know about so that when they meet with them first, they can explain about the care. And so if anything happens. And they follow-up with the family doctors. They're our link back to the community.”</p> <p>ALX 214 – “But you just have the ability to identify what the patient needs with the patient, and ensure that those needs are being addressed. And speak to those needs when collaborating with other team members.”</p> <p>ALX 423 – “I like to think I improve patient outcomes by providing them with good care, good</p>
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			<p>nursing care, with collaboration of care, with system navigation.”</p> <p>ALX 312 – “So we have the ability to recognize the gaps because we have a full sense of how the whole system integrates. And we’re not the only profession who has that but we have a very good sense of how to navigate the entire health system. We speak the language of every discipline. So we understand how to get what patients need. ... So I understand that in order for the patient to seamlessly move through the system, they need somebody who understands the entire system and just not the clinical care. ... I help patients with any particular issue related to their disease conditions. But also I help them with the bigger picture.”</p> <p>ALX214 – “...So that means touching base with the primary physician... And I feel that just a verbal discussion goes much further to ensuring that the patient is seen and there’s ongoing sort of continuation of that plan or reassessment of that plan by the primary physician.”</p> <p>ALX 321 – “I think there is a care coordination aspect. I think its leadership in ... It’s the care but also bringing the pieces together sometimes so that the care isn’t so fragmented. I think as a leader, you can see the bigger pictures and try to pull it together. ... I do a lot of communication amongst all the players and just try to keep things moving.”</p>
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Table D2: Patient-focused leadership capability domain 2: Coaching and educating			
Leadership capability domain with definition	Leadership capabilities (ALX### is the participant identifier)	Perceived outcomes PF = Patient/ Family NH = Nursing/ Health Provider HS = Healthcare System	Examples of supporting data
Coaching and educating = fostering trusting relationships and capitalizing on teachable moments	Facilitating independence and autonomy – ALX 232, 424, 214, 341, 312, 421 Listening, explaining ALX 332, 321, 214, 332, 424, 341	PF - Patients and families feeling safe, comfortable, competent caring for self PF - Increase in patient/ family knowledge PF - Patient and families develop new skills	ALX 232 – “It’s really about empowering and the focus is always on facilitating as much independence and autonomy as possible ... Because that’s what you need. You need the person to sort be at a point to take charge.” ALX 341 – “I think one of the things we do here, and maybe I am off, but that with a patient when we’re mentoring, we help patients understand what the care should be so that their expectation of what happen in care ...” ALX332 – “Well I think part of my leadership is say on an in-patient unit is taking care a step beyond routine standard level of care. And so explaining things a bit more, listening a bit more, advocating for them a bit more. ... So hopefully is improves their outcomes or at least their satisfaction. ... But I hope that they’re more informed and more pleased with the experience and comfortable with caring for themselves.” ALX 312 – “The ability for a patient to better self-manage their care through, you know, enhanced

			<p>education. The ability to spend more time with the client or the patient enables the patient to learn more about their illness or their whatever.”</p> <p>ALX 214 – “That you’re able to do a lot of family education, and they kind of regard you as a more senior team member. So I do a lot of family discussion education.”</p> <p>ALX 424 – “One of the other team members and myself, we do an education group. So we lead that. It’s a skills-based group that goes through a lot of, you know, we teach, several different skills to patients.”</p> <p>ALX 242 – “We go out into the community and do a Health fair. ... We are trying to build people’s awareness this disease really does happen.”</p>
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Leadership capability domain definition	Leadership capabilities (ALX### is the participant identifier)	Perceived outcomes PF = Patient/ Family NH = Nursing/ Health Provider HS = Healthcare System	Examples of supporting data
Advocating = Bring a respected voice for the patient population	Being a strong voice, negotiating on their behalf ALX 421, 332, 341, 321, 214, 232, 242, 431, 424, 421, 312	PF - Patient and family voices are represented PF - Patients and families feeling secure and cared for within the system PF - Increased visibility for patient population	ALX431 –“I want advocacy for my individual patient but I also advocate for the bigger community group. For example, we brought 2 new drugs for the treatment of this disease. The provincial government was going to put them on the formulary but they need help. So I help them, because I know what I want for these patients and what would be best for them without any boundaries.” ALX 421 – “And a lot of what I do too is advocating for my patient population. You know, just letting people know that, you know what they have a right to be here, they have a right to be a part of the healthcare system.” ALX 424- “And even from an illness perspective, you’re advocating for, you certain populations have a lot challenges postoperatively. You’re advocating for a good assessments and for ... you know, kind of challenging that.” ALX 312 – “And the amount of advocacy and negotiation work we do with, you know, Pharmacare, Social Services, Canada Pension and Disability, insurance companies, other healthcare providers, you know its ongoing.”

			<p>ALX232 – “One of the challenges also is to keep the population in the eyes of the administration because it becomes nebulous. ... care for this population, care for that population is a little different then another population. And so part of this is, we don’t always have leadership now that have an understanding, even in the population. Like it’s not necessarily a criteria for an administrator. And so also part of that is to be always communicating and talking and, making sure all of the needs and perspectives of the population come forward to the different forms.”</p> <p>ALX 242 – “That’s what I tell people. The reason we are here is patients. Patients in their beds and the family, that’s why we are here. ... So I say don’t look at the age, don’t look at the name, it’s a person who’s related to somebody, and how do we look after them? That’s what we need to do. And sometime’s you’ve got to remind people.”</p>
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Table D4: Patient-focused leadership capability domain 4: Initiating meaningful communication			
Leadership capability domain with definition	Leadership capabilities (ALX### is the participant identifier)	Perceived outcomes PF= Patient/ Family NH= Nursing/ Health Provider HS=Health System	Examples of supporting data
Initiating meaningful communication = Initiating the tough conversations	Addressing the uncomfortable topics ALX 312, 341, 413, 421, 321, 424	<p>PF - Patient and family satisfaction</p> <p>PF - Patients and families engage in conversation about uncomfortable/ difficult aspect of their care.</p> <p>NH – Teams are held accountable for their actions.</p>	<p>ALX- 312 “We do know that our patients who see us and are more comfortable discussing psychosocial and sexuality uses with us then they are with their specialist.”</p> <p>ALX 214 – “And I think they really appreciate the APN support and that holistic focus, and they often allow you to take the lead. Not that it’s a relief for them but they just know... you know. They are not as comfortable as the APN in dealing with palliation.”</p> <p>ALX421 – “... We have flat out, open conversations with families and patients about end of life issues which was kinda taboo 4 or 5 years ago.”</p> <p>ALX 321 – “And pay attention to this person. Don’t write her off. The team was making her comfort... But she doesn’t want comfort care. And this person had a whole bunch of stuff done. The patient was no longer required our service at that point. And she went home. And I was talking to her family and she was happy to be home. And it was only because of pushing. So that’s advocacy role for outcomes. But in the interest of the patient and family. You know you don’t kind of just go in</p>

			<p>and barrel through.”</p> <p>ALX424 – “There was a complex patient that we had followed for a bit. We met with the team and they noted we weren’t needed anymore. So I am trying to get our team to go up and meet with the patient and family and say this is why we are no longer involved in your care. We need to document it on the chart why we’re no longer involved, and we need to communicate that with the family because that’s not fair to the family ... that family deserves to understand from us why we’re no longer involved ... But we made a commitment to the family that, you know, we are here to provide the care that’s needed. And if its not needed at this point in time, they need to hear from us. Because who knows what’s going on in their mind. They could think we’ve abandoned them. And we said we would be back but we never came back. You know, I think there is an accountability I feel is important.”</p>
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Appendix E Organization and System-Focused Leadership Capability Domains, Capabilities, Perceived Outcomes and Supporting Quotes

Table E1: <i>Organization and system-focused leadership</i> capability domain 1: Improving the quality of care provided			
Leadership capability domain with definition	Leadership capabilities (ALX### is the participant identifier)	Perceived outcomes PF = Patient/ Family NH = Nursing/ Health Provider HS = Healthcare System	Examples of supporting data
Improving the quality of care provided = Using advanced nursing knowledge and clinical expertise to facilitate changes, resulting in patient and families receiving higher quality care	Identifying gaps and assimilating knowledge of patient population, team and system find solution ALX 232, 234, 321, 341, 332, 424, 341, 412, 431	NH - Improved communication NH - Collaboration between staff HS - Efficient use of health resources HS - Safer local healthcare	ALX 332 – “I started this working group with this group of nurses. ... They were very much working in silos, you know they had never changed. So by bringing them all together and now we meet, you know, once every couple of months, and I chair it, we just talk and we just have like informal discussions and share ideas. I’m bringing them together, and making the agenda and enabling them to talk and get ideas from one another and now they are working on project together. So that’s making change ...” ALX412 – “I think its about knowing the population. And I think its something we do well as APNs is we synthesize stuff. We take from 5 or 6 different areas or 5 or 6 different roles or whatever, and we can pull it together. ... But I think the synthesis piece is where you break it down and build it again and make something new out of it, that’s the piece APNs do really well.” ALX412 – “ I chair this committee, we’ve been meeting with

		<p>administration around the fact that the hospital does not have a policy around this topic. The committee has had several consults on the issue and the answers aren't easy ... there is a role for the committee but we need a policy.”</p> <p>ALX424 – “Our patients, when I started, it was there's no place to transition them to, there's no place ... So I spoke with the managers, the directors. I spoke with the clinic. And then we develop a committee. We met on a regular basis. Developed a transitions plan and develop a transition program. So it's identifying that gap, getting all the players together and hopefully moving forward and achieving the outcome we want. So now we have a successful transition program.”</p> <p>ALX 413 – “And once people recognize that, if you work as a nurse to full scope and you include... and you run teams, you make critical decisions, you help families, you move forward policy, you work at evidence based practice, you work collaboratively with teams, you lead, you consult and you do things that are specialize. You are enacting everything because you work as an advanced practice nurse.”</p> <p>ALX232 – “Well leadership, its having, I guess, expertise. But again, like I said, you can't know everything. But what you gain in knowledge as you go through is you get to really understand your structure of care, and where gaps occur, and what are the strengths. So then part of leadership is anticipation.”</p> <p>ALX312 – “So we need a champion and we don't have one yet. We're building an argument now for government. To do that, we have written letters. We're in the process of doing up a SBAR and all that.”</p> <p>ALX232 – “So now patients are coming for care. And initially</p>
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	<p>Leading by example ALX 234, 214, 242,</p>	<p>NH - High standard of care made visible PF - Safer, high</p>	<p>we have no means in-house of providing the medication. We use to get the medication from the community pharmacy via a courier. We had a snowstorm and the courier couldn't bring the medication. So I walked through a snowstorm. And I'm going, and I think this is ridiculous and it needs to change. So very quickly after I meet with our team to change this. And now we have temporary privileges and all of that's gone away. ... Now, some of this is getting better because a lot of the regions are starting to do their own management of the population. So now I am working with our team, seeing how we can support the other regions.”</p> <p>ALX431 – “In our population we have a lot of “no shows” to appointments. And there are a lot of reasons for this. And its kind of like how do we deal with this? And that’s how we started to link with others. And because of that, we’ve had a huge practice change in our district because we are doing this project together.”</p> <p>ALX 312 – “And also in advocacy is challenging the status quo. So just because a patient or a system has done something the same way all the time, you have to, based on evidence, based on best practice, based on clinical knowledge, you have to advocate for improvements in the system to best meet the needs. You could be advocating for improved technology. All kinds of things that will help you manage the volume of care that is required to be managed today.”</p> <p>ALX 321- “A lot of it is role-modeling. Going out and modeling how would I do clinical care, how would I respond to this family, how would I respond to this patient? Because role-modeling at this point is bigger then nursing. It’s role-modeling</p>
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	<p>321, 424, 413</p> <p>Scanning the environment for best practices and ideas, creating and implementing change ALX232, 312, 431, 424, 332, 234</p>	<p>quality patient care</p> <p>PF - Safer, timely, high quality patient care</p>	<p>within the whole healthcare team.”</p> <p>ALX 234 – “So I think I’ve been able to change people’s minds, like, we can send this person home yes. Or no, that person can’t go home for all these reasons because they’re just going to be back here. ... Like one of the quality things I do is follow up with people who leave without being seen. It’s like a safety net. ... I have caught a few significant things and brought them back in. ... And this has really changed people’s perceptions of if this person has come in for 3 days in a row, there’s something wrong with them. This is just not, you know, they can’t get in to see their family doctor.”</p> <p>ALX 431 – “ So I spend a lot of time talking to people across the country about what’s going on. And there are key leaders in which you know what’s going on and what you can translate in to different situation and what you can’t translate into different situations. What happen in downtown x at the x is no going to happen in y. And the other thing I like to do is look at what’s worked in other countries. And so I try and challenge people that this is how we should be. It works. They’ve shown it.”</p> <p>ALX 312 – “What we do know is through the establishment of our APN led urgent access clinic, clinic in the community, telephone triage and telephone helpline, we have reduced hospital admissions and emergency room visits.”</p> <p>ALX 424– “This non-pharmaceutical method was being used in a part of the facility all the time for procedures. And then, you know, patients and families were coming from here saying “What are you doing that procedure for? ” So we got together and we developed a policy. We developed preprinted orders. So now it is just a standard part of practice. So I think that’s an</p>
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	<p>Generating and using evidence in practice ALX232, 423, 234, 321, 214, 431, 424, 341, 412, 413</p>	<p>PF - Patients received evidence based care HS - Evidence based/ informed practice made a reality HS - Quality of care evaluated</p>	<p>improvement in patient outcomes”.</p> <p>ALX 332 – “One of the things I’m doing now is creating practice guidelines for how we take care of patients with this diagnosis, It’s hopefully helping to improve care. That nurses, you know, at the bedside understand why we do what we do each day, you know.”</p> <p>ALX234 – “I knew that I wanted that role developed somehow, some way, before I even got into the program. So I think I kind of had the discussion with the key people at the time. So there was an awareness of my plans. And the director and physician lead, were just incredibly supportive and knew that is was going to happen. And just the right people at the right time knew it needed to happen. I used the PEPPA framework to develop the role. So we had a multidisciplinary collaborative approach to deciding what the role could look like, ensuring people were educated on what an APN could and couldn’t do and where they could and couldn’t work. So it was a methodical well strategized roll out of the role.”</p> <p>ALX413 – “...Research is part of everything I do. Not only from conduct but also from the dissemination and also helping others and mentoring others to be able to understand research findings, evidence-based practice. And that’s just incumbent in everything I do ...”</p> <p>ALX341 – “You know, the evidence expert in the sense of knowing the evidence and bringing that to the bedside in whatever way.”</p> <p>ALX 242 – “Research, it’s working with our professional practice groups within each area to kind of develop research questions that we look at trying to change practice, which could</p>
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		<p>be policies and procedures, it could be changes in routines or guidelines. ... Its getting staff interested in that fact that research can be a simply a good clinical question which you look at the evidence. Are we doing best practice? If we're not doing best practice, how can we get to best practice and make a difference?"</p> <p>ALX431 – “This is my project this year. Health Canada says all patients with this disease should receive this medication. Well the province doesn't pay for them, right. So we need to figure out how we get them funded. So I said this year, we will collect data on all patients and we will find out why they don't get the medication. And one of the questions we're going to ask is cost? And if cost is the reason then we have to go back and say we cannot adhere to the guideline we don't have the funding.”</p> <p>ALX431 – “With our screening program I wanted to ensure we were meeting the benchmarks, there are no Canadian stats so we had to look to the US, the largest provider. We should at least be equal to the largest provider in the US, but we're actually better than them.”</p> <p>ALX234 – “My role has flexibility, sometimes I do a lot of quality work, quality control and quality assurance. ... I've had journal club in the program for a number of years. And I've tried to initiate like nurse-led research in the program.”</p> <p>ALX232 – “And I think part of its being bold, and to be able to go forward and propose new stuff. It's really hard. And that's particularly when you're enacting change. So if you have the confidence in yourself and you feel good about the change, and you can bring the evidence and have that ability to bring the evidence, that's the leadership.”</p> <p>ALX321 – “ I was leading a research study here, and those</p>
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			<p>days that took a large chunk of my time.”</p> <p>ALX232 – “The nurses will sometimes come and leave little notes and sort of say do you have any information on this? I have a patient with this situation. So it’s really neat when you get the teams to that point of independence that they are already thinking ahead. And I always say to them, I may not know but I usually know where to go. ... Sometimes, particularly if it is a patient I am involved with, families that I’m involved with clinically, then I usually do up these individualized care plans. Sometimes there are background articles in it. And so that again helps them focus care.”</p>
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Table E2: Organization and system-focused leadership capability domain 2: Enhancing professional nursing practice			
Leadership capability domain with definition	Leadership capabilities (ALX### is the participant identifier)	Perceived outcomes PF = Patient/ Family NH = Nursing/ Health Provider HS = Healthcare System	Examples of supporting data
Enhancing professional nursing practice	Advocating for nurses ALX 332, 412, 214, 423, 332, 424, 412	NH - increase visibility of nursing NH - increased awareness of APN role NH - Nurses working to full scope	ALX332 – “I think I do speak up for nursing. Like I always bring the nursing point of view to the table where there may be other disciplines. ... I am always trying to promote the APN role. So that people feel comfortable with the role and understand everything that we do.” ALX321 – “So I think as a leader in a leadership role, that has to be part of my role, I want those nurses to be fully functioning and safe and good practitioners. ... so a larger part of my role is promoting and supporting nurses.” ALX 312 – “The advantage I have as an APN is the unique relationship with my medicine colleagues that is a bit different I think. It enables me to sit at a similar table with them and feel that the care we are giving is similar, yet to take the opportunity to show them how it’s different. And that’s leadership too, being able to articulate your role and what you do and the difference you make.” ALX 321 – “I am always doing things to push what nurse is and what patient care is, and how can we improve that.”

	<p>Modeling professionalism ALX 242, 423, 341, 412</p>	<p>NH - Professional behavior role modeled for others</p>	<p>ALX 412 – “ I think we are the voice. I certainly feel I am the voice of nursing on the unit.” ALX 332 – “So that they understand that I have an invested interest in the speciality, and I’m trying to promote nursing.” ALX423 –“ And I think advanced practice nurses have a role in that, in promoting nursing. And in saying its good to be a nurse. This is why I’m a nurse.”</p> <p>ALX412 – “There was a notice for staff posted on the unit the other day, by a person, the tone was very passive aggressive, I as appalled by the notice. ... I approached the person and explained my concerns, we had quite a discussion about the notice and the notice came down. ... So in terms of a vision for nursing you pick your battles, what are really important things? And the sign, its not the notice its self, but I just don’t think its fair to nurses who do whatever the person wanted to done, its not fair to them if they’re actually enacting the vision and behaving appropriately to make them feel bad when its only a few that aren’t doing their job.” ALX 341 – “Because I think you learn what nursing is at school but very quickly you’re socialized a totally different way once you get into a new culture. And so that when you talk to people, they do remember back to what they went into nursing for and what they were going to focus on. And then it</p>
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	<p>Providing informal bedside teaching ALX214, 232, 321, 423, 234, 242, 332, 341, 412, 413, 421</p>	<p>NH - Real-time learning NH - Skill development</p>	<p>gets quickly pounded down. That what I want to pull out, ignite the spark. You know its helping them make that happen with all the realities around them for safety things they have to do and other things.” ALX423 – “So leadership for me is active. It’s demonstrating constantly what it means to be a professional nurse. ... So I think it’s to give those new nurses grounding and give those new nurses a sense of, you know, that we care about them and their professional development, and our expectations as an organization. ... So that they’re coming in and they’re knowing that at our organization, we’re expected to practice in a certain way. And there’s a high standard for that practice.”</p> <p>ALX 234 – “They look to me everyday for answers to questions, clinical questions. So I think that being and APN, you have a level of knowledge that nurses acknowledge, appreciate and want to learn from.” ALX 234 – “It’s bedside leadership, bedside education ... the onus is on x to create nurse leaders at the front-line. And I think that’s what I do.” ALX321 – “I attempted to provide leadership with care of the elderly on the floors. That’s one example. Because I know its an area that over... In the past when I first started in particular people would be frustrated. So I’ve done little sessions with staff and getting them trying to reflect on what kind of care is beneficial, and how care is affecting people. So I’ve tried to promote leadership on enjoying caring for</p>
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	<p>Visioning ALX 332, 321, 232, 423, 234, 312, 431, 341, 413</p>	<p>NH - advancing nursing</p>	<p>this specific population of patients on the floor.”</p> <p>ALX 341 – “You know its very much to lead nursing. ... I think you need to be able to stimulate passion, stimulate excellence, stimulate ongoing learning, stimulate the desire to grow as a nurse, provide holistic care ...”</p> <p>ALX232 – “I think so much of it is facilitating, seeing where we are, where do we need to go, and then what do we do to get there? And its either me or who else that would do that.”</p> <p>ALX 312 – “So I think my goal in the next year is to re-establish this group and create an avenue for a collective voice, and to be working collectively on some projects that will benefit all APNs in this organization.”</p> <p>ALX431 – “Having the opportunity to have started and then being with the College when we first got legislation and got through the legislation process with that group really, really consolidated in my own head what I wanted APN practice to look like. And how would we envision it would be after legislation.”</p>
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Table E3: Organization and system-focused leadership capability domain 3: Being an expert clinician			
Leadership capability domain with definition	Leadership Capabilities (ALX### is the participant identifier)	Perceived outcomes PF = Patient/ Family NH = Nursing/ Health Provider HS = Healthcare System	Examples of supporting data
Being an expert clinician = extensive knowledge of the population and a proven ability to translate that knowledge to improve patient care	Establishing clinical credibility ALX 232, 421, 312, 214, 423, 332, 341, 413, 421	HS - More informed policies HS - Evidence based practice or policies changes NH - Nursing represented at different tables HS - Organizational representation	ALX232 – “... So now my power isn’t formal. So its built on my ability to prove my credibility and to be able to somehow insert myself at key positions and key ears to sort of say we should be doing this...” ALX321 – “I chaired the committee. I did that for a term and am still one of the committees, and I am providing leadership with that. And we are pushing address with initiative to address a particular disease. And we’ll be meeting with the government officials on those initiatives.” ALX413 – “I would say I am considered an expert both as an APN and in my clinical area. And that been shown as I have been asked to sit to choose a VP, strategic planning groups for the program and organization. And I also work with several committee at the College with respect to legislation...” ALX421 – “We were asked by the provincial government as leader in the field of the disease, to come to the table and assist with developing a program or process where by these folks are monitored and watched over.”

		<p>ALX431 – “The only thing I do know is people call me. Somebody thinks I know something, and they’re willing to listen. People do respect us (APNs) when I come up with a comment, whether it be ... You know like we do work with industry and how we want to go about doing things and we work with the lab on how we want to change process. So they do ask. So they do listen.”</p> <p>ALX 312 – “We really are leaders in the disease. Our physicians come to us for consultation because all we are these patients. So we have developed an expertise. ... We do education within the community. We do education with specialists in the community, family docs, nurses.”</p> <p>ALX 312 – “And I think that from a system perspective, as advanced practice nurses bring their population specific knowledge to other professional organizations, they have the ability to impact the health of that population at a larger level, a larger scale than they would within their organization. So for example, right now I’m taking my knowledge of the disease and I’m working with a national foundation to create a document to send out to governments and hospitals, looking at the fact that the disease is not a preventable disease but it is a chronic illness and needs to be looked at in that perspective and needs to be funded and supported. ... So its bringing together that knowledge, clinical leadership, respect and ability to broker with others, and build capacity so that you help other organizations, governments, you know, national bodies, funding agencies, all of that, understand the importance of the work you do with a particular population.”</p> <p>ALX 234 – “I think it means being a respected stakeholder in</p>
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	<p>Formal teaching to nursing students and other healthcare providers ALX214, 232, 423, 234, 321, 431, 332, 424, 341, 413, 421</p> <p>Having confidence in one's self as a</p>	<p>NH - Learning from the experts NH - Sharing of knowledge NH - Skill development</p>	<p>important things that are disease-specific. I think leadership is when people look at you as an expert. You know, have respect for you because of your clinical judgment or just knowledge base in general. ... I think being an APN catapults that a bit more ... And I think that in itself puts me in a leadership position that I have to kind of be mindful of at all times.”</p> <p>ALX413- “With respect to formal teaching ... I still do, I would say 95% of all the nursing care orientation to the nursing staff coming into our area with respect to my area of expertise. I continue some formal teaching on sort of my research findings but also teach in the fellowship program through the department because I have a cross appointment there.”</p> <p>ALX 232 – “I’ve gone off to do a lot of education. People have called a lot of its with certain communities ... Then the next thing I find myself driving to the community to give a half day workshop... The word gets out. And I would never say I am an expert. I never grew up in this. But again, but you do work in it because you have to because that’s part of the role. So much of my leadership very much depends on the networks that I make.”</p> <p>ALX423 –“And I do organize a yearly education day for specialty nursing. This year, we had nurses from around the province.”</p> <p>ALX413 - “I mean you have to understand, we were the first APNs working in the organization. So we when started it wasn’t about sort of what all you were doing, it was actually</p>
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	<p>person and practitioner ALX 234, 232, 312, 332, 424, 412, 413, 421</p>	<p>who you were, you know. And there was a lot of give and take about expectations, role development, and role implementation. We had tremendous support in which ... And I think we led that as well. Fortunately we're all very senior nurses and had a lot of experience, and were not afraid to be our own voice, advocate and leader. ..."</p> <p>ALX 234- "I think advanced practice nurses, need experience for sure. And that comes with time. They need to have confidence in their ability to be a leader, confidence in their ability to make decisions that are, you know, what is right for the patient, the staff, the department, whatever it is. So confidence, knowledge. So you obviously need to have a strong knowledge base as well. It just can't be in name only. It has to be in action as well."</p> <p>ALX312 – "Coming into my role as an APN, I knew how to negotiate, I had a lot of connections. I was confident in who I was as a nurse and my abilities and what I was able to achieve."</p> <p>ALX413 – "You know, the leadership though that you have in clinical arena, I mean it still is about helping others and that whole senior role in mentoring and being able to step back and really work with other people to improve their clinical skills and their clinical expertise. And you can't do that in the same way when you yourself are not comfortable ... the whole you know novice to expert, you need to feel confident and comfortable before you can lead others."</p>
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Table E4: Organization and system-focused leadership capability domain 4: Communicating effectively			
Leadership capability domain with definition	Leadership capabilities (ALX### is the participant identifier)	Perceived outcomes PF = Patient/ Family NH = Nursing/ Health Provider HS = Healthcare System	Examples of supporting data
Communicating effectively = Listening and expressing your opinions and ideas in a constructive, productive way.	Demonstrating effective communication ALX232, 214, 234, 242, 321, 424, 412, 413, 421, 232	HS – Identifying ideas for change NH – Conflict management HS – Improving practice	ALX421 – “Leadership in a lot of ways is just sitting there and listening and saying, ok you know, these are your ideas, what are you going to do about them, and how can I help you get there? And its been amazing, if you just give them a little push, its so gratifying.” ALX 312 – “So I think the ability to communicate effectively stems not only from experience and knowledge but it’s a mutual trust that you have with your colleagues that says, you know what, this is somebody who should be listened to.” ALX242 – “And it’s having the skill set to have conversations. Conflict is good, and conflict can be good in good conversations. But a lot of people don’t like conflict. So it’s knowing how can you have a difficult conversations in a respectful way? You know, we don’t need to agree, and we may choose to disagree. But listening is a skill. ... I’m all about conflict, but in a positive way. Like let’s talk about this.” ALX412 – “I think its really being able to step out of your comfort zone, you know, do the hard work or ask the hard

	<p>Understanding your audience ALX 424, 412, 413, 234, 432, 232</p>	<p>NH - relationship building NH - Establish buy-in HS - Improving practice</p>	<p>questions that everybody in the room is thinking and nobody wants to say. Being willing to put your head above the parapet and say, but this is not acceptable.” ALX412 – “I went and did a orientation on professional boundaries. ... There were lots questions, one question was asked but interrupted as there were concerns in was similar to an exam question. I said ok backup we’re not going to talk about the question specifically, but we can address the topic. ... After the session I was approached afterward by the person who interrupted and was scolded. I left the situation and called the College for clarification around the matter. ... I later went back and found the person and ask to speak with her in a more private area where we could sit down... And I said to her, you did not have the right to speak to me that way, you need to understand communication is a huge tool that you’re going to use in nursing, and you need to be able to do it well. ...”</p> <p>ALX 332 – “So people see me as being very approachable, having an expertise, being able to talk at different tables and with different levels of folks within the hospital, whether it be administration or, you know, a small nursing group up on the floor. But people feel comfortable seeing me as the face of the population. So they understand that I have a vested interest in the population, and I’m trying to promote nursing. ... And physicians come to me because they know I can get the message out to whomever. But nurses also feel comfortable talking to me because they can ask be the very basic of question as a bedside nurse.”</p> <p>ALX 424 – “So going into a meeting as the expert, as the person who knows how they have to implement this into practice is not</p>
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			<p>appropriate. You're not going to get anywhere. You're going to get everyone's back up. Versus saying, you know, what questions do you have, what challenges do you have, how do you think you could overcome those challenges, what support do you need? ... It is best practice and you know your practice better than I do. I don't know how you practice. I don't know what's required of you day to day. So how can you incorporate this into your practice?"</p> <p>ALX 234 – “ And again, feeling like an informal nurse leader and breaking through the physician barrier of like, I need your buy in but its going to happen, but I still need your buy in. Just knowing the right way to go up the ladder, I think. Sometimes like the little things I would change. You have to be careful with how you talk, and you have to be careful with what your message is. So your intended message, your intended audience. Sometimes you have to be very political in how that's delivered.”</p> <p>ALX432- “... So what I learned is you have to speak the language of the individual, find out what the individual is or the groups is interested in, and try to meld your agenda or your patient's agenda in with that. ...”</p> <p>ALX232 - “So now my power isn't very formal, so its built on my ability to prove my credibility and be able to somehow inset myself at the key positions and key ears to sort of say we should be doing this.”</p> <p>ALX424 – “Being mindful of how I communicate as well as ensuring that you're communication with the appropriate stakeholders and players involved in whatever you're doing.”</p>
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Table E5: Organization and system-focused leadership capability domain 5: Mentoring and coaching			
Leadership capability domain with definition	Leadership capabilities (ALX### is the participant identifier)	Perceived outcomes PF = Patient/ Family NH = Nursing/ Health Provider HS = Healthcare System	Examples of supporting data
Coaching and mentoring = fostering trusting relationship with the goal of building capacity within others	Engaging others ALX232, 423, 242, 431, 424, 413, 421	NH – Healthcare professionals working to full scope NH – Safe learning environment	ALX 421 – “Leadership is not just being at the forefront of teaching and leading and showing by example. It’s encouraging other staff members. It doesn’t necessarily have to be nursing. It could be OT, it could be physio, and it could be social work. That you can take the lead, you can be a leader, and here’s how you can do it. And I’m right behind you. You are working under the same principles that I am. So you know, you can make you’re way and form a bit of an autonomous practice for yourself if you take these things on. But in a very diplomatic way and make sure you’ve got all the team on side and you follow your principles and you don’t go outside your scope.” ALX 321 – “The staff are very comfortable coming to talk to me about lots of things. It could be interactions on the units, bedside clinical things. So how do you ... I do a lot of coaching as to what might you say, how to you approach a situation.” ALX 242 – “I mean our nurses have presented at each national conference. So helping them do abstracts so they can present a poster or an oral. ... I get staff involved and help to give them confidence to stand up and present.”

	<p>Being a mentor ALX232, 423, 242, 332, 412, 413, 421, 341, 321</p>	<p>ALX 341 – “I think that you need to be able to stimulate passion, stimulate excellence, stimulate ongoing learning, stimulate the desire to grow as a nurse, to provide holistic care, to ...”</p> <p>ALX424 – “From a clinical perspective, I lead and guide and sort of hope to work myself out of a job by building competence and building skills, and developing that in other nurses and other healthcare providers. ... So even a couple of years ago myself and another APN worked with a team, to help the nurses work to full scope. I see leadership as a way that you’re kind of guiding and mentoring other nurses and healthcare providers to push the practice forward and feel confident and able.”</p> <p>ALX 232 – “For a while, patients with this diagnosis got this treatment, new evidence came up ... so then they started patients on a new therapy and I suddenly became that nurse. So I began building capacity in the teams and in the nurses to understand this, and working with the therapy, and making sure the nurses had the support around what they needed. And do now the population isn’t even referred to me. I certainly still understand the population but there’s no need for me to take any kind of leadership in their care.”</p> <p>ALX332 – “I work with an RN in my clinic. She didn’t always like her job, but in my clinic she’s given more autonomy and I help her understanding and working to full scope.”</p> <p>ALX413 – “We have both junior and senior roles with in the APNs. So there’s a junior and senior on. So your role is not only looking after the patient within your scope as an APN, but also have a significant role in mentoring and being the go to person for the junior ...”</p> <p>ALX 423 – “And I also think that its important to mentor new</p>
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		<p>staff in professional nursing, what it means to be a professional nurse, and not to fall into sort of the norm, the status quo, to think and to be the kind of nurse that you would want to have caring for your family member. So leadership for me is active. It's constantly demonstrating what its means to be a professional nurse.”</p> <p>ALX 423 – “Encouraging nurses that have been around for a long time to be mentors and to be leaders. And it doesn't require a lot of energy. It requires you to be there and to be open.”</p> <p>ALX424 – “A couple of nurses have expressed interest in attending an upcoming conference. We brought it to the administrator for support. But then we were discussing a way that can actually get the nurses to commit to it. Because they're encouraged, but how do we get them to take a good idea and move it forward? So today I had a conversation with x and then touched base with another APN who's connected with different teams on how we can work together and how we can help those nurses achieve their ultimate outcome of attending the conference. But how can we make it work clinically within management without doing for them. ... But to be mindful of the fact that doing for isn't always as helpful as helping people build that skill and competence.”</p> <p>ALX 413 – “I've been very fortunate with tremendous mentorship and support. And it's all about passing it on and helping others to do that. Well if you think about inspiring and mentoring other, I mean it's being able to ... it's basic communication right, and its respect, and it's believing in them and role modeling. I think when people see what you can achieve and how that happens, and you inspire others to want to do the same things, they learn a lot by that.”</p>
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Table E6: <i>Organization and system-focused leadership</i> capability domain 6: Providing leadership role on internal or external committees			
Leadership capability domain with definition	Leadership capabilities (ALX### is the participant identifier)	Perceived outcomes PF= Patient/ Family NH= Nursing/ Health Provider HS=Healthcare System	Examples of supporting data
Leadership on internal and external committees = chairing or co-chairing committees	Chairing or holding an executive position ALX423, 312, 242, 321, 431, 332, 341, 412, 413, 421	HS - Bring back new evidence or practices to the organization HS - Representation of the organizations at provincial and national forms NH - Nursing representation at committee level HS - Advancing practice at local, provincial, national and international levels	ALX 413 – “From the unit level assisting with policies, the hospital-wide policy, to sitting on the committee at CNA and working with them to revamp their toolkit with respect to my area of expertise. That crosses populations across the country. ALX341 – “I think its important that you stay involved in your specialty associations. You need to be a leader on working groups. You need to be at conferences and doing things.” ALX 431 – “I sit on the Canadian Association of specialty Nurses. And in the last few years have helped write standards because there were never any. I first wrote competencies. Then we wrote standards for population. ... That will be the end of my mandate co-chairing and chairing it. The competencies are being used by an academic centre as a credit course. Its specifically for

			<p>this population of patients. It's interdisciplinary. It was really exciting they took that work and created a course.”</p> <p>ALX 423 – “I chair this committee here, currently we are focused on this aspect of care.”</p> <p>ALX 423 – “I head up the committee for the national specialty association. So I am involved at the executive level of that.”</p> <p>ALX413 – “I'm chair of the nurse special interest group of the Canadian specialty Society. So that's a national level of taking a different type of leadership. And then several committees more nationally and internationally.”</p> <p>ALX 312 – “I submitted a nursing grant and organized, in collaboration with College and University, and advanced practice outcome measurement day. With keynote speakers. It was to start to build capacity within the province for APNs to begin to measure outcomes associated with their practice.”</p> <p>ALX321 – “ I am part of a international group which is developing population specific nurse competencies. So I try to provide leadership here but also on a broader scale, but everything you learn elsewhere, you bring back here.”</p>
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Table E7: Organization and system-focused leadership capability domain 7: Facilitating collaboration			
Leadership capability with definition	Leadership capabilities (ALX### is the participant identifier)	Perceived Outcomes PF = Patient/ Family NH = Nursing/ Health Provider HS = Healthcare System	Examples of supporting data
Facilitating collaboration = building effective partnerships	Engaging other people/ organizations to purposefully work as a team ALX232, 312, 234, 413, 421	<p>HS - Productive partnership across healthcare spectrum to improve healthcare</p> <p>HS - Increase team functioning effectiveness</p> <p>PF - Continuity of healthcare</p> <p>HS - Safer care processes</p>	<p>ALX 413 – “We pull together and started working with all the stakeholders. So key champions, all the staff, administration, and the hospital. We did a hospital wide policy because that was needed. ...”</p> <p>ALX 232- “So patients with this diagnosis, I didn’t particularly ask it and view myself as an expert. But we were getting quite a few of these patients, there was a lot of stigmatizing and marginalization. So that’s how I got into it. So I thought, I need to know more – who’s out there, who’s working with them? So that’s how I connected with the teams in the community. Realize they were as hungry to do a connection liaison. So part of the work I did was to sort of start to bridgework, how would we look at this. And so we’ve developed a really nice collegial work. ... So we’ve built some really nice bridges with the teams and built supports. We developed a strategy... This is again where you build partnerships.”</p> <p>ALX 232 – “It’s knitting everybody together and making sure who needs to be there is there, right. It’s the whole team and pulling them together. But making those</p>

		<p>opportunities.”</p> <p>ALX 234 – “So I collaborate really well. I have formed really good relationships with people in the community as well. So certain family doctors, the health team, the Community Centre. I think its really important to, even in acute care, to build these important community partnerships”</p> <p>ALX 421 – “I think I’ve developed a really good relationship over the years with people who are completely separate from us altogether. And it always use to be “we” and “they” type of thing. But its come together in such a way that now if they are looking for advice or are you are seeing this patient, I’ll wait until your assessment, until I go see them and see how we work together to get the right flow for the patient.”</p>
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Appendix F APN Sample Demographic Profile

APN Demographic Questionnaire *missing response			
1. What is your sex?			
Female	14	Male	0
2. * What is your age?			
Less than or equal to 49	7	Greater than or equal to 50	6
3. *Location of employment?			
CDHA	7	IWK	6
4 Employment title?			
CNS	6	NP	8
5. Highest level of education achieved?			
Graduate degree or higher	14		
6. *Number of years in nursing practice?			
Less than or equal to 25	4	Greater than 25	9
7. Number of years as an APN?			
Less than or equal to 10	5	Greater than 10	9
9. Is leadership part of your APN job description within your organization?			
Yes	14	No	0