



A Literature Review of Advanced Nursing Practice

To inform the development of an Advanced Nurse Practitioner
Model for a Specialist Palliative Care Service

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Introduction

Introduction

Specialist Palliative Care Services, Health Service Executive, Dublin North-East for the three local health offices of Louth, Meath, Cavan/Monaghan and Hospital Network 3, is pleased to publish this comprehensive literature review, which was conducted as a preliminary project to inform and direct the planning, development and implementation of the Advanced Nurse Practitioner model for their service.

The literature review was undertaken with regard to a clearly defined need within the service (NEHB 2003), the Framework for the Establishment of Advanced Nurse Practitioner (NCNM 2007) and government policy on specialist palliative care (DOH&C 2001). However, no single model emerged that fulfilled all requirements.

The findings from this review identified the need for the service to develop a new model drawing on national and international experience to address the complex and dynamic needs of their patients. The full report on the development of this model is available in the publication ISBN 978-1-906218-04-1.

Personally I would like to thank the steering group for all their help and expertise in compiling this report.

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Preamble

Preamble

A comprehensive literature review was conducted about role development and evaluation of Advanced Practice Nursing (APN). Facilitators and inhibitors of role development were identified to inform and direct the planning, development and implementation of the advanced nurse practitioner (ANP) role within Specialist Palliative Care Services (SPCS), Health Service Executive (HSE), Dublin North-East Area, for the three local health offices of Louth, Meath and Cavan/Monaghan and Hospital Network 3. The international literature that informed this review is mainly from the United States of America (USA), United Kingdom (UK), Canada and Australia, reflecting the early stage of development of the ANP in Ireland.

This review is presented in a number of subsections:

- The Irish definition of advanced nurse practitioner (ANP), including an historical background to its development
- An international exploration of advanced nursing practice in relation to competencies and education requirements
- The evolving roles of advanced nursing practice, emphasising the developing roles of nursing in the speciality of palliative care
- Identifying the facilitators and barriers to the implementation of advanced nursing roles
- A review of international models of advanced practice
- A discussion of lessons learned from the review.

The review concludes with an appraisal of the findings obtained within the literature and identifies the gaps in order to highlight what is fundamental to the development of the ANP role within Specialist Palliative Care (SPC). Finally, the review identifies the factors to circumvent when scoping the role.

Definition

1.1 Definition

As advanced nursing has evolved, so too has its definition (Lewis 2000). Therefore it is important to define what advanced nursing practice is from an Irish perspective.

The National Council for the Professional Development of Nursing and Midwifery (National Council) of Ireland defines advanced practice as being synonymous with advanced nurse practitioner (ANP) and describes the ANP as highly experienced in clinical practice and educated to Masters degree level or higher. Nurses are eligible to practice and use the title of ANP only when they have been successfully accredited following appointment to an approved post accredited by the National Council (NCNM 2007).

The ANP is an autonomous, experienced practitioner who is competent, accountable and responsible for his or her own practice. They utilise advanced clinical nursing knowledge and critical thinking skills to independently provide optimum patient/client care through caseload management of acute/chronic illness. Advanced nursing/midwifery practice is grounded in the theory and practice of nursing/midwifery and incorporates nursing/midwifery and other related research, management and leadership theories and skills in order to encourage a collegiate, multidisciplinary approach to quality patient care (NCNM 2007).

1.1.2 Advanced Nursing Practice

The field of nursing has undergone tremendous change, particularly in the area of advanced nursing practice, which has developed in many different ways (Lewis 2000). Originating in the United States of America, the concept of advanced nursing has emerged as an international phenomenon. Developments in modern healthcare have created the demand for expanded and enhanced roles for nurses (Schwirian 2002). While much literature exists supporting the development of advanced nursing roles in relation to their effectiveness to deliver high quality care (Chang *et al.* 1999, Mundinger *et al.* 2000, Smith 2003, Nevin-Brady 2005, Griffin & Melby 2006) that is safe and effective (Chiarella 2006), there is still confusion and overlap between various titles and roles that are used around the world (Hodson 1998, Mick & Ackerman 2002, Carnwell & Daly 2003, Griffin & Melby 2006). Confusion also exists with regard to boundaries of practice, levels of practice, levels of clinical autonomy and preparation for the roles (Castledine 1991, Sutton & Smith 1995, Wilson-Barnett *et al.* 2000, Daly & Carnwell 2003).

This ad hoc development internationally has resulted in confusion regarding the extent to which some of these roles truly reflect advanced nursing practice. There is a lack of clarity concerning roles, responsibilities and qualifications and clarification is required (Schober 2006). While variability among advanced nursing practice roles is expected and desirable (Bryant-Lukosius *et al.* 2004) and differences in practice competencies will exist (Daly & Carnwell 2003), consistency in core characteristics is important for advanced nursing practice to occur (Daly & Carnwell 2003, Bryant-Lukosius *et al.* 2004).

The way in which the varied titles of advanced practice nursing are used synonymously and interchanged for each other internationally does not give full regard to the context of the Irish advanced nurse practitioner (ANP). Caution should be exercised when comparing ANP roles within and across countries due to the differences in definitions, education requirements, scope of practice and legislative and regulatory authority (Adams 2007: 22). It is suggested that the title of clinical nurse specialist (CNS) be reserved for the advanced practitioner prepared to Masters level because use of the title for less well prepared nurses will continue to result in role confusion (Storr 1999).

For the purpose of this review the Irish definition of advanced nurse practitioner is utilised when comparing the many titles and roles found within the literature, since the purpose of this review is to inform the development and implementation of an ANP in SPC within the HSE, Dublin North-East Area.

1.1.3 History of Advanced Nursing Practice

The title advanced practice nurse (APN) was initially adopted in the United States in the 1970s as an umbrella term encompassing four speciality nursing roles: clinical nurse specialist (CNS); nurse practitioner (NP); certified nurse midwife (CNM); and certified registered nurse anaesthetist (CRNA). More recent developments have resulted in the evolution of a fifth role - advanced practice nurse case managers (APNCM) (Schwirian 2002). The evolution of advanced nursing practice in the United States has been mainly in two related but distinct directions, the nurse practitioner (NP) and the clinical nurse specialist (CNS) (Calkin 1984, Dunn 1997). This two-role evolution was in response to social demands for increased access to affordable, quality primary care and at the same time in response to the increasingly complex advanced nursing care requirements of patients (Calkin 1984).

Nurse educators developed the concept of the CNS in an attempt to decrease fragmentation of patient care whilst bringing expertise to the patient bedside and simultaneously providing an avenue for advancement (Dunn 1997). The nurse practitioner (NP) movement grew initially in response to a shortage of primary care physicians in the 1960s and 1970s (Schwirian 2002). Nurse practitioners evolved out of a need to provide patient care in generalist primary settings, whereas the clinical nurse specialist evolved to improve patient care focusing on acute specialities.

Kuebler *et al.* (2007) suggest that differentiations between the CNS role and the NP role are a result of educational preparation, focus, state practice acts and specific practice settings. However, continued changes have seen the NP role expand from generalist primary settings to acute settings, whilst the CNS has broadened its focus from acute specialities to more population-based approaches. Some of the current literature advocates for the amalgamation of the two roles (Skalla 2006) since both roles are beginning to share similar attributes, with the nurse practitioner moving towards the multidimensional focus of the clinical nurse specialist (Manley 1997). However, others advocate that they remain distinct practice roles (Mick & Ackerman 2000).

In the UK the recent proliferation of new nursing roles has led to confusion. Titles such as clinical nurse specialist, nurse practitioner, advanced nurse practitioner, higher-level

practitioner and nurse consultant are being adopted with little understanding or consensus as to the nature of or the difference between such roles (Daly & Carnwell 2003). The clinical nurse specialist emerged in the late 1980s, primarily fulfilling a specialist practice role. These roles were very different to the American roles and were underdeveloped compared to their American counterparts, especially with regard to their educator and consultancy roles (Manley 1997). The nurse practitioner role initially emerged in the primary care setting in the UK and later developed in emergency departments in response to increasing waiting times and reduction in junior doctors' hours (Griffin & Melby 2006).

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) refused to recognise the NP role within the emerging higher level of practice (Castledine 1993), resulting in a lack of standardization with regard to educational preparation and standards for practice (Griffin & Melby 2006). This has resulted in the role of the nurse practitioner not being clearly defined within the UK, and nurses from a wide range of educational backgrounds practicing in NP posts (Horrocks *et al.* 2002). In the USA all NPs must undertake a Masters degree to practice, while in the UK the majority are not prepared to Masters degree level (Obeid 1998). However, the American NP role encompassed primarily direct practice, with no requirement to include the other sub roles as defined in Ireland (NCNM 2007). The UKCC has commissioned a project on Higher Level of Practice to define advanced practice and inform the development of a framework for advanced nursing practice in the United Kingdom. A definition has been proposed but the framework remains outstanding (NMC 2004).

Similar confusion regarding role titling, education requirements and role confusion exists in Canada. The initial major focus of the evaluation of such posts was on the medical replacement function of the nurse, perpetuating the stigma of the nurse practitioner as simply 'a physician replacement.' It is suggested that for the future development of such posts in Canada there is a need for agreement regarding title, education and competencies and the development of national standards and certification (de Leon-Demare *et al.* 1999). As a result, a national framework for advanced nursing practice in Canada has been developed (CAN 2002).

Western Australia has successfully developed the role of the nurse practitioner within a clear operational framework that is supported by legislative authority, and underpinned by a fundamental principle of partnership and collaboration with other health professionals while responding to patient needs and service demands (Adams 2007). Similar developments have occurred in New Zealand, where the Nursing Council of New Zealand has developed a framework for the regulation of the nurse practitioner. This framework includes the competencies, education requirements and process the Nursing Council applies to assess applicants seeking 'nurse practitioner' status (Ministry of Health New Zealand 2002).

Ireland has learned from the international experience. The National Council has clearly defined the role and educational requirements and competencies required to practice in an advanced practice role. A national framework to guide the provision of advanced practice roles has been developed and revised (NCNM 2001, 2004a, 2007a). Masters degree programmes are now offered in seven third-level institutions in Ireland (Nevin-Brady 2005) and as a result there has been a progression of the number of sites prepared for ANPs. There are currently 70 ANPs in Ireland (NCNM 2007b).

A recent preliminary evaluation of the role of ANPs in Ireland suggests that patients benefit from complete holistic care and treatment initiated by the ANP (NCNM 2005). However, it also highlighted the difficulty in fulfilling all four concepts of the role due to the clinical demands. The full potential of the role is not being fulfilled in relation to the research, leadership and education components of the role.

Despite the availability of clear guidelines and a definition of advanced practice, an Irish survey (n=70) found that the overwhelming majority of nurses thought more information on the implications of advanced practice was needed (Nevin-Brady 2005). Therefore, there is a need to demonstrate through research the effectiveness of the ANP role within the Irish context so that their contribution to the transformation of the health service is visible to both employers and clients.

1.1.4 Summary

A review of the national and international experience highlights that advanced nursing practice has evolved differently in different countries despite common influencing factors. Defining the concept of advanced practice remains problematic (Woods 2000) mainly due to the variation between settings (NCNM 2005). While there is no single definition of advanced nursing practice (Bryant-Lukosius *et al.* 2004), there is consensus that advanced nursing practice extends the traditional scope of practice, involves highly autonomous practice, maximises the use of nursing knowledge and contributes to the development of the profession (CAN 2000, Castledine 2002, NCNM 2004a).

There is consensus that the role involves multiple interacting domains broadly relating to clinical practice, education, research, professional development and organisational leadership (NCNM 2004, Bryant-Lukosius *et al.* 2004), and that the status of the advanced practitioner is defined by their level of education and practice (Calkin 1984) and not by the range of tasks performed.

Competencies

1.2 Competencies and Educational Requirements

There is a general consensus that advanced nursing practice concerns what nurses do in the role (Bryant-Lukosius *et al.* 2004, NCNM 2005). Nurse practitioners are required to exercise higher levels of judgement, discretion and decision-making in the clinical setting. Competence is the ability to demonstrate the knowledge, skills and behaviours necessary to perform the role of advanced nurse practitioner (ABA 2000). Specific competencies are required to carry out advanced practice, including education at a postgraduate level in a specific area of practice, professional accreditation in a specialist area of practice and demonstration of expert clinical practice (Hamric *et al.* 2000). Therefore, appropriate preparation, education, demonstrated competence to practice and formal recognition of such competence is integral to the success of the role (Government of Western Australia 2003: 21, NCNM 2007).

It is agreed that competencies for advanced nursing practice can be grouped into five main domains: clinical practice, education, research, organisational leadership and professional development (Hamric *et al.* 2000). These competencies are demonstrated in roles that require highly autonomous, independent, accountable, and ethical practice in complex, often ambiguous and rapidly changing environments (CAN 2002). This has resulted in the suggestion that role competencies involving the domains of practice (clinical practice, education, research, organisational leadership and professional development) are better at discriminating ANP roles than role titles alone (Bryant-Lukosius *et al.* 2004).

Bousfield's (1997) study into the experience of the CNS in the UK discusses barriers and enablers to the CNS role and in doing so, highlights some key competencies of the role: leadership skills, expert knowledge, time management skills, role evaluation skills and empowerment of self and others. A Delphi study undertaken in the UK demonstrated the importance of clinical competence to advanced practice. In particular, comprehensive assessment skills in taking a systemic patient history, diagnostic decisions based on interpretation of clinical and other data, the development of an individualised care plan outlining both nursing and medical management, as well as the prescription of treatment

including medication based on sound knowledge of pharmacology were mentioned (Roberts-Davis & Read 2001). While the competencies for advanced practice are grouped into five domains, *'it is the effective interaction, blending and simultaneous execution of the identified skills, knowledge, judgement and personal attributes in complex practice environments that characterise advanced nursing practice'* (CAN 2002: 6).

These competencies require educational preparation and there is consensus within the literature that this education should be at Masters degree level (Woods 1998, Manley 1997, Hodson 1998, NCNM 2004, Griffin & Melby 2006). Carnwell & Daly (2003) advocate that it is the combination of specialist knowledge combined with a thorough grounding in, and reflection on practice that distinguishes advanced practice from specialist practice. Manley (1997:23) argues that a postgraduate degree at Masters level is *'vital for the research sub role'* and is necessary to demonstrate familiarity with knowledge at all four levels - empirical, personal, aesthetic and moral knowledge (Carper 1978). Therefore it is the application of advanced nursing knowledge that determines whether nursing practice is advanced; not the addition of functions from other professions (MacDonald *et al.* 2005).

In the USA, the educational level for advanced practice nursing has been at Masters degree level for the last thirty years (NCNM 2005). Currently a Masters degree is required in New Zealand (Gardner *et al.* 2004), Norway (Lorenson *et al.* 1998), the Netherlands (Van Offenbeek & Knip 2004) and Canada (CNA 2002, MacDonald *et al.* 2005). Western Australia specifies a minimum of postgraduate education. However, it is unclear if there are plans to upgrade education level to Masters degree as outlined in the ANMC report (ANMC 2004). The UK has funded a number of large projects relating to NP education and practice (Cameron & Masterson 2000, ENRiP 2000) and has published a guide for the profession on the development of NP roles, competencies and standards for education and practice (RCN 2005). However, there is no minimum standard. This is reflected in a varied level and type of education for nurse practitioners (Woods 1997).

Evolution

1.3 Evolution of Advanced Roles

Innovation has been a key principle in the evolution of advanced nursing practice in response to changes in healthcare policies. This has resulted in a shift in work settings from rural ambulatory care, where practitioners often operated on their own, extending into institutional settings such as hospitals and nursing homes (Daly & Carnwell 2003, Hamric *et al.* 2000). As a result, more NPs have become involved in the direct, multiprofessional care that modern healthcare organisations and networks provide (Spilsbury & Meyer 2001). Many NPs deliver care concurrently across different locations for patients who have high levels of acuity and complications related to chronic illness (Swartz *et al.* 2003). This is of particular significance to specialist palliative care nursing where the pathway of care may cross a number of interfaces: hospital – community; low dependency – high dependency or critical care.

While nurse practitioners are becoming more involved in direct, multiprofessional care in complex healthcare organisations, most evaluative studies have been directed at the individual level, comparing the care provided by nurse practitioners with that provided by other healthcare professionals. There are few studies into NP roles that take an organisational perspective. One such study, Offenbeek & Knip (2004:680), was conducted to evaluate the organisational and performance effects of nurse practitioner roles in Dutch hospitals. They used a case study approach and proposed a conceptual model based on patterned systems contingency theory. They concluded that *'innovative forms of advanced nursing practice can only enhance the effectiveness of care processes when they are embedded in a work structure that is internally consistent and adjusted to the task environment and the available skill mix.'*

The literature highlights an increase in the number and type of advanced nursing practice roles. Roles have emerged in many different clinical arenas, for example: surgery (Hylka & Beschle 1997, Hodson 1998), primary care (Cox 2001, Carnwell & Daly 2003, Sibbald *et al.* 2006), A/E (Heaney & Paxton 1997, Dolan *et al.* 1997, Smith 2003, Giffin & Melby 2006), gastroenterology (Hillar 2001), urology (Gidlow & Roodhouse 1998), neonatal (Dillan & George

1997, Gibbins *et al.* 2000, Smith & Hall 2007), and oncology (Giarelli & Throckmorton 2004, Cummings & Mc Lennan 2005). There are very few examples of ANP roles within the speciality of palliative care.

In summary, there is an emerging consensus that advanced nursing is concerned with what nurses do, what nurses know, and how they exercise that knowledge to the benefit of the patient. It describes an advanced level of nursing practice that maximises the use of in-depth nursing knowledge and skill in meeting the needs of patients (individuals, families, groups, populations, or entire communities). The core competencies of the role must be demonstrated in a way that requires highly autonomous, independent, accountable, and ethical practice in complex, often ambiguous and rapidly changing environments. While the literature highlights an increase in the number and type of advanced nursing practice roles, there is a need to further examine the concept within the speciality of palliative care as few examples have been described to date.

1.3.1 Evolution of Advanced Nursing Roles in Palliative Care

The concept of advanced practice nursing within palliative care is gradually emerging within the literature (Williams & Sidani 2001, Kuebler 2002, Emnet *et al.* 2002, Coyne 2003, Kuebler 2003, Meier & Beresford 2006). However, most of the literature sourced is anecdotal. The American Nurse Association advocates that the advanced practice nurse integrates education, research, management, leadership and consultation into clinical roles. Furthermore, it is suggested that ANPs are uniquely qualified to expand their roles into palliative care (Coyne 2003) by providing support for acutely ill patients whose care is becoming more complicated and technical through their roles of specialist educator, information resource, collaborator and advocate for the hospice movement (McHale 1998).

A recent review of advanced nursing roles discusses the pivotal role and perspective of advanced practice nursing within palliative care (Meier & Beresford 2006). They advocate for the evolving role of the advanced practice nurse in palliative care, highlighting that they often play clinical leadership roles on palliative care teams as well as acting as clinical consultants, program administrators, educators and researchers. Advanced practice nurses are required to define their scope of practice based on educational preparation and the certification they obtained.

However, while they advocate positively for the role, they highlight difficulties from an educational viewpoint as the speciality of palliative care emerges within the USA. Because palliative care is a new speciality, the majority of advanced practice nurses working in the area are educated and certified in other nursing specialities and have become subsequently certified in palliative care by undertaking a postgraduate certificate in palliative care. This varied speciality background of advanced palliative care nurses is envisaged to change as more Masters programmes specialising in palliative care are launched. However, in the meantime it is important for all advanced practice nurses working in palliative care to work within their scope of practice based on their educational background (Meier & Beresford 2006).

Kuebler (2003), a practicing nurse practitioner in palliative care in the USA, provides an overview of the role and the required clinical skills. She defines the advanced practice nurse as a registered nurse who has advanced graduate education (Masters/Doctoral degree) with clinical skills beyond basic nursing education. According to Kuebler, the palliative care advanced practice nurse is a key person within the healthcare team to deliver high quality, evidence-based palliative care interventions to patients living with and dying from advanced illness.

She further maintains that the advanced practice nurse, through skilled and knowledgeable palliative practice, is able to improve the quality of life for patients living with advanced illness, while also contributing to the continuity and coordination of services through assessment and appropriate referral (Kuebler 2003). The advanced practice nurse in palliative care is complementary to, rather than competitive with, the physician as both collaborate to meet the needs of this complex population (Coyne 2003). Ideally, all advanced practice nurses should work in team settings where a pooling of talent between and among a variety of professional staff members contributes to the holistic care of patients and families (Kuebler *et al.* 2007). This is of significance to the palliative care multidisciplinary focus (DOH&C 2001, Meier & Beresford 2006).

The most frequently cited model of advanced practice nurse within palliative care is the Macmillan Nurse in the UK (McHale 1998, Kuebler 2003). Macmillan nurses play a significant role in specialist palliative care services within hospice, community, and hospital settings across the United Kingdom, providing direct and indirect care to patients with complex palliative care needs and to their families (Skilbeck *et al.* 2002). The role is based on the model of the CNS, which has five distinct competencies: clinical, consultative, teaching, leadership and research. They act as a knowledge resource to the primary care team and make themselves available in a consultative, educative and supportive way, thus empowering primary nurses (McHale 1998).

There are some key elements of the Macmillan nurse that inform the site preparation for an ANP in SPC: clinical, consultative, teaching, leadership and research. However, it must be emphasised that at the time of inception of the role, education to Masters degree level was not a requirement. Many of the Macmillan nurses do not have a Masters degree. In the UK Macmillan Nurses are not required to be educated to Masters level. For the purposes of this review it was considered that the Macmillan model compares more favourably with the CNS role as defined by the National Council (NCNM 2004b).

In America the Robert Wood Foundation launched a programme promoting excellence in End of Life Care in an effort to improve care and quality of life for dying Americans and their families. In 2001, the foundation compiled a report of pioneering practices in palliative care to illustrate successful models of palliative care (Emnett *et al.* 2001). This report describes many different models of advanced practice in the USA. The practice settings (public and private) span the spectrum from hospital-based, community to independent practice.

Most of the advanced nurses work as part of a multidisciplinary team while others act as consultants to teams or physicians. However, while all report being educated to Masters degree level, their primary background did not always include palliative care. This does not meet the requirements needed to practice as an ANP in SPC in Ireland nor government policy in relation to specialist palliative care, i.e. part of an interdisciplinary team (DOH&C 2001).

1.3.2 Summary

There are a wide variety of models of advanced nursing practice within the literature but very few of them relate to specialist palliative care. Some of the examples from palliative care are inconsistent with national policy for advanced nursing practice and specialist palliative care.

There is consensus that the concept of advanced practice nursing within palliative care is gradually emerging (Williams & Sidani 2001, Kuebler 2002, Emnet *et al.* 2002, Coyne 2003, Kuebler 2003, Meier & Beresford 2006). However, while there is agreement regarding the educational preparation for advanced roles within the USA (Masters degree level), the newness of the speciality of palliative care has resulted in a varied speciality background of advanced palliative care nurses practicing in the USA. This is likely to change as more Masters programmes specialising in palliative care are launched.

While the Macmillan model is modelled on the clinical nurse specialist incorporating the five areas of clinical practice, provision of consultation services, teaching, leadership and research, the model does not require a Masters degree level of education. This results in role confusion when titles such as CNS are used for less prepared nurses (Storr 1999).

A clear model for the role of an ANP has not emerged from the review of the literature that would be consistent with national policy, local practice and need.

Facilitators

1.4 Facilitators and Barriers to Advanced Nursing Roles

The literature highlights the unprecedented increase in number and types of ANP roles in various settings and suggests that the increasing demand for advanced practice roles is expected to continue (Bryant-Lukosius *et al.* 2004). Various factors are known to influence effective practice in innovative nursing roles within acute settings (McDonnell *et al.* 2001) and there are many challenges to the successful implementation of ANP roles (Woods 1998, Bryant-Lukosius *et al.* 2004, Nevin-Brady 2005). The operationalizing of the ANP role requires an organisation to examine organisational policies and processes. This may be a creative opportunity. Within the literature there are a number of factors that recur irrespective of the domain of practice that may facilitate or inhibit this process (Woods 1998):

Facilitators:

Support (Glen & Waddington 1998, Woods 1998, Jones 2005);

Clear definition and framework (Woods 1998, Sidini *et al.* 2000, Bryant-Lukosius *et al.* 2004, Jones 2005, Nevin-Brady 2005).

Inhibitors:

Uncertainty and medical opposition (Tye & Ross 2000);

Absence of supportive measures, resistance to change (Glen & Waddington 1998, Woods 1998);

Negative attitude and lack of resources (Wilson-Barnett *et al.* 2000);

Fear of litigation, lack of preparation and training and lack of support from physicians (Magennis *et al.* 1999, Tye & Ross 2000, Nevin-Brady 2005);

Disempowerment, which included lack of support, lack of autonomy, isolation and conflict (Bousfield 1997).

Jones (2005) undertook a systemic review and meta-analysis of qualitative research studies, reporting barriers and facilitators affecting practice in specialist and advanced nursing roles. The factors most widely identified as important were relationships with other key personnel and role definition and expectations. She further suggests that in order to reduce role ambiguity, clear role definition and objectives are developed and communicated to all relevant groups when roles are being introduced.

However, Nevin-Brady, in a descriptive survey to establish Irish endoscopy nurses' (n=70) perceptions regarding the development of advanced practice, found that despite the availability of clear guidelines and a definition of the ANP role, the majority of nurses thought more information on the implications of advanced practice was needed (Nevin-Brady 2005). Therefore, care must be taken to alleviate fears among the other team members affected by the implementation of the new role. This may be achieved by clearly defining and communicating the new role and by highlighting how the role will function as complementary to existing roles.

Woods (1999) describes the contingent nature of advanced nursing practice as NPs in the UK attempt to implement their new role (n=5). Within this study the roles were new, both to the ANPs and the institutions. He found that the ANPs commonly experienced conflict, role challenge and frustration resulting from differing perspectives of the aim and purpose of the role. He further elaborates that resistance and resentment towards ANP roles was mainly cited from nursing colleagues. Problems with consensus and control over their scope of practice made the ANPs feel that they were being used as '*junior doctor replacements*', which was not how they envisaged the role (Woods 1998). Tye & Ross, using a case study approach, also found the potential medicalisation of the role problematic which resulted in many of the emergency department ANPs in their study emphasising the nursing aspect of their role (Tye & Ross 2000).

Bryant-Lukosius *et al.* (2004) highlights and discusses six issues that influence the introduction of advanced nursing practice: confusion about advanced practice terminology; failure to define clearly the roles and goals; role emphasis on physician replacement/support; under-utilisation of all role domains; failure to address environmental factors that undermine the roles; and limited use of evidence-based approaches to guide their development, implementation and evaluation. They conclude with recommendations to guide future introduction of advanced practice nursing roles. These include the need for a collaborative, systemic and evidence-based process designed to provide data to support the need and goals for a clearly defined role and support for a nursing orientation.

Advanced nurse practitioners value the non-clinical aspects of their role, and these activities contribute to role satisfaction (Mick & Ackerman 2000, Sidini *et al.* 2000). However, competing time demands for clinical practice and insufficient administration support are reported as barriers to participating in research, education and leadership activities (Storr 1999, Sidini *et al.* 2000, Bryant-Lukosius *et al.* 2004). Ackerman *et al.* (1996) suggest that a balance between clinical and non-clinical activities is required to facilitate innovative nursing practice. It is important for ANPs to realise the full potential of their roles by operationalizing all the domains of their role.

1.4.1 Summary

An ANP is a senior clinician within an organisation and there are many challenges to the successful implementation of this role (Woods 1999, Bryant-Lukosius *et al.* 2004). A number of factors have been defined that may impact on the way this role is implemented (Tye & Ross 2000). The individual practitioners will require multidisciplinary support and continuing education in order to meet the challenges involved in this role transition (Tye & Ross 2000), especially if all four domains are to be realised.

In anticipating such a development it is imperative to put structures in place that will enable the ANP to realise the full potential of the role given the challenges outlined in implementing ANP posts in the literature (Woods 1999, Bryant-Lukosius *et al.* 2004).

Models

1.5 Models of Advanced Nursing Practice

A lack of a unified approach to advanced practice roles and functions, education, titles and credentials has contributed to disorganisation and confusion within nursing as well as for other members of the healthcare system (Berger *et al.* 1996). It is suggested that conceptual models are useful for guiding and evaluating this role evolution (Hodson 1998, Hamric *et al.* 2000). They may also be used as a tool to explain practice (Hodson 1998). However, given the heterogeneity of the healthcare systems and the domains in which ANPs work it is not possible to describe a model that is applicable in all settings (Deutschendorf 2003).

A review of the literature found several models supporting the concept of advanced nursing originating predominantly from America, Canada, Australia and the UK:

Acute care models (Ackerman *et al.* 1996, Manley 1997, Hodson 1998, Howie *et al.* 2002, Whitcomb *et al.* 2002);

Primary care models (Broton *et al.* 1988, MacDonald 2005, Twinn *et al.* 2005).

Most of these models advocate that clinical practice is the primary focus of advanced nursing (Calkin 1984, Ackerman *et al.* 1996, Dunphy & Winland 1998, Hamric *et al.* 2000). There is an emerging consensus that the main roles of the advanced practitioner include expert practitioner, client advocate, educator, leader, consultant and researcher (Calkin 1984, Castledine 1991, Obeid 1998, Hamric *et al.* 2000). However, it is emphasised that advanced clinical practice should not occur in isolation from the other roles (Manley 1997, Hamric *et al.* 2000). The models reviewed incorporated a variety of approaches including consultative/collaborative (Manley 1997, Gibbons *et al.* 2000, Plummer & Hearnshaw 2006, Wand & Fisher 2006), holistic (Ackerman *et al.* 1996, Williams & Sidani 2001, Pieper & Dacher 2004) and a transformational caring approach (Dunphy & Winland-Brown 1998).

Advanced nursing has been described by Calkin (1984) as the deliberate diagnosis and treatment of a full range of human responses to actual and potential health problems. The Calkin (1984) model differentiates basic from advanced nursing practice and may be used as a

tool in deciding whether an advanced nurse practitioner or another grade is required for a specific development. According to Calkin, a key element of ANPs' ability to assess and predict clinical problems and outcomes was their level of clinical experience.

Her research demonstrated that ANPs who were educated to Masters degree level and had extensive clinical practice experience were better able to assess situations and predict clinical problems than those educated to Masters level but having less clinical experience. When experience is combined with wide-ranging theoretical knowledge it enhances the ability of the ANP to adapt and deliver care to patients in any given situation, even if their condition falls outside the remit of a specific protocol or guideline (Fulbrook 1998).

The Strong Model (Ackerman *et al.* 1996) describes a model for the acute care nurse practitioner in the USA. The model is designed like a web with the patient central to the model. The model defines five domains of practice, including direct comprehensive care; support of systems; publication and professional leadership; research and scholarship. Variations are found in each domain due to the different levels of practice expertise. All ANPs bring unique contributions and may not be experts in every domain.

The model outlines three conceptual strands - collaboration, empowerment and scholarship.

Collaboration includes six critical attributes¹ and reflects the belief that care cannot be rendered effectively by a single care provider but that the skills and abilities of the various care providers contribute to the goal of excellent patient care. This is of particular importance to the philosophy of palliative care.

Empowerment is central to the advanced practice model and includes independent decision-making, authority, and accountability. Empowerment requires the acute care NP to accept accountability for decision-making and represent information, beliefs, values and judgements openly, accurately and with confidence. Empowerment exists within the boundaries of speciality knowledge and expertise.

¹Cooperation, assertiveness, responsibility, communication, authority and co-ordination.

Scholarship focuses on constant inquiry to promote thoughtful evaluation and identify the need for change. Scholarship requires a high degree of clinical competence, professional sophistication and self-confidence and directs the performance of the ANP.

The model importantly outlines the novice to expert continuum allowing for role development. Two strands remain open and may be filled with new evolving concepts.

Manley (1997) describes a conceptual framework for the development of advanced practice within a British context utilising an action research approach. The framework consists of three parts; the advanced practitioner, characterized by four integrated sub-roles and a set of skills and processes; the context in which the advanced practitioner nurse operates; and the outcomes in practice resulting when such roles, processes and contexts are combined (Manley 1997). The practitioner is seen in the context of the organisation, requiring an organisational culture of empowerment supporting clinical leadership to deliver high quality patient care (Clegg 2001). The strength of the model is the explicit link between advanced practitioner/consultant nurse roles, its context and its outcomes. In this way the model provides a guiding framework for those aspiring to advanced practice roles in the sense that specific theoretical and practical experience needs to be developed.

1.5.1 Summary

Several models supporting the concept of advanced practice were reviewed. Many of the models advocate that clinical practice should be the primary focus of advanced nursing (Calkin 1984, Ackerman *et al.* 1996, Dunphy & Winland 1998, Hamric *et al.* 2000), and that the main roles of the advanced nurse practitioner include expert practitioner, client advocate, educator, leader, consultant and researcher (Calkin 1984, Castledine 1991, Obeid 1998, Hamric *et al.* 2000). While the models reviewed incorporated different approaches within different settings, there was no one model that described practice within the clinical setting of specialist palliative care as recommended by the Report of the National Advisory Committee on Palliative Care (DOH&C 2001).

Learning

1.6 Learning from the Review

The literature review was undertaken with regard to a clearly defined need within the service (NEHB 2003), the Framework for the Establishment of Advanced Nurse Practitioners (NCNM 2007a) and government policy on specialist palliative care (DOH&C 2001). Local need and relevant policies determined that the required model would be nursing-based and patient-centric. It should incorporate the components of caring, leadership/educator and clinical expert and be consistent with a collaborative, interdisciplinary team approach. The model would be robust and extend to interdependent stakeholders. The ANP was not to be a surrogate physician, but rather a pioneering nursing role through the application of advanced clinical practice, research and education (Dunn 1997) incorporating the skills and knowledge of transformational leadership (Manley 1997). No single model emerged that fulfilled all requirements.

Following widespread consultation the steering group adapted the following concepts from different models (Calkin 1984, Ackerman *et al.* 1996, Manley 1997):

- Expertise in the practice of palliative nursing (caring/holistic, knowledgeable, skilled, competent).
- Ability to develop and maintain a learning culture (facilitate individuals, team & organisational learning, support).
- Leadership qualities (visionary, facilitate change, enhance profile, communication, negotiation, collaboration, team-orientated).
- Effective practitioner (evaluate and demonstrate impact, improve quality of service for patients and their families, provide ongoing evaluation of the role related to pre-determined goals).
- Practice autonomy (function both independently and interdependently in the delivery of healthcare).

- Appropriate fit (between the new post holder and the colleagues within the multidisciplinary palliative care team, creates an environment that supports role development).Patient-centric (reorganisation of service delivery to meet individual needs, and as a mechanism to better understand patient needs, wants, priorities, preferences, and expectations for care).
- Nursing orientation (a clearly defined role that supports a nursing orientation to advanced practice and promotes full utilisation of all of the role domains).

Alternatively it was also agreed that the following developments would be undesirable:

- Insignificant role not complementary to existing roles within the service.
- Development of a role that does not improve the quality of the service.
- Duplication of roles.
- Too broad of scope.
- Isolated role, not integrated into the wider context of services. Surrogate doctor role.

1.6.1 Conclusions

Advanced nurse practice has evolved in a variety of ways in different healthcare settings around the world. However, it appears that there are a number of universal drivers of change: an identification of service need, medical shortages, an increase in population, a decrease in access, improvements in nurse education and competency and the pioneering of nursing to challenge role boundaries (NCNM 2005).

A number of countries have developed their own legal framework and policy infrastructure (Offredy 2000, Cameron & Masterson 2000). A consensus has emerged on the level of education required and titles used.

Whilst the process for implementing and evaluating advanced practice roles can be very complex (Bryant-Lukosius *et al.* 2004) and it is acknowledged that there are many challenges to the successful implementation of ANP roles (Woods 1999, Bryant-Lukosius *et al.* 2004), there are significant benefits to these roles. There is significant scope for creativity and flexibility and ANP roles may be shaped to address complex and dynamic healthcare needs.

The ANP role in specialist palliative care is relatively new. In many cases models and nurses have been 'imported' from related care areas despite the fact that clinical expertise in the area appears to be a key determinant of success of the role (Calkin 1984, Fulbrook 1998).

A single model has not emerged that fulfils the Irish or local requirement. It will be necessary to develop a new model drawing on the national and international experience. The model must be underpinned by a nursing philosophy and incorporate realistic, achievable and measurable outcomes that can be utilised to evaluate the effectiveness of the role as it evolves within the service.

Individual practitioners will require multidisciplinary support and continuing education in order to meet the challenges involved in the role transition (Tye & Ross 2000). Specific consideration needs to be given to the factors that might inhibit or facilitate the development and implementation of advanced practice roles. The impact the new role will have on existing roles within the service requires scoping out.

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