Advanced Practice in Nursing
Under the Auspices of the *International Council of Nurses (ICN)*
Series Editor: Christophe Debout

Lisbeth Maria Fagerström

A Caring Advanced Practice Nursing Model

Theoretical Perspectives And Competency Domains

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Christophe Debout
GIP-IFITS
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Paris, France

This series of concise monographs, endorsed by the International Council of Nurses, explores various aspects of advanced practice nursing at the international level.

The ICN International Nurse Practitioner/Advanced Practice Nursing Network definition has been adopted for this series to define advanced practice nursing: "A Nurse Practitioner/Advanced Practice Nurse is 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 master's degree is recommended for entry level."

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Foreword

I am delighted to write the foreword for this book introducing the *Caring Advanced Practice Nursing Model*, which offers an insight into the theoretical perspective and competence domains. There has been much written globally about the role of the Advanced Practice Nurse (APN) but little focusing on what caritative theory and practice can add to the role.

Professor Fagerström is a global leader in the field of Caritative Nursing and Advanced Practice Nursing and has been instrumental in advanced practice developments in Nordic countries. Her expertise and experience have led to this eloquently presented book which initially discusses the APN role, its benefits, and characteristics. The APN role is well established in many countries providing care in all settings. Where the APN role is evident, we can see them helping to expand healthcare provision, addressing healthcare inequalities and the shortages of physicians. APN growth and development will help to manage the global increase in complexity of health needs, an increase in long-term conditions and polypharmacy. This has been clearly seen during the Covid 19 pandemic where APNs have risen to the challenges faced utilizing their full capabilities.

It could be argued that the Covid 19 pandemic has led many of us to an existential crisis. I would suggest this was already in full flow, many societies were becoming embedded in individualism, and health care globally has often moved to a mechanistic rather than person-centered approach. This book addresses many of the issues that come to the fore in an existential crisis and it provides an important contribution to the APN literature. As nurses continue to advance and bring together the best of nursing with the best of medicine the focus needs to remain with the patient and with the fundamentals of caritative nursing. Professor Fagerström articulates fully the need for person-centered holistic care to be at the heart of APN practice.

After introducing the development and progression of APNs the reader is guided through the Caritative perspectives and the Caring APN model. The domains of clinical nursing practice, ethical decision-making, coaching and teaching, consultation, collaboration, case management, leadership, and research and development are described and illustrated well to help the APN understand the context and application to practice. An exploration of the connection between epistemology, a three-dimensional view of knowledge (epistêmê, technê, and phronesis) and the caring perspective, as well as the central theoretical aspects of nursing, e.g., health, holism, and ethics/ethos is meaningfully captured.

I first met Professor Fagerström 10 years ago through the International Council of Nurses Nurse Practitioner/Advanced Nurse Practitioner Network (ICN NP/APNN) where we both connected on our passion for ensuring holistic care is at the focus of Advanced Practice. We have both served for many years with the ICN NP/APNN working to support the development of advanced practice nursing globally. Our work has many parallels. I write widely about the need to integrate spirituality into advanced practice nursing and health care. Spirituality is at the core of person-centered care; it includes all the concepts of caritative caring and supports patients to find hope, meaning, and purpose during illness and times of stress. Spirituality challenges us to compassionately engage with the whole person as a unique human being, in ways which can provide a sense of hope, meaning, and purpose. It necessitates emotional involvement within our professional boundaries where we can provide a humanistic approach which meets the needs of our patients. In my own research and practice I put forward the concepts of "Availability and Vulnerability" which enable the APN to reveal aspects of their own humanness within the APN-patient relationship. These concepts mirror the domains presented in this book, and integrating these into practice will enable the APN to offer truly holistic approaches to care.

Spirituality should be a simple concept which remains at the heart of clinical practice and ensures that our patients remain at the center of our work. It can also help us to address many of the existential questions patients often ask "why me?", "how will I cope?", "what does it mean for my life?" In the same way caritative caring also gets to the heart of what it means to connect with our patients as fellow human beings.

I will never forget the first time I heard about caritative caring; it was at a large medical conference where a Nordic Nurse talked about what is needed at the heart of health care. She focused on caritas as compassionate love. Initially there was an audience of about 200 people. The audience appeared engaged as she talked about the demands of health care and research into the challenges health care faces. She then moved on to discuss the need to fundamentally revise how we provide health care. Once she started talking about love many of my medical colleagues got up and walked out of the session. For me, the presentation was incredibly powerful and insightful. She explained how throughout her career she had become a well-recognized nursing scholar, as well as advancing her clinical career. She had written widely on the application of nursing theories into practice. She talked of being careful about how she presented her work to ensure it fitted into the sociopolitical contexts of the time. However, she recognized that she had avoiding talking about the central tenet of her work because of how it would be received. This central tenet was "love" and for me is a fundamental principle of spirituality and caritative caring. I wanted to highlight this point as I believe that compassionate love is fundamental to the caring advanced practice model as it reminds us that we are fellow human beings who are navigating this life journey together and as such we should practice with kindness, empathy, compassion, and "love."

All of us who work as APNs know how significant a therapeutic relationship with patients is in providing a safe and caring environment. We have the opportunity

as APNs to offer our care, compassion, empathy, kindness, and love to those in our care, however they present. The ability to connect fully with those in our care as fellow human beings is key to caritative caring.

This book is a valuable resource for the international community of APN students, practitioners, educators, researchers, and policy makers alike. I fully recommend it and hope that the principles of caritative caring will become a primary focus for all practicing APNs as they embed holistic care into their focus. The Caring Advanced Practice model focuses on the humanity of the patient; it challenges us all as practitioners to engage the core competencies of advanced practice within caritative philosophy. As we do this, we will drip by drip move from the mechanistic, conveyer belt healthcare systems many of us work within toward a humanistic healthcare service where patients remain the focus.

February 4, 2021

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Preface

My interest in advanced practice nursing was awoken nearly two decades ago when as Dean for the Swedish-language nursing educational program (2000–2007) in Vaasa, Finland, I had the opportunity to participate in a European Union-funded project with the aim to develop the Nurse Practitioner role in Europe. Several European countries were represented in the project, among these England and Ireland. During the course of the project I met highly committed instructors and professors from the north of England who spoke about nurses with a master's level education in clinical nursing; nurses who could meet patients' needs for care and treatment in a manner that I considered novel. With advanced clinical skills and solid clinical competence, these nurses were able to run own independent clinics and independently make decisions about patient care and treatment. The reasoning behind such innovative thinking was that these so-named nurse practitioners could help increase access to care and treatment. Even today, access to care and treatment is still a current and burning problem in many countries. Healthcare systems throughout the world, even in so-named welfare states, lack the capacity to meet in full expanding populations' growing need for care.

While a full-time professor in nursing science at the University of Southeast-Norway (USN; 2008–2016), my continued interest in advanced practice nursing led me to become the leader of a Nordplus-funded project. A total of six universities and university colleges throughout Sweden, Finland, Norway, and Denmark were represented in the GEROPROFF project, through which a master's module (45 ECTS) built on core advanced practice nursing courses was developed. I have also had the privilege of developing a new master's program in advanced practice nursing at USN, which started in autumn 2015 and was designed in accordance with International Council of Nurses guidelines on advanced practice nursing. As an affiliated professor I still contribute to this program as an instructor and am extremely proud of its design, which includes not only a focus on general advanced clinical competence but also primary care.

At nearly the same time as the USN master's program in advanced practice nursing was being developed and started, I was granted funding from the Research Council of Norway (through the PRAKSISVEL program) for a project entitled "Providing person-centred healthcare—by new models of advanced nursing practice in cooperation with patients, clinical field and education" (04.2015–04.2021). The aim of this project was to evaluate USN's aforementioned master's program as

well as develop new advanced practice nursing models and roles for the Norwegian healthcare sector. Following 6 years of research within the framework for this project, I together with my esteemed fellow research colleagues can note that—thanks to active cooperation with regional representatives, leaders from both hospital and primary health care, and highly motivated newly trained advanced practice nurses—several interesting advanced practice nursing models and roles have been tested and developed. I can furthermore note that changing established work methods and roles in healthcare service work models is challenging. Changing a professional group's responsibilities and roles impacts the entire healthcare team. Leaders have an important role to play as agents for change. Leaders' understanding for new roles and tasks is crucial. Even support from an organization's leadership is required for the implementation of new advanced practice nursing functions and work tasks. Change takes time and requires patience and a clear vision, without which change does not occur. Continuous organizational changes in the healthcare sector make the implementation of new work models difficult.

In the autumn of 2016, I was offered the opportunity to lead the Department of Caring Science at the Faculty of Education and Welfare Studies at Åbo Akademi University, as the department head. My vision as department head and "newly minted" caring science professor has been to start a new university-level master's program in advanced practice nursing in Finland, in which the theory of caritative caring that has been meritoriously developed at the university since 1987 is united with advanced practice nursing. In the autumn of 2021, a new English-language master's program in advanced practice nursing will be offered at the university. I personally look forward to developing the program in accordance with the new International Council of Nurses guidelines on advanced practice nursing 2020 and collaborating with experts from both England and Norway to ensure the development of a high-quality clinically oriented master's program. The aim is to contribute to the development of advanced practice nursing roles in Finland and other countries where the role and/or function is relatively new. The vision is advanced practice nursing models that include clearly delineated expanded rights for nurses and which correspond with international standards. It is important to note that advanced practice nursing is still nursing and has at its heart the maxim that "caring is the core of nursing." One can therefore describe an advanced practice nurse as "a maxi nurse with some medical skills." A clear theoretical foundation in nursing/caring science is needed, and I believe that advanced practice nursing as an area of research will contribute not only to improvements in both access to care and treatment but also improved care quality for those in need of care and treatment.

I hope this book provides its readers with new knowledge of what advanced practice nursing is and even inspires and encourages visions of a professionally independent advanced practice nursing function that in the future is considered a natural and significant part of healthcare services throughout the world.

February 14, 2021

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Advanced Practice Nursing: A Justified Need

1

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Abstract

In this introductory chapter, a brief description of advanced practice nursing on an international level and the background to and motivation for why advanced practice nursing provides an opportunity whereby healthcare services can be improved and developed are presented. First, advanced practice nursing is briefly introduced as an international phenomenon, including common positive effects of advanced practice nursing as demonstrated in earlier research and international experience. Then four clear reasons for why it is worthwhile to invest in the development of advanced practice nursing are presented. This includes the current need to improve access to nursing, care, and treatment; more effective use of available resources to meet increased demand for healthcare services; how advanced practice nursing supports the recruitment of future nurses through clinical career paths; and how advanced practice nursing can contribute to the sustainable development of healthcare services.

Keywords

Advanced practice nursing · Motivations for advanced practice nursing · Effects Sustainable development

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Born two centuries ago, Florence Nightingale is today considered a leading figure in nursing. She had the foresight to realize that nurses can play an important role in healthcare and highlighted the importance of collecting and systematizing data on patients' health status. She also advocated for a healthcare environment, including fresh air, nutritious and good food, and beauty in care. She was furthermore a fiery debater, who among other things fought for reasonable salaries for nurses. In modern terms one could perhaps summarize her endeavors using the term "sustainability." Nursing has changed immensely over the past two centuries—as has society in general. Especially since the end of the Second World War in 1945, all aspects of society have undergone palpable development. From the perceptive of the tenty-first century, it is possible to look back and conclude that nurses in many countries currently work on an advanced clinical level and that nursing as a whole is in a phase of development. This has been fueled by a clear desire to implement advanced-level nursing that includes expanded rights, e.g., the right to prescribe treatment or medication, refer patients to other professionals, or admit patients to the hospital. Nurses in many countries have taken courageous steps forward and "challenged" existing traditional, hierarchal power structures, with the clear intent to improve the quality of care and treatment and, above all, patients' access to care and treatment. Nevertheless, in many countries where the concept of advanced practice nursing is new or unexplored, even more marketing and knowledge of what advanced practice nursing entails is needed: among nurses themselves, other healthcare professionals, leaders, politicians, and the general public. It is still necessary to spread information on why the development of advanced practice nursing is motivated and develop sustainable and consistent advanced practice nursing educational and research programs.

This book is built on the central premise that advanced practice nursing can contribute to making healthcare systems more effective and person-centered and can contribute to the sustainable development of healthcare. Advanced practice nursing significantly contributes to the overall competency of a healthcare team, and nursing competence can be more efficiently used if nurses are allowed to professionally develop and progress to the advanced level. With its starting point in the individual patient's unique health needs, advanced practice nursing can contribute to new innovations in the development of healthcare and thereby contribute to improved quality, care, and patient health. Accordingly, one can maintain that advanced practice nursing contributes to the sustainable development of healthcare.

1.1 Advanced Practice Nursing as an International Phenomenon

Advanced practice nursing is the common theme running through this book. In international literature and research today, the concept "advanced practice nursing" is used in various ways, and clear consensus on how the concept should be defined does not currently exist (Delamaire and Lafortune 2010). The North American model is commonly used, which includes four professional titles/roles: clinical

nurse specialist, certified nurse anesthetist, certified midwife, and nurse practitioner (Schober and Affara 2006; Hamric 2009; Hamric and Tracy 2019). The "clinical nurse specialist" title/role should not be confused with "specialist nurse." While in many countries, specialist nurses have a postgraduate education and a specialization in a specific area, they do not have the advanced competence in clinical assessment of patients' health problems that is obtained from a master's-level advanced practice nursing education (International Council of Nurses 2020).

The expansion of nursing's traditional professional boundaries can be described using the international concept "advanced practice nursing," which is a collective term for nursing on the advanced level. In many countries, the development of nursing has occurred through nursing on the specialist level, from a system where nurses have specialist education to advanced practice nurses who bear a clear, independent responsibility and have a clear, autonomous, professional role with a defined place in the healthcare organization and in relation to other professions. The term advanced practice nurse is used in this book as a concept for both "nurse practitioner" and "clinical nurse specialist." These titles are considered to be the most frequently used and are in accordance with the new International Council of Nurses' guidelines (2020). As early as 1997, research on the nurse practitioner function in England was published. In studies from that time, researchers found that nurse practitioner-led actions worked well as an initial point of contact for patients with acute medical problems (Myers et al. 1997; Sakr et al. 1999).

The development of advanced practice nursing can lead to tension between nurses with specialist educations and clinical nurse specialists, who have competence in a narrower and more closely defined area, or nurse practitioners, who usually have expanded rights: prescribing rights, the right to order laboratory tests, radiography, and referrals. The health situation of each country and the career opportunities available to nurses in the national context are relevant to the form that a country's healthcare system takes. Still, an important starting point for the development of care and nursing is that healthcare systems need nurses with varying skills and varying levels of competence: bachelor's, master's, and doctoral levels. Each nurse should determine, based on his/her life situation and interests, which level feels most meaningful and relevant to him/her. Such a person-centered perspective is even needed regarding career development. Nurses should ask themselves: "Who am I as a person and what constitutes a meaningful contribution to patient care for me?" More detailed reflection on this topic and a description of the similarities and dissimilarities between the various nursing levels are seen in Chap. 2.

Professional demarcations between nursing functions have noticeably emerged in many countries during the past 10–25 years, among others, in Australia, England, Ireland, Scotland, New Zealand, Singapore, and the Netherlands (Schober and Affara 2006; Schober 2016; International Council of Nurses 2020). Even in certain parts of continental Europe, e.g., France, Spain, and Lithuania, one sees a growing interest in advanced practice nursing, not only in education and research but also clinical practice: seen as new advanced practice nurse or nurse specialist roles (Hassmiller and Pulcini 2020; Debout 2020).

The development of a more independent clinical nursing role started in the United States of America more than 50 years ago (Ford and Silver 1967). Already in the 1940s, the development of medical specialties and technologies in the United States of America lead to the emergence of nurses practicing at a higher degree of specialization, in turn evolving into the clinical nurse specialist role (International Council of Nurses 2020). Today there are approximately 72,000 clinical nurse specialists in the United States of America, and the demand for both advanced practice nurses and clinical nurse specialists is expected to grow 31% between 2012 and 2022.

This can be compared to Canada, where the development of the clinical nurse specialist role began in the 1970s. While in many countries the clinical nurse specialist role was first implemented in a hospital setting (Delamaire and Lafortune 2010), the role has since evolved to include the provision of specialized care for patients with complex health needs in outpatient, emergency department, home care, community, and long-term care settings (Bryant-Lukosius and Wong 2019). As seen in a 2010 survey by the National Association of Clinical Nurse Specialists, most clinical nurse specialists work in inpatient hospital settings. However, as noted previously, clinical nurse specialists today work in settings across the span of healthcare delivery systems, including hospitals, clinics, private practice, schools, nursing homes, corporations, and prisons (https://explorehealthcareers.org/career/nursing/clinical-nurse-specialist/).

Many countries are facing healthcare provider shortages and imbalances, especially in primary care, and the shortage of healthcare professionals is expected to increase immensely in the future (WHO 2018). The rise in chronic diseases and multimorbidity all over the world has been defined as the main impetus behind the introduction of new advanced practice nursing roles. Around the world, the advanced practice nurse role continues to evolve, but education, credentials, and scope of practice vary between countries (Maier et al. 2016). Advanced practice nurses have a varied scope of practice, which can include the right to prescribe treatment or medication, e.g., for patients with acute infectious diseases, refer patients to other professionals, or admit patients to hospital. Looking at data between 2005 and 2015, Maier et al. (2016) analyzed the size, annual growth, and extent of nurse practitioner's advanced practice in six Organisation for Economic Co-operation and Development (OECD) countries. As can be expected, the United States of America showed the highest absolute number and rate of nurse practitioners per population (40.5 per 100,000 population), followed by the Netherlands (12.6), Canada (9.8), Australia (4.4), and Ireland and New Zealand (3.1, respectively). The annual growth rates were high in all countries and between three and nine times higher compared with physician growth rates. As part of this same study, in the empirical studies from their literature scoping review, Maier et al. (2016) even saw that nurse practitioners provide between 67% and 93% of all primary care services, though this conclusion was considered to be based on limited evidence. They concluded that nurse practitioners "are a rapidly growing workforce with high levels of advanced practice potential in primary care."

In addition to North America, Australia, and parts of Europe, advanced practice nursing has "spread" to other continents. For example, advanced practice nursing is on the rise in Singapore, Taiwan, and China (Hu et al. 2018). In a new overview of the development of advanced practice nursing in China, the clear development of nursing from the diploma (generalist) level and up to the master's (advanced) level was revealed, especially evident from 2005 forward (Wong 2018). From studies set in Africa, one sees that new nursing models that incorporate advanced practice nursing are being developed, with the objectives to improve access to care and treatment and enable qualitative and cost-effective care (Mboineki and Zhang 2018; Christmals and Armstrong 2019).

In the Nordic countries, while the nurse specialist role has been developed, the clear independence and formalization/standardization of the advanced practice nursing role have not yet been fully developed. In both Finland and Sweden, advanced practice nursing educational programs on the master's level were introduced more than a decade ago, but enrolment and matriculation are still slight (Hallman and Gillsjö 2005; Fagerström 2009; Jangland et al. 2014; Ljungbeck and Sjögren 2017). In Norway, the first master's-level advanced practice nursing educational program in advanced geriatric nursing was started in 2011 (Hauge et al. 2011), and interest in master's-level advanced practice nursing educational programs has increased, with several such programs currently being offered. In 2019, the Norwegian Directorate of Health and Social Affairs instituted new regulations concerning the authorization, licensing, and specialist approval for nurses (*Forskrift om spesialistgodkjenning for sykepleiere*), in which it was delineated that nurses holding a master's degree in advanced practice nursing are allowed to seek recognition as specialists (https://lovdata.no/dokument/SF/forskrift/2019-11-19-2206). In Norway, an advanced practice nurse (*avansert klinisk allmennsykepleiere*) is defined as having advanced clinical competence with a specific focus on community healthcare. During preparation of the Norwegian regulations, it was emphasized that any master's-level advanced practice nursing educational programs must also include an adequate foundation in the medical, humanistic, and social sciences. Furthermore, such programs must include a thorough introduction to the advanced practice nursing role and the skills and competencies necessary for the systematic clinical assessment of patients' health status; the aim is that nurses should be capable of identifying and differentiating between various types of health issues/problems, formulating suggestions and creating plans for measures to be taken, implementing measures to manage complex patient conditions, as well all as making ethically justified decisions.

The expanded right to perform tasks, e.g., prescriptive authority, has not spread as much in the Nordic countries. Yet of the Nordic countries, Finland is the country where expanded rights have most been implemented (Fagerström 2016, 2019). A new law was introduced in Finland in 2011, in which it was delineated that registered nurses who have completed 45 ECTS credits as part of a standard postgraduate educational program would be allowed limited prescriptive authority in primary care. Since 2019, the list of medications certain nurses can prescribe has been expanded, and prescriptive authority extended to not only include registered nurses

in primary care clinics but also registered nurses working in primary outpatient care, joint acute/emergency departments, private medical clinics, and hospital outpatient clinics (Social- och hälsovårdsministeriets förordning 922/2019). In Sweden, an investigation into specialist nursing education has been started, including an analysis of access to and the need for nurse specialists. The goal is to create a new postgraduate advanced practice nursing educational program and implement a new nurse practitioner role including expanded rights and prescriptive authority (SOU 2018).

While the overall competence of healthcare staff has perhaps never been higher than what it is today, nurses in many countries nevertheless engage in work steered by "old," set traditions and rigid hierarchies and structures, which hinder nurses from taking greater responsibility for patients' care and treatment. As nurses we can ask ourselves whether we wish to take on greater responsibility and/or have the energy and strength to transcend the professional patterns hereto determined by tradition.

1.2 Advanced Practice Nursing Yields Positive Effects

Advanced practice nurses' work is characterized as evidence-based practice, and their care should lead to positive patient outcomes. The result of several years' experience with implementation of the nurse practitioner role in New Zealand has led to the following conclusions:

> A nurse practitioner combines the best of nursing with some skills from medicine. Nurse practitioners can deliver a large proportion of the services the average person needs in terms of minor, acute illness and long-term conditions such as asthma and diabetes. Through nurse practitioners, we are able to offer the public a whole new access arrangement into healthcare. (Ministry of Health 2009)

Several years' worth of extensive international research indicates that advanced practice nursing models lead to positive patient outcomes and contribute to the development and improvement of healthcare services, especially access to nursing, care, and treatment.

In many countries, there have been good outcomes associated with the introduction of advanced practice nursing roles in emergency care, e.g., significantly shorter wait times, shorter hospital stays, improved quality of treatment, and patient satisfaction (Boman et al. 2020, 2021). Still, researchers have not been able to draw definite conclusions with regard to the impact on costs (Jennings et al. 2008, 2015). Nevertheless, the results are still positive for the nursing profession. Advanced practice nurses have more autonomy and a significantly expanded role experience that both colleagues and physicians show them greater trust and respect. They also simultaneously report that they have become prouder of their own skills and knowledge (Kleinpell 2005; Wisur-Hokkanen et al. 2015).

Interest in advanced practice nursing in community healthcare is on the rise in many countries. Nursing-led treatment has been shown to have a clearly positive

effect on patient satisfaction, length of hospital stay, and mortality (Maier et al. 2016; Maier et al. 2017). Ambulatory advanced practice nursing teams are also seen to yield good treatment outcomes and have even in new research been linked to promising cost-effectiveness outcomes (Martin-Misener et al. 2015). For example, healthcare models that include advanced practice nurses caring for women with incontinence have been shown to reduce patients' symptoms and improve patients' life quality (Teunissen et al. 2015).

In many countries, advanced practice nurses have been given a strong and central role in community healthcare and care for the elderly. Advanced practice nurses can take responsibility for both acute health assessments and the follow-up of patients with chronic health conditions. Researchers have found advanced practice nurses' holistic approach to patients and patients' families to be very valuable (Fahey-Walsh 2004). For example, in a study from Canada in which the nurse practitioner's role in long-term care was examined, researchers found that advanced practice nurses contribute to the effectiveness and development of clinical activities and that there is high satisfaction with the role (Stolee et al. 2006).

Researchers have shown in many studies that there are lower rates of depression, urinary incontinence, pressure sores, and aggressive behavior and that fewer physical restraint measures are needed on units where advanced practice nurses work in long-term care (Donald et al. 2013). Patients on such units report improvement of own goals, while patients' families are more satisfied with the medical treatment being provided. Another example is advanced practice nurse in-home health consultation programs, which have been shown to reduce negative health consequences with regard to, e.g., acute events, falls, and hospitalizations (Imhof et al. 2012). In that study, the in-home program was provided by advanced practice nurses and guided by the principles of health promotion, empowerment, partnership, and family-centeredness. Advanced practice nursing models have even been shown to improve access to treatment for harder-to-serve populations and reduce the use of acute services (Roots and MacDonald 2014). Researchers in that study sought to identify the impact of nurse practitioner role implementation and found that the implementation of the role resulted in changes in other practitioners' provision of care, among others, increased job satisfaction, and that physician colleagues sought to remain in their current work environment. The researchers also found that a group style of practice, in which practitioners work side by side rather than together and there is a collaborative advanced practice nurse-physician relationship, was central and determinative to good patient outcomes.

The effectiveness and quality of advanced practice nursing-led treatment are often assessed and compared to physician-led treatment. In a 2-year follow-up phase of a randomized study comparing outcomes of patients assigned to either a nurse practitioner or physician primary care practice, with follow-up at 6 months and 2 years, researchers found no differences between patients' health status, disease-specific physiological measures, satisfaction, and use of specialist, emergency room, or inpatient services (Lenz et al. 2004). In a systematic review of 69 studies published from 1990 to 2008 encompassing 27,993 patients, researchers found that advanced practice nurse outcomes were similar to and in some ways

better than physician-led care regarding several central variables (Newhouse et al. 2011). For those 37 studies in which nurse practitioner care groups and physicians/teams with nurse practitioners were compared, the researchers found high levels of evidence for equivalent rates of patient satisfaction, self-reported perceived health, functional status, glucose control, blood pressure, emergency department visits, hospitalization and mortality, and better serum lipid control. In other studies, researchers have found positive treatment outcomes for similar result variables (Horrocks et al. 2002; Laurant et al. 2005). Still, in many studies where advanced practice nursing-led and physician-led care are compared, researchers have not seen significant differences. Nevertheless, there is more than enough evidence that advanced practice nurses can contribute to the development of new, innovative methods whereby patients' health is promoted and patients' capacity for self-care is supported.

To date, health economic analyses (cost studies) have not yielded definitive answers to whether advanced practice nurse-led or physician-led care practice is better. Researchers in several studies have concluded that nursing and treatment provided by nurses increase the quality, cost efficiency, and person-centeredness of care (Horrocks et al. 2002; Lenz et al. 2004). Even though advanced practice nurses receive a lower salary than physicians, they have been found to engage in significantly longer consultations, perform and order more tests, and more often schedule patients for follow-up appointments than physicians (Hollinghurst et al. 2006). Yet some researchers have found that advanced practice nurse care practices are not cost-efficient, primarily because the time spent per patient consultation is too lengthy (Marsden and Street 2004). Still other researchers have seen that the introduction of an advanced practice nursing care practice in a hospital setting was clearly linked to a reduction in wait times and shorter consultations (Jennings et al. 2008). One can conclude by stating that longitudinal health economic analyses are lacking but needed to fully assess advanced practice nursing and the care, treatment, and follow-up of patients with chronic disease that advanced practice nurses provide. It is only through a future perspective that eventual cost efficiency will be fully revealed.

An interesting question regarding health economic analyses and the comparison of advanced practice nursing-led versus physician-led care practice is whether the time spent on patient consultation is a significant variable. Efficiency and outcome-based thinking in healthcare have its origins in the philosophy surrounding industrial manufacturing (see Chap. 7). While it is true that the care and treatment of certain health issues can be standardized and realized in a production line-like manner, in many instances a “patient-tailored” solution is needed, and such requires time for both the investigation of the reasons underlying the health issue and guidance in self-care. Giving patients the time to speak to, e.g., an advanced practice nurse, can be considered a good investment. The traditional view is that professionals should “solve” patients' health problems. Yet today a clearer focus on what the patient him/herself can do for own health is needed and preferably at as early a stage in care as possible. It is each individual him/herself that holds the ultimate responsibility for his/her own health, not professionals. It

is important that advanced practice nurses increase patients' awareness of the significance of self-care and the health promotive and disease preventive measures they can engage in (see Chaps. 7, 8, and 9).

Those who work with advanced practice nurses are generally positive to the implementation of advanced practice nursing, even if some general practitioners in some studies are seen to be less positive than other nurses and hospital-setting physicians. Researchers have found that the primary reason some general practitioners are critical of advanced practice nursing is that they themselves experience a decrease in the number of patients they treat. Another reason healthcare staff can be ambivalent to the implementation of advanced practice nursing is uncertainties about the role in the organization (Long et al. 2004; Marsden and Street 2004; Griffin and Melby 2006; Altersved et al. 2011; Boman et al. 2019a, b).

Patient satisfaction with the nursing, care, and treatment that advanced practice nurses provide is usually very high. Researchers in several studies have found that patients who consult an advanced practice nurse are more satisfied with their treatment than those who consult a general practitioner, and this is especially true for children, who highly appreciate receiving treatment from advanced practice nurses (Venning et al. 2000; Horrocks et al. 2002). For example, patients are seen to perceive that they receive more information about their conditions when they consult an advanced practice nurse versus a physician (Kinnersley et al. 2000).

From many countries' experiences, it is possible to see that advanced practice nurses work in a patient-centered manner and employ a holistic approach in which dialogue with patients and patient's families is emphasized. This combined with advanced practice nurses' broad knowledge base and good clinical skills contributes to good patient outcomes. Emanating from research findings, one can conclude that the nursing, care, and treatment that advanced practice nurses provide are often of high quality and often increase patient satisfaction and patient safety.

1.3 Access to Nursing, Care, and Treatment Must Be Improved

According to the World Health Organization (2018), the proportion of the world's population aged 60 years and older will nearly double from 12% to 22% between 2015 and 2050. In 2020, the number of people aged 60 years and older is estimated to outnumber children aged 5 years or younger, and in 2050 about 80% of older people will be living in low- and middle-income countries. By 2050, the world's population aged 60 years and older is expected to total 2 billion up from 900 million in 2015. In 2018, about 125 million people were aged 80 years or older; by 2050 there will be about 434 million people in this age group worldwide, and 80% of all older people will live in low- and middle-income countries. Due to aging populations, all countries face major challenges to ensure that their healthcare and social systems can manage such an expected demographic shift.

The average age of the old also is increasing, and the over-85 age group, "the oldest olds," is the fastest-growing segment of the older population. At least 80% of those over 65 years of age have been diagnosed with one or more chronic illnesses, partly because people now survive conditions that previously led to early death. Even today this prevalence of multiple chronic illnesses challenges healthcare professional' knowledge and abilities. Terms such as "elder boom" and "elder tsunami" are often used in societal debates and in the media to describe and imply an impending explosion in the need for healthcare services. Still, it must be emphasized that many of those aged 65 or older are healthy and often in good physical shape. It is believed that the big challenge that healthcare systems will face is the increase in the over-85 age group, which is expected to significantly increase in the years to come. The majority of these "oldest olds" have several chronic diseases and require follow-up, health guidance, and nursing, care, and treatment over the course of many years (Nygren 2006; Kazer and Grossman 2011). Access to highly competent healthcare professionals and good interprofessional collaboration is a condition for quality of life and good health during the final stages of life.

Psychosomatic and mental health problems are also areas where demand is increasing (Delaney and Vanderhoef 2019). One interesting patient group is those with undiagnosed medical illnesses. This group includes patients who from a medical perspective have received good treatment but who nonetheless maintain that they are "still" ill and who have symptoms and complaints that traditional medicine cannot solve. This patient group is challenging for traditional healthcare systems. In traditional systems, if a medical diagnosis cannot be applied to a patient's symptoms, then that patient is at risk of not receiving treatment. Many such patients find that they themselves must learn to master and live with their conditions and seek quality of life and well-being: despite their chronic symptoms and need for professional help.

For many patient groups (the vulnerable, the underprioritized, the undiagnosed, those with psychosomatic or mental health problems), the wait for a health assessment and/or treatment is much too long. Today the need for healthcare services is greater than the availability of such services, and this disparity will continue to dramatically increase. This fact must be addressed, and this places new demands on the division of labor and how healthcare services are organized, including a redistribution of tasks and responsibilities among healthcare professionals (Finnbakk et al. 2010). Access to care and treatment should be offered quickly and should occur as close to the patient as possible. This has been recognized, for example, in Norway in parliamentary reports on The Coordination Reform (St.meld. nr. 47 2008–2009) and the primary health care and services of tomorrow (St.meld. nr. 26 2014–2015). In these reports, it is emphasized that nursing, care, and treatment in Norway must be transferred from hospital to community healthcare contexts.

Citizens in the Western world are constantly bombarded with information about the latest medical advances but also made aware of the shortcomings and problems that exist in our healthcare systems. One understands that patient safety is not given and that mistakes occur in complex patient pathways all the time. An older patient

with poor health and impaired memory who experiences acute health problems, e.g., because of possible infection, may have to wait a long time for a comprehensive examination and health assessment. Those who seek help for diffuse symptoms may not be able to access the help, support, and care they need. Being put on a waiting list for nursing, care, and/or treatment by a physician is in many countries the norm rather than the exception. Even though the cost of care has increased significantly in recent decades, more and more people are reporting that access to care and treatment is not meeting current demands (Kittelsen et al. 2007). The need to travel great physical distances to access a physician or hospital is a challenge that many patients in many countries must overcome.

Improved access to nursing, care, and treatment is often mentioned as the most important impetus for introducing new advanced practice nursing models (Dawson et al. 2015). In a Nordic study including healthcare leaders, physicians, nurses, politicians, and older people, researchers found that advanced practice nursing functions can improve access to health services for older people (Boman et al. 2019a, b; Christiansen and Fagerström 2016; Smailhodzic and Fagerström 2016). New healthcare models that incorporate advanced practice nursing functions are also being developed in Africa, with the aim to improve access to care and treatment by offering good and cost-effective care (Mboineki and Zhang 2018; Christmals and Armstrong 2019). For example, in Tanzania a shortage of physicians and a lack of interest in working in rural areas have been seen to underlie insufficient access to care and treatment.

It is primarily advanced practice nurses' skills in being able to perform thorough and systematic clinical health assessments of patients' undiagnosed health needs as well as their skills in following up the treatment of patients with chronic disease that comprise the extra resource that advanced practice nurses have and which improves access to care.

Health technology and the development of e-health services can improve access to healthcare services. In a comprehensive, randomized study in England, researchers found that nurse-led computer-supported telephone triage could improve the management of same-day consultation requests. Nurse-led telephone triage was seen to be safe, and no differences in patients' health status were seen when compared to physician-led telephone triage (Campbell et al. 2015). In England and Australia, there are many nurse-led "walk-in" centers, where computer technology is used to support the clinical decisions being made (Parker et al. 2012).

In many countries, advanced practice nursing has developed to respond to the fact that vulnerable and underprivileged patient groups have not been able to access the nursing, care, and treatment that they need. Vulnerable and underprivileged patient groups exist in all countries. Furthermore, ever-increasing movement between countries has led to an increased need for healthcare services, and this in turn has placed new demands on all countries' healthcare sectors. Advanced practice nursing is not only a resource for all patient groups but also especially for those who have traditionally been underprioritized.

1.4 Available Resources Must Be More Effectively Used to Meet the Increased Demand for Healthcare Services

The need for healthcare services is increasing dramatically throughout the world, and to increase access to care, how various professional groups' competence is used should be reconsidered. All healthcare professional roles are undergoing major changes, including the nursing role. The combined skills of the entire healthcare team must be used efficiently. Is the diversity of skills and knowledge that various healthcare professionals possess being captured in the correct way today and being steered toward the right patient at the right time? In many reports and studies, researchers find that professionals, politicians, and decision-makers neither have the capacity nor the flexibility to meet the challenges that the future will bring. Conservative mindsets, power, and privilege within the medical profession, bureaucracy, and inertia are major problems in the traditional (medical model) professions. Healthcare services in many countries are characterized by a hierarchy that stealthily inhibits innovation and the development of new treatments and service forms (Vallimies-Patomäki et al. 2003). Task-sharing/task-shifting among healthcare staff is an international phenomenon increasing in countries that do not have clearly defined advanced practice nursing models (Maier et al. 2016). Task-shifting has been tested as a method of shortening waiting times for treatment (Helsedirektoratet 2014).

The need for home healthcare services is increasing, regarding both quantity and complexity, and this places greater demands on home healthcare nurses' clinical competence and autonomy (Vaartio-Rajalin and Fagerström 2019). In the future, well-functioning home care services will require that greater attention be placed on nurses' competence and will require sufficient competence from the entire healthcare team as a whole (Johansen and Fagerström 2010; Bing-Jonsson et al. 2016; Vaartio-Rajalin et al. 2019; Holm Hansen et al. 2020). Inadequate access to physicians and/or clinically competent nurses in home healthcare services results in unnecessary hospital admissions. One supposition is that advanced practice nurses could reduce the need for and/or refocus the activities of general practitioners in home care services. Advanced practice nurses can act as a link between the different care levels needed and seen in home healthcare. Advanced practice nurses can take on the case manager role, to provide care and treatment and plan, coordinate, and ensure that patients receive the care they need (see Chap. 7, "Case Management").

Health promotive and disease preventative work should be supported throughout the healthcare sector. The need to follow-up patients with complex and chronic diseases is increasing, especially for those with mental health problems, addiction, dementia, or lifestyle diseases. Emergency clinics and general practitioners seldom have the possibility to meet all these needs. Advanced practice nurses can greatly contribute and are capable of bearing great responsibility in these areas. The competence that advanced practice nurses have is well-suited to safeguarding that the needs of many of these patient groups are met: through expanded medical skills (systematic physical examination, health assessment, clinical decision-making), a patient-centered approach based on a holistic view of the human being and his/her life situation, and a clear emphasis on health and health promotion.

1.5 Clinical Career Paths Support the Recruitment of Future Nurses

Nurses and midwives make up approximately 50% of the total number of healthcare staff in the world and subsequently comprise the largest single group of nurses. In the coming years, the current shortage of nurses is expected to increase significantly and lead to significant problems (World Health Organization 2016). Future nurse recruitment can be improved through new advanced practice nursing roles and models (Delamaire and Lafortune 2010).

Many nurses today are considering switching activities/profession (Jokiniemi 2014). It is therefore imperative that further education in nursing leads to new clinical work duties and is not merely designed to prepare for educator/faculty researcher or development duties. Higher education that includes the development of clinical competence leads to good opportunities for clinical career paths. The model of advanced practice nursing realized as clinical leaders who are close to colleagues, patients, and patients' families must be brought forth. As role models, advanced practice nurses can motivate young nurses to continuously develop their competence. Nordic research on advanced practice nursing roles has already revealed that advanced practice nurses perceive a high degree of work satisfaction (Glasberg et al. 2009; Lindblad et al. 2010). If nurses feel satisfied with their work, profession, and career choice, young people will be more motivated to apply to work in the healthcare sector. Advanced practice nursing is a demanding job, and advanced practice nurses need clear support from their leaders and good work conditions. For example, a nurse practitioner working in a nurse-led clinic with a high degree of independency can experience loneliness.

1.6 Advanced Practice Nursing Contributes to the Sustainable Development of Healthcare

In 1987, a special United Nations commission called the World Commission on Environment and Development published a report entitled "Our common future," also known as the Brundtland Report, in which guiding principles for sustainable development as generally understood today were included. In the report, sustainable development is defined as, "…development that meets the needs of the present without compromising the ability of future generations to meet their own needs" (United Nations 1987).

The concept "sustainable development" is used to refer to the conditions for good social living, where the following three dimensions for sustainability are considered essential: ecological, social, and economic sustainability. Sustainable development requires a long-term and holistic approach as well as a global perspective.

Education, research, and development should contribute to the sustainable development of all societal activities, of which healthcare accounts for a significant proportion of costs. Awareness of ecological and climate aspects should be strengthened in all nursing education and even in healthcare organizations.

The pluralism and complexity inherent in both today's and tomorrow's society allows us as human beings to live in a variety of different ways. There are different lifestyles, different cultures, and different perceptions of what "good" care and treatment entail. Nursing staff are already experiencing increased expectations related to individual and person-centered care and treatment. Today's young adult generation, who in 20–30 years will have a greater need for healthcare services, are perceived as being dissatisfied with "routine" healthcare services. Those using healthcare services today are more aware of their rights and more demanding than two decades ago. Seen from a nursing perspective, social sustainability entails that the individual's background and preferences are truly taken into account when healthcare solutions are given. A healthcare system where the individual does not understand the solutions that the service gives for his/her health problems cannot be considered a socially sustainable solution.

Technological developments have facilitated immediate access to information and knowledge in parts of the world, but this leads to a question: how should one interpret what is correct and what is incorrect? Welfare technology is developing rapidly and is already being used today to improve access to healthcare services for certain patient groups through, e.g., PC, tablet, or mobile chat functions, whereby, for example, patients can receive postoperative self-care instructions (Eide and Eide 2020). When developing various technological solutions for healthcare, both healthcare staff's and patients' views and experiences should be taken into consideration. An assumption is that advanced practice nurses will also start to use digital e-health solutions for healthcare services even more than today. However, experience has shown that new welfare technological solutions must truly meet both healthcare staff's and patients' needs; otherwise users of such technology have little or no use for the solutions being offered. The development of welfare technology without a clear client and person-centered perspective is neither socially nor economically sustainable.

Several examples of the usefulness of advanced practice nursing functions and models, such as nurse-led clinics, have been described above in this chapter, and further examples will be presented later throughout this book. One should note that regarding advanced practice nursing functions and models, in both nursing literature and research, the economic aspect of such solutions is often mentioned as being "the weakest link." Can advanced practice nursing truly contribute to more economically sustainable healthcare systems? Today, whether the medical model of solving patients' health problems is sufficiently effective is often called into questioned, because patient satisfaction is now considered one of the most important performance objectives. The medical model is based on the core concepts of etiology, pathology, and symptoms and solutions and has hitherto characterized clinical work. Yet today one understands that a short consultation, where, for example, a patient is merely given a new medication, is no longer sustainable. The health problems that patients experience are much more complex than the aforementioned "solution" allows for. Some promote the biopsychosocial model, where the patient's functioning is the focus of healthcare, as an alternative to the traditional and medical

model (Roodbol 2016). In the biopsychosocial model, health is described as the ability to adapt and self-manage in the face of social, physical, and emotional challenges (activities and participation). Others promote holistic healthcare, which emanates from a "one size does not fit all" perspective. Still others promote the chronic care model, in which treatment goals are shifted from cure to care and monitoring: to improve functional status, help patients cope with psychosocial distresses caused by pain or disability, avoid complications, and improve the quality of life (Bodenheimer et al. 2002).

One sees that there is a clear and evident need to apply a more holistic perspective in the development of nursing, care, and treatment, through which the patient's distinct, individual needs are taken into consideration and through which the patient and his/her family are given choices and the possibility to engage in user involvement. Prosser and Olson (2009) maintain that the structural change of healthcare services is no longer sufficient. All healthcare professionals must find new and more holistic perspectives through which to steer their work. Healthcare staff's values and care philosophies have an impact on concrete patient care. Research on the philosophy of person-centered care indicates that person-centered care has a discernible effect on care and treatment outcomes (Talerico et al. 2003; McCormack 2004). Economic analyses in which physician-led and nurse-led care are compared have often been based on a focus on short-term performance objectives. The effect of health promotive and supportive interventions through which patients' self-care is emphasized are conspicuous in their absence. There is subsequently a clear need to develop healthcare services so that the patient's background and personal preferences are taken into consideration to a greater degree. This also includes the need to offer solutions that are, seen from the patient's perspective, "actual solutions" and which support the patient's capacity for self-care. It is first after such occurs that one can maintain that socially and economically sustainable care and treatment are being offered. Another common thread running through this book is that caritative caring and person-centered advanced practice nursing contribute to the development of sustainable healthcare.

The World Health Organization has developed The Global Strategy on Human Resources for Health: Workforce 2030. Primarily aimed at planners and policymakers, the overall vision underlying the initiative is to hasten advancement toward universal health coverage and the United Nation's Sustainable Development Goals. One of the four objectives delineated in the strategy is related to the best possible use of resources. To expand access to primary care, the World Health Organization recommends increasing the number and contribution of mid-level providers, including nurse practitioners and other professions, and reducing what they consider to be "excessive reliance" on physician specialists and tertiary care. The World Health Organization furthermore delineates strategic directions through which nursing and midwifery in the European region can be strengthened to improve primary care and population health (World Health Organization 2016).

In an International Council of Nurses policy brief, Bryant-Lukosius and Martin-Misener (2017) outline important implications for integrating advanced

practice nursing roles by summarizing evidence on facilitators and strategies for effective advanced practice nursing role implementation, the contribution of advanced practice nursing roles in improving health and health system outcomes, and the alignment of advanced practice nursing roles with the World Health Organization's Global Strategy on Human Resources for Health and the United Nation's Sustainable Development Goals. In their report, Bryant-Lukosius and Martin-Misener (2017) find that advanced practice nurses can contribute to the sustainable development of healthcare, noting the following Sustainable Development Goals (SDG):

SDG 1—*No poverty*: Advanced practice nurses improve access to healthcare for at-risk hard-to-reach populations such as those who live in inner cities as well as those who live in rural and remote communities. Access to health promotion and preventive health services as well as treatment of illness and injury enables people to participate in opportunities for self- and paid employment.

SDG 3—*Good health and well-being*: Advanced practice nurses improve access to healthcare for at-risk, hard-to-reach populations such as those who live in inner cities as well as those who live in rural and remote communities. Access to health promotion and preventive health services as well as treatment of illness and injury enables people to gain or regain their health. In turn, this enables opportunities for their participation in social and economic systems.

SDG 4—*Quality education*: The opportunity to participate in graduate education is especially important for women who, in many countries, have not had access to higher-level education. Advanced practice nurses contribute to the education of other nurses as clinical faculty and preceptors for Schools of Nursing and through education, coaching, and mentorship provided to nurses at the point of care.

SDG 5—*Gender equality*: Advanced practice nursing education and employment opportunities empower women with the knowledge, skills, confidence, and capabilities to assume clinical leadership positions within a country's healthcare system. These opportunities enable social and economic security and well-being for women, thereby reducing gender inequalities.

SDG 8—*Decent work and economic growth*: Advanced practice nursing is a satisfying and fulfilling career opportunity for women. It builds on their knowledge and skills as nurses to enable them to apply their advanced knowledge and skills in new and challenging healthcare settings. Advanced practice nurses, in turn, are of benefit to the country's people and communities. Achieving a healthier population is important for economic growth.

SDG 10—*Reduce inequalities*: Developing advanced practice nursing roles in a country reduces inequalities by improving the social and economic well-being and status of women and by improving access to healthcare and the potential for a healthier life to some of the most vulnerable populations within countries.

SDG 17—*Partnerships for the goals*: Advanced practice nursing roles are being implemented in low-, middle-, and high-income countries around the world to address country-specific health needs and goals. Within countries, advanced practice nurses are well positioned to develop inter-sectoral partnerships to achieve health, education, and economic goals.

1.7 Key Messages to Policy-Makers

As noted in the International Council of Nurses' "Nursing Now" campaign, "Nurses are at the heart of most health teams, playing a crucial role in health promotion, disease prevention and treatment. As the health professionals who are closest to the community, they have a particular role in developing new models of community-based care and support local efforts to promote health and prevent disease" (https://www.icn.ch/what-we-do/campaigns/nursing-now). Bryant-Lukosius and Martin-Misener (2017) determined that advanced practice nursing is an essential component of human healthcare resources on the country level. They even noted that advanced practice nurses constitute a powerful instrument whereby healthcare can be innovated and reformed. The policy priorities advanced practice nurses can help with are formulated in the following key messages to policy-makers:

- Improving health outcomes for disadvantaged, complex, and hard-to-reach patient populations (e.g., indigenous people, homeless, immigrants, elderly, mentally disabled, at-risk children and youth, and those living in rural, northern, and remote communities) by increasing access to specialized, acute, and general primary healthcare services.
- Reducing the burden of chronic illness by achieving a better balance in the delivery of health promotion and chronic disease prevention services.
- Achieving efficiencies through the appropriate mix of providers, reduced complications, decreased acute care service use, and the more appropriate use of community and homecare services that best meet patient needs.
- Improving the quality of healthcare services through the development and uptake of best practices by patients and providers.
- Improving patient healthcare experiences and satisfaction with care through enhanced healthcare team functioning, continuity of care, care coordination, and system navigation.
- Strengthening the nursing profession through increased access to graduate education, leadership, and career laddering opportunities.
- Improving the recruitment and retention of nurses through education, coaching, and mentorship at the point of care.

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Nurses as Advanced Specialists and Advanced Generalists

2

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Abstract

The term "advanced practice nurse" is used to refer to a nurse who practices and engages in nursing on an advanced level. The definitions of two advanced practice nursing roles presented below, nurse practitioner and clinical nurse specialist, are in line with the International Council of Nurses' new guidelines on advanced practice nursing, launched in April 2020. Nurse practitioners have mastered advanced practice nursing and have the capacity to diagnose, refer, and prescribe medications for patients. While nurse practitioners mainly work in community healthcare settings, they can also work in hospital settings. Clinical nurse specialists are expert nurses with advanced nursing knowledge and skills who are capable of making complex decisions in a clinical specialty and often utilize a systems approach to influence optimal care. Nursing can be performed on three levels: the generalist, specialist, and advanced levels. The characteristics of and differences between these three levels are discussed, and the question of competency regarding specialist versus advanced practice nurses is problematized. Examples include the caring advanced practice nursing model (from nurse specialist to master's-level educated nurses), the bi-continuum model (specialist versus generalist model) from Scotland, and the T-shaped model from the Netherlands.

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Keywords

Levels of nursing competence · Specialist nurse · Nurse practitioner · Clinical nurse specialist · Competency · Differences · Characteristics

The educational system, legislation and nursing certificate scheme that exist in a country influence nurses' opportunity to practice clinical nursing in a given country. The various European systems of higher education were harmonized through the Bologna Process, which changed nursing education in many European countries. Today, many similarities and common characteristics are seen in nursing education on both the generalist and specialist levels in Europe. Within the European Union, there is free movement of generalist nurses. Internationally, greater differences are seen regarding master's-level nursing education. For example, in the Nordic countries, master's-level nursing programs have undergone relatively large changes; continuing education elements have been integrated into these programs, the number of programs has increased at an explosive rate, and even interdisciplinary programs have been introduced.

2.1 Progression from Generalist Nurse to Advanced Practice Nurse

In this book, the term "advanced practice nurse" is used to refer to a nurse who practices and engages in nursing on an advanced level. The International Council of Nurses launched new guidelines on advanced practice nursing in April 2020 (ICN 2020). There, advanced practice nurse is defined as:

> *An Advanced Practice Nurse (APN) is a generalist or specialized nurse who has acquired, through additional graduate education (minimum of a Master's degree), the expert knowledge base, complex decision-making skills and clinical competencies for Advanced Nursing Practice, the characteristics of which are shaped by the context in which they are credentialed to practice (adapted from ICN 2008). The two most commonly identified APN roles are [clinical nurse specialist] and [nurse practitioner].*

Following several decades of advanced practice nursing role development, one can conclude that advanced practice nursing encompasses two main professional profiles: nurse practitioners and clinical nurse specialists (Hassmiller and Pulcini 2020). Nurse practitioners have mastered advanced practice nursing and are capable of diagnosing, making prescriptions for and referring patients. They mainly work in the community but also in hospital settings. Clinical nurse specialists are expert nurses with advanced nursing knowledge and skills who are capable of making complex decisions in a clinical specialty and often utilize a systems approach to influence optimal care (ICN 2020).

Differences exist between the specialized nurse and clinical nurse specialist roles, as seen in the International Council of Nurses' new guidelines (2020). Nursing

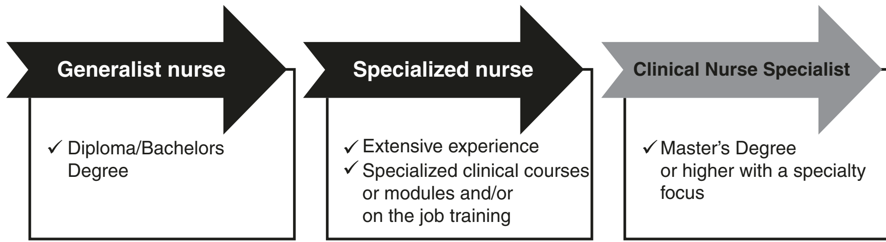

Fig. 2.1 Progression from generalist nurse to clinical nurse specialist. (Figure 1 from ICN 2020, p. 17)

can be performed on the generalist, specialist, and advanced levels (see Fig. 2.1). The first, generalist level, is a nurse holding a bachelor's or postgraduate degree, which equates to the ability to provide basic nursing and care in various practice settings (Carnwell and Daly 2003; Daly and Carnwell 2003). The second, specialist level, is a functionally competent nurse with further education, e.g., specialized courses or modules and/or on-the-job training, who is capable of shouldering responsibility for defined tasks in a specialized clinical area, e.g., a specific patient group (wound care, diabetes, etc.). The third, advanced level, entails an expansion of a nurse's independent responsibility and function, e.g., comprehensive, systematic clinical examinations and health evaluations, and clinical decision-making care and treatment. A master's degree or beyond with a specialty focus is the recommendation. The expansion of an advanced practice nurse's responsibilities can also entail being responsible for tasks traditionally performed by physicians or new types of healthcare services such as support for patients' self-care, walk-in services, acting as a case manager for vulnerable patient groups, etc.

"Nurse practitioner" is the most internationally used advanced practice nursing title, and the nurse practitioner role is considered to entail a more advanced clinical competence than the specialist nurse role. "Certified registered nurse anesthetist," advanced practice registered nurses who administer anesthesia to patients leading up to surgical, obstetrical, or trauma care procedures, and "midwife" are other advanced practice nursing titles. In nursing literature, one also finds descriptions of a mixed role, in which the advance practice nurse and specialist nurse roles are combined (Spross and Hamric 1983; Canadian Nurses Association 2008). Even if the clinical nurse specialist role is also considered an advanced nursing role, several researchers emphasize that differences exist between a specialist nurse and a nurse engaging in advanced nursing (Roberts-Davis and Read 2001; Carnwell and Daly 2003; Hassmiller and Pulcini 2020; Fagerström 2019; ICN 2020). The characteristics of the nurse practitioner and clinical nurse specialist roles differ between countries.

There is an ongoing debate regarding the similarities and differences between the specialist nursing and advanced practice nursing roles (Furlong and Smith 2005). Typically, a specialist nurse is described as a nurse who works in a specialist area for a longer period with patients with a specific diagnosis and who works in close

collaboration with physicians (Ministry of Health 2002). In contrast, an advanced practice nurse treats and cares for diverse patient groups, possesses competency in independent assessment, and treats and takes responsibility for undiagnosed patients, including their health and need for care. Advanced practice nurses, therefore, have more sharply defined autonomy and independence than specialist nurses (Roberts-Davis and Read 2001; Carnwell and Daly 2003; Fagerström 2019; ICN 2020).

In conclusion, there are no special or specific skills that determine what differentiates nurses from a generalist or specialist level from nurses on an advanced level; it is instead a combination of the factors mentioned above (Carlisle 2003; Castledine 2003). Nevertheless, in a recent study, researchers found that clinical decision-making and clinical reasoning appeared to be the main differences between generalist, specialist, and advanced practice nurses (Levy-Malmberg et al. 2020). In that study, the researchers found that advanced practice nurses facilitated and evaluated new alternatives more than the other nursing groups in shared decision-making and clearly used their expertise in decision-making. In this chapter, the question of specialist versus advanced practice nursing competency is problematized.

In the advanced practice nursing model seen in Scotland, emphasis is placed on a nurse's clinical competence regarding two aspects: generalist versus specialist competency and novice versus expert level (see Fig. 2.2). A nurse's clinical competence is developed through education and clinical experience. Today, there are nurses with bachelor's degrees who have "extended" their degree through either shorter or longer educational programs or have continued their studies and obtained a master's degree. The principle of "life-long learning" still prevails, i.e., that one gradually can build on one's generalist education. The consequences of this are that the nursing workforce consists of nurses with different levels of clinical competence. In this book, a fictional model of nursing serves as a starting point for discussion, including the two following assumptions. First, there are three levels of clinical nursing competence: the generalist, specialist, and advanced levels. Second, a healthcare system needs nurses from all three levels, in accordance with societal and patient needs.

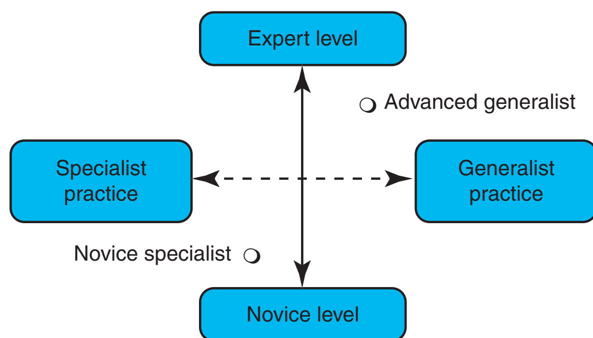

Fig. 2.2 The relationship between clinical practice on the specialist and advanced levels. (Modified from Fagerström 2019)

2.2 From Nurse Specialists to Nurses with a Master's Degree: Examples from the Nordic Countries

Through a historical review of specialist nursing education and the role that nurse specialists have had in the Nordic countries, one can see how advanced practice nursing in this setting has evolved over the years: from practical training modules to more academic educational programs. This is an evolution also seen in many other countries.

In the 1970s in the Nordic countries, various in-service, hospital-specialist educational programs for nurses were introduced. Today, all Nordic countries implement various continuing education frameworks, e.g., for psychiatric nursing, pediatric nursing, preoperative nursing, palliative care, etc. National assessment and accreditation systems for specialist nurses exist in Denmark, Iceland, Norway, and Sweden, but these systems vary (Fagerström 2019). In Finland, an accreditation system only exists for emergency care nurses, district nurses, and midwives. All other nursing accreditation, e.g., specialist nurses, was stopped in Finland at the beginning of the 1990s when nursing education on the generalist level was lengthened from 2.5 to 3.5 years. A discernable trend in Norway and Sweden is that specialist nursing postgraduate programs have been included in master's degree programs. In Norway, for example, this has occurred simultaneously with an "explosion" in the number and variety of master's degree programs being offered. In parallel with this is the trend to offer interdisciplinary master's degree programs, for which there are obvious benefits with regard to teamwork and cooperation: but which also can entail that nurses have insufficient opportunity to deepen their clinical competence and/or subject knowledge.

In the Nordic countries, midwives have for some time had a more independent role and are considered to practice on an advanced clinical level. In Norway and Sweden, nurse anesthetists have also traditionally had a more independent role alongside other specialist nurses. In the Nordic countries, district nurses have traditionally practiced relatively independently. In Sweden, midwives can prescribe hormonal medications, and district nurses can enroll in a pharmacology course worth 15 ESTC credits. While completion of that course gives limited prescriptive authority, in reality most of the medications are over-the-counter (non-prescription). In Norway, midwives and district nurses have the right to prescribe birth control for females aged 16–19 (Fagerström 2019). In 2019 in Norway, the Ministry of Health and Care Services instituted new regulations concerning the authorization, licensing, and specialist approval for registered nurses (*Forskrift om spesialistgodkjenning for sykepleiere*), in which it was delineated that nurses holding a master's degree in advanced practice nursing (*avansert klinisk allmennsykepleie*) are allowed to seek recognition as specialists (Lovdata 2019). In Norway, advanced practice nurses with a master's degree have advanced clinical competence with a specific focus on community healthcare.

In the Nordic countries, trained specialist nurses have to a certain degree taken on specially designed roles, e.g., diabetes nurse, cardiac nurse, etc. Even if these roles have existed in some form since the 1980s, a clear expansion of clinical

practice that includes greater independent clinical responsibility for patients' care and treatment had not previously been seen in the Nordic countries. Such an expansion even encompasses the same characteristics seen in the independent advanced practice nurse role, i.e., clinical examination, assessment of health needs, diagnostics, further referral, ordering of laboratory tests or radiographic examinations, and adjustment of prescription medications. The various national nursing organizations in the Nordic countries and/or healthcare system nursing leaders have not to date sufficiently clearly and resolutely demanded an expansion of nurses' rights and responsibility in clinical contexts, as has occurred in, e.g., Canada and the United Kingdom. It is also worth noting that actors in the academic world (specialist area professors/instructors, researchers, scientific/nursing science representatives) in the Nordic countries also have not targeted, strategically invested in, or advocated for a more advanced practice nursing role, as has occurred internationally.

2.3 A Bi-continuum Model of Specialist Versus Generalist Nurses

For many years a debate about whether specialist nursing should be considered a lower level of nursing than advanced nursing level has been ongoing. In Scotland, this question has been addressed via an emphasis on that both specialist and advanced nursing practice roles exist on the same continuum, derived from Barton's generalist-specialist novice-expert continuum (Barton et al. 1999; The Scottish Government 2008). In Scotland, specialist nurses' clinical practice is considered to occur in a specific context, e.g., a patient group, skill set, or organizational context. Accordingly, specialist nurses' clinical competence corresponds to the requirements that the specific contexts have. Advanced nurses' clinical practice is characterized by broader competence and is not linked to any specific context. Advanced practice nurses can provide, e.g., acute care or care for and treat patients with undiagnosed health problems (see Fig. 2.2), and parallels can be drawn to the type of competence that physicians possess. The generalist competence that an advanced practice nurse has is especially needed and valuable in community health services and acute situations (Cooper et al. 2019).

In the Scottish model, advanced practice nursing is described as a level of clinical practice, i.e., it lies on a continuum between "novice" and "expert" practices. An advanced clinical role is characterized by a high degree of clinical skills, competence, and the ability to make autonomous decisions. Thus, even among specialist nurses and advanced practice nurses (who possess generalist knowledge), one can see different levels of competence. Newly practicing nurses, whether specialized or advanced practice, are novices at the start of their careers. As their experience and knowledge expands, they reach expert competence in their field. In line with this clinical model, one can expect that with a master's degree both specialist and advanced practice nurses can, through lengthy work experience, provide their patients with care on an advanced clinical level.

There nevertheless still exists international agreement on the existence of a lack of awareness in the healthcare sector about the differences between the clinical nurse specialist and advanced nurse practitioner roles. To address this issue, the goal of the European Specialist Nurses Organisation is to facilitate and provide an effective framework for communication and cooperation between the organization and its constituent members (https://www.esno.org/). In a review of the similarities and differences between clinical nurse specialists and nurse practitioners, Cooper et al. (2019) found that because both roles are predominately clinically based and include education, leadership, and research components, both are valuable and effective. This implies that not only is there a significant overlap of knowledge, confirmed by researchers, but also knowledge specific to each role (Stark 2006). Cooper et al. (2019) also saw that clinical nurse specialist roles were always specialist roles, whereas nurse practitioner roles were more often generalist roles. As noted above, specialist competence implies greater knowledge of a specific clinical area. Thus, as generalists, nurse practitioners should possess much broader clinical knowledge, and their educational requirements will accordingly vary in relation to clinical area and service needs. This is presented diagrammatically in Fig. 2.3. Lastly, Cooper et al. (2019) even found a link between national regulation and governance and more clearly defined and structured nurse practitioner roles. Unfortunately, there is still a lack of such regulation and governance in many countries.

Traditionally, the direct clinical role has been the most central role in advanced practice nursing, as is still the case today. Other central roles include teaching, research, consultation, and leadership (Zwygart-Stauffacher 2010). An advanced practice nurse must build clinical credibility with both patients and colleagues and act as a consultant and leader for other staff on clinical issues. Direct clinical skills

SCIENTIFIC RESEARCH	EDUCATION AND TRAINING	COORDINATING PRACTITIONER	DEVELOPING QUALITY OF CARE
> judging the worth of research findings for professional practice > initiating, designing and conducting research aimed at professional practice > participating in knowledge networks	> supervising, coaching and educating co-workers > training of nurse practitioners in training > initiating and participating in peer evaluation	> coordinating the care process and functioning as first point of contact for care recipients, their families or legal representative > playing a substanial role in the care recipient's treatment	> initiating, developing and implementing measures to improve quality of care, and innovativeness and professionalization of the profession > participating in knowledge networks

INDEPENDENT PRACTITIONER
> methodologically and systematically making a diagnosis, and proposing, organizing and provide nursing care and medical care > counseling care recipients with a focus on the illness and being ill, in their own contexts, with outcomes relating to maintaining or regaining health, physical and/or mental functioning, quality of life and dignity of life > specialist knowledge, skills and attitude in one's own focus area and field of expertise in somatic health care or mental health care

the nurse practitioner's specialist competencies

Fig. 2.3 The nurse practitioner: a T-shaped professional. (Kappert and de Hoop 2019, p. 11)

are therefore the most important skills the advanced practice nurse has. The advanced practice nurse's clinical skills for direct care comprise his/her most fundamental competence (Tracy 2009, 2019). Advanced practice nurses make use of advanced clinical assessments, have a more systematic work method, and thereby have greater independent responsibility for their decisions and actions than nurses on a lower level. Subsequently, advanced practice nurses can take responsibility for patients with more complex health problems.

2.4 The Advanced Practice Nurse as a T-Shaped Professional

The question of specialist versus generalist competence also has another dimension. Sound experiences of care and treatment as a generalist nurse practitioner can lead to expert and specialist knowledge in one's specific area of knowledge. In those countries where advanced practice nursing is more developed, clear specialist roles in specific areas have developed, e.g., primary care nurse practitioner, adult-gerontology acute care nurse practitioners, certified nurse-midwife, certified registered nurse anesthetist, etc. (Hravnak et al. 2019).

In the Netherlands, a certified nurse specialist is a nurse practitioner who has completed a 2-year dual master's program, the Master Advanced Nursing Practice program, and is registered in the official Dutch registry for nurse specialists (MANP, Kappert and de Hoop 2019). Only after registration with the Registration Commission for Nurse Specialists is a nurse legally allowed to use the title "(certified) nurse specialist" in the Netherlands. Difference exists between nurse specialists and specialized nurses, and separate registries are maintained. Specialized nurses are registered in the official Dutch registry for nurses and have one or more areas of expertise, e.g., intensive care, oncology, or geriatric care.

In the Dutch model of advanced practice nursing, two specialist areas for nurse practitioners have been defined: somatic health nurse practitioners and mental health nurse practitioners. Here follows a clear description of what is expected of nurse practitioners overall:

> *In her treatment, the Nurse Practitioner focuses on care that contributes to the health, functioning, quality of life and dignity of life of the care recipient, wherever it is needed, both at home and in institutions. The Nurse Practitioner follows the patient journey and, if necessary, looks beyond the boundaries of her own workplace. The Nurse Practitioner is a connecting professional with generalist and specialist skills or competences who takes on challenges in care as a collaboration partner with the care recipient, the care team, and with others within and outside the care organization*. (Kappert and de Hoop 2019, p. 5)

In Kappert and de Hoop's (2019) Nurse Practitioner Professional Competency Framework, nurse practitioners are considered T-shaped professionals, i.e., considered to have in-depth problem-solving skills in their own area of competency and the ability to interact with other professionals from other specialties (IfM and IBM 2008). For a graphical representation of a T-shaped professional, see Fig. 2.3 (Kappert and de Hoop 2019, p. 11). In that figure, nurse practitioners' specialist

competencies are placed and described in the vertical portion of the "T" (Roodbol 2019). This includes methodologically and systematically making a diagnosis; counselling care recipients with a focus on illness and being ill; and specialist knowledge, skills, and attitude in own focus area and field of expertise in somatic or mental health. In the horizontal portion of the "T," nurse practitioners' general competencies are described and associated with knowledge and skills defined: scientific research, education and training, coordinating practitioner, developing quality of care, and showing leadership.

2.5 Nurses' Clinical Practice on the Generalist, Specialist, and Advanced Levels

Examples of the development of nursing specialist educational programs in the Nordic countries reveal that many countries need both nurses with generalist education (shorter and longer programs) and those with master's level degrees. Clinical competence includes theoretical knowledge, clinical skills, and an ethical approach to patients (see Chap. 4, cf. *epistemology*). For each nurse, own personal work experience in caring for patients is of paramount importance regarding actual clinical skills. Therefore, a formal education that automatically equates to guaranteed clinical outcomes or a professional's actual clinical competence does not exist.

In one study in which the clinical nurse specialist and nurse practitioner roles were compared, nurse practitioners were found to spend more time on direct patient-oriented nursing activities (direct care) than clinical nurse specialists (Lincoln 2000). Nurse practitioners were seen spending an average of 84% of their time on somatic nursing, clinical examinations, ordering of laboratory tests, and prescribing medications. In comparison, clinical nurse specialists were seen only spending 24–37% of their time on such direct patient-oriented nursing activities (i.e., direct care).

In many countries, the clinical nurse specialist role can be considered more of a combined role, which encompasses professional development, leadership, research, and education (see Fig. 2.2). For example, in Finland the clinical nurse specialist role as seen in a hospital setting often requires completion of a master's-level educational program (MNSc) in nursing science, and work tasks are for the most part composed of promoting evidence-based nursing, developing care quality, and supporting an organization's strategic development work (Kotila et al. 2016; Jokiniemi et al. 2020). Conversely, those advanced practice nurses acting in a clearly defined nurse practitioner role in Finland usually engage in a much greater amount of patient-related clinical care. Still, this varies from country to country and from healthcare system to healthcare system.

One supposition is that the more clinical time a nurse spends on patients, the greater the possibility he/she has to advance his/her clinical knowledge to an expert level: regardless of whether a nurse has a generalist education, further education, or a master's degree. Through a model in which nursing roles are more integrated (see Fig. 2.4), another type of competence linked to leadership, research, and strategic

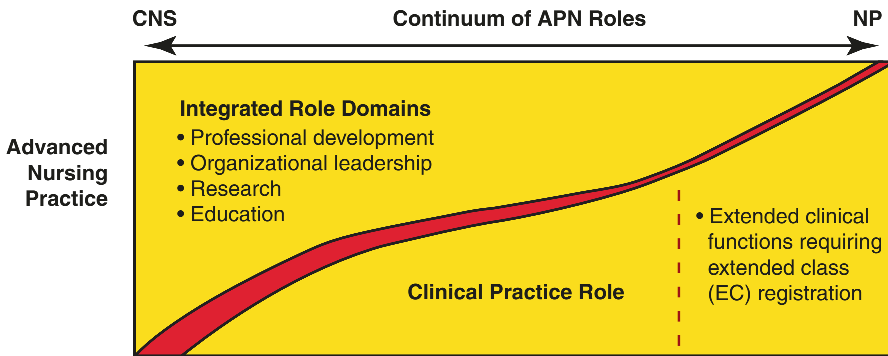

Fig. 2.4 Continuum for advanced practice nursing roles. (Bryant-Lukosius, D. (2004 & 2008), unpublished; International Council of Nurses 2020)

development work can evolve. The provision of healthcare is a complex matter and requires a mix of various types of competence to ensure that overall care for each individual patient is as good as it possibly can be.

To achieve clarity on nursing terminology, national consensus on the definition of nursing competence levels and the titles used is needed. Furthermore, national authorization and accreditation schemes related to advanced practice nursing should be established.

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3 What Is Advanced Practice Nursing?

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Abstract

How advanced practice nursing is defined primarily emanates from nurses' basic functions and responsibilities, where traditional nursing tasks are preserved, but also includes some functions and responsibility areas that have been expanded to an advanced level. To facilitate recognition of the role, its practice, and its implementation in a country's health system as a whole, each country should clearly define what an advanced practice nursing role entails. Through definitions it is possible to identify new roles, including new areas of responsibility and limitations, in clinical practice. Definitions provide an overview of the type of nursing, care, treatment and services that can be expected from the person engaging in a certain practice. In this chapter, the concept "advanced practice nursing" is described and defined from an international perspective. Thereafter follows a brief introduction to the Caring advanced practice nursing model and how it and its central concepts can be defined, as well as a reflection on the difference between the specialist and advanced levels.

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Keywords

Definition · Advanced practice nursing · Characteristics · Caring advanced practice nursing model

Nursing can be practiced on the generalist, specialist, and advanced levels (see Chap. 2). According to the International Council of Nurses, it is necessary to clearly define what the advanced practice nursing role entails to facilitate recognition of the role, its practice, and its implementation in a country's health system as a whole (Schober and Affara 2006; ICN 2020).

Generally, there are two main professional advanced practice nursing roles and titles seen in the international context, i.e., nurse practitioners and clinical nurse specialists (Schober 2016; ICN 2020). One can briefly say that nurse practitioners have mastered advanced nursing practice and are capable of clinical examination, assessment of health needs, diagnostics, further referral, ordering of laboratory tests or radiographic examinations, and adjustment of prescription medications. Though nurse practitioners primarily work in a community healthcare context, they can also work in a hospital context/setting. Clinical nurse specialists are expert nurses with advanced nursing knowledge and skills, who are capable of making complex decisions in a clinical specialty and often utilize a systems approach to influence optimal care (ICN 2020). They are expert nurses who deliver high-quality nursing care to patients and promote quality care and performance in nursing teams.

In the International Council of Nurses' new guidelines for advanced practice nursing, it is emphasized that nurse practitioners are generalist nurses and autonomous clinicians (ICN 2020). A master's-level education should result in the capacity to diagnose and treat conditions based on evidence-informed guidelines that include nursing principles in which there is a focus on treating the whole person rather than only the condition or disease, i.e., a holistic perspective (see Chap. 6). In the nurse practitioner role, clinical expertise in diagnosing and treating health conditions, including prescribing medications, is combined with disease prevention and health management.

Clinical nurse specialists are described as, "a nurse with advanced nursing knowledge and skills, educated beyond the level of a generalist or specialized nurse, in making complex decisions in a clinical specialty and utilizing a systems approach to influence optimal care in healthcare organizations" (ICN 2020, p. 12). Clinical nurse specialists provide a combination of direct and indirect patient care and have a broader and extended range of accountability and responsibility for staff development and improvements in the healthcare delivery system.

3.1 The Concept of Advanced Practice Nursing: An International Perspective

In 2002, the board of directors for the International Council of Nurses recognized a definition of advanced practice nursing. Note that this definition should not be considered normative, because it was developed to facilitate common understanding

and discussion on an international level (Schober and Affara 2006; Schober 2016). According to the International Council of Nurses (2002, 2008), an advanced practice nurse is defined as:

> *… 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 she/he is credentialed to practice. A master's degree is recommended for entry level.*
>
> Important key concepts in this definition are:
>
> - Expert knowledge and skills to engage in complex decision-making (complex decision-making skills).
> - Clinical competence to maintain expanded responsibility in practice (clinical competencies for expanded practice).
> - Advanced practice nursing must be designed in accordance with the needs of each specific country and health system. (ICN 2002, 2008)

Just recently, the International Council of Nurses (2020, p. 6) updated their guidelines on advanced practice nursing. There, an advanced practice nurse is defined as:

> *… a generalist or specialized nurse who has acquired, through additional graduate education (minimum of a Master's degree), the expert knowledge base, complex decision-making skills and clinical competencies for Advanced Nursing Practice, the characteristics of which are shaped by the context in which they are credentialed to practice (adapted from ICN 2008). The two most commonly identified [advanced practice nursing] roles are [clinical nurse specialists] and [nurse practitioners].*

In 2018, in the United Kingdom, the Royal College of Nursing (2018) also renewed their definition and standards on advanced practice, stating that:

> *Advanced practice is a level of practice, rather than a type of practice. Advanced Nurse Practitioners are educated at Masters Level in clinical practice and have been assessed as competent in practice using their expert clinical knowledge and skills. They have the freedom and authority to act, making autonomous decisions in the assessment, diagnosis and treatment of patients.*

The Royal College of Nursing (2018) also determined that registered nurses working on an advanced level in the United Kingdom must meet the following seven standards:

- Have an active registration with the Nursing and Midwifery Council.
- Practice within the four pillars (advanced clinical practice, leadership, facilitation of education and learning, evidence research and development).
- Have a job plan that demonstrates advanced nursing practice and has equity with peers working at this level.
- Be educated to the master's level.
- Be an independent prescriber.
- Meet the Nursing and Midwifery Council revalidation requirements.
- Demonstrate autonomous evidence.

The specialization and expanded knowledge that an advanced practice nurse has results in a *generalist competency and the ability to take greater responsibility and undertake a more independent professional practice in one's professional nursing function. Yet over time this generalist competency can even develop into specialist competency, depending on the advanced practice nurse's field of work and the type of patients he/she cares for and treats* (see Chap. 2). This means that advanced practice nurses can even undertake tasks that physicians have previously been responsible for. In several countries, e.g., Australia, New Zealand, the Netherlands, the United Kingdom, and the United States of America, advanced practice nurses have non-limited prescriptive authority. In other countries, e.g., Finland, registered nurses with a postgraduate education of 45 credits have limited prescriptive authority (see Chap. 10). Briefly speaking, advanced practice nurses also have an expanded role in relation to several other nursing functions: among others, education/guidance, health preventive/promotive activities, research and development, and leadership (see Chap. 7) (Hinchliff and Rogers 2008; Altersved et al. 2011; Bergman et al. 2013; Wisur-Hokkanen et al. 2015; Schober 2016; ICN NP/APN Network Research Subgroup, Report 2019. https://international.aanp.org/Research/SG).

Greater and expanded individual responsibility for a patient's nursing, care, and treatment and more complex clinical tasks require in-depth knowledge of the nursing profession, good interdisciplinary knowledge, and advanced clinical skills. This includes, e.g., the comprehensive and systematic registration of a patient's health history (ability to take adequate anamnesis); advanced-level clinical examination methodology (e.g., heart/lung auscultation, assessment of neurological status); careful assessment of the patient's health needs; clinical decision-making linked to diagnosis, intervention, care, and treatment; and the ability to assess a patient's pharmaceutical treatment (pharmacotherapy) and eventual polypharmacy (often defined as five or more medications daily) (Åberg and Fagerström 2005, 2006; Fagerström 2008, 2009, 2019a; Lindblad et al. 2010; Schober 2016; Kappert and de Hoop 2019).

An advanced practice nurse is concerned about the patient, including the patient's close and extended family. To be able to engage in advanced practice nursing, sufficient clinical experience following one's bachelor's-level education in nursing, further education on the master's level (minimum requirement), and certain personal characteristics are needed.

In nursing literature, one sees three fundamental criteria associated with the implementation of advanced practice nursing: education (expansion of knowledge), authorization (national adaptation), and clinical practice with an emphasis on the patient and the patient's family (Schober and Affara 2006).

Expand knowledge base in accordance with the International Council of Nurses' (2002, 2020) definition of advanced practice nursing, the expanded responsibility inherent to the advanced practice nursing role requires greater competence and further education on the master's level, i.e., both profound theoretical knowledge and master's-level clinical skills. A master's-level advanced practice nursing degree

program can include courses on prescription rights, or such knowledge can be gained from independent (external) courses, either before or after competition of one's master's degree.

National authorization and adaptation Even though a master's-level education is considered a requirement for authorization and the ability to work as an advanced practice nurse, in many countries this criterion can be difficult to meet due to economic and/or educational policy reasons. One should remember that a nurse's actual clinical competence is the most central aspect in advanced practice nursing; even a lower educational level combined with extensive clinical experience, strong self-motivation, and certain personal characteristics can result in advanced-level competency in practice. Standardization, authorization, and accreditation systems for advanced practice nursing vary from country to country (Schober and Affara 2006; Schober 2016). A clear and evident system whereby advanced practice nursing education is standardized, authorized, and accredited on the national level is not only relevant to patient safety but also can even provide advanced practice nurses with a sense of security.

Adequate clinical practice Even the necessity for adequate clinical practice is emphasized (Hamric 2009). In many countries, at least 3–5 years of post-bachelor-relevant clinical work experience are required to be accepted into a master's-level advanced practice nursing degree program. Furthermore, during one's master's-level studies in, for example, Ireland, the United Kingdom, and the United States of America, about 500 h of clinical experience toward the end of the program are required (ICN 2020). Both requirements are intended to ensure that advanced practice nurses demonstrate a high standard when performing tasks. Nevertheless, precise, agreed-upon, international standards and/or principles related to advanced practice nurses' scope of clinical practice do not yet exist.

3.2 Characteristics of the Advanced Practice Nursing Role

In 1992, the International Council of Nurses established an international nurse practitioner/advanced practice nursing network (http://icn-apnetwork.org/), overseen by a board of representatives composed of individuals from all parts of the world. Through the International Council of Nurses' NP/APN network, the development of advanced practice nursing throughout the world is supported. The network also includes area subgroups, e.g., education, practice, research, communications, and even fundraising (earmarked for developing countries). To support and develop the definition of advanced practice nursing, the International Council of Nurses has identified the characteristics that an advanced practice nurse should possess and be provided the following recommendations (adapted from International Council of Nurses 2008, p. 29; Schober 2016):

- Educational preparation
  - Educational preparation at the advanced level (beyond generalist nursing education)
  - Formal recognition of educational programs preparing nurse practitioners/advanced practice nurses for the advanced practice nursing role, accredited or approved
  - Formal system of licensure, registration, certification, and credentialing
- Nature of practice
  - Integrates research, education, evidence-based practice, and clinical management
  - High degree of professional autonomy and independent practice
  - Case management/ability to manage own caseload on an advanced level
  - Advanced health assessment, decision-making, and diagnostic reasoning skills
  - Recognized advanced clinical competencies
  - Ability to provide consultant services to other healthcare professionals
  - Plans, implements, and evaluates programs
  - Recognized first point of contact for clients
- Regulatory mechanisms: country-specific regulations underpin NP/APN practice
  - Right to diagnose
  - Authority to prescribe medication (prescriptive authority)
  - Authority to prescribe treatment
  - Authority to refer clients to other professionals
  - Authority to admit patients to hospital
  - Officially recognized titles for nurses working in advanced practice roles
  - Legislation to confer and protect officially recognized titles (e.g., nurse practitioner, advanced practice nurse, clinical nurse specialist)
  - Legislation, policies, or other forms of regulatory mechanism specific to advanced practice nurses

3.3 Definition of Advanced Practice Nursing: A Conceptual, Caring Model

To define advanced practice nursing, concepts and a description of how those concepts can be linked to one another are needed, e.g., a conceptual model. According to Fawcett (2005), a conceptual model or theoretical framework provides a coherent, unified, and orderly way of envisioning related events or processes relevant to a discipline. In nursing literature and research, the terms "conceptual model" and "theoretical framework" are often used interchangeably. Fawcett and DeSanto-Madeya (2013) find that the term "conceptual model" is synonymous with the terms "conceptual framework," "conceptual system," "paradigm," and "disciplinary matrix." However, conceptual models should not be considered theories that try to explain and predict with precision. Instead, conceptual models can yield guidelines for middle-range theory development (Fawcett 1988).

Using a heuristic perspective to determine the structural hierarchy of contemporary nursing knowledge, Fawcett and DeSanto-Madeya (2013) identified five components that can be used to describe nursing knowledge: metaparadigm, philosophies, conceptual models, theories, and empirical indicators. In nursing, conceptual models have been used to provide a structure for both research designs and nursing practice and to guide the development and testing of interventions and hypotheses based on the tenets of a theory. Conceptual models are also used to explain and interpret study results and relate study findings within the context of science (Radwin and Fawcett 2002).

The aim of the Caring advanced practice nursing model is to provide a framework whereby both abstract ideas, i.e., theoretical perspectives as the cornerstones of the caritative philosophy, and general phenomena, i.e., the core competencies of advanced practice nursing, are organized and made visible. The Caring advanced practice nursing model gives both a philosophical and pragmatic orientation to the nursing, care, and treatment that advanced practice nurses provide to patients. This model can also strengthen professional identity: through clarification of the mission and boundaries of the role as well as the responsibility and accountability inherent to the role. Accordingly, the model contributes to common understanding of what advanced practice nursing is in the nursing profession itself, within professional teams, and in society (Fagerström 2019a). The model can also be used for the further development of distinctive concepts, to investigate the relationships between concepts, to organize ideas, for the development of educational programs/curricula, to design research, or to even develop knowledge on advanced practice nursing.

In international nursing literature, several conceptual frameworks or models of advanced practice nursing are seen (Spross and Lawson 2009). Hamric and Tracy (2019, p. 61) begin their conceptual description by noting that advanced practice nursing is based on the fundamental and core values inherent to nursing science. In Hamric's (2009) model of advanced practice nursing, which has been under development since 1996, the following core competencies are associated with advanced practice nursing: direct clinical practice, expert coaching and advice, consultation, research skills, clinical and professional leadership, collaboration, and ethical decision-making. In Hamric's most recent interpretation of the model, the component "research skills" has been replaced by "evidence-based nursing" (Hamric and Tracy 2019). The International Council of Nurses' definitions and guidelines for advanced practice nursing (Schober and Affara 2006) are largely the same. In international literature, the roles performed by the two main categories of advanced practice nurses, nurse practitioners and clinical nurse specialists, are often described through clinical practice, consultation, education, leadership, and research (Schober 2016; Hassmiller and Pulcini 2020).

When defining advanced practice nursing, the International Council of Nurses emphasizes that the model for each country should be used and modified with respect to the country's culture, tradition, and history (ICN 2020). For example, there is a strong theoretical nursing tradition in the Nordic countries, in which emphasis is placed on both the nurse-patient relationship and humanistic values.

Accordingly, when developing advanced practice nursing in that setting, it is of great importance to preserve this tradition. Underlying the development of the Caring advanced practice nursing model is also an attempt to further develop and build on the international caring tradition represented by Leininger, Watson, Roach, Swanson and Boykin and Schoenhofer (Marriner-Tomey and Alligood 2006).

In other international advanced practice nursing conceptual models, an emphasis on the importance of the nurse-patient relationship is fairly evident, but nursing perspectives on health, ethics, and/or value bases have not been as clearly investigated or stressed. The reason underlying such could possibly be that these aspects are considered self-evident. One strong explanation for why nursing science perspectives are specifically highlighted in current models might be the often-expressed criticism of advanced practice nursing and especially the nurse practitioner role, i.e., that advanced practice nursing is heavily influenced by the medical model and the tendency toward "mini physicians." Another explanation is that there is a need to more clearly theoretically anchor advanced practice nursing in nursing as a discipline. In the Caring advanced practice nursing model, this is realized by using a theory of knowledge perspective and a theoretical perspective based on four main concepts that are the cornerstones of the theory of caritative caring originally developed by Professor Katie Eriksson (1943–2019), a very well-known and highly appreciated Nordic caring science theorist (Lindström et al. 2006; Fagerström 2019b), thereby providing definition to theoretical reflections in relation to other disciplines as well as deepening the articulation and understanding of the clinical implications of theoretical perspectives on advanced practice nursing (Fagerström 2019a):

> *Caritative caring means that we take 'caritas' into use when caring for the human being in health and suffering …. Caritative caring is a manifestation of the love that 'just exists' … Caring communion, true caring, occurs when the one caring in a spirit of caritas alleviates the suffering of the patient*. (Eriksson 1992, p. 204, 207)

When developing conceptual models and concepts for advanced practice nursing, it is important to emphasize a setting's prevailing culture, tradition, and history and purposefully hold on to and strengthen developed and accepted nursing perspectives. The Nordic nursing and caring science perspectives can be summarized in the following central concepts (Fagerström 2011, 2019a, b):

- A holistic approach to the patient as a unique person and to his/her life context and life conditions
- Health
- Ethos as a person-centered fundamental ethical approach
- Caring

These four main concepts are the cornerstones of the theoretical perspective underlying the Caring advanced practice nursing model, i.e., the caritative philosophy that underpins the competence areas' part of the model, which subsequently influence clinical practice, education, and research.

The Nordic tradition, which is based on the core values of the discipline of nursing, is in many ways reflected in international models of advanced practice nursing. According to Fawcett (1984), the central concepts and themes, i.e., human beings, health, nursing, and environment, are identified and formalized as the metaparadigm of nursing. A holistic view of humankind and health is a consistent theme in international nursing research and theory creation, and the aforementioned core values (components) can be considered essential to the development of nursing. Ethical codes for nurses have been strengthened rather than weakened over the years. The statement "caring as the core of nursing care" does not need any further justification in the discipline of nursing today. According to Hamric (2009, p. 75), advanced practice nursing has a clear theoretical foundation in the discipline of nursing: "The advanced practice of nursing builds on the foundation and core values of the nursing discipline."

It is interesting to note that, in the United Kingdom, the Royal College of Nurses (2018) has revised their standards for advanced-level nursing practice to now include that registered nurses working on the advanced level should show evidence of being holistic practitioners: the capacity to address nursing as well as medical needs and the ability to "see" the whole person, i.e., fuse biomedical science with the art of caring. Such nurses should furthermore provide health promotion advice, counselling, assessment, diagnosis, referral, treatment, and even discharge patients.

Also in the Dutch competency framework of advanced practice nursing, there is an emphasis on that nurse practitioners are: "independent practitioner[s] … offering integrated treatment to care recipients based on clinical reasoning in complex care situations, ensuring continuity and quality of treatment, and supporting the care recipient's autonomy, control-taking, self-management and empowering him or her within the patient journey" (Kappert and de Hoop 2019, p. 8). In this framework, advanced practice nursing is described as a combination of care and cure together with a holistic perspective; an advanced practice nurse focuses on a patient's illness and on the patient being ill, and the patient as a human being in his/her context is central.

The Caring advanced practice nursing model as defined in this book is in line with the International Council of Nurses' definitions and guidelines, Hamric's model, and the other frameworks and international research in the discipline presented throughout the book. It has moreover been inspired by Eriksson's theory of caritative caring (2018; Lindström et al. 2006; Fagerström 2019b) as well as a person-centered perspective on nursing (see Chap. 5). The model encompasses the Nordic nursing and caring science tradition, in which the importance of a holistic and person-centered approach is emphasized. This definition of advanced practice nursing includes a visionary perspective on advanced practice nursing models with clear clinical autonomy and necessary rights, e.g., the right to prescribe medications (prescriptive authority), the right to referral, and the right to order laboratory tests or radiographic examinations. Accordingly, the definition of advanced practice nursing can be summarized as follows (adapted from Fagerström 2011, 2019a, b):

> *A nurse with advanced clinical competency shall be able to independently assess, diagnose and treat common acute health problems and conditions related to disease as well as take*

responsibility for the management of the follow-up and nursing needed for chronic health problems. Advanced practice nursing is characterized by a holistic view of the patient, caritative caring, and ethos as a person-centered fundamental ethical approach, where both objective and subjective health are focused on. The advanced practice nurse works in an evidence-based manner and is capable of systematically carrying out the comprehensive physical examination of a patient, investigating the patient's health history, and determining the patient's health needs on an advanced level. Based on his/her clinical assessment, the advanced practice nurse has the capacity and is able to make decisions about the patient's health needs and can realize the nursing and treatment measures required. He/she has the right to organize and refer patients for tests, such as laboratory tests or radiographic examinations, the right to prescribe medications, the right to referral as well as the right to admit or discharge patients, i.e., he/she can provide holistic and person-centered caritative nursing, care and treatment. The advanced practice nurse takes responsibility for, leads and coordinates health promotive and health preventative work. Other important areas of responsibility include the evaluation and development of healthcare services, quality assurance and research in own professional field. The advanced practice nurse holds a Bachelor's degree in nursing, has sufficient work experience and has an education equivalent to a Master's level degree in advanced practice nursing.

3.4 What Is the Difference Between Nurse Practitioners and Clinical Nurse Specialists?

In international literature, the discussion of the differences between nursing on the specialist and advanced levels primarily revolves around three factors considered important and which should thus be taken into consideration (Fagerström 2011, 2019a, b):

- Knowledge base and degree and breadth of competency
- Degree of autonomy in clinical practice
- Personal characteristics

How the specialist level of nursing is defined has often been based an extension of the nursing role, i.e., the responsibility for new tasks: for example, when a nurse specialist stitches a wound or treats a child with an ear infection. An extension of the role entails that new skills and areas of responsibility that have previously belonged to another professional group (e.g., physicians) are integrated into the (new) nursing role. This has occurred in many countries to ensure, e.g., continuity in care and treatment or secure access to treatment.

A clearer expansion of the role occurs when greater responsibility and/or more complicated tasks are transferred from one profession or professional group to another, e.g., the examination of patients with acute and/or undiagnosed infections. This, for example, can include a responsibility for the nursing and treatment of patients who require a prompt diagnosis for acute health problems or patients with chronic health problems linked to diseases such as diabetes, asthma, or cardiac failure. The advanced practice nurse role is characterized by an independent, expanded clinical practice that requires advanced clinical knowledge and the skills relevant

for both stable and non-stable complex situations. Through a visibly expanded role and own area of responsibility, nurses are discernably given clear clinical autonomy—and can therefore be considered an advanced practice nursing role. This advanced, third level[1] of nursing involves a clear development of the nurse's role and function and should be compared to the nurse's nursing and treatment outcomes, which in many instances change radically. Based on experiences from many countries, prescriptive authority also appears to be "key" for clear clinical autonomy as well as effective and efficient patient care pathways (Daly and Carnwell 2003; Furlong and Smith 2005; Bryant-Lukosius et al. 2009).

Using a typology of named clinical nursing roles, Roberts-Davis and Read (2001, p. 40) discerned the similarities and differences between clinical nurse specialists and nurse practitioners. Already in 2001, they found that the following competencies are required (primarily) for the nurse practitioner role:

- Carry out a full systematic physical examination including cardiopulmonary and neurological assessment where necessary.
- Take a systematic patient history as "clerking in."
- Make diagnostic decisions based on interpretation of clinical and other findings such as laboratory results and X-rays.
- Prescribe treatment including medication based on a sound knowledge of pharmacology.
- Devise an individual care plan which includes both nursing and medical management of care ("medical management" would include recommending a course of treatment or investigation).
- Screen patients for early signs of disease and risk factors.
- Carry out, where appropriate to the specific area of clinical practice, simple invasive and non-invasive diagnostic and therapeutic procedures. (Roberts-Davis and Read 2001, p. 40)

In many countries, especially those where advanced practice nursing is a new phenomenon, there is a lack of awareness on the similarities and differences between the nurse practitioner and clinical nurse specialist roles. In a systematic literature review of 118 articles of potential interest (Cooper et al. 2019), researchers investigated the similarities and differences between these roles. Based on the 12 articles ultimately included, the researchers concluded that "both roles are valuable and effective, predominately being clinically based with education, leadership and research components." They also found that clinical nurse specialist roles were always specialist roles, whereas nurse practitioner roles were more likely to be generalist. In a graphical representation of their findings, one sees that there is a significant overlap of knowledge between the roles. They moreover concluded that when there is regulation and governance, the nurse practitioner role is also clearly defined and structured. Nonetheless, they found that there still exists a lack of governance and regulation in many countries (Fig. 3.1).

[1] Generalist, specialist, advanced.

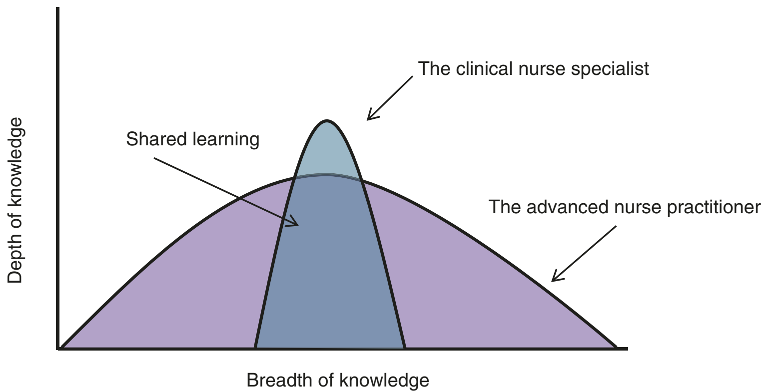

Fig. 3.1 A graphical representation of the difference between an advanced nurse practitioner and clinical nurse specialist (Cooper et al. 2019, p. 1314)

One sees in the list of competencies above certain skills that traditionally have not been performed in the nursing profession. While several are considered to "naturally" belong to the nursing profession, it is through deeper and broader knowledge that an advanced practice nurse can "read" (interpret) and understand patients with more demanding needs. These competencies are needed for clinical decision-making and arise from a broad knowledge base and sufficient work experience. There is international consensus on that it is the ability to engage in clinical decision-making that is what is unique to advanced practice nursing, not specific skills (Hamric 2009; Schober 2016; Tracy 2019).

In the list of Roberts-Davis and Read (2001, p. 40), one can also discern that direct clinical practice and clinical skills are important. In accordance with Hamric's (2009) model of advanced practice nursing, this means that a nurse educated in advanced practice nursing who works in an administrative, leadership, or educational role yet who does not him/herself engage in advanced practice nursing cannot be considered an advanced practice nurse. Nevertheless, international consensus still does not exist on the importance and necessity of an active, clinical role in relation to whether a nurse can be considered an advanced practice nurse. For example, the Canadian Nurses Association's definition of advanced practice nursing does not appear to include the same strict requirements for clinical practice (Bryant-Lukosius et al. 2004).

In the United Kingdom, the Royal College of Nursing's (2018) new standards for advanced-level nursing practice include that registered nurses working on an advanced level must "… Show evidence of: Having the freedom and authority to act autonomously and independently; Being innovative, highly skilled at assessing and managing risk and consciously competent; Have the responsibility for decisions made and actions taken." It is possible to argue that if one does not actively engage in advanced practice nursing it is difficult to maintain these competencies. Still, the various standards and definitions used in different countries are being steadily developed and updated to include that advanced practice nurses must be clinically active with patients.

3.5 The Advanced Practice Nurse's Knowledge Base and Broad Competence

The first determinative factor for whether a nurse is capable of advanced practice nursing is related to his/her knowledge base and extent of competence, i.e., whether he/she has sufficiently broad knowledge and comprehensive clinical competence to develop independent professional responsibility. In 1978, Carper identified four patterns of knowing in nursing: empirics, ethics, esthetics, and personal knowing. This was modified later on, with the addition of sociopolitical knowing (White 1995). Furthermore, multidisciplinary knowledge, such as knowledge from medical science, pharmacology, or the behavioral sciences and social sciences, is needed.

Daly and Carnwell (2003) emphasize the importance of having the competency to be responsible for undiagnosed patients. This can include, e.g., taking a health history (anamnesis) or completing a comprehensive clinical examination of patients with acute symptoms. To determine/diagnose such health needs requires a sufficiently broad knowledge base and good clinical skills: sufficient clinical experience is an absolute necessity in this context. In addition to broad competence, international research, and experience, in the Canadian Nurses Association's findings on advanced practice nursing, for example, the need for specialization in a chosen area is seen, e.g., gerontology, acute nursing, pediatrics, oncology/palliative care, family nursing, mental health nursing, etc. The need for different specializations can be developed when new advanced practice nursing models are implemented, and again this should vary from country to country and from setting to setting.

3.6 Degree of Autonomy in Clinical Work

The second determinative factor is the degree of autonomy, i.e., how dependent or independent the role is (Castledine 2003; Ball and Cox 2004; Bryant-Lukosius et al. 2004; Royal College of Nursing 2018). Autonomy can be described as the freedom to make decisions based on judgment, expert competence, and clinical knowledge in relevant clinical areas (Ulrich et al. 2003). In advanced practice nursing, there must always exist the possibility, right, and competence to make independent professional decisions and realize nursing and treatment emanating from these. Legal responsibility is therefore of great importance with regard to advanced practice nursing roles (Griffith 2008). National guidelines for advanced practice nursing care and treatment must be developed and anchored in legislation. However, during the start-up phase of new advanced practice nursing models, the local delegation of work tasks and responsibility can be used to provide a temporary solution.

In the Dutch model of advanced practice nursing, specifically the Nurse Practitioner Professional Competency Framework, the autonomous function of nurse practitioners is described as:

> *Nurse practitioners are independent professionals offering integrated treatment to patients based on clinical reasoning in complex care situations, ensuring continuity and quality of*

treatment, and supporting the care recipient's autonomy, control-taking, self-management and empowering him or her within the patient's journey … a combination of care and cure, holistic perspective, master educated, officially registered (Kappert and de Hoop 2019, p. 8).

In the Dutch model, it is emphasized that the treatment provided includes both medical and nursing interventions.

3.7 The Nurse's Personal Characteristics

The third determinative factor is the nurse's personal characteristics, i.e., to what degree the nurse is motivated, has own capacity, personal qualifications, and a certain willingness to bear expanded responsibility in his/her professional role (Roberts-Davis and Read 2001; Griffith 2008; Gardner et al. 2008). A certain degree of self-awareness and the ability to critically reflect are needed in advanced practice nursing, because these allow the nurse to be able to engage in consulting and leadership functions and assume the role of expert when working with other professional groups (Furlong and Smith 2005). An independent and expanded responsibility requires that a nurse is mature and courageous, both on the personal and professional levels (Wisur-Hokkanen et al. 2015). Personal maturity can take the form of personal wisdom (see Chap. 4). Being courageous means daring to stand up as an advanced practice nurse, taking up "space" and trusting that one's clinical competence is sufficient.

3.8 Conclusion

Post education, an advanced practice nurse has a broader knowledge base than a nurse specialist and is capable of being able to interpret, understand, and assess a broader spectrum of patients' undiagnosed health problems. For example, a nurse specialist with expert competence in wound care does not necessarily also possess the competence to evaluate the signs of acute cardiac problems nor evaluate how serious a problem is. This nurse specialist's competence lies in wound care; he/she does not have the competency to evaluate a patient's overall health condition. Such an ability is a key component in the competency that an advanced practice nurse needs to make independent clinical decisions.

The special competence that an advanced practice nurse needs, therefore, can include but is not limited to a narrow and predefined specialization or area (Roberts-Davis and Read 2001; Daly and Carnwell 2003). Nevertheless, an advanced practice nurse can through years of work experience, e.g., in acute care, gerontology, or palliative care, develop specialist competence in an area. "Nurse practitioner" is the internationally most commonly used advanced practice nursing title, and the nurse practitioner role is considered to include a need for more advanced clinical competence than what is needed for the nurse specialist role. Over time, advanced practice nursing roles and educational programs that also include an in-depth focus on

various specialist areas, e.g., gerontology, acute nursing, pediatric care, oncology/palliative care, family nursing, mental health nursing, etc., will be developed. One even sees in nursing literature evidence of a mixing of the advanced practice nurse and nurse specialist roles (Spross and Hamric 1983; Canadian Nurses Association 2008). In summary, one can reiterate that it is neither specialist nor specific skills that are determinative for and differentiate nursing on the specialist and advanced levels, but it is instead a combination of these aforementioned factors (Carlisle 2003; Castledine 2003; Griffith 2008). Societal needs will influence how various advanced practice nursing roles develop.

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4 The View of Knowledge in Advanced Practice Nursing

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Abstract

The view of knowledge that is taken in a discipline and professional domain is determinative for its research, practice, and education. In this chapter, a three-dimensional view of knowledge related to the development of advanced practice nursing is presented, as an area of research in nursing science, nursing professional practice, and higher education. The three dimensions part of this view of knowledge are *epistêmê, which is theoretical-scientific knowledge; technê, which is practical knowledge; and phronesis*, which is practical wisdom. A nurse's advanced clinical skills are a synthesis of these various forms of knowledge and are revealed through his/her approach to a patient or the patient's family and through concrete nursing and care for the patient's best. The three-dimensional view of knowledge is related to Kim's view of knowledge domains and related to nurses' advanced clinical competence as knowledge in action.

Keywords

View of knowledge · Epistemology · Aristotle · *Epistêmê* · *Technê* · Phronesis · Knowledge in action · Knowledge synthesis

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New knowledge is continuously developed through the research being undertaken in a discipline's professional and academic domains, both nationally and internationally. Comparable to how a rolling snowball increases in size, knowledge increases as new and earlier research findings accumulate. In each discipline, the objective is the development of sustainable theories that can be used to describe, explain, understand, and predict the phenomena encompassed in the discipline's professional and academic domains. Accordingly, the development of theories is an important part of knowledge development.

To develop nursing on the generalist, specialist, and advanced levels, nursing theoretical frameworks that encompass practical activities, education, and the various areas of research are required (Kenney 2006). Nursing is defined as a practice-oriented discipline part of the health sciences. The discipline of nursing has its own theoretical foundation, which can be described through models and theories used in clinical nursing practice (Benner et al. 2010). Theoretical knowledge taken from the natural sciences, life sciences, and social sciences is also an essential element linked to both education and research in the discipline and the implementation of advanced practice nursing in clinical practice.

Paradigm is a concept used to characterize an academic discipline. A paradigm can be described as a worldview that serves as a philosophical foundation used to explain any phenomena of interest to a discipline (Fawcett 1984). A metaparadigm is global in scope and substance, is perspective neutral, and is used to identify a domain that is distinctive from other disciplines' domains. A paradigm includes the common vision that the members of an academic field or profession have on the discipline's knowledge areas (domains), research focus, research methods, the role of the researcher, and those aspects that distinguish the discipline from other disciplines (Jakobsson and Lützén 2009). Today, several nursing philosophers offer various paradigms, which together have contributed to the development of nursing knowledge (Alligood 2018). Nevertheless, Fawcett's metaparadigm of nursing, built on four central concepts (the domains of person, health, environment, and nursing), is still the most commonly used paradigm (Fawcett 1984; Slevin 2003).

Paradigm is a concept used to characterize an academic discipline. Often-used, Fawcett's metaparadigm of nursing is still the most commonly used paradigm. It includes four basic concepts: person, environment, health, and nursing (Fawcett 1984; Slevin 2003). A metaparadigm is global in scope and substance and perspective neutral and is identifying a domain that is distinctive from the domains of other disciplines. A paradigm can be described as a worldview which serves as a philosophical underpinning for explaining any phenomena of interest to a discipline. Paradigm includes the common vision that the members of an academic field or profession have on the discipline's knowledge areas (domains), research focus, research methods, the role of the researcher, and those aspects that distinguish the discipline from other disciplines (Jakobsson and Lützén 2009). Today, there are

several nursing philosophers offering various paradigms that together contribute to the development of nursing knowledge (Alligood 2018).

Philosophy Fawcett and DeSanto-Madeya (2013) state that the function of a philosophy is to communicate what the members of a discipline believe to be true, what they believe about the development of knowledge, and what they value in their practice. Through nursing philosophies, answers to the questions "What is nursing?" and "Why is nursing important?" are sought, and ontological, epistemological, and ethical claims are articulated. Nursing philosophies are also used to attempt to express and describe the meaning of nursing and nursing phenomena (Alligood 2018). Ontological claims linked to philosophies are used to state what is believed about the nature of man, health, nursing, and/or the environment. Epistemological claims are used to describe "knowledge itself," i.e., what knowledge is, what its properties are, and why it has these properties (Fawcett and DeSanto-Madeya 2013). Ethical claims are used to express central values for clinical practices and the characteristics of the practicing nursing.

Epistemology "the theory of knowledge," relates to the study of knowledge and theories. What is it to know, and how can we defend what we know or what we claim is valid and true knowledge? One sees and understands the surrounding world through the theoretical "lenses" one has acquired through education, professional traditions, and/or a scientific subject area/discipline. Knowledge is also something that is deeply human and personal and which is developed in a social and cultural context (Gustavsson 2000).

Knowledge domains Carper (1978) identified four patterns of knowing in nursing: empirics, ethics, esthetics, and personal knowing. Note that in sociopolitical knowing a fifth pattern is included (White 1995). Kim (2000) is another nursing theorist who grouped nursing knowledge into domains: the domain of client, the client-nurse domain, the domain of practice, and the domain of environment. Through knowledge domains, nursing science phenomena and clinical practice concepts are bound together into meaningful entities in the discipline and clinical practice. Knowledge domains are needed to identify the foundational and important aspects of clinical reality and to define future visions for nursing as a part of overall health services.

4.1 The Tree-Dimensional View of Knowledge in Advanced Practice Nursing

This three-dimensional view of knowledge has its origin in Aristotle's philosophy on the various forms of knowledge as described in the Nicomachean Ethics (Aristoteles 1993). Aristoteles (1993) distinguished between epistêmê (knowledge), technê (skills and craft), and phronesis ("wisdom") (Gustavsson 2000) (see Fig. 4.1). Aristoteles'

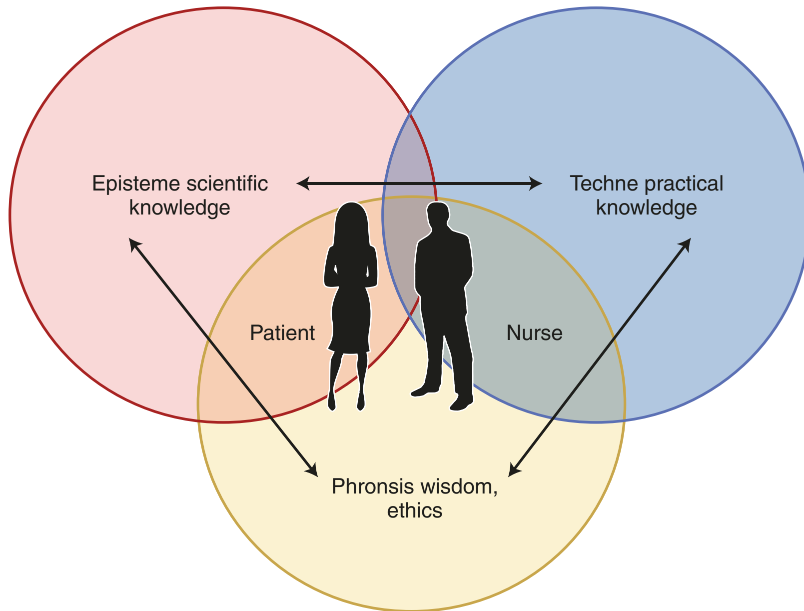

Fig. 4.1 The three-dimensional view of knowledge as a synthesis of knowledge, skills, and wisdom. (Modified from Fagerström L 2019a, p. 53)

(1967) three-dimensional approach to knowledge as a theoretical-scientific knowledge (knowing what), practical skills (knowing how), and practical wisdom (*arete*, translated as virtue) has been further developed by Gustavsson (2000). Gustavsson emphasizes that these three forms of knowledge must be considered in context. No one form of knowledge is better than or has a greater worth than another; all three are necessary in a knowledge- and evidence-based clinical nursing practice.

The purpose of the three-dimensional knowledge synthesis is to prevent "scientific reductionism," i.e., one science or scientific tradition "takes up too much room" or dominates or that practical and personal knowledge becomes less emphasized (cf. Gustavsson 2000).

Thinking in terms of thesis-antithesis in professional and scientific contexts must today be considered as belonging to a bygone era. Regardless of whether a thesis is from the natural sciences or the humanities, the goal should be a knowledge synthesis between the areas. In advanced practice nursing a dialectic epistemological synthesis is wholly necessary for research, education, and clinical practice (Fagerström and Bergbom 2010).

4.2 The Three-Dimensional View of Knowledge as a Synthesis of Knowledge, Skills, and Wisdom

Knowing (epistêmê) refers to the knowledge needed for understanding how the world is structured and for understanding the functions it has, i.e., theoretical-scientific knowledge (Gustavsson 2000). Epistemic knowledge concerns thinking

and is therefore the thoughts and words used to describe, explain, and justify knowledge/the truth. Knowledge, to know something, is to be convinced of a fact. Knowledge that is considered safe or objective is knowledge that researchers have found through systematic searches of reliable and widely accepted scientific methods. "Safe" knowledge is nonetheless a problematic concept, because it is known today that such "safeness" is short-lived and that previous knowledge can quickly be overturned by new research. What was confirmed or verified yesterday can be invalidated or disproved today. "Objective" knowledge, or objectivity, is also a challenging concept in research and is a classical philosophical question, because different perspectives and methods reveal different dimensions of the actual phenomenon (Gustavsson 2000; Alvesson and Sköldberg 2017). A good principle in research is to strive for objectivity while simultaneously being aware of own prejudices. In phenomenology, where knowledge of the life world and human beings' everyday knowledge are developed, human consciousness is the foundation for knowledge (Gustavsson 2000). Also this foundation for knowledge is today included in what one can refer to as "knowing."

Technê can be described as a practical skill and proficiency that one has the ability to do and execute while simultaneously understanding what one is doing, a so-named practical-productive knowledge (Gustavsson 2000). To possess technê implies the ability to act based on good arguments. Practical skills are about "doing" and standing for the knowledge that exists in the action itself. In other words, it is knowledge that exists in the actual execution, which in many trades and professions is interpreted as a professional competence or an expression of professional "art."

Practical knowledge is the starting point for human actions, i.e., knowledge expressed in action. Technê as "know-how" knowledge is the skills one trains to realize a craft when making or producing something with material or symbolic tools (Jensen 1990). The expression or term "professional practical skills" is used to encompass competence and "dexterity" that is a competence in practical actions. Some of this knowledge lies in rules, procedures, or guidelines relevant to various areas, either in relation to preparation or completion (*poiesis*) or in relation to working with human beings (practice). This form of knowledge is developed through training, role-modeling, and execution in practice. To develop technê in clinical nursing, the importance of clinical experience, clinical skills, and clinical study must be emphasized.

Practical wisdom (phronesis) is the knowledge needed to develop good judgment and behave as an ethically certain human being and democratic citizen. Practical wisdom is also characterized by ethical and moral knowledge (Gustavsson 2000). Practical wisdom relates to a one's attitudes and is expressed in concrete actions (Aristoteles 1993), i.e., acting in accordance with which is good for fellow human beings. Practical wisdom can be understood as comprising an attitude and good judgment used to do which is right and correct in a situation. This requires a situational awareness where one understands the particular and the concrete. Aristoteles (1993) emphasized the significance of wisdom as an important form of knowledge that is needed for cooperation and dialogue with one's fellow human beings.

Practical wisdom and judiciousness in action emanate from the depths of an individual's personality and emotional life. Such "knowledge of the heart" is a practical knowledge aimed at acting ethically (Aristoteles 1993; Gustavsson 2000). This knowledge is existential; it is anchored in lifestyle and life view and confirmed in the meeting with fellow human beings. Practical wisdom is developed through practical actions and experiences of what is "good" and "correct" for humankind (Unneland 2009) and has its foundation in profound life experience. It also requires the ability to understand different perspectives and phenomena in various ways, all to be able to assess them wisely (Gustavsson 2000). Phronesis can also be described as a practical wisdom, where one has experience of successful interactions with fellow human beings (Eide 2006). Phronesis is essential for the development of one's character (see Chap. 5, cf. *ethos*).

Seen through the prism of phronesis, the importance of ethics, intuition, personal maturity, and wisdom are emphasized in clinical nursing. In nursing, practical wisdom is about realizing what could be "best," or at least good, for each patient in accordance with his/her specific needs. Nurses must be able to reason through which actions will lead to the desired outcomes in specific situations, emanating from both their knowledge (epistêmê) and technical skills (technê). Nurses' judgment also includes being able to assess consequences for a patient in clinical situations.

4.3 The Three-Dimensional View of Knowledge as Related to Kim's Knowledge Domains

Similarities exist between Kim's (2000) knowledge domains and the three-dimensional view of knowledge presented above. Kim's knowledge domains, which were originally developed for nursing, presuppose a complementary view: a view of knowledge that combines (synthesizes) scientific knowledge with human science knowledge. Kim (2000) emphasizes the need for a synthesis between the following spheres of knowledge: generalized, situated hermeneutic, critical hermeneutic, and ethical/aesthetic.

Three key terms associated with Kim's generalized sphere of knowledge can be summarized as "explanation, understanding and predictability" (Kim 2000). In the generalized sphere of knowledge, general explanations (e.g., micro-, meso-, and macrotheories) and systematic explanations for physiological processes, situations, and human experiences are developed. Using generalized knowledge it is possible to chart general and universal patterns and trends as well as use them in one's work with a specific patient.

In the situated hermeneutic sphere of knowledge, the goal is to develop situation-specific knowledge about human experiences, i.e., the lived and the subjective alongside which creates meaning (Kim 2000). Phenomenological and hermeneutic knowledge underlines and illuminates the individual's subjective perspective and experience, with the goal to help develop "deep" understanding for both the nurse and patient. In this sphere of knowledge, the importance of understanding the individual is emphasized.

The critical hermeneutic sphere of knowledge can also be described as encompassing interpretive critical knowledge with a liberating perspective or as a dialogic knowledge with reformative interests. In this sphere, contributing to change is central.

The ethical/aesthetic sphere of knowledge relates to what is desirable and worth striving for, even if such can be considered expected when viewed from a normative perspective. Values are built-in, integrated into both science and practice. One example of research in this area is the development of knowledge of ethical behavior and how this influences nursing outcomes.

Various methodological approaches are needed to create new knowledge syntheses whereby different forms of knowledge are combined and to steer research, education, and the development of healthcare and nursing science. Both the natural sciences and humanistic knowledge are needed, and the research methods inherent to these various professional and academic traditions should be treated equally and given the same value (a complementary view). In nursing research, a multitude of methods are needed to develop different types of knowledge.

The assertion that healthcare services and nursing are complex phenomena provides a strong motivation for the use of a complementary view. Nursing on all levels occurs in a complex reality that includes many factors and actors and where the human being is a multi-dimensional person with both "measurable" and more "unmeasurable" dimensions (Fagerström 1999, 2000; Fagerström and Bergbom 2010). The application of knowledge synthesis (cf. Gustavsson 2000) and a complementary view challenge clinical nurses, instructors, and researchers to engage in constant dialogue about the continuously consistent, consecutive three-way division between theory, practice, and research.

4.4 Knowledge Synthesis in Advanced Practice Nursing

The three-dimensional view of knowledge in advanced practice nursing and the knowledge synthesis between the three different forms of knowledge integrated into concrete actions are illustrated in Fig. 4.1. The nurse and patient are placed in the center of the figure, to illustrate that all knowledge and skills should benefit the individual patient. As a reader of this book, you are asked to remember that nursing on the advanced level has the overarching objective to always contribute to better health for the patient and to improve the patient's care and treatment.

A higher level of theoretical-scientific knowledge is required for the practice of nursing on the specialist and advanced levels than for nursing provided by nurses with a bachelor's degree. Such higher-level knowledge should include, e.g., greater understanding of how human beings are constructed and function, how one can assess the various effects of different nursing measures, how one can promote health and prevent actual health problems, and knowledge of the patient's current life situation. An advanced practice nurse must therefore develop deeper knowledge and understanding of the human being as an entity of body, mind, and spirit and even who the patient is as a person.

Human beings are affected by physiological conditions, and in advanced practice nursing, this provides good justification for clinical nursing interventions. Advanced practice nurses should be able to use their theoretical-scientific knowledge to logically argue (defend) their clinical decisions. They must “know everything” about the specific decisions they take. Knowing also includes theoretical-scientific knowledge from the humanities, for example, “What is a human being?” or “How can one understand the human existence?” Consequently, the patient’s conditions for living and current life situation become a central question (Fagerström 1999). Knowledge of the patient’s subjective experiences and opinions are essential in advanced practice nursing, i.e., these are matters that cannot be ignored.

Technê, that is, practical skills in advanced practice nursing, emerges above all in a nurse’s ability to realize the various parts of the nursing process on a more advanced level. Advanced practice nursing requires a deeper ability to understand the patient’s need for complex nursing, care, and treatment (see Chap. 5). Such a depth of knowledge provides an advanced practice nurse with a readiness and ability to acquire more independent professional skills than nurses with a bachelor’s degree and facilitates the realization of “knowing how knowledge” (know-how) that is expressed in the form of expert competence in practical actions. You can read more about practical skills in Chap. 7, *Core Competency Domains in Advanced Practice Nursing*, where clinical examples of advanced practice nursing functions and roles are described.

Phronesis, that is, practical wisdom in advanced practice nursing, is the ability to assess what is good, correct, and useful for the individual patient in a specific situation (to “know who”). It also includes the ability to use this knowledge to “know how” and “know when” one should act to meet the patient’s needs and desires.

Advanced practice nursing is a practice conducted in collaboration and ongoing dialogue with the patient, the patient’s family or relatives, and other professional colleagues who are involved in the nursing process. Practical wisdom and judiciousness (in action) is a part of one’s personality, emotions, lifestyle and life philosophy and is an expression for the “knowledge of the heart” (Gustavsson 2000). This existential knowledge is wisdom and a resource when the challenge is to understand the patient as a person: to understand his/her life, health, and life situation. A caring approach, as an expression for care, compassionate love, and mercy, is an expression for the good as “the motive of the heart” (Fagerström et al. 1999; Lindström et al. 2006; Eriksson 2018).

4.5 Nurses’ Advanced Clinical Competence as Knowledge in Action

In a concrete nursing reality, it is not possible to distinguish between theory and practice (Molander 1996). Knowledge is essential for clinical competence, but it is not enough. Practical and rational skills and personal attitudes and experiences from clinical nursing practice are essential for the development of clinical competence. Clinical competence is expressed through actions.

Years of practical experience lead to details standing out and practice becoming more detailed, all while the overall picture becomes simultaneously clearer. Prior to starting to build a piece of furniture, a furniture carpenter will typically have

gathered together materials and his/her tools and ascertained an idea of the client's needs and what constitutes a comfortable piece of furniture. It is with these that the furniture carpenter can begin his/her task (Molander 1996). In the nursing process, attention should be placed on what the patient needs, and a nurses' ability to reflect on this is of great importance. There are common attributes to the everyday realities that both furniture carpenters and nurses experience while working with multiple and complex "materials." For nurses, this is seen as solving clinical problems, concretely helping the patient as a person in the best possible manner, and contributing to health and wellness are complex processes.

Nursing competence is reflected in the nurse's attitude toward the patient and in care and action. In other words, one can say that knowledge is embodied in attitude, care, and actions. Knowledge in action is central to the concept of clinical competence. A person who is clinically competent in a professional domain is also skilled in action. Such skill in practice requires wisdom and knowledge, which in turn facilitate insight into how something should be, is, or is created (Stigen 1983). Accordingly, it is in action that the three various forms of knowledge are made concrete: knowing, practical skills, and practical wisdom. This means that a nursing action contains both an attitude toward and care for a patient (the other). In advanced practice nursing, this entails striving to attain personal capability, which according to Kirkevold (1996) includes the following dimensions: theoretical knowledge, practical knowledge, reflection, critical thought, and intuition.

Advance practice nursing as knowledge in action always occurs in a context and in a concrete situation. Action therefore requires openness to the world and sensitivity to the unique patient. Advanced practice nursing can also be described as an advanced knowledge in action that is characterized by hermeneutic processes. A practical work process includes a variety of ingredients, and one must be able to assemble and abstract theoretical knowledge, earlier experiences, and current impressions into more meaningful wholes (entities). This entails hermeneutic processes, where the objective is to reveal greater understanding of the phenomenon. Nursing as a concrete action can be described as a process where the various forms of knowledge are united or become knowledge in action. In clinical nursing on an advanced level, there is a greater requirement for knowledge in all its different forms.

The development of nurse's personal competence occurs through clinical exercises and personal experience, that is, "learning by doing." In this manner knowledge becomes integrated and personal and can thus be expressed in practical actions. Subsequently, clinical practice is emphasized in advanced practice nursing educational programs.

According to Benner et al. (1996), expert nursing skills are an independent form of knowledge and not merely the application of theoretical knowledge. In their research, Benner, Tanner, and Chesla described advanced practice nurses' clinical competence as a competence where clinical and ethical competences are inseparably linked. They also described advanced practice nurses' expert competence as consisting of four different dimensions: clinical understanding/reasoning and action-based nursing, physically integrated "know-how" skills, the ability to see the "bigger picture," and the ability to discern the unexpected. Expert skills are seen in the performance of nursing actions, e.g., various concrete actions to ease the patient's suffering, reduce the patient's vulnerability, and preserve the patient's dignity.

The first dimension is clinical understanding/reasoning and action-based nursing. Advanced practice nursing competence and clinical understanding of the patient's specific health needs are inextricably linked. Being able to act in an adequate manner requires clinical understanding, which is described by Benner et al. (1996) as sensitivity to the unique patient. This sensitivity even entails being able to take into consideration both clinical and human dimensions as well as an understanding of the patient's past, present, and foreseeable future. A nurse's ability to read a patient's reactions is important for the nurse's ability to understand which actions are correct and true in the actual situation and react immediately. A close relationship between understanding, action, and outcome is assumed.

The second dimension is physically integrated "know-how" skills or professional expert knowledge. This means that one has the capacity to use knowledge in action. Such knowledge is "built into" the body, hands, eyes, and experience-based reactions in various situations. In Benner et al.'s study, the participants demonstrated that professionality under stress required finely tuned and well-integrated skills.

The third dimension is the ability to see the "bigger picture." Forming an understanding of the overall picture also includes understanding the patient's ideas about the future. Expert skills in nursing require the ability to predict the patient's probable course of disease (prognosis) and the ability to predict the patient's development, based on the patient's health status and other significant factors. The ability to understand the overall picture moreover includes sensitivity to the skill level required. An advanced practice nurse should have the ability to see his/her own limitations and skill shortcomings.

The fourth dimension is the ability to discern the unexpected. This is an important dimension in expert competence in nursing. This entails the ability to see and recognize when something is wrong with the patient and/or his/her situation. Moreover, it also entails being able to recognize when the clinical situation is not developing as expected, as well as being able to adequately react to (and based on) the unexpected data.

An expert nurse's ethical competence also includes the ability to personally engage in the patient's suffering and meet the patient's vulnerability through engagement (Benner et al. 1996). Ethical skills also include the ability to set limits on the degree to which technical procedures are allowed to dominate a nursing situation. For example, when handling equipment, it is important that a nurse works in such a manner that unnecessary and disruptive technological procedures are prevented. An advanced practice nurse works with and through others. A good clinical "eye," which is also related to how one reacts and acts, makes it possible for an advanced practice nurse to assert his/her position during collaboration with other professionals and employees and facilitates provision of what the patient needs.

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The Caring Advanced Practice Nursing Model

5

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Abstract

In this chapter, a conceptual model of advanced practice nursing is presented, i.e., an abstract description of selected advanced practice nursing characteristics and central concepts. The model emanates from a caritative perspective and is based on theoretical studies and international research on advanced practice nursing, and knowledge of clinical reality in and experiences of different models of advanced practice nursing. The Caring advanced practice nursing model should not be considered a normative or final model but is instead intended to provide a simplified picture of reality, which is what a theoretical or conceptual model normally represents. Originally developed for the Nordic setting, this model is nonetheless transferable to all contexts, because it is in line with other international theoretical models. It is a conceptual model that built upon a modified version of the International Council of Nurse's principles on advanced practice nursing and Hamric's Model of Advanced Nursing Practice. The model encompasses central advanced practice nursing competency domains, critical contextual factors, and descriptions of central theoretical perspectives. Understanding of the model is deepened by relating it to an

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interpretative framework on patients' need for nursing and care, i.e., a model for "the basis of good care."

Keywords

Advanced practice nursing · Competence domains · Theoretical perspectives · Theoretical model

The Caring advanced practice nursing model has been developed from the International Council of Nurse's principles on advanced practice nursing (Schober and Affara 2006) and Hamric's (2009) Model of Advanced Nursing Practice and has been inspired by the Nordic theory of caritative caring (Eriksson 2018; Lindström et al. 2018) and a person-centered perspective on nursing (Fagerström 2011, 2019a, b). The nurse-patient relationship is the core of the Caring advanced practice nursing model, which is and has been a core concept in Nordic nursing research since the beginning of nursing science. The Caring advanced practice nursing model includes eight competency domains, of which the most important is *direct clinical practice. In the model, central theoretical perspectives, i.e., a holistic view of human beings, a person-centered fundamental ethical approach (ethos), caring, and health, are considered to characterize and be determinative for the quality and outcomes of nursing*. Understanding of the model is deepened by relating it to an interpretative framework on patients' need for nursing and care, i.e., "the basis of good care" (Fagerström 1999, 2000; Fagerström and Bergbom 2010).

5.1 The Caring Advanced Practice Nursing Model

In this chapter, a conceptual model of advanced practice nursing is presented, i.e., an abstract description of selected advanced practice nursing characteristics. The model emanates from a caritative perspective developed by the Nordic caring theorist Katie Eriksson (2018) and is based on theoretical studies and international research on knowledge of clinical reality in advanced practice nursing and experiences of different models of advanced practice nursing. The Caring advanced practice nursing model should not be considered a normative or final model but is instead intended to provide a simplified picture of reality, which is what a theoretical model normally represents. The theoretical perspectives part of the Caring advanced practice nursing model form a philosophical approach to nursing and the patient and therefore influence the provision of clinical practice.

The model was originally developed for the Nordic setting and is a conceptual model built on a modified version of the International Council of Nurse's principles on advanced practice nursing and Hamric's Model of Advanced Nursing Practice (see Fig. 5.1). The model encompasses central advanced practice nursing competency areas, critical contextual factors, and descriptions of central theoretical perspectives, presented in more detail in Chap. 6. The epistemological view employed

in the model is based on a three-dimensional view of knowledge (see Chap. 4; Fagerström 2011, 2019a).

Eight core competency domains are delineated in the Caring advanced practice nursing model:

1. Direct clinical practice
2. Ethical decision-making
3. Coaching and guidance
4. Consultation
5. Cooperation
6. Case management
7. Research and development
8. Leadership

For a schematic illustration of the model, see Fig. 5.1.

5.2 The Nurse-Patient Relationship

The mutual and dynamic nurse-patient relationship lies at the core of the Caring advanced practice nursing model. In each moment and during all phases of the nursing process, the mutual nurse-patient relationship and clinical practice are characterized by the nurse's view of knowledge and theoretical perspectives. Both the nurse's view of knowledge and theoretical nursing perspectives influence the nurse's thoughts, feelings, decisions, and actions and therefore the quality and outcome of the nursing he/she provides.

The nurse-patient relationship, seen in the middle of Fig. 5.1, is an area of research that has been of a great interest throughout the history of nursing. In an etymological analysis of the concept "relationship," one sees that the term is derived from the Latin word *relatio*, which means to carry or turn back, narration (story), or relations (Kasén 2002). Semantic analysis reveals that the concept encompasses important dimensions such as "story," "touch," and "connection." In the nurse-patient relationship, which is based on mutual trust, the patient's message about his/her health needs and suffering are expressed and emerge (Eriksson 1994; Fagerström et al. 1998). For the nurse, this entails being able to interpret and understand the patient's message. Through nurse-patient conversations and dialogue, the common goals for the health process are formulated. Through both action (doing) and approach (being), the nurse meets the patient's health needs.

5.3 Central Theoretical Perspectives

The central theoretical perspectives in the Caring advanced practice nursing model (see "stars"; Fig. 5.1) can be understood as philosophical "common denominators" that influence how phenomena and situations in nursing are perceived, interpreted,

and understood (Fagerström 2011, 2019b). The theoretical perspectives considered important in advanced practice nursing are listed below and described in more detail in Chap. 6. They are:

- A holistic view of mankind and human beings, related to life context
- Ethos as a person-centered fundamental ethical approach
- Caring as the core of advanced practice nursing
- Health as the primary focus of all nursing

In the schematic description of the Caring advanced practice nursing model (see Fig. 5.1), the dynamic nursing process that occurs in advanced practice

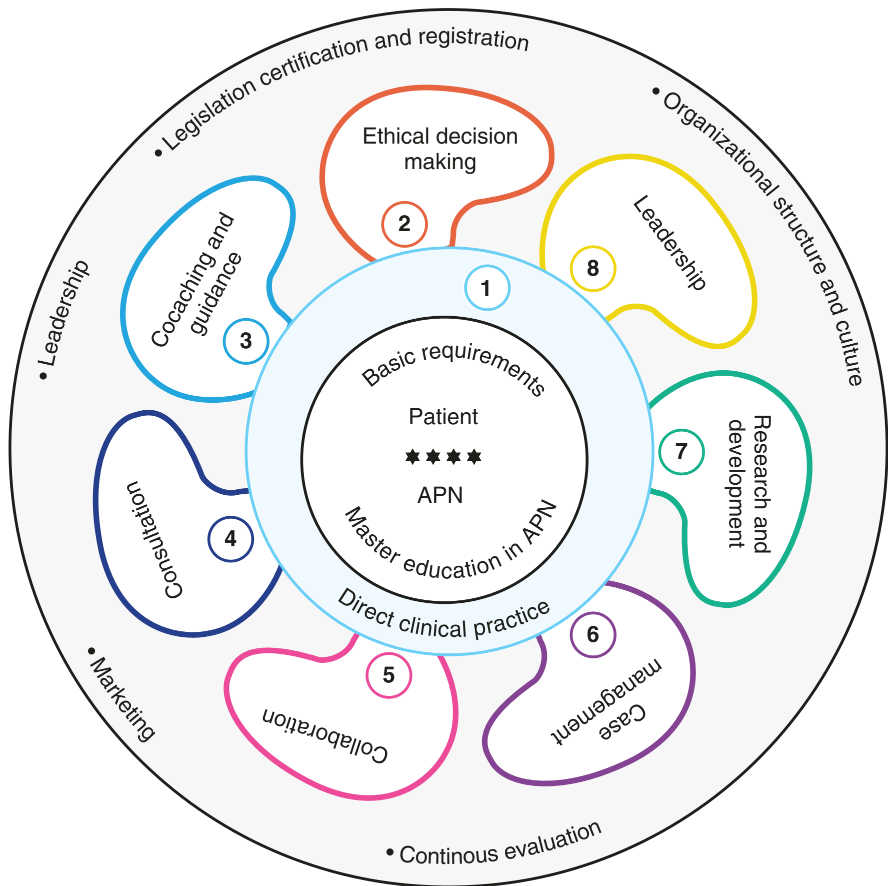

Fig. 5.1 The Caring advanced practice nursing model. A schematic description of core competency domains and central nursing science perspectives (Fagerström 2011, 2019a, p. 63). The central theoretical perspectives—holistic view, ethos, caring, and health—are represented by four stars in the middle of the figure. The critical contextual factors that influence advanced practice nursing are represented by points on the outer edges of the circle

nursing is illustrated. The state of each individual human being's health/unhealth and suffering are constantly changing, which can be illustrated using a description of a boat engine (the total clinical competence of the nurse) with several propeller blades (nursing competency areas). The nurse-patient relationship and theoretical perspectives form the primary axis of the actual motor. Advanced practice nursing is realized in various guises and forms, depending on both nurse and patient factors as well as factors related to the patient's environment and current living situation. An advanced practice nurse's competency is constantly changing and evolving, in accordance with a patient's care and nursing needs and societal and organizational requirements and needs. In actual clinical situations, different demands are made on an advanced practice nurse's competence, and subsequently the type of competence needed varies in accordance with each patient's needs and desires. This means that different advanced practice nurses develop different areas of competency, depending on the role they have. For example, an advanced practice nurse in an emergency/acute care unit more often develops competency in systematic ("top to toe") clinical examination, whereas an advanced practice nurse who works with asthma or diabetes-related patient follow-up more often develops competency in coaching, guidance, and motivating patients with chronic conditions to change their lifestyles.

5.4 Contextual Factors

In accordance with Hamric (2009), the development of advanced practice nursing is influenced by critical factors in one's environment (see outer edges of Fig. 5.1). For example, managerial support, organizational attitudes, legislation, professional cultures, the knowledge that one's colleagues possess, and the general public's awareness people's awareness of what advanced clinical nursing is have clearly influenced the development of advanced practice nursing models, also in the Nordic countries (Altersved et al. 2011; Bergman et al. 2013; Lindblad et al. 2010; Wisur-Hokkanen et al. 2015; Jokiniemi et al. 2015a, b). Note that the use of the term "environment" here refers to the various clinical contexts where the advanced practice nurse role has been introduced, encompassing also the surrounding culture and society. The following contextual factors are considered critical to the development of advanced practice nursing:

- Organizational structure and culture
- Legislation, certification, and registration
- Leadership
- Continuous evaluation
- Marketing

5.5 "The Foundation for Caritative Caring" for Nursing on the Generalist, Specialist, and Advanced Levels

The model of "the foundation for caritative caring" has been developed over the course of several years and is based on research on how patients' need for nursing and care can be measured and understood on the generalist, specialist, and advanced levels. The overall objective has been to achieve deeper understanding of patients' need for nursing and care in relation to the suffering he/she experiences. The nurse's understanding of the patient's care needs and suffering can be related to three different levels, i.e., the personal, in relation to actual life context, and organizational (see Fig. 5.2). The model for "the foundation for caritative caring" encompasses elements that are considered to be important for good nursing practice: the patient's message of suffering, comfort and well-being, caring, competence, life context, "the caring moment," and time and place. See Fig. 5.2 for an illustration of the most central elements of the model of "the foundation for caritative caring" (Fagerström et al. 1998; Fagerström 2011, 2019a; Fagerström and Bergbom 2010).

On the personal level, it is important that nurses truly attempt to interpret and understand a patient's health needs as well as his/her message of suffering (Eriksson 1994; Arman 2012). That a patient perceives health and well-being despite illness, poor health, discomfort, and/or pain is a vital objective for both nurses and patients. Such understanding is closely linked to the concept of care, which for the patient is

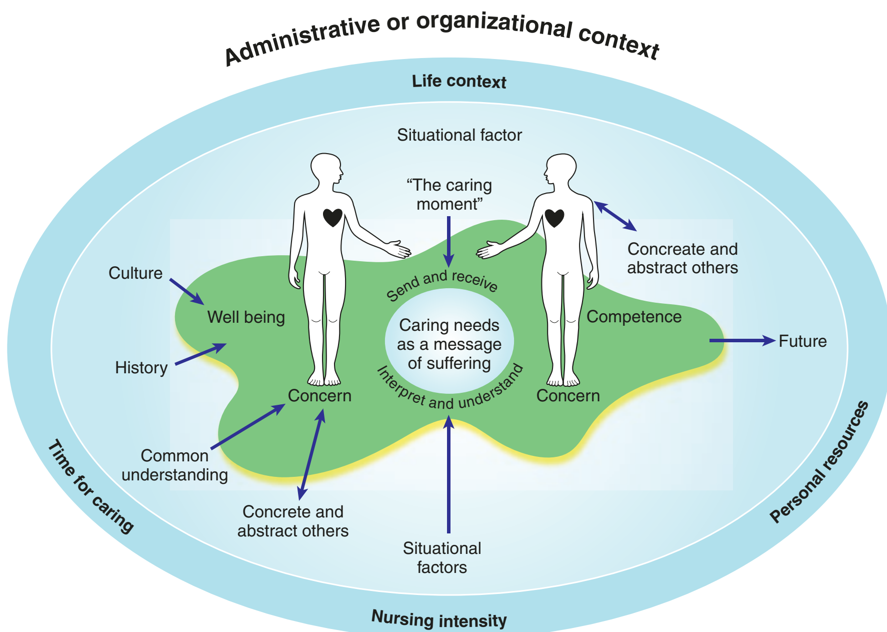

Fig. 5.2 The model of "the foundation for caritative caring" on the personal level, in relation to the actual life context and on the organizational level. (Modified after Fagerström 1999, 2019a, p. 67)

about what is important and really matters to him/her. The patient's need for health and care emerges which is for the patient an important and determinative concept: concern. That nurses understand a patient's "why" is the key to understanding the patient's needs, i.e., what each unique patient perceives to be his/her problems, needs, and desires. For nurses, this is about demonstrating care. The patient needs both the nurse's and the entire care team's competence. Patients today still continue to have great faith in professional staff's competence.

Both patients and nurses exist in a cultural and historical context. A person's current life context is shaped by concrete and abstract others, e.g., family members, friends, social networks in one's close environment, and, for some, belief in a higher power or god (person-dependent). In a cultural context, phenomena and events perceived in the same manner are assigned common meaning, e.g., what a patient is or how a patient should act (Benner and Wrubel 1989). In a cultural context, important values and attitudes toward and experiences of mankind and life in general exist. Both nurses and patients carry their own life history, which includes experiences from one's past and which is something that influences both the now and thoughts about the future (Fagerström et al. 1998; Fagerström 2000).

In the caring moment, when a nurse meets a patient, a variety of different factors affect the situation. All the elements mentioned above affect the nursing process, even organizational factors. A central question is whether the time and place for "the good nursing and caritative caring" exist. If one seeks to preserve patient safety while achieving good treatment outcomes, human resources composed of both qualitative (skills and competence) and quantitative (nursing intensity and nursing resources) should be in balance with what the patient needs. Leadership for an organization and the prevalent organizational culture are of great importance to whether "the good nursing and caritative caring" can be realized (Fagerström and Salmela 2010; Salmela et al. 2011).

5.6 Advanced Practice Nursing in the Dialectical Tension Between the General and the Specific

All nursing is composed of complex wholes and realized in complex contexts. Models and theories cannot fully describe the complexity and variation of clinical reality. Awareness of this fact does not make nursing as a subject area less interesting; on the contrary, it challenges and encourages the investigation of those factors that influence nursing in the clinical context.

Knowledge as scientifically tested theories (knowing why) and the expressions and patterns that a patient reveals (knowing what) together with practical knowledge (knowing how) can often be considered general knowledge (cf. Oberle and Allen 2001). Conversely, having personal competence, where one's general knowledge is integrated into and can be discerned in concrete patient situations, and having knowledge of each unique patient's need for care and treatment can be considered specific knowledge. To understand why a situation is the way it is and know how one's practical knowledge can best be used in a concrete patient situation, a nurse

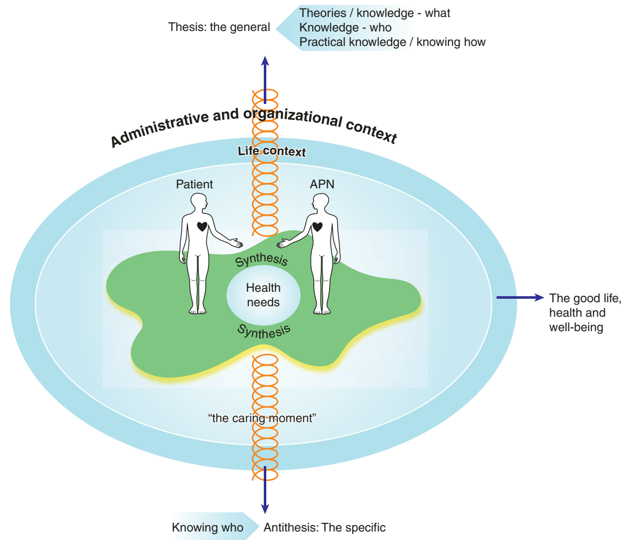

Fig. 5.3 Advanced practice nursing in the dialectical tension between the general and the specific. (Fagerström 2019a, p. 68)

must use his/her personal competence and practical wisdom. For an advanced practice nurse to be able to interpret and understand all the information that a patient reveals, the complexity of a situation as a whole, a person-centered ethical approach, and inner wisdom of what can be good for the individual patient are needed. Specific, scientific knowledge and practical intelligence and wisdom must be joined into a whole (synthesis). Consequently, the nursing process can be understood as the creation of a synthesis between general and specific knowledge. This process can thus be described as a dialectical tension between the thesis (the general) and the anthesis (the specific) (see Fig. 5.3).

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Theoretical Perspectives on Advanced Practice Nursing

6

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Abstract

The definition of nursing as an academic subject is still challenging internationally, and because of this, no explicitly manifest common theoretical foundation exists. Advanced practice nursing as a field of research and professional practice is based on the same theoretical and ethical foundation as nursing on the generalist and specialist levels. It is therefore vital to stop at fundamental nursing science perspectives when deepening understanding of what advanced practice nursing is. The characteristics of the theoretical development in nursing science and societal development in the Nordic countries can be summarized in four nursing science perspectives: health, holism, ethos as a person-centered fundamental ethical approach, and caring. Theoretical diversity and pluralism are essential in nursing science, but a common understanding of the central fundamental nursing-theoretical perspectives among clinical practitioners, instructors, and researchers can contribute to good treatment outcomes and better health for the patient.

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Keywords

Theoretical perspectives · History of nursing · Nursing as a discipline · Ethos · Ethics · Caring · Holism · Person-centered · Health

As seen in the context of this book, theoretical perspectives relate to how professional nursing situations and patient phenomena are perceived, interpreted, understood, and incorporated both in practical professional nursing and in nursing education and research.

Nursing is a profession, a professional field, and an academic discipline/field of knowledge, consisting of scientific, evidence-based, aesthetic, and ethical knowledge. According to Meleis (2007), nursing as a professional domain can be described using four general characteristics: a *human science focus*, a *practical activity*, and a tradition that is characterized by *caring* and *on orientation toward health*. These can be considered nursing scientific perspectives that are valid on an international level (Meleis 2007).

6.1 A Historical Perspective

The Nordic nursing science tradition has in recent decades not only been characterized by international trends but also the work of Nordic nursing theorists. At an early stage in the development of nursing science in the Nordic countries, Virginia Henderson's thoughts on nursing, with an emphasis on basic needs, became an important model in nursing education on all levels (Kirkevold 1996). In the 1980s and 1990s, nursing education became characterized by numerous international theorists such as Callista Roy, Dorothea Orem, and Imogene King (Jakobsson and Lützén 2009). The importance of self-care as well as preventative and health-promotive perspectives was emphasized.

The nursing process as a model for decision-making and problem-solving was introduced during the 1980s, during which the need for a systematic approach in the practice of nursing to ensure good quality was emphasized. At the same time, new theoretical models were launched in which human beings were considered part of the cosmos and the self was seen to be the center of human existence, i.e., the "non-observable" and "non-measurable" phenomena in nursing (Fagerström 1999). Of relevant note are international theorists such as Martha Rogers, Rosemarie Rizzo Parse, Betty Neuman, and Jean Watson (Kim 2000; Meleis 2007; Jakobsson and Lützén 2009). The foremost nursing theorists in the Nordic countries during this period were Kari Martinsen, who was active in both Norway and Denmark, and Katie Eriksson, who from 1992 to 2013 held the only Swedish-language professorship in caring science in Finland. Martinsen and Eriksson have been characterized as caring theorists, and they have both strongly emphasized the ethical aspects of nursing (Lindström et al. 2006; Jakobsson and Lützén 2009; Fagerström 2019a, b).

Such theoretical development in nursing science combined with the social development of the Nordic countries, in which the importance of the assessment of each unique human being has increasingly been emphasized, can be summarized in four central perspectives: health, holism, ethos as a person-centered fundamental ethical approach, and caring as the core of nursing. These can be defined as the nursing scientific perspectives that most representatives for nursing education, clinical practice, and research agree on today.

These four perspectives can also be understood as the common denominators of a philosophical approach that is essential to good nursing, regardless of context or health problem. The idea underlying these perspectives is that even though there are different perspectives in nursing science, it is important to be able to unite, "gather round," and achieve consensus on some common denominators. Doing so can unify and impact collaboration in research environments, both for instructors and clinicians (Fagerström 2019a). Through these perspectives one sees that nursing is based on human science and influences how the patient's health is promoted, supported, and strengthened and how one should meet and show the patient care.

The theoretical perspectives underlying and fundamental to the Caring advanced practice nursing model form a philosophical approach to nursing and the patient and therefore influence the provision of clinical practice. Bruce, Rietze, and Lim highlighted the vital role that philosophy has in nursing in their article, "Understanding Philosophy in a Nurse's World: What, Where and Why?" (Bruce et al. 2014, p. 65). There they note that, "Philosophy helps nurses to think more critically and reflect on how their own values influence their practice and way of being. A better understanding of the importance of philosophy in the nurses' world is not only relevant but vital to our discipline and professional practice." The perspective underlying the Caring advanced practice nursing model is that a broader understanding of the interdependence of practical and philosophical matters in professional nursing is also needed in advanced practice nursing. The Caring advanced practice nursing model can be understood as a philosophical approach to life through which nursing values are enacted in the nurse's world (cf. Bruce et al. 2014). Theory and practice, the personal and professional, and knowing and doing are all inseparable and are realized in both clinical practice and through how all core competency domains appear in clinical practice.

The four perspectives are described in greater detail below, including their importance with regard to advanced practice nurses' work with patients.

6.2 Health

In nursing, an emphasis on health has always taken precedence over an emphasis on illness. As early as the nineteenth century, Florence Nightingale wrote that nurses' main task is to preserve health and that nurses should work to ensure that the patient regains his/her health despite illness. Nursing is therefore a health-oriented knowledge domain (Meleis 2007). In many cases and contexts, however, nursing is practiced in a context where an orientation on disease and illness still strongly dominates.

Health is a multifaceted phenomenon and defined and understood in different ways depending on one's views on humanity and religion and the context. The World Health Organization's (WHO) 1947 definition of health as "a complete physical, mental and social well-being and not merely the absence of disease or infirmity" should give way to a more nuanced understanding of the subjective dimensions of health (WHO 1948). Today, the achievement and maintenance of full health are considered a utopia. Health is more than the absence of disease, and human beings experience having good health despite illness (Eriksson 1984). Health has both subjective and objective dimensions and can be described as a "coin with two sides" (Fagerström 2009b). Health is therefore relative and constantly changing (Salmela et al. 2007). Understanding of a person's health is anchored in an understanding of who he/she is as a person. It is thus important to understand what motivates the person to achieve good health.

The goal of nursing is that the patient experiences health and well-being and even "blooms" and develops, despite illness and suffering. At times it can be difficult for the patient to experience health, but in most situations, it is possible to experience well-being, despite illness and suffering. It is therefore important to stop and reflect on what the patient needs and what he/she perceives as good and meaningful in life. Optimal health is based on the person's own resources and conditions, and a more realistic and desirable objective is therefore the moments of well-being despite illness and suffering. For nurses, it is important to support and help the patient to experience optimal health, despite illness and health challenges (Fagerström 1990, 1991, 1995).

6.2.1 The Ontological Model of Health

In the ontological model of health, deeper dimensions of health are revealed (Eriksson 1994). Through nursing ontology, the nature of nursing, personhood, environment, health, and illness is examined (Bruce et al. 2014). The ontological model of health reveals what is believed about the nature of health (cf. Fawcett and DeSanto-Madeya 2013).

Health can be understood as a movement between three different levels: health as "doing" in the form of a healthy lifestyle; as "being," in which the aim is to be in balance and harmony; and in "becoming." This last level, becoming, is related to the human being's experience of the meaning of life, innermost desires, will, and vitality. Health as becoming is about developing and blooming as a human being and realizing one's potential opportunities (Eriksson 1984, 1987; Sellman 1997). Eriksson (1987, p. 66) describes being a human being as having the courage to be and become the person one is and furthermore maintains that when courage and joy coincide, one dares to face reality as one is. When something is created and becomes, development and a becoming occur, which can be considered an expression of being who one is and finding and realizing one's potential. Still, personal development can also occur because of illness, suffering, and/or difficult life events. Suffering and health are therefore closely linked. The meaning and value of health can noticeably

emerge, but not always, when a human being is threatened by illness and suffering. Yet there are times when the patient cannot find meaning in his/her suffering and, in such situations, it can be difficult for the patient to achieve an experience of well-being.

6.2.2 The Dialectic of Health as a Synthesis of Pathogenesis and Salutogenesis

Emanating from dialectics, the world, and our reality is developed through the tension between contradictions, i.e., thesis and antithesis. Hegel established dialectics as a philosophy, including the dialectical method derived from Aristoteles (Fagerström and Bergbom 2010). Human thought and history develop in a dialectic manner, where a form (the thesis) fades into and becomes the opposite (anthesis), which is thereafter merged into a new overarching thesis. Dialectics can be described as a landscape where differences can meet. The essence of dialectics can be understood as an acknowledgment of the contradictory nature of reality (Molander 1988).

How can dialectics be illuminated and deepen our understanding of health? In healthcare, pathogenesis as a thesis and salutogenesis as a new antithesis can be perceived as opposites, but in clinical situations, these two should be understood as complementary perspectives that should be combined into a new synthesis.

In the disease perspective, the classic pathogenesis in which emphasis is placed on identifying symptoms and signs of disease, the aim is to provide correct care and treatment, and an indication of health is the lack of signs of illness and symptoms. Thus health can only be verified through the absence of symptoms. Prevention is accordingly focused on inhibiting the development of disease and poor health, preventing the progression of disease or reducing limitations caused by functional disability or failure.

In the salutogenesis perspective, emphasis is placed on that which can be the source of health (Antonovsky 1987; Eriksson and Lindström 2006). In this perspective, the question of the cause of disease/illness is changed to an investigation of what can give more health and how health can be supported. Health promotive work accordingly becomes a process through which individuals are given the opportunity to have greater control over the conditions that influence their health and in this manner attempt to improve their health (WHO 1986). Health in and of itself is not considered the goal, but is instead perceived to be a resource and part of life quality. Consequently, health promotive nursing is not disease specific but instead aims to improve conditions for patients, including their surroundings, in order to achieve good health.

Antonovsky (1987) maintained that salutogenesis and pathogenesis have a complementary relationship to one another. Keyes (2005, 2007; Westerhof and Keyes 2010) is another researcher who in recent years has expressed similar thoughts. Keyes questions the idea that mental health is only measured through the absence of signs of illness. He developed a two-continuum model of health, in which psychiatric suffering (illness) and subjective health (well-being) are described as two

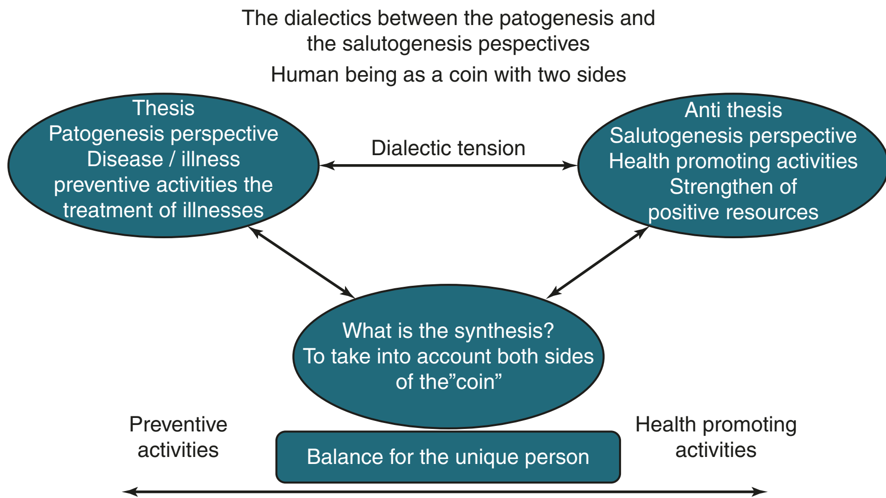

Fig. 6.1 The dialectic between the salutogenesis and pathogenesis perspectives. (From Fagerström 2019a, p. 75)

separate continua related to one another. This theory has been supported by other researchers in several studies (Fledderus et al. 2010; Peter et al. 2011), where the need to identify both the patient's symptoms and resources, such as emotional, mental, and social well-being, has been emphasized. Emotional well-being can in this perspective be described in terms of happiness and experience of joy. Keyes describes mental and social well-being as a happiness that can be related to a meaningful and socially useful life. While mental well-being is described in terms of autonomy and awareness, social well-being is considered to include aspects of social belonging and how the individual works socially.

Seen thus, salutogenesis and pathogenesis have a complementary relationship to one another. In advanced practice nursing, therefore, it becomes a major challenge to be able to unite and retain both perspectives. In other words, an advanced practice nurse has the capacity to carefully asses a patient's health problems while simultaneously understanding and supporting the patient's inherent resources, in order to ensure own health. Seen from the perspective of dialectics, new understanding of these two different poles, thesis and antithesis, is needed, including how they can be combined into a new synthesis in nursing, care, and patient treatment (see Fig. 6.1).

6.3 A Person-Centered Health Perspective in Advanced Practice Nursing

A person's health can be described in the form of health resources and health barriers. *Health resources* have been described as something that promotes the experience of health, while *health barriers* are something that hinders a person from

experiencing health (Eriksson 1984). A person's health resources can be understood as inner and external health resources. The person's inner health resources are his/her own resources, e.g., physical resources such as good physical condition or mental or spiritual resources. The person's external health resources are found in the person's current life situation, i.e., the context that the individual lives and acts in and which he/she is a part of. Social and cultural contexts and present-day life situation, such as close family relationships, networks in one's close environment, work place, or school, are all central components of the individual's current life situation and external health resources.

A positive attitude to life has been described as the ability to selectively focus one's attention on the positive, which is meaningful in each situation; zest for life; and vitality are important inner health resources (Fagerström 2010, 2012; Glasberg et al. 2014). In longitudinal studies, researchers have shown that older persons with a positive attitude to life have less need for healthcare services than those with a negative attitude to life (Pitkälä et al. 2004). That which is meaningful in life gives zest for life. A safe and confirming communion, meaningful activities, and optimal health strengthen vitality. Illness, age-related limitations, and/or negative events in life or in one's local community or world can threaten that which gives life its meaning. This can lead to mental illness and depression and can thereby negatively influence one's vitality (Söderbacka et al. 2017).

That which has previously been a resource for a person can in an instant become a health barrier (Kulla et al. 2006). An individual's external health resources can be supported and strengthened through health-promoting factors in his/her current life situation (e.g., important relationships, social networks, cultural values, living conditions, economic situation). Promoting inner health resources includes supporting and strengthening the person's physical, mental, and spiritual strengths and abilities.

An advanced practice nurse should have a more thorough knowledge of pathogenesis than a nurse with a bachelor's-level degree and should be able to answer a patient's questions about the cause of illness. Doing so facilitates the clarification of the reason underlying the patient's suffering and can thereby help the patient achieve optimal help. At the same time, an advanced practice nurse should also focus on the patient's health resources which can contribute to the patient's experience of health and well-being and how he/she as an advanced practice nurse can support and improve the patient's health resources despite illness and suffering.

When an individual becomes ill, new aspects of the person's life can develop into strong health resources. The person's health resources and "healthy side" can be used in a new manner, despite his/her illness (Kulla et al. 2006). To promote health processes, an advanced practice nurse must strive to understand the balance between salutogenesis and pathogenesis, so that a patient can experience health and well-being and "bloom" despite illness and suffering. The importance of both practical skills (technê) and practical wisdom (phronesis) can in this context not be underestimated (see Chap. 4). The advanced practice nurse's experience-based knowledge, inner wisdom, and a clear ethical approach can contribute to the realization of this.

In a person-centered health resource perspective, the individual's own health strategy is emphasized. The individual's health strategy can be defined as a personal

plan for how he/she can use his/her resources and promote own health in order to experience optimal health and well-being and be able to maintain his/her own self-care in the best possible way (Kulla et al. 2006). In advanced practice nursing, it is therefore important to focus on each individual patient's own health strategy, what the patient can him/herself do to retain and promote own health, as well as reflect on what nurses can do to support and promote the patient's health processes.

6.4 A Holistic Approach to Advanced Practice Nursing

The concepts of "holism" or "holistic approach" can be considered old-fashioned or outdated; they can be considered "mantras" or clichés (especially in nursing education) that are often repeated and even perhaps sometimes unconsidered. Still, is it the case that these concepts are used habitually, or is it more that we do not adequately stop and reflect on what a holistic approach to the patient can entail for nursing practice?

In contrast to reductionism, in which the human being is seen as being divided into various parts, in a holistic approach, the human being is described and understood as a whole an indivisible entity comprised of body, mind, and spirit. In nursing, a holistic approach to the patient includes the recognition of the various dimensions of the patient as a human being, such as physiological, psychological, social, or spiritual dimensions and that the patient cannot be separated from his/her life context. The patient's physiological, psychological, social, and spiritual dimensions form a whole and consequently must be jointly instead of singly considered.

Medical science has been criticized for not implementing a holistic view of the human being and instead reducing the patient to "parts" that can be treated, repaired, or fixed. Yet for many years, nursing researchers have argued that a holistic view of the human being should be integrated into healthcare systems. This polarity as well as the thesis-anthesis school of thought seen between different professional disciplines steers our approach to one another in a negative manner and is no longer relevant. At the same time, one now sees that discussion on the societal level increasingly encompasses a holistic view of the human being. Consequently, one understands that nursing science by no means has a monopoly on a holistic approach to the human being.

What does a holistic view of the human being mean for nursing, care, and treatment? While the patient's physiological, psychological, social, and spiritual dimensions are fundamentally a theoretical matter, in clinical practice the balancing and integration of these dimensions into a holistic perspective can be considered an art. It is in clinical situations that an advanced practice nurse must understand how these dimensions influence one another and form an entity. Advanced practice nurses must be able to see and understand that because of poor health and suffering the patient's health balance is disturbed and disintegration is a fact. The challenge in nursing is to be able to provide an appropriate response, through care and clinical interventions, while also contributing to seeing the patient as a person and promoting his/her health, wholeness, and integration.

The holistic approach is not only about the human being as an entity of body, mind, and spirit but also his/her life context, which consists of three levels (Fagerström 1999). The first level is the life context closest to the patient. Each person lives in and is a part of a life context that means something to him/her. The person's current life context consists of the context around him/her and his/her closest relations (family/relatives) and networks that he/she is a part of. The second level is composed of the patient's close environment and arenas where he/she lives, which even includes the person's work life and the spheres where he/she spends his/her leisure time. The third level can be termed the societal level and is compromised of the patient's sociocultural context. The multidimensional human being has his/her own personal life context that is important to him/her but is also simultaneously part of the larger context that is his/her surroundings and community. Therefore, seeing and understanding each person in consideration of his/her current life situation are of great importance in the meeting with the unique patient (Fagerström 1999, 2000; Kulla et al. 2006).

When an advanced practice nurse meets a patient and performs a thorough health assessment, it is important that the advanced practice nurse focuses on the patient's own perspective on his/her health problems, including how these problems impact the patient's daily life, how the patient manages them, and what is important for the patient with regard to his/her life (Tracy 2009). An evaluation of the patient's functional ability in everyday life is also part of a holistic and person-centered health assessment. During such the advanced practice nurse should observe how the patient describes his/her own health and life quality and his/her capacity for self-care and management of own household and work. The advanced practice nurse should discern whether there are social, physical, economic, environmental, or spiritual factors that impact the patient's abilities and determine which strategies the patient and his/her family use to manage the new situation that has arisen due to the patient's poor health.

Researchers have found that nurse practitioners perform health assessments and make clinical decisions based on an integrated and holistic approach and that their decisions are grounded in the patient's life context (Burman et al. 2002). Researchers have also found that nurses report that after completing a master's degree in nursing they have gained deeper insight into and deeper understanding of what the holistic view means during clinical work (Glasberg et al. 2009; Wisur-Hokkanen et al. 2015), even though their (new) clinical practice contains elementals and tasks from the medical profession (Sidani et al. 2006). Thus one can understand that the application of the aforementioned theoretical perspectives during nursing practice is still important, despite changes in tasks, greater responsibility, and greater clinical autonomy.

Clinical practice is also part of a larger context. In advanced practice nursing, it is important to understand this larger context. Direct clinical nursing occurs in an organizational context, and it is continuously influenced by surrounding factors. The quality (competence) and quantity (number of person-years and staff) of nursing staff determine to a greater degree the outcomes of care and treatment (Fagerström 2009a).

6.5 Ethos as a Person-Centered Fundamental Ethical Approach

A person's fundamental ethical approach or ethos can be understood as a fundamental position that one as a person and fellow human being has toward the other. Originally a Greek term, the concept "ethos" in a nursing context is seen to mean "customs" or "character" (Eriksson 2003). Ethos can be understood as a fundamental value and as a hierarchy of values, which are expressed as the innermost core of culture. According to Eriksson (2003), ethos and ethics belong together; ethics that is developed without a foundation in ethos becomes a more formal ethics, lacking a deeper value base.

An advanced practice nurse's ethical approach (ethos) can be understood as his/her fundamental attitude that influences his/her clinical nursing practice and ethical decision-making, which are part of the key competence needed in advanced practice nursing. The advanced practice nurse's ethos is decisive for how he/she meets the other; how he/she perceives, understands, and interprets the patient's health needs; and how he/she promotes, supports, nurses, relieves, and treats the person who is ill.

A person's ethos, as his/her fundamental ethical approach, can be described in three dimensions: dignity and respect for the patient as a person, caritas as compassionate love and mercy, and virtue as a force.

6.5.1 Dignity and Respect for the Patient as a Person

Fundamental ethical values in healthcare and also, generally speaking, in all human activities are built on the safeguarding of human dignity and respect for the patient as a person. How can human dignity be understood? Symbolically speaking, human dignity is absolute and can be considered "holy." Each human being should be met with respect and openness, and vigilance should be shown for the individual's constant process of becoming as a human being (Eriksson 2003). Edlund (2003) refers to the individual's right to dignity as an attitude that shows respect for the individual. To acknowledge dignity is to realize that all human beings have the same infinite and inviolable value (Barbosa da Silva and Andersson 1991).

Human beings have the need to feel valuable and respected in all situations. The absolute worth of a human being should be preserved and taken into consideration in every clinical nursing situation. In a clinical context, human dignity is manifested as a belief in and reverence and love for fellow human beings in the most degrading situations. That the patient has a feeling of dignity despite emotionally difficult situations is of great importance to the patient's experience of well-being. Protecting human dignity in nursing situations in such a manner thus constitutes a fundamental and central component in a nurse's ethical approach and ethos (Edlund 2003; Näsman 2010).

The core values in person-centered care are care and respect for the person, the person's right to self-determination, and mutual respect and understanding (McCormack and McCance 2010; Ekman 2014). In a person-centered nursing and

care, the patient not only has a need for care and treatment but also a need to be met as a person with dignity and vitality. The patient is above all a human being, with own values, abilities, needs, will, and responsibilities, and his/her unique perspective has as great importance as the professional perspective (McCormack and McCance 2010; Ekman 2014). The patient as a person should be "in the driver's seat" for his/her illness and be given the opportunity to articulate his/her needs and desires, which should be considered in equal measure to the needs that professionals identify (The Swedish Society of Nursing 2010). Person-centered care entails respecting and recognizing the patient as a person and his/her values, experiences, and interpretation of his/her illness and health emanating from his/her story and narrative. The goal is to create a partnership between the patient, the patient's relatives, and professional staff, where the patient's story is the basis and premise for collaboration.

One constantly sees examples of how individuals' experiences are neglected in healthcare systems. Even if we as healthcare staff have good intentions, our practice can have negative side effects (outcomes) for the patient. The care situation itself can cause the patient perceived suffering (Eriksson 1994). Inadequate safeguarding of the patient's dignity and his/her worth as a human being is unfortunately a common form of suffering in care situations. This can be expressed as a negligence and carelessness, where healthcare staff are unable to "see" the person or understand his/her suffering and vulnerability. If a nurse's clinical competence is inadequate but the nurse consciously continues to work without improving his/her nursing and/or medical knowledge, this should also be considered an expression of negligence and carelessness and thus a violation of the patient's dignity (Fagerström 1999, 2000).

An important element in the advanced practice nurse's fundamental ethical approach is the deliberate attempt to prevent human abuse. To misuse one's power in various ways or to overlook the patient's will also constitute violations of human dignity. Eriksson (1994) even defines a lack of care as a suffering related to the care situation. The development of new advanced practice nursing models increases access to care and treatment and can therefore become a means whereby unnecessary suffering is reduced.

6.5.2 Caritas as Compassionate Love and Mercy

Caritas can also be understood as a fundamental motive for all health services. This motive emerges from a nurse's fundamental ethical approach. Nursing and compassionate love are linguistically related. The concepts "nurse" and "nursing" are both considered to be derived from the French word *nourrice*, which means to "tenderly protect," be fond of, and love, and from the Latin word *carus* (care; Eriksson 1990). These synonyms contribute a "teaching" or learning dimension to the concepts, in addition to the aforementioned tenderly protect and love. The English word "nutrition" is derived from a later form of the Latin concept of *nutrir*, to nourish, with related words in the English language being "nourish," "nourishing," "close," and "nurturing." Alvsvåg (2012) mentions three forms of love: epic, poetic, and logical.

Epic love can be conveyed through stories about love. Poetic love refers to educational methods, art, and poetry that show what loving actions are. Still, it is not enough to hear about love (epic love) or gain knowledge of how one can demonstrate love (poetic love); one must also concretely manifest love in a concrete acts or actions (logical love). Healthcare professionals realize the logic of human love.

In the healthcare context, compassionate love is expressed in both close relationships and professional contexts. Martinsen (1996) calls love for a fellow human being *agape*, while Eriksson (1994) uses the term *caritas*. Agape describes a selfless love. Caritas can be succinctly defined as compassionate love and mercy (Lindström et al. 2006). Caritas as compassionate love and mercy constitutes a source of power and an inner motive for practicing/realizing/engaging in nursing. Love and care for one's fellow human beings have been described as the fruits of love. To help patients in need is an essential ethical requirement for all healthcare professionals and can be understood as an expression of love (Alvsvåg 2012). Love for one's fellow human beings develops through practicing care and is an expression for altruistic love, directed toward what is best for the other. Each meeting with a patient includes an ethical demand where the nurse can choose to meet and see or not meet and see the patient's needs and desires. Love and mercy for one's fellow human beings are expressed through a healthcare professional's words, actions, and attitude toward the patient.

Love is expressed through care actions, which in a professional context should emanate from professional values (Martinsen 2005; Alvsvåg 2002, 2010). In all nursing, nurses should listen to the patient's needs, dare to become engaged in the patient's situation and suffering, and reflect on and use all of one's competence to prove good care and treatment (Fagerström et al. 1998). Love becomes visible when nursing provides good care and treatment, which can be described as an art, that is, "the art of caring" (Arman and Rehnsfeldt 2006). Being able to show love in nursing entails more than merely fulfilling professional duties; it also entails being able to provide the "little extra" and dare to become engaged in the patient as a person in his/her health processes and suffering.

6.5.3 Virtue as a Force

Virtue as a concept and phenomenon can be traced back not only to the start of Western philosophy but also Chinese philosophy, that is, Confucianism (Näsman 2010). Plato discerned four cardinal virtues: prudence (wisdom), courage, temperance, and justice. Aristotle described the human character in terms of four moral types: the Virtuous, the Continent, the Incontinent and the Vicious. The difference between the Virtuous and the Vicious lies in the individual's values, and a virtuous person is not conflicted about moral actions; he/she is in harmony with him-/herself. In Christianity, there are seven virtues: chastity, temperance, charity, diligence, patience, kindness, and humility.

According to Aristoteles (1993), human beings seek *eudaimonia*, which is a contemplative (introverted, pondered, profound) state of happiness. Like all of nature,

human beings have a natural goal, *telos*. The human being seeks the good and seeks to realize his/her true nature. In this human quest to do good, the human being develops and trains his/her different virtues (Näsman 2010). Virtues should not be considered emotions, but are instead dispositions, clear intentions, and character traits (Aristoteles 1993). Sellman (1997) differentiates between virtues and being virtuous, noting that virtues relate to a specific orientation, while being virtuous relates to morally good actions. Näsman (2010) describes human virtue as a stable character that is about choice.

Virtue as a dimension of the fundamental ethical approach/ethos can therefore be understood as a force that makes individuals moral and good. Virtue can therefore also be linked to the good and to the motive for love (Näsman 2010). Virtue is a certainty about what is good, and it is expressed in moral actions. Virtue is closely related to both caritas as compassionate love and mercy and to an individual's dignity, relative to whether he/she is met with humility, kindness, and respect.

Virtue as a force in advanced practice nursing has, to date, not emerged as a topical theme in nursing research. The desire to take greater independent responsibility for a patient's care and treatment indicates a virtue, i.e., a clear motivation and character trait that indicates moral goodness based on a clear value base. Virtue as a force in advanced practice nursing is a fundamental prerequisite for an ethos expressed as a person-centered fundamental ethical approach.

6.6 Caring as the Core of Advanced Practice Nursing

Demonstrating caring for one's children and loved ones is also a part of human nature. In the anthropological perspective, caring is a natural phenomenon, and since the later part of the 1980s, caring has been considered a professional expression (Eriksson 1987). Caring as a phenomenon has often been described as the core of nursing (Roach 1997; Lindström et al. 2006), seen in both nursing actions and in relation to the patient. Caring as the core of nursing is expressed to the patient through concrete actions and through a nurse's attitude toward the patient (Fagerström et al. 1999).

An interesting question is whether a human being's capacity for care is a fundamental quality and ability or whether this capacity can be developed and deepened. Can this capacity be influenced through education, or is it innate and already present at birth? Can a nurse's capacity for caring be changed and developed, from a generalist to an advanced level? These questions were addressed in Benner et al.'s (1996) research on expert competence in nursing. In an intensive care unit setting, Benner found that those nurses who demonstrated good capacity for reflection were able to develop their clinical skills to an advanced level and even demonstrated clear signs that they were capable of developing a greater capacity for empathy, sensitivity, and understanding of the other's situation. Those nurses who did not reflect on their experiences to the same degree as the first (more reflective) group were seen to stagnate in their development of competence.

In another qualitative study including 26 advanced practice nurses and eight advanced practice nurse students, researchers sought to describe and investigate advanced practice nurses' advanced clinical competencies (Nieminen et al. 2011). There, five dimensions of advanced practice nurses' advanced clinical competencies were revealed: evaluation and assessment of patient's caring needs and nursing care activities, the nurse-patient caring relationship, multi-professional teamwork, development of competence and nursing care, and leadership in a learning and caring culture. The importance of bearing responsibility for the patient and creating a safe and trustful relationship is also clearly seen.

For many clinical practitioners, educators, and researchers, it is obvious that caring as the core of nursing is essential to advanced practice nursing. Depending on the theoretical tradition, various concepts such as caring, care therapeutic relationship, and caritative approach are used. Yet, overall, these terms all encompass approximately the same content. For example, in international literature, both "therapeutic partnership" and "therapeutic relationship" are used, in which care is described as the central part of the relationship or partnership (Spross 2009; Tracy 2009). The therapeutic relationship requires that the nurse is emotionally available and does not adopt a distanced attitude. Advanced practice nurses cannot solely rely on scientific theories and technical competence when providing care to patients. It is evident that an approach in which genuine caring for the other is expressed is necessary. In other words, a caritative approach characterized by caring is a prerequisite for being able to provide high-quality advanced practice nursing (Roach 1997; Lindström et al. 2006). According to Benner (1984) and Tanner et al. (1993), advanced practice nursing requires a person-centered approach characterized by caring and a timely, contextual understanding of the patient as a person.

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Abstract

The Caring advanced practice nursing model is composed of eight core competency domains: direct clinical practice, ethical decision-making, coaching and guidance, consultation, cooperation, case management, research and development, and leadership (Fagerström 2011, 2019a). In this chapter, a more in-depth look at these competency domains is presented, emanating from actual nursing literature and research. This is followed by a discussion on the importance of the critical factors linked to and/or associated with advanced practice nursing and how these influence how advanced practice nursing functions are developed in practice.

Keywords

Caring advanced practice nursing model · Core competency domain · Direct clinical practice · Ethical decision-making · Coaching and guidance · Consultation Cooperation · Case management · Research and development · Leadership

The definition of advanced practice nursing emanates from the definition of the nursing role on the generalist level (see Chap. 2). To step into a more advanced role, specific in-depth knowledge and broad clinical skills must be integrated. This means that the prerequisites for the development of a nurse's clinical practice to an advanced level are a solid and comprehensive post-bachelor's-level education and work experience of at least 3–5 years. Advanced practice nursing requires autonomy. Autonomy in this context can be defined as the freedom to make decisions based on expertise and knowledge in one's own area of expertise and the power to make decisions on what should be done for each patient (Ulrich et al. 2003a; Petersen et al. 2015).

Concepts such as *core competence, competency areas,* and *capability* are often used to describe advanced practice nursing functions (Cattini and Knowles 1999). The International Council of Nurses defines advanced practice nursing practice domains as, "groupings of concepts and activities that make up an area of practice that is common to each nurse functioning in a defined role" (ICN 2008: 11). In an investigation of the nurse practitioner role in Australia and New Zealand,

researchers found that the advanced practice nursing role is characterized by independent and expanded clinical practice (Gardner et al. 2004). To be able to care for patients in both stable and shifting or complex situations, advanced practice nurses need advanced clinical skills and knowledge. In the review of literature included in this chapter, important components of advanced practice nursing such as the concepts "competency" and "capability" (the ability to do what is necessary) are described. Capability can be described as, "the combination of skills, knowledge, values and self-esteem which enables individuals to manage change and move beyond competency" (O'Connell et al. 2014).

As described in Chap. 6, the Caring advanced practice nursing model can be understood as a philosophical approach to life and nursing. The inseparability of theory and practice, the personal and professional, and knowing and doing affects how all competency domains appear and are realized in advanced clinical nursing. The caring philosophy that underpins the model should not be perceived as a purely theoretical and/or abstract endeavor separated from nursing in practice. By using a philosophical approach, nurses can better understand the role, function, and competency domains of advanced practice nursing. It should be noted that it would be almost impossible to fully describe how nurses' caritative approach can be expressed in relation to each core competency domain and in different clinical situations. Consequently one should separately reflect on the form that the caritative approach can take in a clinical situation.

7.1 Competency Domain 1: Direct Clinical Care

In accordance with Brown (2005), "direct clinical care" and "direct clinical practice" are the activities and tasks that an advanced practice nurse performs during direct patient contact. These concepts are used to describe the most central advanced practice nursing competency domains and include the activities, actions, and interventions that occur during direct patient contact (Tracy 2009). The term "direct clinical care" is used throughout this book (Hamric 2009; ICN 2008).

Indirect nursing is the activities and interventions performed outside of direct patient contact, e.g., consultations with other healthcare staff, planning of discharge, coordination of care and treatment, as well as instructing and guiding colleagues. Indirect and direct nursing are intertwined in many clinical situations, and it can sometimes be difficult to distinguish between the two concepts. For advanced practice nurses, both direct patient and patient-close care are necessary for the development of the independence and responsibility they need for the role.

There is a fundamental difference between practice and praxis. Praxis is an expression of creativity and value-based (Chinn and Kramer 1999). Clinical nursing should not be considered a practice, i.e., it is not only the technical manifestation of a myriad of practical tasks, e.g., purely technical skills. Clinical nursing should be considered and conducted as a praxis, defined as an interaction between thoughtful reflection and concrete action (Chinn and Kramer 1999; Oberle and Allen 2001). Engaging in praxis requires greater self-awareness of own ethical approach. Note

Table 7.1 Six characteristics of direct clinical care provided by advanced practice nurses

1. Use of a holistic perspective
2. Formation of therapeutic partnerships with patients
3. Expert clinical performance
4. Use of reflective practice
5. Use of evidence as a guide to practice
6. Use of diverse approaches to health and illness management

(Tracy 2009)

that throughout this book whenever the term "practice" is used, one should understand the term in the sense of "praxis."

Advanced practice nursing can take the shape of various roles, can be seen in various contexts, and can be aimed at various patient groups. Yet despite its diverse forms, roles, and functions, certain commonalities exist – regardless of the patient group the advanced practice nurse works with (Tracy 2009) (see Table 7.1).

Briefly describing the competency domains inherent to direct clinical care is challenging, because direct clinical care is a broad domain. In Strong Memorial Hospital's Model of Advanced Practice Nursing (also known as the Strong Model; Ackerman et al. 1996), direct clinical care is considered to encompass a range of assessments and interventions performed by advanced practice nurses. This includes history taking, physical assessment, requesting and/or performing diagnostic studies, performing invasive procedures, interpreting clinical and laboratory data, prescribing medications and other therapies, and the case management of complex, critically ill patients. Both patients and patients' families are involved in activities when nurses empower them to make informed decisions about own care. In the Strong Model, the direct clinical care activities that an advanced practice nurse should engage in include (Sprong 2013; Ackerman et al. 1996):

1. Conduct and document patient history and physical examination.
2. Assess psychosocial, cultural, and religious factors affecting patient needs.
3. Make a medical (healthcare provider) diagnosis within specialty scope of practice and practice guidelines.
4. Identify and initiate required diagnostic test and procedures.
5. Gather and interpret assessment data to formulate plan of care.
6. Perform specialty-specific procedures.
7. Assess patient or family response to therapy and modify plan of care on the basis of response.
8. Communicate plan of care and response to patient and family.
9. Provide appropriate education to patient and family.
10. Document appropriately on patient record.
11. Serve as a consultant in improving patient care and nursing practice on the basis of expertise in area of specialization.
12. Facilitate the process of ethical decision-making in patient care.
13. Coordinate interdisciplinary plan for care of patients.
14. Collaborate with other services to optimize patient's health status.
15. Facilitate efficient movement of patient(s) through the healthcare system.

Clinical assessment and the nursing, care, and treatment of patients with health issues and/or chronic disease have always been core components of nursing. Yet in an advanced practice nursing context, especially clinical assessment and treatment require the inclusion of new nursing roles and functions that have traditionally been performed in a medical practice context (Willis 2008). It is very important to carefully define what clinical assessment and treatment in an advanced practice nursing context includes, in the form of guidance and support for those who seek to become advanced practice nurses. The identification and assessment of the patient's health needs through a health history, physical examination, and establishment of diagnosis as well as care and treatment are especially important (Horrocks et al. 2002).

The following core components are discussed more at length below: clinical assessment and knowing the patient (knowledge of the patient's health condition), health assessment (health history and physical assessment), clinical decision-making, and nursing care and management of patient's health issues.

7.1.1 Clinical Assessment and Knowing the Patient

Clinical assessment and good advanced practice nursing practice are central elements in advanced practice nursing competence. According to Tanner et al. (1993), clinical assessment is built on three different types of knowledge: scientific and theoretical, experience-based, and individual knowledge of the patient as a person (knowing the patient). During clinical assessment, all these forms of knowledge are used and "interact," and this contributes to the quality of the assessment.

A clinical assessment often starts with the healthcare provider/advanced practice nurse quickly gaining an overview of the patient's situation. This can be achieved by reviewing the patient's medical journals (records), observing the patient for signs of ill-health or disease (observing the patient's appearance and behavior), or observing what the patient says or does not say (Tracy 2009). Truly "knowing the patient," i.e., being able to see that which is general versus that which is specific to each patient, is determinative for a correct and accurate clinical assessment. Knowing the patient is also about seeing the patient's unique pattern of reaction over time, which facilitates the capacity to detect changes in the patient's health status.

The extent to which an advanced practice nurse knows his/her patient is linked to the nurse's ability to observe relevant risk factors, detect early signs of health problems, observe atypical symptoms and indications of health problems, and act in a timely and preventative manner. The ability to recognize atypical data as evidence of change requires broad experience and the ability to weigh alternative hypotheses and make clinical, differential diagnoses. Atypical data can include symptoms not typical/common for a certain illness. An important feature of advanced practice nursing is the ability to examine and assess stable, unstable, and undiagnosed patients.

Clinical reasoning can be described as detective work, i.e., investigative thinking that includes questioning and reasoning. The clinical reasoning process is largely dependent on whether the advanced practice nurse knows his/her patient well or not (Tanner et al. 1993; Benner et al. 1996; Tracy 2009). If an advanced practice nurse

knows his/her patient as a unique person, with distinct feelings and reaction patterns, it is possible to interpret and subtly understand any eventual underlying changes in the patient's health condition (Tanner et al. 1993).

An advanced practice nurse relies on his/her ability to interpret impressions and observations as well as his/her ability to assess both objective findings and the patient's subjective symptoms and experiences. Thus it is solely a formal or experience-based knowledge that influences clinical assessment. The nurse's ethical approach toward the patient influences both the nurse's clinical reasoning and, thereby, how the patient is "met," as well as the nurse's assessment of what must be done for the patient. The goal of clinical assessment is to try to understand the processes occurring and what the patient is going through. This can also be expressed as knowing the patient and being able to understand the patient's perspective and message of suffering, i.e., the health problems that the patient considers important and the deeper existential health needs that the patient seeks help for (Fagerström et al. 1999; Fagerström 1999, 2000).

7.1.1.1 Health Assessment, Part 1: Health History

The assessment of a patient's health, health problems, and symptoms of disease starts with compiling the patient's health history (Bickley and Szilagyi 2013; Jarvis 2020). This is then followed by a physical examination. Health history, also known as anamnesis, is collected relevant to the patient's chief complaint and current general condition and situation. The advanced practice nurse performing the health assessment determines the patient's general condition based on an overall impression of the patient's health. All the information collected as part of the health history is used as the foundation for the completion of a relevant assessment of the patient's clinical status. This means that the scope of the assessment and charting of information/data will vary in accordance with the patient's problems.

The patient consultation (visit) is started by greeting the patient and presenting oneself using both name and title. This is an important element of the visit, because it facilitates the creation of a trusting relationship where the patient feels safe and feels seen as a person. It is also important to let the patient know that he/she is being treated by an advanced practice nurse, as this also provides an opportunity to explain to the patient "what" an advanced practice nurse is. The patient can, e.g., be told that advanced practice nurses have the specialist competence needed to complete a health assessment and examination, a competence that differs from what other nurses or specialist nurses have. Note that when meeting children or adolescents, it is important to greet the child/adolescent presenting with the problem first and then the accompanying guardian. It can be advantageous to collect the patient from the waiting room and lead them into the examination/consultation room, because this provides a good opportunity to observe and assess the patient's general condition. Once in the room, one should ensure that conversation and assessment and examination can be conducted without disturbances. It is important to place oneself and the patient in such a way that communication is promoted, e.g., sit on the same level so that eye contact can be maintained.

When beginning the health assessment, use open-ended questions such as “How can I help you today?” or “What is the reason for your visit today?” to start the conversation. While the patient is replying, observe the patient and make a general assessment of the patient’s general health condition. Active listening, allowing the patient to finish speaking, and not interrupting the patient are all good principles that should be followed. Only once the patient has finished speaking should further or more in-depth questions be asked, and such questions can be either open-ended or close-ended. Once this discussion has finished, summarize what the patient has said by reiterating the central parts of the patient’s history and asking the patient whether everything has been understood correctly or whether the patient would like to add something. The health history is followed by a physical examination of the various organ systems relevant to the determination of the patient’s clinical status. Note that it is important to always ask the patient for consent before touching the patient or conducting any physical examination (Bickley and Szilagyi 2013; Jarvis 2020).

Collecting Information for the Patient Health History

A broad spectrum of information is needed for the patient health history. Collect the following information to start:

- Identifying data: Social identification number, name, gender, address, telephone number, and next of kin.
- Patient information: Patient’s name, next of kin’s name, and relationship with the patient (mother, son, friend, partner).
- Chief complaint: Patient’s description of the reason for the visit. Avoid the use of professional terminology and diagnoses, e.g., “sore throat” instead of “inflammation of the tonsils” or “tonsillitis.”
- Past history: Chronic diseases and relevant acute syndromes/injuries, hospital admissions, operations, and pregnancies. Also provide information on health promotive and preventative activities such as vaccinations or routine screening tests (mammograms, Pap smears). Even include previous reports and findings, medical records, and epicrises.
- Functional capacity: Eventual functional disability or use of mobility aid/assistive devices, e.g., wheelchair, rollator (“wheeled walker”), hearing aid, dentures, etc.
- Note any recent weight change.
- Children: Normal or complicated pregnancy and/or birth. Early development, growth curve, and expected level of development (contactability, motor skills, linguistic skills/language).
- Patient’s eventual self-care measures, e.g., “patient has taken a maximum dose of paracetamol with good effect.”
- Medications: All medications currently being taken, including prescribed and over-the-counter medications, vitamins, and dietary/health supplements.

- Family history: Presence or absence of cardiovascular disease (hypertension, coronary artery disease), diabetes, cancer, and other specific illnesses prevalent in family.
- Social and psychosocial factors: Marital status, family status, profession, work status, living situation, stress, relationships, and well-being.
- Social support services: e.g., homecare services, personal alarm, and (community-based) meal services.
- Lifestyle-related factors: Hobbies/interests, physical activity, nutrition, sexual behavior, alcohol, tobacco, and other narcotics/drug use.
- Allergies, hypersensitivities, and intolerances: Known allergies, e.g., medications, dietary, pollen, etc. Document all earlier allergic reactions and symptoms, e.g., "rash with itching" and anaphylactic shock.

(Bickley and Szilagyi 2013; Jarvis 2020)

7.1.1.2 Health Assessment, Part 2: Assessment of Patient's Current Health Condition and Physical Examination

After the patient's health history is taken and a physical examination is performed, an *assessment of the patient's current health condition occurs*, which can be based on the patient's chief complaint and description of actual problem and health condition. The assessment of the patient's general health condition emanates from what one has learned during one's advanced practice nursing training and education and one's overall impression of the patient's health condition, including both physiological and psychological perspectives. It is important to conduct a careful analysis of both the patient's subjective and objective symptoms and signs of actual health needs. There should be a focus on the following:

- Localization: Where is the problem located? Ask the patient to touch his/her body or point to the location. When taking notes write, e.g., "ache behind left eye" not "headache." Note possible radiation or change of region.
- Timing: When did the problem/symptoms first start (date and time), duration, and progression (improvement, worsening, or constant over time)?
- Provocation/palliation: What seems to trigger or aggravate the problem?
- Quality: Ask the patient to describe quality, frequency, intensity, and variety. For example, pain can be described as stabbing, cutting, burning, throbbing, or dull. Is the pain persistent or periodic?
- Quantity: Ask the patient to quantify the symptoms, e.g., using a scale from 1 to 10. To evaluate pain, a visual analogue scale (VAS) can be used. When taking notes write, e.g., "bleeds through four sanitary towels" instead of "abundant menstrual bleeding."
- If there are signs of infection, it is important to ask the patient whether others in the patient's close environment or surroundings have experienced similar symptoms.

(Bickley and Szilagyi 2013; Jarvis 2020)

One should remember to ask important, key questions based on actual problems, general health condition, and organ functions. The information gathered is of enormous importance to the eventual further actions one takes, such as which further investigations should be carried out and the evaluation of the seriousness of the patient's condition. To evaluate the seriousness of the condition, various instruments such as the National Early Warning Score (NEWS)/Modified Early Warning Score (MEWS), ABCDE (Airway and cervical spine, Breathing, Circulation, Disability, Exposure), and the ISBAR framework (Introduction, Situation, Background, Assessment, Recommendation) can be helpful. The results one obtains from the health assessment and the aforementioned instruments can act as "warning lights" that indicate serious symptoms, e.g., rapid weight loss, blood/mucus in fecal matter, and acute stomach pain. It is also important to note the absence of common symptoms, e.g., no loss of consciousness in cases of concussion.

Patients' expectation of the visit can vary, and therefore it can be good to ask questions such as "What can I help you with?" (Jarvis 2020). It is important to try to prompt the patient's general perception of his/her health by asking open-ended questions, e.g., "How are you feeling now?" or "How do you normally feel?" Such questions can provide a good overview of how the patient perceives his/her physical and psychosocial health (Jarvis 2020). The patient may even have an opinion on the reason for his/her health problem, so further questions such as "What do you think can be the reasons for this problem?", "Do you have any special concerns?", or "Is there something specific bothering you?" are recommended.

Further information related to natural functions is also sought, e.g., urinary and bowel function and menstruation. It is even important to investigate how or whether the patient's health problem(s) are affecting his/her life situation using questions such as "Has the problem affected or changed your life in any way?" Further information on daily activities related to factors such as diet, fluid, and alcohol intake, sleep, physical exercise, and work should be documented. This contributes to the overall assessment of the patient's general health condition, for instance, if the patient is bed-ridden or cannot sleep or work because of pain.

It is important to try to gain an understanding of the patient's health condition and overall situation, because such understanding is important for the creation of a good nurse-patient relationship and meeting. This also provides a good foundation for decision-making. That the patient is involved in the decision-making process is crucial to whether the patient decides to follow (or continue following) the recommended treatment and health advice as well as how the patient perceives the visit (i.e., whether the visit was positive or negative).

Once the necessary health history information has been collected, a physical examination of the organ systems considered relevant to the patient's health problem (emanating from the patient's health history and general health condition) occurs. Below is a brief introduction to the various organs and organ systems that can be included in a physical examination. For more detailed guidance, please see medical textbooks/guides by, e.g., Jarvis (2020) or Bickley and Szilagyi (2013).

The methods used during a physical examination include listening, inspection, palpitation, percussion, auscultation, etc. Using the classic description "top to toe," the following organs/organ systems can be examined: skin, hair, and nails; head and neck (head, eyes, ears, nose and sinuses, mouth, throat, neck); thorax and lungs; cardiovascular system (heart); abdomen (liver, spleen, kidneys, bladder); breasts and axillae; genitalia; peripheral vascular system (arteries, veins, lymphatic system, arms, legs), muscles and joints and musculoskeletal system (shoulder, elbow, spine); nervous system (brain, spinal cord); mental health; general appearance (posture); behavior; cognitive functions; thought processes; and perceptions (Jarvis 2020).

7.1.2 Clinical Decision-Making

Like the framework of the nursing process, clinical decision-making can be described as "a continuous, purposeful, theory and knowledge-based process of assessment, analysis, strategic planning and intentional follow-up" (Smith 2006: 79). Clinical decision-making involves balancing experience, awareness, knowledge and information gathering, and using appropriate assessment tools (The National Health Services of England and Wales 2016).

The Nursing and Midwifery Board of Ireland's (2017) Advanced Practice (Nursing) Standards and Requirements is composed of six domains, the second of which is clinical decision-making. In that model, the advanced practice nurse should be capable of utilizing advanced knowledge, skills, and abilities to engage in senior, clinical decision-making. This should include the following:

1. Conduct a comprehensive holistic health assessment using evidenced-based frameworks to determine diagnoses and inform autonomous advanced nursing care.
2. Synthesize and interpret assessment information, particularly history, including prior treatment outcomes, physical findings, and diagnostic data to identify normal, at-risk, and subnormal states of health.
3. Demonstrate timely use of diagnostic investigations to inform clinical decision-making.
4. Exhibit comprehensive knowledge of therapeutic interventions including pharmacological and non-pharmacological advanced nursing interventions.

Different models are used for clinical decision-making in nursing. In one review, researchers compared the function of and research on three models, two of which are historical and one which is newer: the information-processing model, the intuitive-humanist model, and O'Neill's clinical decision-making model (Banning 2008). They noted that nurses can use all three forms of decision-making represented in the models both independently and concurrently and that a nurse's clinical decision-making improves with experience. Regardless of model,

there are several stages common to the decision-making process: problem definition, data collection, definition of alternatives, weighing the advantages and disadvantages of each alternative, choosing the preferred alternative, and implementation. These stages are similar to the six stages of the nursing process (assessment, diagnosis, outcome identification, planning, implementation, evaluation), which is a decision-making process used in nursing in general and by advanced practice nurses in particular.

As early as the 1950s, Virginia Henderson maintained that nurses are legitimately independent practitioners who make independent decisions or judgments concerning diagnoses, treatment, health promotion, and the prevention of complications and diseases (Levy-Malmberg and Boman 2019). Regarding the process of decision-making, Henderson maintained that nurses made continuous decisions using a systematic approach.

In advanced practice nursing, clinical decision-making is based on a systematic outcome-directed approach that ensures that patients get care and treatment in accordance with the principles of evidence-based care. Clinical decision-making on an advanced level is a complex process that often occurs under conditions of uncertainty, with time restraints and sometimes even with insufficient information. A systematic approach to decision-making is required in advanced practice nursing, i.e., a nursing process framework through which arguments and alternatives are found. Also required is the ability to exclude care alternatives, so that the best possible alternative can be found. Critical, evidence-based thinking is essential in clinical decision-making. Nevertheless, nurses on all levels, even the novice practicing on the generalist level, use their experience and intuition to arrive at decisions (Price et al. 2017).

To meet the objectives of patient care identified during the first stage of the nursing process, i.e., history taking and physical examination, advanced practice nurses make decisions. Advanced practice nurses' clinical decision-making includes components related to assessment, diagnosis, prevention, intervention, communication with patients, communication with other healthcare providers in multidisciplinary teams, information seeking, as well as setting priorities for clinical decisions (Levy-Malmberg and Boman 2019). Accordingly, clinical decision-making must be balanced against clinical reasoning. The result of the clinical decision-making process is a decision that leads to actions intended to yield a certain outcome. Factors such as cultural context, laws and regulations, employer, public opinion, economic resources, professional requirements, education, practice placements, etc. can influence the decision made. It is important to note that the care context is the one factor that distinguishes clinical decision-making from other decision-making processes. In the care context, the objective is to discover the best method whereby health and well-being are promoted. Furthermore, the decisions made in the care context have a direct impact on human lives and as such are bound by ethics. Ethics, which are deeply rooted in a caritative approach, play an important role in clinical decision-making (Levy-Malmberg and Boman 2019).

7.1.3 Nursing Care and Management of Patients' Health Issues

In the confines of this book, it is not possible to exhaustively describe all of the various methods and measures that an advanced practice nurse can use when providing care and treatment for patients' health problems. Diagnoses and health problems can manifest in many different combinations, and each unique case requires specific methods and care and treatment measures. An advanced practice nurse's direct clinical care is also shaped by the actual context he/she works in, e.g., emergency care, primary care, geriatric care, pediatric care, etc. Role development for advanced practice nursing has tended to be diverse and include a significant blurring of interprofessional role boundaries (Daly and Carnwell 2003), i.e., it has tended to include a mix of nursing, caring, and curing elements. Still, below is a brief introduction to various methods and measures that can be used in advanced practice nursing.

According to Read and Roberts-Davis (2000), an advanced practice nurse must have the ability to perform a comprehensive, systematic physical examination including assessment of cardiac and pulmonary function (heart/lung auscultation) and complete assessment of neurological status. This entails:

- Charting/screening for previous symptoms, signs of disease, and risk factors.
- Systematically gathering/obtaining patient's health history (anamnesis).
- Making diagnostic decisions based on interpretations of clinical and other findings, such as results from laboratory tests or radiographic examinations.
- Prescribing treatment, including medications, based on sufficient knowledge of pharmacology.
- Creating individual nursing and treatment plans with respect to both medical and nursing aspects.
- Performing clinical interventions—in other words realizing the necessary nursing, care, and treatment.

In the Nursing and Midwifery Council's (NMC) Proposed Framework for the Standard of Post Registration Nursing (NMC 2005; Willis 2008), the following central skills for clinical assessment and management of patients are seen:

- Health promotion strategies.
- A holistic health assessment approach, which includes diagnosis and management of acute, chronic, urgent, and complex patient problems.
- Evidence-based practice.
- Autonomous/independent practice within a multidisciplinary team context.
- Self-awareness of the competency level.

(Nursing and Midwifery Council 2005)

These competencies are considered relevant for different advanced practice nursing roles in a variety of contexts.

During the clinical assessment and management of patients, theoretical knowledge should be integrated into clinical practice. This places great demands on the advanced practice nurse's analytic and reflective ability and critical thinking, and he/she must at the same time have the capacity to engage in clinical assessment and decision-making (Willis 2008). When an advanced practice nurse performs specific nursing interventions on an advanced level, he/she demonstrates his/her advanced skills (see Table 7.2).

Table 7.2 Competency domain 3: Management of patient health/illness status (Nursing and Midwifery Council 2008, Hinchliff and Rogers 2008: 236–240, Appendix 1)

Health promotion/health protection and disease prevention (see Appendix 1, Hinchliff and Rogers p. 236–240)	
1	Assesses individual's health education/promotion-related needs
2	Plans, develops, and implements programs to promote health and well-being and address individual needs
3	Provides health education through anticipatory guidance and counselling
4	Develops and uses a follow-up system within the practice workplace to ensure that patients receive appropriate services
5	Recognizes environmental health problems affecting patients and provides health protection interventions that promote healthy environments for individuals, families, and communities
Management of patient illness	
6	Analyzes and interprets history, presenting symptoms, physical findings, and diagnostic information to develop the appropriate differential diagnoses
7	Diagnoses and manages acute and long-term conditions while attending to the patient's response to the illness experience
8	Prioritizes health problems and intervenes appropriately, including initiation of effective emergency care
9	Employs appropriate diagnostic and therapeutic interventions and regimens with attention to safety, cost, invasiveness, simplicity, acceptability, adherence, and efficacy
10	Formulates an action plan based on scientific rationale, evidence-based standards of care, and practice guidelines
11	Provides guidance, counselling, advice, and support regarding management of the health/illness condition
12	Initiates appropriate and timely consultation and/or referral when the problem exceeds the nurse's scope of practice and/or expertise
13	Assesses and intervenes to assist the patient in complex, urgent, or emergency situations: A. Rapidly assesses the patient's unstable and complex healthcare problems through synthesis and prioritization of historical and immediately derived data B. Diagnoses unstable and complex healthcare problems using collaboration and consultation with the multiprofessional healthcare team as indicated by setting, specialty, and individual knowledge and experience C. Plans and implements diagnostic strategies and therapeutic interventions to help patients with unstable and complex healthcare problems regain stability and restore health, in collaboration with the patient and multiprofessional healthcare team D. Rapidly and continuously evaluates the patient's changing condition and response to therapeutic interventions and modifies the plan of care for optimal patient outcome

(continued)

Table 7.2 (continued)

	For health promotion/health protection and disease prevention and management of patient illness
14	Demonstrates critical thinking and diagnostic reasoning skills in clinical decision-making
15	Obtains a comprehensive and/or problem-focused health history from the patient or carer
16	Performs a comprehensive and/or problem-focused physical examination
17	Analyzes the data collected to determine health status
18	Formulates a problem list and prioritized management plan
19	Assesses, diagnoses, monitors, coordinates, and manages the health/illness status of patients over time and supports the patient through the process of dying
20	Demonstrates knowledge of the pathophysiology of acute and chronic conditions or conditions commonly seen in practice
21	Communicates the patient's health status using appropriate terminology, format, and technology
22	Applies principles of epidemiology and demography in clinical practice by recognizing populations at risk, patterns of disease, and effectiveness of prevention and intervention
23	Acquires and uses community/public health assessment information in evaluating patient needs, initiating referrals, coordinating care, and program planning
24	Applies theories and evidence to guide practice
25	Provides information and advice to patients and carers concerning drug regimens, side effects, and interaction in an appropriate form
26	If legally authorized, prescribes medications based on efficacy, safety, and cost from the formulary
27	Evaluates the use of complementary/alternative therapies used by patients for safety and potential interaction
28	Integrates appropriate non-drug-based treatment methods into a plan of management
29	Orders, may perform, and interprets common screening and diagnostic tests
30	Evaluates results of interventions using accepted outcome criteria, revises the plan accordingly, and consults/refers when needed
31	Collaborates with other health professionals and agencies as appropriate
32	Schedules follow-up visits appropriately to monitor patients and evaluate health/illness care

There are seven domains included in the Nursing and Midwifery Council's Proposed Framework for the Standard of Post Registration Nursing (NMC 2005). Domain 3, "Management of patient health/illness status" includes the subdomains "Health promotion/health protection and disease prevention," which includes five competencies, and "Management of patient illness," which includes eight competencies. There are additional 18 competencies relevant for both health promotion and the management of patient illness (see Table 7.2).

7.1.4 Health Promotion and Disease Prevention in Advanced Practice Nursing

Direct clinical care is often described using terms such as clinical decision-making, health assessment, nursing care, or management of health problems. The purpose of this section is to highlight health promotion and disease prevention as important components of direct clinical care. The concept "health" has previously been

discussed in Chap. 6, and the concept "health promotion" is linked to the competency domain coaching and guidance.

The World Health Organization defines health promotion as "the process of enabling people to increase control over, and to improve, their health" (WHO 1986). In an evolutionary concept analysis of community health, researchers found that health promotion as a concept was developed to emphasize the community-based practice of health promotion, i.e., community participation and health promotion practice based on social and health policies (Baisch 2009). Researchers have proven that nurse-led health promotion can result in many positive health outcomes such as adherence, improved quality of life, patients' knowledge of their illness, and self-management (Bosch-Capblanc et al. 2009; Keleher et al. 2009; Kemppainen et al. 2012).

Health inequalities are increasing globally, and the most vulnerable population groups find it difficult to access healthcare systems and receive patient-centered care (Maier et al. 2018). Advanced practice nurses are therefore vital to strengthening community-based health promotion. Nursing roles in both chronic care and health promotion are being developed in many countries worldwide in response to growing patient needs, including expansion of the nursing role in health promotion in many countries. Traditionally, the focus of nurse-led health promotion has been on disease prevention and changing patients' health behavior. In an investigation of how nurses in expanded roles can strengthen community-based health promotion and chronic care, researchers found that, among others, in Israel the second most frequently reported set of activities performed by community nurses working in new, expanded roles was related to health promotion (30%; Maier et al. 2018). There researchers found that community nurses in Israel primarily worked with identifying target populations for health promotion and disease prevention (86%) but also provided counselling related to nutrition, smoking, and physical activity (79%, 65%, and 73%, respectively). In Canada and the United States of America, nurse practitioners engage in health promotion, health literacy activities, and other prevention services, often for vulnerable groups. Even nurse practitioners in rural British Columbia, Canada, were linked to work with marginalized groups (e.g., patients with HIV/AIDS, mental health conditions or elderly, frail patients) (Maier et al. 2018).

In Finland, since the implementation of the Primary Health Care Act (66/1972) in the early 1970s, nurses have had (and still have) a strong role in health promotion. Primary healthcare in Finland is defined as "health promotion addressing individuals, the population and their living environment, including illness and injury prevention, and medical care for individuals." As part of the Primary Health Care Act, healthcare centers were built up in municipalities and became the foundation of the primary healthcare system. In accordance with the act, municipalities must provide health counselling services and health checks for residents (including birth control, maternity services, child health clinic services for pregnant women and expectant families/children). In 2015, the Finnish Nurse Association published an eHealth strategy (2015), in which the primary objective of nurses' role in eHealth service

provision was defined as "Nurses develop and use eHealth services in caring, rehabilitation, alleviating the suffering and health promotion of clients, and in increasing the wellbeing of citizens." Digital services are already and are expected to become an even more extensive part of nurses' work in Finland—and even throughout the world. Consequently, advanced practice nurses' competency in using welfare technology solutions and eHealth services in health promotion is crucial in health promotion activities. In Finland, nurses with an advanced practice nursing education bear expanded responsibilities for health promotion and the annual follow-up of the treatment plans for patients with chronic diseases (Ahonen et al. 2016; Nylund 2019).

Nurse-led healthcare has been shown to lead to improvements in terms of patient access to healthcare, professional satisfaction, and hospital admission rates (Roots and MacDonald 2014). In the United States of America, nurse practitioners and other advanced practice nurses are more likely than physicians to work in rural areas or care for vulnerable patient groups, e.g., the uninsured or other marginalized populations. Advanced practice nurses can thus be considered to contribute to the reduction of inequitable access to healthcare (Kaplan et al. 2009; Desroches et al. 2013; Barnes et al. 2018).

In an integrative review of nurses' roles in health promotion practice, researchers found that individual perspective was the most common factor that influenced health promotion orientation (Kemppainen et al. 2012). When nurses' activities were guided by individual perspective, they demonstrated a holistic approach and focused on activities such as helping patients make health decisions or supporting patients in engaging in health promotion activities. The second most common factor was empowerment (related to collaboration with individuals, groups, and communities), the third most common was social and health policy, and the fourth most common was community orientation. In 25 of the 40 research papers included in the review, the theoretical basis behind nurses' health promotion activities was identified, i.e., the type of practical actions that nurses engage in to promote patients', families', and communities' health. The theoretical basis that nurses emanate from was seen to be either holistic and patient-oriented or chronic disease and medical-oriented. Registered nurses were considered general health promoters and their health promotion activities were seen to be based on sound knowledge and the provision of information to patients.

7.1.5 Three Perspectives on Health Promotion in Advanced Practice Nursing

Health promotion is defined as "any activity that improves health status" (Green et al. 2015). Three different perspectives on health can be discerned in nursing literature and research and even the clinical nursing context. How healthcare providers, including advanced practice nurses, work with health promotion is influenced by these different perspectives (Tøien 2019).

7.1.5.1 Health Promotion When Health Is Understood as the Absence of Disease

In the traditional biomedical definition, health is considered the "the absence of illness." This is what is called a negative health definition; it is based on something that is *not* present. It can also be considered an objective health definition, because it is based on the presence of objective symptoms of disease that can be identified by professional healthcare providers who possess adequate biomedical knowledge (Mæland 2011). In this context, health promotion is accordingly understood as preventing disease. Because the prevalence of disease increases with age, in advanced practice nursing health promotive strategies are central to promoting the older person's health (Fagerström 2019a). An advanced practice nurse uses pathogenesis, i.e., biomedical knowledge on causal relationships between risk factors and disease, to form various disease preventative strategies aimed at the general population, specific groups (population strategies), or individuals (high-risk strategies).

Primary prevention involves preventing or hindering illness or injury, e.g., prescribing medications for patients with high cholesterol or high blood pressure to reduce their risk of cardiovascular disease. Primary prevention as a population strategy can include recommendations for the vaccination of older people or risk groups against influenza (Mæland 2011).

Secondary prevention involves diagnosing and treating exiting disease or pathology before it can lead to complications or disability and/or to prevent relapse (Mæland 2011). For example, an advanced practice nurse should be capable of identifying and optimizing the treatment of arthritis or diabetes so that the symptoms of the disease are reduced and long-term complications are prevented.

Tertiary prevention involves reducing the negative effects of disease as related to function and quality of life and improving the patient's ability to live with the disease (Mæland 2011). This can take the form of, e.g., rehabilitation after apoplexy, a fracture, or a cardiac event, through either a recommendation to engage in physical training (e.g., group training for seniors), adjustments to surroundings, or optimization of function.

Preventative measures can be used to modify risk, treat disease, and reduce the effects of disease that can lead to loss of function or reduced capacity to live independently (Mor 2005; Mæland 2011; Green et al. 2015). To harness the potential of a disease preventative approach, advanced practice nurses should possess the skills and knowledge to perform relevant examinations, interpret results, and correctly identify treatment measures. Through their skills in systematic physical examination and advanced knowledge of diseases, advanced practice nurses are uniquely qualified to identify risk factors and early stages of disease (Tøien 2019). Advanced practice nurses also have the competence to support patients during treatment.

7.1.5.2 Health Promotion When Health Is Understood as Well-Being

More complex and long-lasting conditions among an aging population have led to increasing understanding of the importance of subjective or experienced health. Understanding of subjective health as well-being allows for a positive definition of

health, i.e., that health is something that can be strengthened and promoted despite diagnosed disease (Mæland 2011).

The American sociologist and psychologist Corey M. Keyes developed a theory that expanded understanding of subjective health as well-being. Keyes' theory was developed in the context of mental health research and includes non-physical aspects of well-being. In Keyes' two-continua model of mental health (Keyes 2005), mental illness and subjective mental health (well-being) are located on two distinct continua, as distinct but related phenomena. Keyes' theory/model has been supported in empirical studies (Fledderus et al. 2010; Westerhof and Keyes 2010). Keyes emphasizes the possibilities and value of promoting individual well-being regardless of a person's objective disease status. Keyes operationalized the concept "subjective well-being" so that it consists of three aspects with associated indicators: *emotional well-being (*feelings of happiness, perceived quality of life), *psychological well-being* (accepting oneself, personal growth, meaning in existence, mastery of environment, autonomy, having positive relationships with others), and *social well-being* (social acceptance, social actualization, contributing socially, belonging to society, feeling socially integrated), all of which are related to living a meaningful and socially valuable life. An advanced practice nurse can have focus on all these various indicators of well-being to support and promote the patient's well-being, despite diseases and illnesses.

7.1.5.3 Health Promotion When Health Is Understood as a Resource

Health can also be understood as a resource for a good life, a positive function and mastering, and something that can be promoted (Tøien et al. 2014, 2015; Tøien 2019). The World Health Organization's definition of health promotion in the Ottawa Charter is based on health as a resource for everyday life: "Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment" (WHO 1986).

A central theory in which resources and mastery are emphasized is Antonovsky's theory of salutogenesis, i.e., which creates health (Antonovsky 1987, 1996; Eriksson and Lindström 2008). This way of understanding health includes opportunities for health promotive measures that have been shown to be effective in clinical studies (Langeland et al. 2006; Fagermoen et al. 2015). Antonovsky (2012) maintained that health lays on a continuum between best possible health (ease) and worst possible health (disease). Where a person is on the continuum depends on his/her actual ability to master stress and challenges in life. A person's ability to master stressors is dependent on what Antonovsky calls a person's sense of coherence (SOC). Sense of coherence can be described as a mixture of optimism combined with a sense of control, and it has three components: comprehensibility (the extent to which internal and external stimuli are understandable), manageability (the feeling that there are resources for the ability to cope), and meaningfulness (the feeling that life has some kind of emotional meaning; Eriksson and Mittelmark 2016). Disease is one of

several stressors that can reduce health. Health promotion as an advanced practice nurse can therefore be to support a person's resources and strengthen his/her experience of comprehensibility, manageability, and meaningfulness (Tøien 2019).

Other researchers also emphasize the importance of health resources. Fry and Debats (2010) have identified the major sources of life-strengths among older people. Possible health and well-being promoting areas are, e.g., religion and capacity for personal belief, spiritual/existential values, positive attitude toward suffering, personal experience of meaning, contributing socially and to others, courage, self-confidence, optimism, autonomy, experienced control, belief in own capacity and ability to master, experience of having control, social ties and emotional connection, continuity in personal and sociocultural roles, culture in the environment, and experience of fitting in and belonging. It is noticeable that areas related to physical health are not included in this list, quite the opposite. Nevertheless, Fry and Debats (2010) maintain this should not imply that physical function is not important for older people as a resource. Instead they find that it is important to try to understand those lesser known areas in which health for older people can be promoted. Each, individual older person assesses and values the aforementioned areas differently, based on actual situation and resources. Therefore, in advanced practice nursing, it is necessary to employ a person-centered approach when taking steps to support individuals' well-being and mastery (Tøien 2019).

7.2 Competency Domain 2: Ethical Decision-Making

Ethics has always been the cornerstone of advanced practice nursing education. The United Nation's Universal Declaration of Human Rights, the values of the welfare state, the International Council of Nurses' ethical guidelines and several nursing theories emphasize the importance of ethics for good nursing. All these together create an ethically sustainable foundation for nurses.

The advanced practice nurse's ability to recognize ethical problems/issues and offer solutions to more complex ethical dilemmas is an important dimension of advanced practice nursing. Because advanced practice nurses bear a responsibility for patients with more complex health problems, greater demands are placed on their ability to make ethical decisions (Peirce and Smith 2008).

According to Benner et al. (1996), ethical engagement is an expression of clinical competence. Advanced practice nurses possess deeper understanding of ethical problems/issues and ethical theories than nurses with a lower educational level; thus they can act as a resource for patients, patient's families, and other nurses and colleagues (Feldt 2010).

In Chap. 6, ethical approach in clinical nursing was investigated on a general level. The focus here in this section is the deepening of understanding of ethical problems/issues and what ethical decision-making means in the context of advanced practice nursing, including how one's ability to make ethical decisions is developed and the importance of cultural competence.

7.2.1 Ethical Problems/Issues in Advanced Practice Nursing

To provide a more concrete idea of the type of ethical problems/issues advanced practice nurses can encounter, examples of typical ethical conflicts are listed below, modified, and adapted from Feldt (2010):

1. Patient and family conflicts when the prognosis or goals of care and treatment are unclear.
2. Family conflicts related to aggressive, demanding treatment for, e.g., pediatric patients or palliative care patients.
3. Patients who are dissatisfied with their encounter with healthcare services due to insufficient resources.
4. Problems related to patient privacy, electronic patient records, and treatment.
5. Problems paying for healthcare services and the patient's right to the best possible nursing, care, and treatment.
6. Uncertainty when coding and billing healthcare services, e.g., classification in accordance with diagnosis-related group (DRG) systems.
7. Conflict of interest when prescribing of medications due to influence from pharmaceutical manufacturers.
8. Demanding pain management and prescribing opioids to patients with chronic pain.

According to Feldt (2010), research on ethical problems/issues in advanced practice nursing should be developed, e.g., related to ethics in direct nursing care (Laabs 2005, 2007; Ulrich and Soeken 2005), ethical problems/issues linked to organizational aspects (Ulrich et al. 2003a), and the value of human life (Kalb and O'Connor-Von 2007).

While all nurses have a moral responsibility for their patients, advanced practice nurses are even expected to assume a leading position when it comes to solving ethical problems. Advanced practice nurses should also contribute to the creation of an ethically sustainable environment and should promote social justice throughout healthcare services (Hamric and Delgado 2009; Wocial 2019). In the United States of America, nurses' ethical competency is deepened in doctoral-level advanced practice nursing programs through a focus on leadership, through which nurses can develop and evaluate strategies for ethical problem-solving in both patient care and on the organizational level (American Association of Colleges of Nursing 2006).

What characterizes ethical dilemmas in healthcare services? In nursing literature, a lack of or insufficient communication and the erosion of open and honest communication are often mentioned as factors that contribute to the emergence of ethical dilemmas (Hamric and Delgado 2009; Wocial 2019). The importance of being able to actively listen is part of effective communication. Through listening, a person demonstrates tangible respect for the other's opinions and perspectives. It is not true differences in values but rather insufficient communication that can cause ethical problems to arise. Also, open and honest communication is important; an advanced practice nurse should dare "speak up" if he/she feels that patient safety is

being compromised or when evident care or treatment mistakes have been. Advanced practice nurses should learn to "break the silence," e.g., initiate discussion on active treatment versus palliative treatment. This is necessary to support open communication with colleagues, patients, and patients' families.

Another factor that contributes to the emergence of ethical dilemmas is that a variety of different professionals from various professional groups are together involved in providing healthcare services. Healthcare professionals can have varied perspectives, and this has an impact on discussions and ethical decisions (Wocial 2019). For example, issues such as refusal of treatment, end-of-life decision-making, cost containment, and confidentiality are often interprofessional, and this can lead to ethical dilemmas. Interdisciplinary teams are a necessity and a strength but can make communication challenging when many different actors are involved, e.g., in the care of palliative patients.

Another factor that contributes to the emergence of ethical dilemmas is that nurses often have competing responsibilities and duties to fulfill, related not only to patients and patients' families but also physicians, other colleagues, the organization, and, not to be forgotten, themselves (Hamric and Delgado 2009). That advanced practice nurses' work context is composed of many different responsibilities and duties contributes to the emergence of ethical dilemmas, especially when nurses are unable to balance their multiple commitments. An often-relevant issue connected to multiple commitments as an advanced practice nurse is the responsibility to practice self-care; nurses have the same duty to themselves as they have to their patients (Wocial 2019). When is it necessary to set a limit for the lengths one is willing to go to for one's patients? Understandably, risking one's own health as an advanced practice nurse does not benefit patients in the long term.

Ethical problems are made actual in the meeting with the patient and the patient's family as well as in interdisciplinary collaboration and such problems often linked to concrete nursing interventions (Parry et al. 2006). Moral sensitivity can be described as consisting of three components: moral strength, moral responsibility, and moral burden (Lützén et al. 2003). Moral strength is related to whether one can take a position on a particular action and thereafter defend this position. Moral strength and moral responsibility should be a part of an advanced practice nurse's competency. Deeper knowledge increases one's awareness. Yet deeper ethical knowledge can also increase an advanced practice nurse's moral burden, if barriers in the clinical context prevent the nurse from realizing his/her moral responsibility. When a situation requires that a person act against his/her moral values, a poor conscience arises, something that can lead to "conscience stress" (Glasberg et al. 2006). Conscience stress is a burden that a nurse experiences when he/she cannot follow his/her own conscience and that which he/she perceives to be correct.

7.2.2 Elements of Ethical Decision-Making

Ethical decision-making is composed of four elements: knowledge development, knowledge application, creating an ethical environment, and promoting social

Table 7.3 The four elements of developing advanced practice nurse's ethical competency (adapted from Wocial 2019: 319)

Element 1:	Knowledge development—moral sensitivity
Element 2:	Knowledge application—ethical judgment and motivation
Element 3:	Creating an ethical environment—moral action
Element 4:	Promoting social justice within the healthcare system)

justice (Wocial 2019). It is assumed that the development of competency in ethical decision-making is an evolutionary process, where the development of competency takes time and is not purely linear (Hamric and Delgado 2009; Wocial 2019). The development of ethical competency consists of four elements that are based on each other (see Table 7.3; Wocial 2019: 319):

While advanced practice nurses should be exposed to all four of the elements listed above (see Table 7.3) during advanced practice nursing education on the master's level, further, more in-depth study of elements 3 and 4 should occur on the doctoral level, where it is assumed that the advanced practice nurse has gained more clinical experience and "matured" in his/her role. In elements 1–4, emphasis shifts from the individual level (elements 1 and 2; e.g., ethical issues in own specialty) to the systems level (element 3; e.g., awareness of environmental barriers to ethical practice in organization) and political level (element 4; e.g., health policy issues affecting a specialty population). The ability to make ethical decisions can thus be considered a part of leader competence. The ability to make ethical decisions can also have a preventative effect, in that ethical decision-making prevents the occurrence of ethical problems both linked to patients' nursing, care, and treatment (the individual level) and on the organizational level (Tracy 2009). Ethical decision-making as a core competency is developed and matured not only through theoretical studies but also, primarily, through clinical experiences and reflection.

Knowledge development is the first element in ethical decision-making. It is derived from one's knowledge of ethical theories, ethical principles, and specific ethical problems and can be linked to a particular patient group or a certain clinical context. Knowledge development can be considered the integration of philosophical and theoretical concepts with practical and clinical issues. During advanced practice nursing studies, advanced practice nurses should learn the theories, ethical principles, and current laws and regulations relevant to ethical decision-making processes in various clinical contexts (patient cases). This can be considered the start of each advanced practice nurse's personal journey toward a clear, holistic, ethical approach, i.e., ethos. In this phase it is important that each person's own moral sensitivity is further developed through the clarification of own personal and professional values (Hamric and Delgado 2009; Wocial 2019). Prior to working with patients from diverse cultures, it is particularly important that a nurse uncover personal values that may have been internalized and not openly acknowledged (Gastmans 2013).

Knowledge application is the second element in ethical decision-making. It can be described in terms of a nurse applying the knowledge he/she developed during the first level of clinical practice, including the nurse's ability to use theoretical

models and an evidence-based and systematic manner to make ethical decisions when faced with clinical problems (Wocial 2019). According to Gastmans (2013: 142), "the ethical essence of nursing is the provision of care in response to the vulnerability of a human being in order to maintain, protect, and promote his or her dignity as much as possible." Gastmans developed an ethical framework in which the following three aspects were considered essential to one's capacity to adequately address ethical issues in nursing care: lived experience, interpretative dialogue, and normative standard. Gastmans also identified and explored a further three core concepts in nursing care, vulnerability, care, and dignity. Gastmans maintained that concrete lived experiences (e.g., caregiving, care receiving, vulnerability, dignity) rather than abstract principles (e.g., respect for autonomy) should be the primary guide for developing a nursing ethics framework. He furthermore argued that seeking to improve the ethical quality of nursing care practice solely based on an external framework of normative principles was insufficient; any such approach must be embedded in the practice of care itself. He even stated that an individual's intuitions or subjective feelings and ideas about care practices must be clarified, because these are illuminative regarding the phenomenon of nursing care as experienced in everyday life.

An advanced practice nurse should develop his/her ability to distinguish between ethical dilemmas and morally difficult or stressful situations, i.e., situations that give rise to "moral distress." Moral distress has been defined as knowing what is most ethically correct or incorrect but, because of obstacles in the current situation, lacking the courage to do what is right for the patient (Tracy 2009, 2019). Moral distress in ethically difficult situations can in many cases be caused by organizational obstacles, including a shortage of time. This means that nurses are unable to act based on their moral values, and this can lead to their actions being governed by organizational or cultural factors (Lützén et al. 2003). To develop new perspectives on how ethical dilemmas can be approached, advanced practice nurses should actively seek ethical positions that diverge from their own and learn to identify situations where ethical conflicts can arise. The goal is to become proactive in identifying ethical issues, so that ethical dilemmas can be prevented or hindered. Through fundamental knowledge of ethical concepts and a continuous reflection on own experiences, advanced practice nurses develop the practical wisdom they need to engage in moral reasoning. It is imperative that advanced practice nurses learn how to approach difficult situations (and conversations) and, later, also act as leaders in resolving ethical conflicts.

Doherty and Purtilo (2016) outlined a six-step approach to ethical decision-making through which the effective choices that lead to a professional and caring response to patients can be ensured. These are as follows: gather relevant information, identify the type of ethical problem, analyze the problem using ethics theories or approaches, explore the practical alternatives, act, and evaluate the process and outcome. Wocial (2019) argues that moral action is an essential component in resolving ethical dilemmas in healthcare. Thus, for advanced practice nurses, it is not enough to "merely" have knowledge of ethical theories and practical

alternatives to ethical dilemmas; they must also possess the motivation and courage to act in accordance with this knowledge and, as needed, engage in interprofessional discussions.

Creating an ethical environment is the third element in ethical decision-making. An experienced advanced practice nurse has a responsibility to ensure the development of a sensitive and sustainable ethical environment in which ethical decision-making is promoted. The ethical environment is an integrated part of an organization's care culture and determines the extent to which the care culture is person-centered. Decades of research on the impact of care culture on the clinical effectiveness of healthcare staff and patients' experiences of healthcare indicate that the importance of the care culture cannot be overvalued. For example, Ulrich et al. (2003b) showed that the more ethical an environment was, the lower the ethical conflict. In turn, the advanced practice nurse's fundamental ethical approach toward a patient, i.e., his/her ethos, influences the care culture. It is especially important in ethically difficult situations to seek to preserve the patient's dignity and demonstrate respect for the patient's values, so that advanced, person-centered care can be guaranteed (Fagerström 2019a, b). By purposefully encouraging and supporting patients and patients' families in expressing their desires and asking difficult questions, advanced practice nurses can contribute to an open care culture where it is possible to recognize and solve ethical conflicts together with patients. Thoughtful, ethical decision-making arises from a care culture that supports and values the critical exchange of ideas and promotes collaboration between professional teams, patients, and patient's families (Wocial 2019). When faced with ethical questions, an advanced practice nurse acts like a mentor, and he/she also identifies the "risks" that can cause ethical conflict to arise in his/her unit. Important skills include being able to address barriers to ethical practice through system changes and being a role model in collaborative problem-solving (Wocial 2019).

According to Salmela et al. (2017), sustainability in healthcare presupposes an ethical leadership, a management of the good care, and a well-educated staff. Ethical decision-making can be supported through the implementation of ethical practice models (EPM). Developed in Finland, the ethical practice model for sustainability in care can be used to start ethical conversations through which nurses' reflections on the ethical issues they experience in a day-to-day care work and the work community can be supported (Nyholm et al. 2018). Ethos lies at the core of this model, surrounded by ethical values central to sustainability such as dignity, responsibility, respect, invitation, and vows. Healthcare professionals can use this model to deeply understand an organization's common fundamental values and what they entail for sustainability in care.

Promoting social justice is the fourth element in ethical decision-making. It includes moving the focus from the individual level and own organization to the larger, patient population level. According to Wocial (2019), the advanced practice nurse's clinical expertise, including a deeper understanding of the needs her/his patient population has, offers an excellent platform from which the advanced practice nurse can talk about social justice issues. Promoting social justice also requires the use of all the other central competency domains, such as communication,

collaboration, and leadership. Doctoral-level advanced practice nursing educational programs should include courses related to the development of policy skills so that students can learn to work more strategically in promoting social justice on the systems level. Furthermore, advanced practice nurses with doctoral degrees should demonstrate an interest in trying to affect the current delivery of care in their clinical/workplace setting and advocate for social justice in the overall healthcare system.

7.2.3 The Importance of Cultural Competence for Ethical Decision-Making

Cultural competence is an important part of the ethical decision-making competency domain. In many countries, a greater mix of societal ethnic and linguistic diversity is seen. Understanding cultural diversity is therefore increasingly important in healthcare services. Cultural competence includes cultural awareness, cultural knowledge, cultural understanding, cultural sensitivity, and cultural interaction (Buruchum 2002; Nyback 2007). According to Hanssen (2007), cultural competence can be defined as sensitivity to and carefulness with the variation that exists in human beings' experiences and reactions. Variations can be linked to variables such as personality, education, social and economic status, ethnicity, or cultural background. Different combinations of these variables can influence how people react to actual health problems and disease and how they experience the nursing, care, and treatment they receive.

An advanced practice nurse can be the first professional a patient meets in healthcare (Callum 2008). To understand the cultural values, prejudices, beliefs, and assumptions that influence how a patient expresses his/her health needs, an advanced practice nurse should have thorough knowledge of the patient's cultural background. The patient's cultural background (seen as his/her values, prejudices, beliefs, and assumptions) also influences how the patient wants to be treated and what he/she perceives to be good nursing. When one takes a patient's cultural background into account, one shows respect for the patient as a unique human being. Cultural competence is therefore a prerequisite for holistic, person-centered, and culturally adapted nursing.

Callum (2008) emphasized that a lack of understanding, tolerance, and respect for others' religious beliefs causes conflicts in nursing and care relationships. It is a great advantage for an advanced practice nurse to become more familiar with, e.g., Muslim, Buddhist, Hindu, Jewish, Christian, or Sami patients' faiths and beliefs (Hanssen 2007).

Nyback (2007) highlighted the importance of understanding that patients from different cultural backgrounds express their suffering in different ways. Nyback's research on both patients, patients' families, and nurses in China revealed that the patient's family was of great importance to understanding the patient's suffering and health and care needs. The patient's suffering should always be understood in light of culture and cultural patterns, including how culture and cultural patterns affect how suffering can be expressed, interpreted, understood, and alleviated. A culturally

competent nurse meets the patient's health needs and suffering while taking the patient's cultural preferences into consideration, which is essential in person-centered nursing, care, and treatment.

Language and culture are closely related. Yet while verbal communication is dependent on (linked to) a language and the form through which it is expressed, body language is universal and something that everyone can interpret and understand regardless of linguistic ability. About 70% of what a person wants to say is conveyed through body language, and non-verbal communication many times conveys a more truthful depiction of thoughts and feelings than words do. It is therefore important for an advanced practice nurse to be observant and sensitive to a patient's facial expressions, manner of speaking (volume, tone), gaze and eye contact, head movements, limb movements (arms, hands, feet), body movements and positions, interpersonal distance (personal space) and desired optimal interaction distance, and physical touch.

7.3 Competency Domain 3: Coaching and Guidance

The concept "coaching" is used in many professional spheres, e.g., sports, business, leadership, and management. Coaching means instruction and guidance. It is a broad term placed in the context of working together, supporting, guiding, developing, and even looking at what can inhibit positive life development. In sports, for example, the coach is tasked with helping those at a lower level which reach a higher level by supporting, encouraging, and developing individuals' physical and mental capacity. Today, coaching in this sense is used by trainers, teachers, mentors, instructors, and all who provide instruction and guidance.

The term coaching is used to describe the interaction between experts and novices, with an emphasis on developing novices' knowledge and skills in the expert's (coach's) area of knowledge (Spross 2009). The coach's own skills and competence are central to whether he/she can provide the necessary support and encouragement. Coaching has been described as a form of conversation and discussion, where the person being coached is him−/herself active and uses own abilities. This can occur by the coach asking a novice reflective questions to help the novice him−/herself find answers. The coach listens to the novice to make the novice feel recognized and taken seriously (Kilburg 2000).

Coaching can also be described as providing help and support to others so that they succeed with their tasks, can solve own problems, deal with the challenges they face, or implement changes that are needed. Gallwey (2000) maintains that coaching entails releasing a person's potential to maximize achievements, i.e., it is a method whereby one can help others learn.

In the section below, coaching and its associated concepts are more fully delineated, including health education, advanced practice nurses as coaches, coaching as person-centered guidance, coaching patients during transitions between life phases, and coaching realized as motivational conversations.

7.3.1 Health Education Concepts Associated with Coaching and Guidance

Anticipatory guidance, patient education, mentoring, and counseling are all concepts related to the coaching and guidance competency domain, and all can be considered health education methods, i.e., methods that can be used to increase or enhance an individual's health literacy. Health literacy is defined as an individual's knowledge, motivation, and skills to access, understand, evaluate, and apply health information (Moreira 2018). In the Norwegian language, the term used for health literacy is *helsekompetanse*, which can be translated into English as "health competence" (Helse-og omsorgsdepartementet 2019). The Ministry of Health and Care Services in Norway defines health competence (*helsekompetanse)* as follows: "Health competence is a person's ability to understand, assess and use health information in order to make evidence-based decisions related to own health. This applies to both decisions related to lifestyle choices, disease preventative measures, self-management of disease and use of health and care services." Similar and related terms in the Norwegian language include, e.g., *helsefremmende allmenndannelse* (health promotive general education), *helsekunnskap* (health knowledge), *helseforståelse* (health understanding), *helseinformasjonsforståelse* (health information understanding), *helserelatert informasjonskompetanse* (health-related information expertise), and *helseinnsikt* (health insight). In the Danish language, the term *sundhedskompetence* (health competence) is used, while in the Swedish language, the term *hälsolitteracitet* (health literacy) is used. In Finnish two terms are used for health literacy, *terveysosaaminen* (health competence) and *terveyden lukutaito* (health literacy).

Healthcare staff's health education competency is determinative for their ability to meet patients' and patients' families' need for information, instruction, and guidance. Health education entails teaching, instructing, and guiding patients through all levels of healthcare (primary care, specialist care, health promotive and preventative care, rehabilitation; Jensen et al. 2016). A health education approach includes being able to lay the foundation for increased knowledge of own health, give social and emotional support, and contribute to mastery of won health despite disease. Health education competency also includes the knowledge and skills to support user involvement and how one can in the best possible manner convey knowledge on health and disease in a person-centered manner that supports the individual's health competence.

Anticipatory guidance, patient education, mentoring, and counseling are all concepts related to coaching and guidance (O'Grady and Johnson 2019). *Guidance* is a broad term and can mean the provision of help, instruction, or assistance. Through guidance, a nurse gives advice or education, while coaching implies that a nurse engages in inquiry and the seeking of answers from a patient. When providing guidance, it is recommended to first determine the level of the patient's knowledge on the actual issue and then give what is needed. With *anticipatory guidance* the aim is to help patients and patients' families know what to expect, e.g., when an advanced

practice nurse informs the patient a priori about expected health processes to promote self-efficacy and reduce anxiety.

Patient education, which can be considered a form of patient empowerment, includes teaching patients about their illnesses and guiding them so that they become more involved in care and treatment decisions (O'Grady and Johnson 2019). Because information is so readily available today, customized and person-centered patient education is needed; patients want to know what information applies to them and how and when they should use it.

Mentoring can be considered a one-on-one relational process, where one person has more expertise and/or experience than the other person (O'Grady and Johnson 2019). Mentors give advice and support based on own experiences, and a mentoring relationship is usually long term. Another typically long-term relationship, *counseling*, is used to empower individuals, families, and groups to achieve mental health, wellness, education, and career goals. The aim of counseling is to solve and fix problems.

Finally, *coaching* can be considered an umbrella concept, because it includes different approaches, philosophies, techniques, and disciplines. O'Grady and Johnson (2019) highlight that coaching is based on a relationship in which the individual identifies his/her goals. They note that coaching can be thought of in terms of "leading change from behind" and "walking with the patient," through which clarity, definition, reflection, and the ability to move forward in the process are realized. Still, one should note that in nursing literature there currently exists no clear consensus on how much advice should be included in coaching.

7.3.2 Advanced Practice Nurses as Coaches

There are several evidence-based theories and frameworks related to advanced practice nursing coaching and guidance, for example, the Midrange Theory of Integrative Nurse Coaching, the transtheoretical model, Watson's model of caring, positive psychology, growth mindset, the self-determination theory, and theories related to transitions in health and illness (O'Grady and Johnson 2019). All the aforementioned are deeply rooted in Florence Nightingale's environmental theory (where she maintains that there is a strong link between a person's environment and his/her health) and the science of human caring (which broadens understanding of the use of self in nursing).

The caring relationship that is created between the advanced practice nurse and the patient is of crucial importance in coaching and guidance (Fagerström 2011, 2019a, b).

Spross et al. (Spross 2005, 2009; Spross and Clarke 1996; Spross et al. 2000) developed a model of the coaching competency of an advanced practice nurse (APN), in which the focus is on the concept "coaching" instead of teaching or learning. Spross (2009) defines advanced practice nursing coaching as a complex and dynamic interpersonal process characterized by collaboration and a holistic perspective and maintains that it is dependent on the interaction of four factors: clinical

competence, technical competence, interpersonal competence, and self-reflection. In Spross' model, the importance of clinical experience and self-reflection for developing competency in coaching is emphasized. Other researchers note that solid nursing experience gives nurses insight into how different patients experience and express health, disease, pain, suffering, and death (Benner 1985; Benner et al. 1999).

Interpersonal competence includes advanced communication and relationship skills that enable the creation of therapeutic relationships characterized by care (Spross 2009). In the meeting with the patient, an advanced practice nurse must be open and flexible and, using a non-hierarchal attitude, demonstrate sensitivity to the patient's non-verbal expressions (Brown 1999). Through active listening and relevant questions, it is possible to understand what is important to the patient and what the patient feels is essential for his/her health. During the coaching process, an advanced practice nurse should summarize, repeat, and interpret the patient's message and his/her needs in the current situation, so that the patient him−/herself can confirm that the message is properly understood.

In various studies, researchers have shown that advanced practice nurses employ a person-centered communication style (Quirk and Casey 1995; Brown 1999). To create a therapeutic and caring relationship with the patient, advanced practice nurses must avoid adopting a distanced attitude and instead seek to be emotionally receptive. A caring and person-centered relationship is a prerequisite for coaching to yield good outcomes (Brown 1999; Parry et al. 2006; Spross 2009).

Self-reflection can be described as a deliberate mapping of own experiences to learn from those experiences (Spross 2009). Advanced practice nurses have been described as "those who see more" than non-experts. "Seeing more" is related to being observant, attentive, and having a sensitive approach to the patient as an entity and a person. Active listening and being present can in this context be described as a form of "mindfulness," i.e., an attitude characterized by a conscious presence. Positive and negative experiences give advanced practice nurses the opportunity to learn. Reflecting on coaching situations where a patient has been motivated or care relationships have failed can yield new insight. Professional guidance can provide an opportunity through which the expert/coach can achieve deeper self-awareness and thereby develop his/her abilities as a coach.

7.3.3 Coaching as Person-Centered Guidance

Around 25 years ago, Benner (1985) described the coaching role that nurses undertake, especially with patients with chronic diseases. Researchers have confirmed Benner's approach in several studies (Fenton and Brykczynski 1993; Benner et al. 1999), finding that advanced practice nurses act as good coaches for their patients when they apply their knowledge and previous experience in patient education and guidance. The importance of advanced practice nurses' coaching for patients with long-term, chronic illnesses or disease, where the goal is to activate and motivate the patient to change his/her lifestyle, is clear (Parry et al. 2006).

A teaching role is a central part of advanced practice nurses' direct clinical competence, and advanced practice nurses' teaching has a positive effect on patient satisfaction and treatment outcomes. Analyzing nurse specialists' work, Brooten et al. (1988, 1991) found that about 68% of nurse specialist interventions (nursing measures) can be categorized as teaching. In another study in which 150,131 advanced practice nurse interventions were investigated, Brooten et al. (2003) identified four categories related to advanced practice nurse functions: surveillance; health teaching, guidance, and counseling; treatments and procedures; case management; and follow-up. Surveillance was the most frequent function, and health teaching, guidance, and counseling the second most frequent function. The concept of a "dose effect" (later changed to "nurse dose") was introduced, i.e., the degree to which a patient receives coaching (seen as the education, expertise, and experience of the nurse). The nurse dose, interpreted here as "coaching dose," was seen to be determinative for follow-up. Thus, one can conclude that health and treatment outcomes for, e.g., vulnerable elderly patients, could be improved through advanced practice nurses' coaching.

Patient training is a central and well-documented area of responsibility in nursing. Heath education provided by an advanced practice nurse has been defined as interpersonal expert coaching and guidance during transitions from one life phase to another, e.g., illness, giving birth, sorrow, or (painful) loss (Spross 2009). The concepts of "empowerment" and "person-centered nursing" are central concepts in coaching. Person-centered nursing entails identifying and respecting a patient's differences, values, preferences, and the actual needs that the patient considers important, all of which should be considered in coaching (Tracy 2009).

Coaching entails motivating and enabling the patient to become involved in his/her own nursing, care, and treatment. According to Benner (1985), an advanced practice nurse has four main duties: interpret unusual health and illness issues; guide the patient through difficult conditions such as anger, grief, or hopelessness; identify changes in health needs and symptoms of ill health; and ensure that the patient's health improves following treatment.

Often, the aim of health information and health education is to realize a lifestyle change, and this requires that the patient also makes the lifestyle change his/her goal. To accomplish this, both the nurse and patient must be fully "present" during coaching (Tanner et al. 1993). While some criticize such an approach by maintaining that it is too idealistic, one cannot sufficiently emphasize the importance of a nurse being "present" for each patient. An advanced practice nurse should continuously develop his/her capacity for person-centered nursing in different situations: both those where a good deal of time is required (e.g., gaining deep knowledge of a patient) and those where quick clinical decisions are required (Spross 2009).

Coaching is a complex process, and an advanced practice nurse must in each situation be capable of listening and adapting the content of the coaching and guidance being provided in accordance with individual patient needs (O'Grady and Johnson 2019). Coaching is inextricably linked to direct clinical nursing competence. In addition to the patient, the patient's family or other healthcare team members can be included in coaching.

Spross (2009) finds that the purpose of coaching can be to alleviate a patient's suffering and help make the suffering easier to bear. Coaching as a process involves all aspects of being human, i.e., cognitive, emotional, behavioral, physical, social, and spiritual dimensions. In the nurse-patient relationship, it is permissible for both parties to show their feelings, which can help facilitate that the patient feels that his/her suffering has been confirmed. When a patient dares to express his/her suffering, he/she is given the opportunity to "suffer out," whereby he/she can later be reconciled with his/her suffering (Wiklund 2009). Advanced practice nurses, therefore, can use coaching as a method to alleviate a patient's pain and suffering, i.e., support the patient in his/her "drama of suffering" (Wiklund 2009).

7.3.4 Coaching Patients During Transitions Between Life Phases

As human beings, we experience continuous change throughout our lives. Changes from transitory life phases can be both predictable and unpredictable. "Transition" is a central concept in nursing research (Schumacher and Meleis 1994). Chick and Meleis (1986) defined transition as "to go across something," in the form of passage from one life phase to another, one condition or status to another. Transitional processes can be described as the various phases that a human being experiences, e.g., being insufficiently supported, losing an important person, experiencing that one's needs are not being met, or when previous expectations no longer correspond to one's present situation. According to Schumacher and Meleis (1994), nurses are involved in four types of transitions:

- Developmental.
- Situational.
- Health-illness.
- Organizational.

Developmental transitions, e.g., giving birth, are part of a normal life cycle (cf. Erikson and Erikson 2004).

Situational transitions are changes that can be linked to education, work life and family roles, or structural and economic changes. Role changes arising from, e.g., being furloughed or early retirement, can entail major transitional phases for the person concerned.

Health-illness transitions have been described as the patient's adaptation to chronic disease, e.g., moving from hospital care to home healthcare services (Schumacher and Meleis 1994). A transitional phase can also be a period of difficult experiences of one's own body, e.g., traumatic experiences of abuse as a child or acute heart problems (Spross 2009). The onset of a disease can actualize difficult events, e.g., from childhood.

Organizational transitions consist of events in organizations or one's surrounding context, e.g., at a person's workplace. Also, the economic change processes that many societies/communities go through can have an impact on patients in need of advanced practice nursing.

A transitional phase is often by nature radical and extensive. It affects the identify, roles, behavior, and important relationships of the person undergoing the transition. To meet the person who is undergoing a transitional process, an advanced practice nurse needs the ability to see and confirm the person's suffering and assess the person's need for coaching and guidance in his/her actual life situation. According to Spross (2009), an advanced practice nurse must support and coach the person in transition in safely transitioning from one phase to another.

Having knowledge of human beings' natural maturation processes can help one better understand transitional phases and the change processes that a human being goes through when he/she suffers from ill-health and disease. In Erik Erikson's theory on the stages of psychosocial development, human beings go through eight different life stages during which they experience psychosocial crises. If these are resolved, a greater degree of psychosocial strength is gained (Erikson and Erikson 2004).

The aging process and gerotranscendence can be noted here as important change processes that contribute to the development of a person's psychosocial strength. If an older person "succeeds" in this last phase of life development (old age), gerotranscendence occurs, i.e., he/she transcends his/her own physical and mental boundaries and fear of death to reach a state of inner joy (Tornstam 1997; Nygren and Lundman 2009). Transcendence is described as not only surpassing one's personal boundaries toward others, nature, and the universal but also one's personal boundaries inward, resulting in increased self-awareness and sense of security (Nyström and Andersson-Segesten 1990; Tornstam 1997; Nygren and Lundman 2009).

7.3.5 Coaching Realized as Motivational Conversations

Advanced practice nursing entails giving patients help and supporting them in resolving their health problems. Still, a patient must understand and know how he/she can take care of own health and seek to prevent complications. Advanced practice nurses, who wish to coach and support a patient's capacity for self-care and support the patient toward a greater degree of health and well-being, can use motivational conversations.

Rollnick et al. (2008) find that patients play a central role in helping prevent, treat, and maintain own health and that this can be determinative for outcome. Motivational interviews or conversations have been described as a refined form of guidance (Rollnick et al. 2008; Barth et al. 2013). Humanistic psychology, behavioral psychology, and systematic narrative approach have inspired the use of motivational interviews/conversations. Self-determination theory, where one seeks to understand a person's behavior and which motives ("drivers") will truly lead to change for that person (Barth 2008), is central to motivational interview/conversation. Self-determination theory is based on the idea that a person has the greatest motivation and is most persistent when three fundamental psychosocial needs are supported, i.e., basic needs related to:

- Competence—the need to master, cope with, create, and succeed.
- Autonomy—the need to experience self-determination, freedom, and independence.
- Belonging—the need for social contact, friendship, community, and to love and be loved.

  (Translated from Barth 2008: 142)

Motivational conversations were first used in healthcare as short-term treatment for people with addictions, e.g., alcohol or tobacco. Today many researchers have found that the method leads to positive outcomes in relation to cardiovascular disease, diabetes, high blood pressure, mental disorders, and HIV/Aids prevention (Brodie and Inoue 2005; Kreman et al. 2006, www.motivationalinterview.org).

A person-centered approach underlies motivational conversations as a method (Rollnick et al. 2008). A person-centered approach as realized in motivational conversations can be described in four main principles: resist the reflex to correct, understand and investigate the patient's motivation, listen with empathy, and help the patient feel the power he/she has over own life. The last main principle can be related to the concept of "empowerment," i.e., empowering the other.

Motivational conversations entail activating the patient's own motivation to change and comply (known as compliance) with treatment. According to Rollnick et al. (2008), the overarching perspective underlying motivational conversations can be described as a collaborative and respectful attitude toward the patient's autonomy. This is about eliciting the patient's own motivation and resources for change. As a professional, one can advise and inform, but it is always the patient who ultimately decides whether to act.

It can be advantageous to combine motivational conversations as a method with the following three communication styles commonly used in nursing, care, and treatment: manage, guide, and follow. Often it is a matter of mixing and matching these three communication styles in accordance with patients' needs. Motivational conversations involve helping the patient make decisions about own health and make lifestyle changes. To ask, inform, and listen are central communication skills in this context. The more one succeeds with the aforementioned communication skills, the greater the chance one can truly motivate the patient (Rollnick et al. 2008).

7.3.6 Coaching and Guidance Key Summary Points

As seen above, through coaching and guidance, the focus of care is placed on patients' goals, preferences, and capacity to engage in self-care. In coaching, focus is placed on the goals the patient has set, and coaching is used to assist the patient in understanding his/her ability to reach these goals. Guidance, however, is dependent on the advanced practice nurse's skills as an expert. Both coaching and guidance are skills that an advanced practice nurse should focus on and develop. O'Grady and Johnson list key summary points related to coaching and guidance, as follows:

- Guidance and coaching require deep listening and strong empathic skills.
- All patients must be assessed for appropriateness of guidance and/or coaching.
- Guidance requires exploring what the patient already knows.
- Patients must be assessed for readiness to change before the coaching methodology is used.
- Integrating guidance and coaching is integral to patient-centered care.
- Although there is broad agreement that patient-centered care is important, developing ways to support it has been challenging.
- Integrating coaching with guidance establishes the patient as the center of care and as the full source of control.
  (O'Grady and Johnson 2019: 202)

7.4 Competency Domain 4: Consultation

The concept "consultation" can be considered a relatively unresearched concept in clinical practice and nursing literature. According to Barron and White (2009), conceptual clarity is needed regarding the concept, because consultation is one of the most important competency domains in advanced practice nursing. As a concept, consultation has traditionally been used in the medical context. Yet the concept has become more interesting following development of the advanced practice nursing function. Christensen (2009), nevertheless, maintains that each nursing intervention is a consultation.

The concept of "consultation" is vague. In medical science, consultation is described as when a patient visits a physician (Gude et al. 2007; Andén 2009). Considered from a broad perspective, consultation can be defined as a professional activity performed by a specialist, with one party a consultant with specialist knowledge, and the other a consultee who seeks the consultant's help for a current problem in which the consultant may have competency (Pearson 2019). According to Barron and White (2009), the concepts "consultation," "collaboration," "co-management," and "referral" must be considered separately. Co-management can be understood as an underlying concept for the other aforementioned concepts (consultation, collaboration, referral) (Hanson and Spross 2009):

- Consultation is an interaction between two professionals, where the consultant is considered an expert. An example of this is when an advanced practice nurse asks a physician for consultancy help or seeks advice from a physiotherapist part of the same treatment team. The person asking for consultancy help then receives expert help and can better solve the patient's problem.
- Collaboration can be understood as when, e.g., a midwife and an obstetrician jointly care for a pregnant woman during childbirth.
- Co-management is a process where one professional is responsible for a certain part of a patient's treatment, while another professional manages other aspects of the same patient's care.

- Referral describes a situation where a clinically responsible person refers a patient, thereby transferring responsibility for the patient's treatment, either temporarily or permanently and either the entire treatment or a part of the treatment, to another person or unit.
  (Adapted from Hanson and Spross 2009)

In the following section, a general description of the various forms that consultation can take is given, as well as the various functions associated with consultancy in advanced practice nursing.

7.4.1 Consultation in Its Various Forms

Consultation can be divided into three different types (Hansson and Spross 2009; Pearson 2019):

- Client-centered consultation. The primary goal is to help the person/consultee so that an effective treatment plan for a specific patient can be developed. In this type of consultation, the consultant often meets the patient to perform a proper assessment and make recommendations for further care and treatment.
- Consultee-centered consultation. The primary goal is to improve patient care, but emphasis is also placed on supporting or helping colleagues with their problems as linked to specific patients.
- Program-centered administrative consultation. Here emphasis is placed on the planning and administration of healthcare services.

7.4.2 Functions Associated with Consultancy in Advanced Practice Nursing

The functions associated with consultancy in advanced practice nursing are based on knowledge, skills, and belief/faith in own skills (Zwygart-Stauffacher 2010; Pearson 2019). Consultation in advanced practice nursing can be described as a sharing of knowledge and experience, where advanced practice nurses can inspire and motivate other colleagues to develop services and patient treatment. The consultancy role can include coaching of both colleagues and patients as a function.

According to the Canadian Nursing Association (2008), the ability to consult and collaborate with colleagues across disciplines and reorganize on the regional, national, and international levels is a particular characteristic of advanced practice nursing. Consultancy in advanced practice nursing is expressed through skills such as the ability to:

- Initiate an appropriate consultation at the correct time, refer, and collaborate with representatives from other professional groups in healthcare services.

- Consult and collaborate with treatment team members to develop quality and risk management strategies.
- Work with others to gather and synthesize qualitative and quantitative information on the factors that influence health, from many different sources.
- Engage in collaboration and build effective coalitions.
- Apply theories related to group dynamics, roles, and organizations.
- Demonstrate knowledge and skills in communication, negotiation, and problem-solving and be able to analyze and negotiate in conflicts.
- Clearly articulate the contributions advanced practice nursing has made to interdisciplinary treatment teams.
- Participate in collaborative projects with academic institutions and liaise with them.
- Advocate for changes in health policy by participating in regional, provincial, territorial, and federal committees that influence decision-making on those levels.
- Engage in colleague-centered administration with the goal to support and help colleagues, e.g., to achieve organizational service goals.
  (Adapted from CAN 2008)

Advanced practice nurse-physician consultation and advanced practice nurse-staff nurse consultation are common advanced practice nursing consultation situations (Pearson 2019). Consultation and collaboration with physicians and/or other healthcare team experts are often an integral part of an advanced practice nurse's interprofessional development. Both more-experienced and less-experienced advanced practice nurses may need to validate own assessments. Pearson (2019) highlights that truly collaborative relationships ensure that consultation is bidirectional. Advanced practice nurses often have specialty expertise in making lifestyle changes and certain health and illness issues, while physicians have expert competence in disease and treatment. The synthesis of both parties' expertise allows patients and patients' families to experience truly holistic, comprehensive, and individualized care. Advanced practice nurse-nurse staff consultation is often first introduced when an advanced practice nursing role is new: when trust needs to be established because staff nurses are unclear about what to expect of the new role. Over time, staff nurses learn to trust advanced practice nurses' competence and expertise and come to regard advanced practice nurses as resources and professionals who seek to improve their competence.

An advanced practice nurse can engage in consultancy services both within (internal to) and outside of (external to) his/her unit or organization. Advanced practice nurses usually engage in internal consultations first and then, as their competency develops, external consultations (Zwygart-Stauffacher 2010). As an advanced practice nurse's experience and competency grow, his/her consultees can include groups of patients, employees, or organizations. The importance of the consultant role is particularly evident in doctoral-level advanced practice nursing educational programs, in which third-level (bachelor's, master's, doctoral) advanced practice nursing competence is encompassed (Barron and White 2009).

The strength of a having an advanced practice nurse in an internal consultancy role is that, because he/she is "in-house," he/she will typically know how an

organization and its activities/services work. Zwygart-Stauffacher (2010) stresses the importance of advanced practice nurses as internal consultants in an organization in relation to questions. Colleagues' "use" of advanced competence is facilitated when they seek answers to particular questions/problems from advanced practice nurses, which in turn impacts patient treatment. The advantage of having internal consultants is that, because they work in the organization, they are always available, which facilitates, e.g., patient follow-up. That the advanced practice nurse enjoys his/her colleagues' confidence is necessary for him/her to engage in an internal consultancy role.

When advanced practice nurses act as external consultants, this benefits not only the organization/service that engages the advanced practice nurse but also that organization's/service's patients. Organizations can employ advanced practice nurses as external consultants to help with reorganization, quality development, or patient treatment (Zwygart-Stauffacher 2010).

The advanced clinical competence (both general and specific to own area) that advanced practice nurses have can be utilized more effectively than what it is today, both internal and external to an organization and in internal and external interprofessional collaborative work. Advanced practice nurses can be a tremendous resource in relation to the development of collaboration between community (primary) healthcare and specialty healthcare services. For example, a municipal home healthcare nurse can consult an advanced practice nurse whose specialist competence lies in, e.g., pain management for palliative cancer patients, which can help prevent unnecessary hospital admissions. Another example is having an advanced practice nurse available for a larger group of home healthcare service patients or service home patients. Even mobile advanced practice nursing services (where the advanced practice nurse travels to patients) can help prevent unnecessary hospital admissions and, most importantly, hinder the unnecessary suffering associated with unnecessary hospital admissions.

Zwygart-Stauffacher (2010) emphasizes the importance of self-awareness of own skills and expertise when acting as a consultant. Each advanced practice nurse should be aware of the domains in which he/she has competency and his/her ability to act as both an internal and external consultant.

The consultant function can also be understood as a leadership role, through which a person can exert power and influence. As such, one's ethical approach during consultations is important. When acting as a consultant, it is important to not impose own opinions, values, and assumptions on patients or colleagues, but instead take the other's dignity into consideration and show the other respect. When acting as a consultant on the organizational level, it is important to be aware of and take into consideration the organization's goals and strategies.

7.5 Competency Domain 5: Collaboration

Collaboration leads to better treatment outcomes. When collaboration is used, both patients and colleagues experience an increase in satisfaction regarding, e.g., treatment. Poor collaboration and non-existent collaboration are well-known healthcare

phenomena. Collaboration failings lead to both significant economic and social costs, and it is often ultimately patients who suffer when healthcare professionals cannot implement or realize collaboration in healthcare services.

In the section below, collaboration as a concept is delineated. The characteristics of effective and good collaboration are first described and then related to advanced practice nursing. The reasons underlying poor collaboration are also explored, as well as strategies for the realization of successful collaboration.

7.5.1 Definition of the Concept of Collaboration

The concept of "collaboration" is often associated with teamwork and partnership. In healthcare, good nursing and treatment are dependent on the sharing of a common objective for the patient care. Colleague's competence should be valued, and different professionals' skills and knowledge used, i.e., knowledge should be shared with others through collaboration between colleagues. Emanating from an analysis of literature on the subject and own experiences, Hanson and Spross (2009) developed a definition of the concept "collaboration," as follows:

> *Collaboration is a dynamic interprofessional process in which two or more health professionals make a commitment to interact authentically and constructively to solve problems and to learn from each other in order to accomplish identified goals, purposes or outcomes. The individuals recognize and articulate the shared values that make this commitment possible*. (Hanson and Spross 1996: 232).

One sees in Hanson and Spross' definition both the complexity of and the challenges inherent to the phenomenon. Collaboration even entails a mutual dependence on the other, through which the common objective is achieved. Yet collaboration must also include openness to differences in opinions and attitude. In the definition of collaboration seen here, one discerns the existence of the need for each person to act in a holistic and authentic manner, i.e., with all one's individual strengths, weaknesses, and feelings. In collaborative relationships, there is a sharing of power that enables opportunities for both personal and professional development and change.

Because collaboration involves the sharing of values and a commitment to these values, or each other, one can consider collaboration to be a process that develops and deepens over time. Collaboration can also be considered an expression of a person-centered attitude toward one's co-workers. Hanson and Spross (2009) emphasize authenticity, i.e., the authenticity of collaboration. This entails that those in the collaborative relationship must together be prepared to share both positive and negative feelings, e.g., in relation to clinical work. Well-functioning collaboration includes developing strategies whereby differences can be managed and processed, which can be equated to true acceptance of differences and diversity.

The terms multidisciplinary, interdisciplinary, and transdisciplinary collaboration are often used to describe the collaboration that occurs between different disciplines (Hanson and Spross 2009). The prevailing philosophy in a multidisciplinary

team should be that each discipline's contribution to the whole is accepted. In an interdisciplinary team, team members are willing to share the responsibility for a patient's nursing, care, and treatment. In a transdisciplinary team, collaboration has evolved into a willingness to share and learn from each other, including the other's manner of practice.

Transdisciplinary team members work "across" professional boundaries to plan and realize a patient's nursing, care, and treatment. According to Hanson and Spross (2009), advanced practice nurses have good capacity for transdisciplinary collaboration. Advanced practice nurses can inspire and help other team members work "across" professional boundaries, and transdisciplinary teamwork promotes and develops new understanding and insights. This type of collaboration consequently leads to new innovations in the "borders" where the different knowledge inherent to the different disciplines involved meets.

7.5.2 The Characteristics of Effective and Good Collaboration

Collaboration entails committing to engaging in a patient care that transcends the individual perspective. Collaboration involves a synergistic alliance and cohesion that maximizes each person's contribution so that a whole is created (Evans 1994). According to Hughes and Mackenzie (1990), there are four prerequisites for effective collaboration between advanced practice nurses and physicians: collegiality, communication, goal sharing, and task interdependence. In addition to common goals and effective communication, diverse and complimentary professional knowledge and skills are important in interprofessional collaboration.

Collaboration requires clinical competence, a clear professional identity, common goals, and effective interpersonal and communicative skills, or at the very least a willingness to develop these and improve one's ability with these. While trust, mutual respect, and appreciation of the other's knowledge and skills are important, these take time to develop (Hanson and Spross 2009).

Often, advanced practice nurses must highlight their clinical competence when in collaborative relationships with physicians, so that physicians have confidence in the advanced practice nurses as partners. Traditionally, nurses have held little authority and limited responsibility for patient outcomes (Larson 1999). When both partners can rely on the other's clinical competence, mutual trust and respect are developed. Good advanced practice nurse-physician collaboration is characterized by the following: mutual understanding and respect, understanding and acceptance of the other's discipline, positive self-image, professional maturity arising from education and experience, acknowledgment that the partners cannot replace one another, and the willingness to negotiate (Steels 1986). Researchers have also shown that well-functioning nurse-physician collaboration is characterized by shared decision-making, good communication, the ability to plan together, and the coordination of work (Baggs 1989; Baggs and Smith 1997).

Carter et al. (2019: 292) described the following essential characteristics of collaboration in advanced practice nursing:

- Clinical competence and accountability.
- Common purpose.
- Interpersonal competence and effective communication.
- Trust.
- Mutual respect.
- Recognition and valuing of diverse, complementary knowledge, and skills.
- Humor.

In the development of common goals for collaboration around patients, the goals that an organization or unit has or delineates could be a good starting point (Hanson and Spross 2009). For example, this could include the quality improvement of the treatment provided to a vulnerable patient group or effective collaboration between various professional groups. In such processes, leaders can "show the way" and indicate the direction that should be taken. This can occur through communicating in an open, clear, and assured manner, both orally and in writing. It should be noted that one's ability to communicate openly and clearly should not only be demonstrated with one's own team or collaborative partners but above all with the patient and the patient's family (Hanson et al. 1994).

7.5.3 Collaboration as a Part of Advanced Practice Nursing

An advanced practice nurse collaborates in several different ways: with various individuals, professional groups, work groups, treatment teams, and organizations (Hanson and Spross 2009). Collaboration is a key competence for advanced practice nursing and requires good interpersonal communication skills.

The ability to collaborate is invaluable in direct clinical practice and ethical decision-making. For example, a well-functioning relationship between a nurse and a patient with diabetes is contingent on effective collaboration concerning the desired treatment outcomes. The nurse-patient relationship can be described as a partnership and a collaboration, where the advanced practice nurse seeks to understand what the patient desires, how the patient wants his/her treatment to be realized, and in what manner the patient wishes to collaborate with the advanced practice nurse. Continuing with the aforementioned example, an advanced practice nurse who is responsible for diabetes patients not only collaborates with the physicians part of the organization's diabetes team, but can also, as needed, consult and collaborate with, e.g., a wound nurse or cardiologist, before making specific treatment recommendations. Advanced practice nurses often themselves work in teams and are often included in treatment teams. International experiences of the advanced practice nursing role indicate that advanced practice nurses frequently have a central role in the development of teamwork and can even often have a leading role. Because one's ability to collaborate develops through more experience, advanced practice nurses have the unique opportunity and skills needed to lead interdisciplinary teams.

An advanced practice nurse with specialty patient-group-related competence (e.g., HIV patients) can be a resource for an organizational-level work group in the development of guidelines for nursing, care, and treatment for the relevant patient group.

Collaboration on the global level is a domain that has become increasingly common. Since the turn of the twenty-first century, new experiences around the management and organization of measures used to prevent the spread of infectious diseases have been gained: effective, global collaboration around such is needed. Collaboration between colleagues spread across the world requires a good willingness to collaborate and an understanding of cultural differences.

7.5.4 Reasons Underlying Lack of Collaboration

There are relatively few studies in which researchers have investigated the effect that collaboration or lack of collaboration has on advanced practice nursing. A clear indication that effective collaboration between different healthcare professional groups exists is that patients can easily move between professional groups as part of their care pathway (Hanson and Spross 2009). A lack of collaboration can lead to patients not receiving the nursing, care, and treatment that they need. Poor collaboration can also lead to reduced workplace satisfaction (Aiken et al. 1994).

In many cases, a lack of communication underlies an absence of collaboration. Patients assume that various healthcare professional groups collaborate and cooperate with one another, but unfortunately this is not always the case. In investigations of patient complaints, a lack of communication or collaboration is often seen to be the reason underlying the complaint.

A lot of the discussion surrounding this topic has historically been focused on the physician-nurse relationship, because there have traditionally been strong tensions between these professional groups. One source of conflict is the different scientific perspectives that physicians and nurses assimilate, i.e., the natural science versus the humanities paradigm. The fundamental structure for large parts of most healthcare systems—care for the patient, which is the core of nursing—is not rewarded. Therefore, that which an advanced practice nurse can contribute is also not valued, while the activities and outcomes linked to medicine (the medical model) are to a greater extent rewarded (Krejci and Malin 2010). Such disparity can create divisions and competition, especially between advanced practice nurses and physicians.

To unilaterally focus discussion on the physician-nurse relationship is to simplify the problem. Interprofessional, interdisciplinary collaboration between nurses and other professional groups is also of great importance, as well as collaboration within nursing groups or with other actors outside of one's own organization.

Barriers between professionals and disciplines have been shown to hinder the development of interprofessional collaboration. That each healthcare professional group has its own culture, with its own values, skills, rules, and norms, is a limiting factor (Reuben et al. 2004). For example, in the medical tradition, there is a strong

emphasis on values that dictate that those in the profession have the right to decision-making linked to medical issues.

Sociocultural aspects also influence collaboration. The nursing profession has traditionally been, and still is, a profession where most of the professionals are female. The gender aspect is of great importance to the development of collaboration in healthcare. Advanced practice nurses are seen to challenge traditional sociocultural values when they are given more independent roles and functions and the expanded right to make clinical decisions.

After several years of investigation on the development of new advanced practice nursing roles in the Netherlands, researchers found that even though collaboration in modern complex healthcare systems is crucial, it is still very difficult to achieve (Roodbol 2010). Researchers have seen that social identity is one of the main problems underlying such difficulties, for both physicians and nurses. In social identity theory, a group is usually defined as a collection of individuals who share certain characteristics, interact with one another, accept expectations and obligations as group members, and share a common identity. Professionals in one group may be afraid to lose their status when they collaborate with professionals from a different group with a (perceived) lower status, and it can be difficult to combine individuals from different professional groups in a team. Furthermore, professionals from the same group can "hide behind" the group, thus making collaboration optional.

Group social identity is linked to questions such as "Who am I?", "Who am I in relation to others?", and "What do I have in common with others and how am I different?" (Roodbol 2010). Social identity can be changed when one seeks to become a member of another group with a higher status or an entire group can also attempt to change their status. Researchers have seen that neither multiprofessional education nor multidisciplinary training for medical and nursing students is enough to stimulate collaboration (Roodbol 2010). While multidisciplinary training can stimulate collaboration, the aforementioned issues of group social identity are a hinder. To stimulate collaboration, a common purpose is needed: for example, care quality or tangible patient outcomes (e.g., reduction in mortality). Joint educational programs have also been seen to stimulate collaboration. The objective of any such measures should be that individuals no longer derive their status from their professional group, but that instead the team (composed of those that they are collaborating with) should become the new source of their identity and/or status.

Today, an individual's collaborative skills are even "tested" in administrative and economic support functions. Researchers have seen that in collaborative work, nurses collaborate by accommodating their colleagues (Krejci and Malin 2010). Accommodating is also used in this way to negotiate different solutions. Researchers also find that this is a learned behavior for many women (Valentine 2001). Through application of the Thomas-Kilmann Conflict Mode Instrument, through which five conflict-handling strategies can be measured (avoiding, compromising,

collaborating, accommodating, competing), researchers saw that nurses often believe that accommodating leads to better patient treatment and good solutions, at least in the short term. Yet there are also negative aspects to accommodating. For example, when a reduction in healthcare costs is sought or needed, nurses often willingly volunteer to engage in economic solutions that negatively impact them as a group. As a professional group, nurses tend to accommodate instead of "arguing for" their group and, thereby, patients' right to good nursing. Such a tendency must be understood in light of the gender perspective.

7.5.5 Strategies for Successful Collaboration

A possible strategy whereby interprofessional collaboration can be developed is to advocate that collaboration between professional groups contributes to the development of care. Both quality development projects and projects in which guidelines for the nursing and treatment of different patient group are developed are often interdisciplinary. Such interdisciplinary projects can have a positive effect on interprofessional collaboration.

Researchers have found that interdependence, rather than independence, can be indicative of a higher level of performance (Carter et al. 2019). Advanced practice nurses, who have competence and confidence in own clinical expertise, are able to move beyond autonomy and toward a higher level of collaboration. For example, working as an advanced practice nurse with advanced diabetes management often involves interprofessional collaboration with other experts and teams, i.e., the sharing of interprofessional competency. Researchers have seen that an assessment of own personal characteristics can help individuals better understand their capacity for collaboration (Rider 2002). Regarding collaboration as an advanced practice nurse, the following list of questions can improve awareness of own strengths and weaknesses:

- Am I clear about my role in partnership?
- What values do I bring to the relationship?
- What do I expect to gain or lose by collaborating?
- What do others expect from me?
- Do I feel good, self-confident, and competent in the collaborative relationship?
- Are there anxieties causing repeated friction that have not been addressed?
- Has serious thought been given to the boundaries of the collaborative relationship?
  (Adapted from Rider 2002)

Rider (2002) delineated 12 strategies for effective communication and collaboration in medical teams. Hanson and Spross (2009) and Carter et al. (2019) further developed these as part of their research (see Table 7.4).

Table 7.4 Practical strategies to promote effective communication and collaboration (Carter et al. 2019: 306)

- Be respectful and professional
- Listen intently
- Try to understand the other person's viewpoint before expressing your opinion
- Model an attitude of collaboration, and expect it
- Identify the bottom line
- Decide what is negotiable and non-negotiable
- Acknowledge the other person's thoughts and feelings
- Pay attention to own ideas and what you have to offer to the group
- Be cooperative without losing integrity
- Be direct
- Identify common, shared goals, and concerns
- State your feelings using "I" statements
- Do not take things personally
- Learn to say "I was wrong" or "You could be right"
- Do not feel pressure to agree instantly
- Think about possible solutions before meeting, and be willing to adapt if a more creative alternative is presented
- Think of conflict negotiation and resolution as a helical process, not a linear one; recognize that negotiation may occur over several interactions

7.6 Competency Domain 6: Case Management

Case management is a concept used to facilitate communication on the term on the international level (Malm 2002). Case management as a competency domain overlaps other competency domains, e.g., collaboration, consultation, and research. Case management is often collaborative and can even be considered an evidence-based approach (cf. Nilsson and Malm 2002). Case management can be described as the management of patient pathways and continuous patient follow-up. The process is based on collaboration and interaction, and it is used to promote both care quality and cost efficiency outcomes for specified patients and groups (Coffman 2001). A general description of the concept is first given in the section immediately below, followed by a description of the advanced practice nurse as case manager and a presentation of various models of care management as seen in healthcare.

7.6.1 Case Management as a Concept

Case management is an ambiguous term. Case management can be described as the management of patient pathways and continuous patient follow-up. Case managers can also provide clinical services and are especially used in connection with certain patient groups, namely, patients with a need for long-term, complex nursing, treatment, and follow-up. A concept often used in combination with case management is "care pathway." The term "care pathway" is used to describe the activities (diagnosis, care, nursing, treatment) that a patient with a particular disease or condition undergoes in the meeting with different care actors during a certain time period. This can

include, e.g., a patient's first visit to a medical professional, referral to an outpatient clinic, admission to and discharge from the hospital, continued rehabilitation, a new visit to the outpatient clinic, continued nursing and treatment through home healthcare services, etc. The care pathway continues until the patient is cured or the treatment is finished. For those with chronic conditions, the care pathway can be defined or demarcated, e.g., a period between 1 and 2 years. The European Pathway Association (European Pathway Association, Slovenia Board Meeting 2005) defines care pathways as "a complex intervention for the mutual decision-making and organization of care processes for a well-defined group of patients during a well-defined period." According to the Belgian Dutch Clinical Pathway Network (Netwerk Klinische Paden 2000), the term clinical pathway can be defined as a process whereby a patient's clinical care is controlled, with the aim to improve clinical outcomes. They recommend a switch to the term "treatment pathway," which they maintain better encompasses the broader consensus and definition of the concept.

Case management as a function can be described as a coordinating role used to help patients with chronic diseases get the care and services they need, when they most need them and for as long as they want them (Nilsson and Malm 2002). Teamwork with a patient and his/her social network as well as the patient's right to effective nursing, care, and treatment are emphasized in case management. A case manager should act emanating from the patient's individual goals. A case manager should act as an ambassador, a pathfinder, a personal representative, and a coordinator of community healthcare services, but he/she must also be capable of a therapeutic role as required (Ohlsson 2002). The development of case management and the case manager role has emerged from the clear need to coordinate community resources for various patient groups.

7.6.2 Advanced Practice Nurses as Case Managers

Some researchers find that the more advanced practice nurses assume active leadership in healthcare systems, the more important their role as case manager becomes (Zwygart-Stauffacher 2010). Advanced practice nurses have the skills needed to manage complex patient cases and patient groups with complex and long-lasting treatment processes.

Hallberg (2002) maintains that nurses have a central role as case managers with, e.g., people with mental disabilities. The nurse's role is to focus on the patient's ability to manage daily life and those activities included in daily life. Hallberg interprets daily life as perspectives on the physical, practical, psychological, social, economic, and existential elements in a person's life. Nurses should perform a systematic evaluation of the patient's ability to manage his/her daily life emanating from these various perspectives. Hallberg even argues that it is not the disease or illness itself that is determinative to the context of nursing, but the requirements that a patient has in his/her daily life.

Advanced practice nurses should focus on strengthening the patient's ability to manage his/her life, including living in harmony with the surrounding world. As

case managers, advanced practice nurses have an important role as coordinator for various healthcare services, between various services/institutions and authorities. Advanced practice nurses act as representatives for their patients and ensure that the interventions and measures necessary for the promotion of desired development are undertaken. Nursing and care plans and treatment objectives that are determined together with the patient are important tools that can be used during the case management process.

Including the patient's family in the patient's situation is an important part of case management. Treatment outcomes can be improved if patients' families are given an active role in the patient's nursing and treatment. There is strong scientific evidence that access to social support is highly important to how well the entire treatment process succeeds. Through his/her social network, a patient can receive emotional or even practical support. Advanced practice nurses as case managers have both the knowledge and skills to work with the patient, the patient's family, other services/institutions, as well as authorities, all with the objective to support the patient's ability to maintain an acceptable and good daily life.

The recommendation that advanced practice nurses should have a role as case managers is made by several nursing researchers (Benoit 1996; Taylor 1999; Donagrandi and Eddy 2000; Jansen and Zwygart-Stauffacher 2010). Advanced practice nurses have the competency to act as coordinators between various professional groups and professions, engage in critical thinking, engage in clinical decision-making processes on an advanced level, and have full autonomy over their role. For various economic and practical reasons, other nurses can assist advanced practice nurses in their role—but it is the advanced practice nurse who always bears the responsibility. In the case management role, the objective of advanced practice nursing should be to promote patient health and prevent disease.

7.6.3 Case Management Models in Advanced Practice Nursing

Taylor (1999) initially described two different case management models: the patient-focused model and the system-focused model. In the patient-focused model, focus is placed on supporting the patient during the entire continuum of care. Thanks to continuous support, the patient's access to healthcare services and treatment is improved. In the system-focused model, focus is placed on the context of services and treatment. Services and treatment in that model are structured and organized to secure the most cost-effective outcomes. In Taylor's expanded case management model, cultural competence as an important factor in the patient care pathway is also emphasized.

Despite the development of standardized patient pathways, advanced practice nurses should place a focus on strengthening and empowering each individual patient. The strong emphasis on standardization seen in healthcare systems throughout the world today has led to a discussion on the ethical aspects of case management. Advanced practice nurses are responsible for defending their patients' interests (Donagrandi and Eddy 2000). The economic interests that steer healthcare

services in a society are not always in line with a patient's wishes. An example of this is the length of hospital stays today, which in many countries has grown shorter and shorter. The advanced practice nurse's fundamental attitude can be tested in such situations, and ethical decision-making can become difficult when the patient's interests conflict with recognized standards.

Case management as a competency domain in advanced practice nursing has been given a slightly different meaning in the British model of advanced practice nursing as presented in Hinchliff and Rodger's "Competencies for Advanced Practice Nursing" (2008). There, the case management role falls under two different domains: managing and negotiating healthcare delivery systems and monitoring and ensuring the quality of healthcare practice (Barton 2008; Whiteing 2008).

Advanced practice nurses have the capacity to understand and use various sources of information, e.g., databases and other forms of information technology (IT), which means they have a good capacity for analyzing or even changing work methods. Advanced practice nurses apply national directives and guidelines during the planning and realization of the overall treatment process. Advanced practice nurses need good interpersonal skills to "negotiate" with other healthcare staff and colleagues. Advanced practice nurses should also have competency in planning, developing, and realizing various health programs and guidelines in relation to various patient groups. Advanced practice nurses are expected to have the ability and willingness to contribute to patients' improved access to nursing, care, and treatment: especially for underprivileged or vulnerable groups, such as patients with dementia.

7.7 Competency Domain 7: Research and Development

In important competency domain, advanced practice nurses must have the capacity and skills to engage in research and professional development. Such competency is becoming ever more important in healthcare systems, because evidence-based practice, the implementation of research results and patient safety still need to be improved and developed. Advanced practice nurses are both clinical practice leaders and directly influence care quality through own clinical practice (DeBourgh 2001).

Advanced practice nurses are responsible for actively leading change. They must therefore develop their capacity for research and development: in own work, in own specialist area, and on the organizational and systems levels. Advanced practice nurses are responsible for promoting evidence-based practice and, in a goal-oriented manner, leading the development of such practice (DeBourgh 2001; Whiteing 2008; DePalma 2009; Gray 2019). Today, understanding research, utilizing data, and participating in research are all integrated parts of both advanced practice nursing educational programs and expected educational outcomes for graduates (Schober 2016). The time between new knowledge being developed and its implementation in healthcare is too long. Advanced practice nurses can reduce this time by contributing to a workplace environment that values evidence-based practice. Clinical leadership in this area requires clear, organizational support (DePalma 2009).

Quality development is another trend that can be considered an impetus for the need to develop advanced practice nurses' competency in research and development. Various models and methods are used when realizing systematic quality work. A common feature for the development of quality is that interprofessional engagement and leadership are needed for development to occur. Advanced practice nurses, with their solid work experience and expertise in own field, who moreover hold master's degrees, can be a resource for driving quality and systematic quality work. Advanced practice nurses' deeper theoretical knowledge and clinical skills can positively contribute to both the development of evidence-based practice and patient safety.

According to DePalma (2009), advanced practice nurses' research competence can be divided into three different dimensions:

- Interpretation and use of research results and other knowledge for clinical decision-making.
- Evaluation of practice.
- Participation in various research projects.

These competencies can be expressed on a generalist or more expanded level. Research competency on the generalist level is expressed in clinical decisions for the individual patient, while research competency on the more expanded level is shown more generally, e.g., through the development of treatment programs or other activities on the organizational level (DePalma 2009).

In the sections below, three different dimensions of research and development as part of advanced practice nurses' core competency are described in more detail: evidence-based practice, the evaluation of advanced practice nursing practice, and participation in research and development.

7.7.1 Evidence-Based Practice

Advanced practice nurses' care and treatment can be said to be characterized by an evidence-based approach to practice, because their clinical decisions should be based on the best and most current scientific evidence. According to Gray (2019), advanced practice nurses' evidence-based practice occurs on three levels: (1) use of research results and evidence in own clinical practice, (2) use of research results and evidence to change practice, and (3) use of research results and evidence to evaluate practice. The clinical expert uses knowledge in a certain way, aimed toward the patient and the patient's families' individual needs (Sackett et al. 2000). DePalma (2009) states that advanced practice nurses can promote evidence-based practice by:

- Promoting values and the usefulness of research-based knowledge in clinical decision-making.
- Recommending reliable sources of information.
- Demonstrating how evidence-based practice can be useful in direct clinical nursing practice and in clinical consultations.

- Exercising leadership on the systems level to contribute to change, especially with the view to reduce obstacles and resistance to change.
- Encouraging organizational changes by promoting evidence-based practice in the actual context.

The first step in the interpretation and use of research results and other knowledge in clinical decision-making to is clarify and define the clinical problem as seen in practice. This is followed by a systematic search for new research on the relevant problem. Thereafter the evaluation of the evidence and the research findings' reliability are undertaken. This includes an awareness of and critical approach on various levels toward the research quality of the evidence and research findings included. This is then followed by a systematic synthesis of the evidence and research. A well-performed synthesis results in a recommendation for clinical practice, which thereafter can be implemented and evaluated (DePalma 2009).

7.7.2 Evaluation of Advanced Practice Nursing Practice

The evaluation of advanced practice nursing practice is essential. Only those advanced practice nursing models and roles that both have a positive effect on patient treatment and are cost-effective are worth maintaining and continuing. Advanced practice nursing's influence on clinical outcomes and nursing and treatment quality have been evaluated in several contexts, e.g., home healthcare (Neff et al. 2003); tertiary nursing and treatment (Derengowski et al. 2000); specific patient groups, e.g., cancer patients (Cunningham 2004); or hospital-based clinics for, e.g., cardiac patients (Crowther 2003). It is important to demonstrate to the general public, decision-makers, and politicians that the care and treatment that advanced practice nurses provide is the best care and treatment and that advanced practice nurses make a difference to both nursing quality and cost efficiency (DePalma 2009).

To evaluate advanced practice nurses' clinical practice, it is necessary to describe the fundamental aspects of clinical practice that are determinative to its evaluation. An evaluation should, if possible, include quality aspects, access to healthcare services and economic aspects (DePalma 2009). The following areas can be included in the evaluation:

- Level of practice and type, as well as competence needed to maintain practice.
- Evidence-based guidelines and national quality indicators.
- Internal descriptions of advanced practice nurses' roles and tasks.
- Objectives of treatment/care programs.

The dimension of quality can be evaluated emanating from the areas listed above and in relation to the desired outcomes for a patient group, e.g., fewer complications, fewer readmissions, better self-care, and better patient satisfaction (DePalma

2009). Access to care, nursing, and treatment is also important, especially for vulnerable groups; access for such groups has previously been poor.

Internal descriptions of advanced practice nurses' roles and tasks, i.e., work-role descriptions, or programs for treatment objectives are also possible starting points for evaluation. The economic dimension can be evaluated through a focus on costs, cost efficiency, and the effect of overuse, under-use, or misuse of healthcare services (DePalma 2009). Through analysis of cost efficiency, it is possible to reveal a reduction in length of treatment (seen as time), complications, or readmission. Annual cost analyses of advanced practice nurse-led clinics should be undertaken (Vincent 2002).

7.7.3 Participation in Research and Development

The third dimension of research and development as part of advanced practice nurses' core competency is participation in research and development projects (nursing and interdisciplinary), e.g., seeking to promote understanding of clinical phenomena and investigating different nursing interventions or specific clinical problems (DePalma 2009). Advanced practice nurses can contribute to the investigation of relevant research questions from a clinical perspective. Advanced practice nurses can also participate by choosing to investigate nursing-sensitive quality and outcome indicators, e.g., pressure sores, infections, falls, or nutrition. Such helps influence the direction of research and ensures that research results are clinically relevant and can be used (Polit and Beck 2008). There are two areas that are especially important in relation to advanced practice nursing research (Clochesy 2002; Jastremski 2002). The first is research that produces knowledge of new actions/interventions that can be used as guidelines for evidence-based clinical practice. The second is research related to outcomes: investigation of the quality of advanced practice nursing and treatment or validation of the various advanced practice nursing roles. Advanced practice nurses should have fundamental knowledge of, e.g., research paradigms, research designs, the various phases of qualitative and quantitative research, and research methods. Such fundamental knowledge gives advanced practice nurses the capacity to participate in research and development projects, e.g., data collection. Through participation in various networks, advanced practice nurses can develop their competence in research and development.

7.8 Competency Domain 8: Leadership

Krejci and Malin (2010) find that because advanced practice nurses develop the ability to lead in the environments and systems they practice in, advanced practice nurses can make the difference between chaos and quality in today's complex healthcare systems. Healthcare is strictly regulated, even to the extent that has become fragmented. As such both healthcare systems themselves and the organizations within have become large and complex. The increased need for nursing and

care as well as the development of healthcare technology, pharmacology, and new treatment methods, combined with healthcare organizations' complexity, has created strong competition for resources. All these place great demands on representatives for advanced practice nursing.

Emanating from nursing literature and research, one sees that advanced practice nurses' possibilities to step into leadership roles can be hindered by an organization's hierarchal structure. Such continues even after decades of advanced practice nursing role development (O'Neil et al. 2008; Krejci and Malin 2010). To develop new advanced practice nursing functions and roles, active support from leaders is needed. Advanced practice nurses have a great responsibility to not only provide high-quality, safe, evidence-based nursing and care but also actively influence and lead the development of healthcare services.

In the sections below, a brief overview of the historical factors that have influenced nurses' position in healthcare is presented. This is followed by a presentation of advanced practice nurses as leaders, including clinical leadership, professional leadership, leadership on the systems level, and health policy leadership. Thereafter, the characteristics of leadership competency in advanced practice nursing, personal characteristics for advanced practice nursing leaders, barriers to the development of leadership on the advanced level, strategies for developing leadership characteristics, and prerequisites for advanced practice nurses' leadership are presented.

7.8.1 Historical Factors That Have Influenced Nurses' Position in Healthcare

Understanding of the historical context of nursing and the factors that have influenced nurses' past and current position in healthcare systems can help direct the future development of advanced practice nursing. Krejci and Malin (2010) find that especially two factors have influenced the development of nursing as a profession and in what manner the profession has articulated and "lived out" its philosophy and values. Note that nursing's position of power can ultimately be considered to be more about nurses' lack of power.

Historically speaking, how work is perceived and organized in industry/manufacturing has influenced the manner in which work related to healthcare has developed. The organization of healthcare services historically can be considered to have been characterized by Taylorism,[1] with the resulting view of healthcare institutions as a type of *industrial factory characterized by a "conveyor belt" model*. Such a bureaucratic model has been dominant and has led to the separation of employees (healthcare staff), with one group being responsible for "thinking," i.e., decision-making, and the other group being responsible for "doing," i.e., realizing the decisions that the first group makes. In accordance with Mintzberg's (1983) theory of organizational structures, nurses can be placed into the second group and defined as

[1] In the late nineteenth century, Frederick Taylor began to develop a theory of or perspective on management in which a scientific approach to management is employed.

"doers," while physicians can be placed into either group. The gender aspect of nursing has also greatly influenced its development. Throughout history, nurses have primarily been female, while the opposite has been true in medicine, which at least previously has been dominated by males (Krejci and Malin 2010).

According to Reverby (2001), nurses have always steadfastly held on to their professional nursing values, philosophy, and vision, which has been rooted in a care-inspired theoretical framework. Investigating the differences between the nursing and medical professions, Reverby argues that because of their steadfastness to their values, etc., nurses have focused on their duty to show care rather than the right to provide treatment. Physicians, however, have understood that to fulfill their duty to treat, a focus on the right to provide treatment has been needed. To secure their right to provide treatment, physicians have (among other measures) sought to protect the economic frameworks, hierarchal structures, and ability to influence decision-making that has traditionally characterized healthcare. Note that the maintenance of physicians' hierarchal position has not been dependent on their contributions to the clinical treatment of patients; it has instead been more of a political positioning.

For nurses, "power" is a term that can elicit negative reactions. For many nurses, the word power is associated with militarism, violence, or hierarchy (Krejci and Malin 1997). Researchers have seen that few nurses are especially concerned with power but that nurses nonetheless do not wish to be powerless. Such an ambivalent attitude to power can create a dilemma for advanced practice nurses, who through their new advanced role should have more influence and authority and in a different way than in their previous role. For many advanced practice nurses, clinical competence and holistic care are the most essential and crucial. However, according to Krejci and Malin (2010), these areas of focus are insufficient, unless advanced practice nurses also develop their ability to lead and influence.

7.8.2 Advanced Practice Nurses as Leaders

Advanced practice nurses can exert their leadership influence in far-reaching ways, from bedside to the highest political level (Carter and Read 2019). Power and influence based on expert competence are important, but advanced practice nurses can also develop a basis for power by advocating for patients' needs (Krejci and Malin 2010). A common strategy used by nurses is to focus on various forms of collaboration. When negotiating, nurses often adapt instead of seeking a new "path" to the solving of a situation (Valentine 2001). To understand a system and be able to lead so as to influence the system, it is important that advanced practice nurses develop their negotiating skills. Furthermore, the advanced practice nursing role is often a group leader function.

In the new International Council of Nurses' (2020) guidelines on advanced practice nursing, advanced practice nurses are considered to have the ability to integrate research (evidence-informed practice), education, leadership, and clinical management. In the list of characteristics ascribed to advanced practice nurses by the Canadian Nurses Association, leadership is mentioned last (Canadian Nurses

Association 2019). Advanced practice nurses have a leadership role in the organizations and contexts they work in. They also act as a driver for change and seek new, effective ways to practice. This is about improving healthcare services, transforming organizations, influencing healthcare policy, and being of benefit to the general public (Canadian Nurses Association 2008).

In the International Council of Nurses' (2020) new guidelines, clinical nurse specialists are seen to function as "expert clinicians in a specialty and are leaders in advancing nursing practice by teaching, mentoring, consulting and ensuring nursing practice is evidence-based/evidence-informed" (ICN 2020: 13). Clinical nurse specialists provide both direct and indirect care. Direct care encompasses direct interaction with patients, families, and patient groups, and the objective is to promote health or well-being and improve quality of life. Indirect care encompasses activities that influence patient care but do not involve direct patient interaction. Leadership is included in indirect care, in relation to developing evidence-based/evidence-informed guidelines or protocols for care and staff development activities. Of the areas listed under indirect care, two out of five are clearly leadership tasks. These include that a clinical nurse specialist should: "provide leadership in appropriate use of research/evidence in practice innovations to improve healthcare services" and "serves as a leader of multidisciplinary groups in designing and implementing alternative solutions to patient care issues across the continuum of care" (ICN 2020). The focus of nurse practitioners' practice is on direct clinical care but also includes the integration of education, research, and leadership (ICN 2020). One sees that leadership is also a clear part of nurse practitioners' duties. Still, in comparison to clinical nurse specialist roles, it is noted that in many nurse practitioner roles, time for leadership may be lacking.

In a review of research on advanced practice nursing leadership in Canada (Bryant-Lukosius et al. 2020), researchers concluded that the leadership role is an important activity both for clinical nurse specialists and nurse practitioners. They saw that both clinical nurse specialists and nurse practitioners spent significantly more time on professional leadership than specialized nurses, e.g., disseminating nursing knowledge, providing consultations for organizations, and representing nurses at patient education (Bryant-Lukosius et al. 2018). In one of the studies included in that review, Canadian clinical nurse specialists reported spending about 18% of their work time on organizational leadership (Kilpatrick et al. 2013).

According to Spross and Hanson (2009), leadership as a core competency in advanced practice nursing can be divided into four areas: clinical leadership, professional leadership, leadership on the systems level, and health policy leadership. Below, follow the brief descriptions of these.

7.8.2.1 Clinical Leadership

While it may not feel "natural" that all advanced practice nurses must be leaders, according to Spross and Hanson (2009), leadership is not an optional activity in advanced practice nursing. In clinical leadership, attention is primarily given to the patient and his/her health needs and on ensuring good-quality nursing care and treatment. The most common tasks in clinical leadership are patient-related, e.g., planning the patient's nursing and treatment; speaking with patients, patients'

families, colleagues, or other healthcare staff; and acting as a group leader or system leader. Advanced practice nurses as clinical leaders also act as role models and mentors who support and strengthen both patients and colleagues (Bally 2007). With the aim to influence others, participating and initiating research, writing articles, and giving presentations on clinical issues are other ways that advanced practice nurses can practice leadership (Engebretson and Wardell 1997).

7.8.2.2 Professional Leadership

A good ability to work with one's colleagues is of great importance in professional leadership. This even includes recognizing and being able to perceive when a colleague needs support in the form of guidance or empowerment (Spross and Hanson 2009). Professional leadership can also be practiced through the active participation in and leading of professional networks, e.g., colleagues in the same clinical area or others who work with the same type of activities. Professional leadership can start on the local level and be further developed until it is practiced on the national or international levels.

7.8.2.3 Leadership on the Systems Level

Leadership as part of advanced practice competency is also about leading an organization or leading on the systems level. Through leadership, advanced practice nurses can influence organizational structures and systems that are of importance to patient nursing and treatment processes (Spross and Hanson 2009). For example, advanced practice nurses can help improve patient outcomes in an organization by investigating the reasons behind an increase in falls or infections on a unit. Being able to contribute to the reorganization of healthcare services, so that a system can better meet patients' needs and desires, is an important leadership role.

7.8.2.4 Health Policy Leadership

Relatively few advanced practice nurses appear to express interest in influencing issues on the political level. The introduction of the advanced practice nursing function involves the restructuring of how patient care is organized, and this even includes the redistribution of resources, something that is led by policy decisions. Advanced practice nurses' ability to influence on the healthy policy level, through their knowledge and experience, is therefore of importance. An important area that requires advanced practice nurses' engagement and leadership is the alteration of laws and regulations, which the goal-oriented introduction of advanced practice nursing requires.

7.8.3 The Characteristics of Leadership Competency in Advanced Practice Nursing

According to Spross and Hanson (2009), there are especially three characteristics that define advanced practice nursing leadership:

- Guidance and empowerment.
- Innovation and the ability to implement change.
- Concrete activities.

Being a mentor involves helping others grow and encouraging others to realize themselves. By acting as a role model, advanced practice nurses can help others with less experience achieve the same level of competency (Fawcett 2002). Competent leaders show their concern for others by being interested in the others' success and well-being. Mentors can build bridges between education and experience and can guide others by taking unexperienced individuals "under their wings" (Barker 2006; Spross and Hanson 2009). Guidance can be either formal or informal. Formal guidance is typically based on a mentorship contract and formally supported in an organization. Guidance between a physician and an advanced practice nursing student as part of clinical educational practice can also be considered formal guidance. Informal guidance is more unstructured and is a mutual and self-selected relationship that often lasts longer than a formal guidance relationship (Tourigny and Pulich 2005). According to Bally (2007), there is a link between concepts such as "mentorship," "organizational culture," and "leadership." A positive organizational culture gives social support and a feeling of well-being, which helps nurture mentorship. Advanced practice nurses act as leaders by:

- Advocating for individuals, families, groups, and society regarding treatment, healthcare systems, and political decisions that influence health and life quality.
- Identifying nurses' and other group members' training/educational needs or developing programs and resources to meet these needs.
- Acting as a mentor and coaching nursing colleagues, other group members, and nursing students.
- Working in a goal-oriented manner to promote the importance of access to healthcare services for all and advanced clinical nursing for other nursing colleagues and healthcare staff, decision-makers, politicians, and the general public.
- Contributing to an organizational culture that supports professional development, life-long learning, and collaboration in practice.
- Evaluating organizational and societal programs and developing innovative approaches to complex problems.
- Understanding and integrating principles on resource allocation and cost efficiency in organizations and systems-level decision-making.

Hierarchal structures in bureaucratic organizations are usually stable. According to Weber (1987), it is easier to remove hierarchical systems than change them if those in power are not motivated to relinquish their power or if those without power do not have sufficient influence to gain more power.

Advanced practice nurses empower others by using their influence with other nurses, colleagues, and patients to help them find and use their own power and strength. A common vision between mentors and novices and a willingness from

mentors to delegate their authority can be considered a clear leadership strategy (Spross and Hanson 2009).

Initiating change and creating sustainable change are important elements that advanced practice nurses should have as part of their leadership competency. Change occurs on both the systems and individual levels, and if one wishes to act as an effective means for change, one must identify one's core values. Resistance to change can be grounded in that one's own values are threatened. Change often leads to emotional tension. To fight this, compassion, patience, and perseverance are required (Senge 2006).

Concrete activities are needed to achieve the strategic development of new advanced practice nursing models, both in units and in an organization. Because the objective is to implement change on the systems level, political-level activities can be necessary. New advanced practice nursing roles can be a radical change for an organization, and this requires that new advanced practice nurses can activate and dare to position themselves strategically on the systems level.

Through a comprehensive integrative review of leadership competencies and attributes in advanced nursing practice, researchers discerned 30 core competencies related to leadership for advanced practice nurses and clinical nurse leaders (Heinen et al. 2019). The material was taken from international literature and official documents of international nursing organizations, and 15 studies and 7 competency frameworks were included. The 30 leadership competencies revealed were linked to three domains: clinical, professional, and health systems. In the clinical leadership domain, core competencies were linked to delivering excellent patient care, and the items included collaboration with professionals and other health agencies, implementation of innovations, and enhancing evidence-based practice. In the professional leadership domain, competencies were clearly formulated, and the items included were considered to provide sufficient direction for further development of the nursing profession. In the health systems leadership domain, competencies were minimally presented, and a shift from direct patient care to the strategic level was seen. For this last domain, the researchers concluded that influencing on the strategic level requires in-depth understanding of healthcare systems. This allows advanced practice nurses to create and share an organizational vision on quality improvement, implementation of change, and evaluation of outcomes.

7.8.4 Personal Characteristics for Leaders of Advanced Practice Nursing

Several personal characteristics are needed to realize fruitful leadership. Having a vision, i.e., the ability to predict the future, and being able to communicate that vision to others are among the most important components in leadership (Carroll 2005). Nevertheless, solely having a vision is not enough; a leader must also be capable of articulating it to others, so that it becomes a common vision (Senge 2006).

Taking risks is a natural part of leadership, and this is closely linked to a leader's degree of independence and autonomy. Daring to take risks is a sign that an advanced

practice nurse wishes to present him−/herself as a leader who can realize change (Spross and Hanson 2009). The willingness to risk a secure work position is also a part of risk-taking as a leader (Wheatley 2005). The motivation to lead, the willingness to be open to becoming involved, and investing time and energy on that which one considers the most important element of one's leadership all of these are important factors if one seeks to change one's surroundings.

Preparing a change takes time, and actively taking initiative to implementing change at the correct time requires wisdom. Acting at the correct time can be critical. Leaders must be capable of communicating clearly and forming relationships and networks that are based on trust and the ability to collaborate. The capacity for self-reflection helps leaders "look back" and evaluate own reactions and actions (Spross and Hanson 2009). Self-reflection is important both in direct nursing practice and in the leader's role as coach and/or mentor.

To preserve own health, it is important that leaders maintain a balance between the personal and the professional. Advanced practice nurses with a clear leadership role can take risk on too many tasks. It is important to delineate personal boundaries and say "no" to new duties, work tasks, projects, etc. if necessary. A recommended method is to schedule a meeting with oneself, i.e., take the time to engage in self-reflection or even perhaps prepare for the next task, project, etc.

7.8.5 Barriers to the Development of Leadership on the Advanced Level

Most barriers to the development of leadership on the advanced practice level arise from interpersonal conflicts or competition between individuals, groups, or organizations. Problematic laws and regulations are the primary barriers that prevent advanced practice nurses from fully realizing their role through optimal clinical practice (Dempster 1994). Competition and a competitive mentality can arise between professional groups or even between advanced practice nursing groups and other colleagues.

Longo and Sherman (2007) use the term "horizontal violence" when describing the atmosphere that can arise being nursing colleagues, which they define as an aggressive act carried out by one colleague toward another. They determined that there are four manifestations of horizontal violence that can limit the ability of advanced practice nurses in leading the star complex, the queen bee syndrome, failure to mentor, and bullying. In the star complex, the desire to be a "star" can lead an advanced practice nurse to deny his/her nursing background and instead seek to define him−/herself as a "mini-physician" or "the great therapist." A good leader is generous and ensures that all colleagues are given the opportunity to develop and grow. In the queen bee complex, the "queen" surrounds him−/herself with a "court" of servile individuals who will not challenge personal authority. An advanced practice nurse with queen bee tendencies feels threatened and challenged by strong colleagues and reacts by denigrating them instead of sharing power and authority. The way to counteract a queen bee is to use knowledge and competence to annul or

move away from such misuse of power and instead work toward collaboration and strengthening other individuals.

Baltimore (2006) finds that the most common form of horizontal violence can be expressed as "nurses eat their young." This can be considered a failure to mentor older, more experienced nurses who ignore or actively undermine novice nurses instead of acting like mentors. Nurses further along in their careers can forget that they were once novices, too, and forget their own, first faltering steps. Another phenomenon is more experienced nurses who have not been further educated or sought further qualifications; they can criticize other nurses who make the choices they did not, i.e., nurses who seek to move forward in their career or develop their skills through educational programs. A lack of encouragement and/or resistance from colleagues can hinder more novice or less-experienced nurses from developing their professional competency. Failed mentorship can take many different forms and be expressed in many different types of negative behavior, e.g., gossiping, "bad-mouthing," criticizing, failure to help and support, setting up roadblocks, bullying, or undermining outcomes or performance (Baltimore 2006; Longo and Sherman 2007).

Horizontal violence is not limited to one's own close surroundings but can even occur between organizational levels, from both above and from below in an organization. As noted previously, when advanced practice nursing roles are new or there is little knowledge of these roles, advanced practice nurses can experience negative comments, resistance, and even bullying. Personal and organizational symptoms of horizontal violence are job dissatisfaction, increased stress levels, and physical and psychological illness (Carter and Read 2019).

Emanating from Longo and Sherman's (2007) research, the following leadership strategies to stop horizontal violence are recommended:

- Examine the organizational culture for symptoms of horizontal violence.
- Name the problem as horizontal violence when you see it.
- Educate staff to break the silence.
- Allow victims of horizontal violence to tell their stories.
- Enact a process for dealing with issues that occur.
- Provide training for conflict and anger management skills.
- Empower victims to defend themselves.
- Engage in self-reflection to ensure that your leadership style does not support horizontal violence.
- Encourage a culture of zero tolerance for horizontal violence.
  (Modified by Carter and Read 2019: 282)

Leadership today entails the management of many different people from diverse backgrounds, and as such cultural competence is needed. Cultural competence is about valuing diversity and clearly showing that cultural, ethnic, and individual differences are valued and respected.

7.8.6 Strategies for Developing Leadership Characteristics

The portfolio method can be used to develop leadership characteristics, which extrapolated to a healthcare setting can be interpreted as collecting and documenting one's experience and competence. As a leader it is important to define one's personal vision, objectives, and timeframe and develop one's leadership competency as an advanced practice nurse leader.

An important strategy is to develop common understanding of what advanced practice nursing is in various contexts. Forums where advanced practice nurses from various environments can meet, discuss, and share their experiences are important to the creation of common strategies. These furthermore facilitate advanced practice nurses in supporting each other during their various stages of self-development. To develop advanced practice nursing on the national or regional levels, it is important to create common understanding of the advanced practice nursing role: for advanced practice nursing as a concept and for the various advanced practice nursing models. This can be realized through the creation of both national and international networks.

7.8.6.1 Prerequisites for Advanced Practice Nurses' Leadership

Emanating from more than two decades of research on advanced practice nurses' development of leadership characteristics, Krejci and Malin (2010) discerned four areas that can be considered common prerequisites. These are:

- Realize change.
- Systems thinking and the creation of effective teams.
- Mediate conflicts.
- Engage in self-awareness.

A newly graduated advanced practice nurse often has a clear vision of how he/she wants to work and which advanced practice nursing model he/she believes is suitable for the organization. However, according to Krejci and Malin (2010), it is challenging to turn a vision into concrete action, and doing so often requires strategic thought and good and well-prepared suggestions for an organization's upper leadership, so that the new vision is accepted. To achieve these objectives, e.g., a model such as the PEPPA framework (see Chap. 13: XX) could be used.

Systems thinking and an understanding of the complexity inherent to organizations are necessary to be able to implement change and new service models. New work methods often require the development of teamwork. Being able to articulate one's visions and objectives for a team so as to awaken interest and create the foundation for new advanced practice nursing models requires good communication, both with colleagues and leaders on various levels within one's organization.

If an advanced practice nurse wishes to realize a big change in an organization, he/she must be prepared to advocate for his/her cause and consciously seek to

maximize his/her ability to influence own surroundings. Accordingly, being able to mediate conflicts is a central leadership characteristic. Developing one's leadership is also about developing one's self-awareness. Self-awareness of own strengths and weaknesses facilitates one's capacity to practice leadership and realize change.

7.9 Critical Factors in Advanced Practice Nursing

According to Hamric (2009), there are several factors in the surroundings that are critical to the development of advanced practice nursing. Often seen central critical factors are organizational structure and culture, leadership, continuous evaluation, and marketing.

In several countries (e.g., Australia, Canada, Finland, the United Kingdom), one sees a lack of access to nursing, care, and treatment in healthcare systems. Access to nursing, care, and treatment is, and has been, a factor that has provided the impetus for the introduction and development of new advanced practice nursing models. Despite an increase in the number of physicians and nurses, access to nursing, care, and treatment is often inadequate.

Planning "human resources" to meet the increasing need for healthcare services is challenging in many countries. The allocation of professional groups as resources should correspond to future population needs. Care for older people and an aging population that will lead (and has already led) to an increased need for care can be described as a "ticking time bomb." Today, it is unknown what the true impact of an increasingly older population will be on the need for nursing, care, and treatment in healthcare systems in the future: those aged 85 or older are increasing significantly throughout the world. This is in addition to other current welfare-related trends (increasing public health problems) such as obesity, which can cause chronic conditions. The expected increase in the number of individuals with diabetes on its own is predicted to more or less devastate healthcare service budgets. Determining and planning how nursing resources should be distributed between various patient groups is a great responsibility that organizations and leaders must shoulder.

An organization is also a culture. To date, organizational cultures in healthcare systems throughout the world have been and continue to be relatively medical model-dominated and controlled. The introduction of new advanced practice nursing models will test and reveal the nature of an existing organizational structure. Is there resistance, or does one dare to attempt to solve problems such as access to healthcare through the introduction of new models?

Researchers have found in many studies that advanced practice nursing models can contribute to the improvement of access to healthcare services and that advanced practice nurses increase the quality of patient treatment (Stanik-Hutt et al. 2010). The question is whether the ingrained cultural attitudes and prejudices that individuals have, linked to professional boundaries (seen even within and between professions), can be changed in those countries that have not seen as radical a cultural change in their healthcare systems as countries such as Australia, Canada, the Netherlands, and the United States of America have.

Regulation is a critical factor for the development of advanced practice nursing. For example, prescriptive authority for advanced practice nurses requires changes to laws, regulations, and guidelines. Systems for the registration and authorization of prescriptive authority vary between the Nordic countries (see Chap. 10).

The importance of leadership for advanced practice nursing is described in greater detail later in this book (see Chap. 12). The fruitful implementation of a new model and the realization of sustainable advanced practice nursing models require clear and strategic leadership on all organizational levels—as well as in healthcare systems overall. Leadership is necessary when working with everything from legislative changes to contributing to a good advanced practice nursing workplace environment. The sustainable development of new advanced practice nursing models requires continuous evaluation. Despite a number of positive research findings, through which advanced practice nurses' contributions, work, and tasks are illuminated, there is a need for the introduction of new advanced practice nursing models throughout the world. Each country's healthcare system has its own specific structures, needs, and challenges, and new models that serve each country's own exact requirements should be developed (Schober and Affara 2006).

In this context, the marketing of advanced practice nursing should not merely be regulated to, e.g., private or third sector healthcare companies that wish to offer such services in the future. During the introductory phase, internal marketing of the advanced practice nursing function is incredibly important. Such internal marketing or illumination should be directed toward clinicians, physicians, and researchers. This marketing or illumination is even of great importance in relation to own colleagues, decision-makers, politicians, patients, and—not to be forgotten—the general public. In a study set in Sweden (Bergman et al. 2013), researchers found that patients who visited advanced practice nurse-led clinics and who were therefore familiar with advanced practice nursing models, reported increased satisfaction with the service they received. Patients in many countries have "decided with their feet" when determining the type of services they prefer, i.e., when they prioritize and choose to visit an advanced practice nurse. This is the best and most effective marketing of all.

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Advanced Practice Nursing in Acute Care

8

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Abstract

In international studies, researchers have concluded that advanced practice nursing in the acute care context has a positive impact on the quality of patient treatment and safety, patient satisfaction, patient flow, and wait times and that advanced practice nurses demonstrate the high-quality deliverance of care and treatment. The implementation of advanced practice nursing models in acute care, where the role is not well known, is a challenging process. The importance of adult-gerontology acute care advanced practice nurses is increasing, and the overall objective of this role is the diagnosis and management of disease and the promotion of the health for patients with acute, critical, and complex chronic health conditions, across the continuum of healthcare services.

Keywords

Acute care · Emergency care · Advanced practice nursing · Outcomes

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The American Association of Critical-Care Nurses (AACN) has defined the practice of what they term the "acute care practitioner" as an advanced practice nurse working in an acute care setting. After completed education and clinical practice, such an advanced practice nurse is capable of independent practice. This includes the capacity to perform comprehensive health assessments, order and interpret diagnostic tests and procedures, use differential diagnosis to reach a medical diagnosis, and evaluate intervention outcomes (American Association of Critical-Care Nurses 2012).

The primary criteria for advanced practice nursing are education on the master's-level degree, certification, and clinical practice in which there has been an emphasis on the patient and the patient's family (Hamric et al. 2014). Advanced practice nursing education must include specialization in knowledge areas such as pathophysiology, pharmacology, and clinical assessment. That which characterizes an advanced practice nurse is that he/she has (1) acquired new clinical skills and knowledge; (2) holds a significant, autonomous role; (3) is capable of being responsible for health promotion, diagnosis, and treatment and has prescriptive authority; (4) is capable of making complex clinical decisions and being a leader for and mentor to other colleagues; ad (5) is specialized on a defined level of advanced practice nursing for a population or patient group (Hamric et al. 2014).

International experience has shown that advanced practice nurses are capable of being responsible for a large part of a patient's care and treatment, even in an acute care setting (Newhouse et al. 2011). Advanced practice nursing clinics can be located in larger hospitals (where medical staff are available for referral), smaller community hospitals, minor injury units, or "walk-in" centers (where medical staff are not always on-site) (Cooper et al. 2002). The tasks that advanced practice nurses engage in depend on the setting, and this is also relevant to the acute care setting (Fagerström 2019). Advanced practice nurses should have the competence to perform independent examination and treatment and discharge patients (Furlong and Smith 2005). Advanced practice nurses perceive that they can influence patients' treatment outcomes in a favorable way (Kleinpell 2005; Boman et al. 2020b, 2021a, b). Still, it is not skill in performing procedures that defines the advanced practice nursing role; the role also requires knowledge of indications, contraindications, complications, and the management of complications (Hamric et al. 2014).

8.1 Advanced Practice Nursing in Acute Care: International Experiences

There is a long history of advanced practice nursing in acute care in different countries around the world, including Australia, Canada, Holland, the United Kingdom, and the United States of America. In the United States of America, the advanced practice nurse role in acute care was developed through the recruitment of nurse practitioners from primary care. This occurred because advanced practice nurses were needed to help manage the increased number of patients with complex medical histories presenting in acute care. Changes in the provisions for physicians'

working hours and a shortage of acute care physicians were also factors contributing to the need for advanced practice nurses in acute care units (Hamric et al. 2014).

Acute care in emergency departments is increasing in many countries, and delays to care are a common problem that can compromise patient safety (Velt et al. 2018; Morley et al. 2018; Greenwood-Ericksen and Kocher 2019; Gaarde et al. 2019). Advanced practice nursing is one approach to meeting this increased demand; researchers have found that emergency department throughput can be increased by expanding nursing roles and the scope of nursing practice (Elder et al. 2015). Researchers have also found that advanced practice nursing in acute care has a positive impact on care quality, patient satisfaction, and wait time reduction (Jennings et al. 2015; McDonnell et al. 2015). Advanced practice nursing has moreover been shown to improve overall staff knowledge, skills, and competence. Some researchers have seen that advanced practice nurses undertaking duties traditionally performed by junior physicians in acute hospital settings can have a positive impact on a range of indicators related to patients, staff members, and organizational outcomes (McDonnell et al. 2015). Furthermore, when compared to physician-led care alone, i.e., traditional models of care, advanced practice nursing has been seen to result in equivalent or better outcomes (Chavez et al. 2018; Pirret et al. 2015; Thompson et al. 2017).

As an example, at Scripps Mercy Hospital in San Diego, California, the United States of America, so-named trauma nurse practitioners (TNPs) work in collaboration with trauma physicians in planning patient treatment (Lome et al. 2010). These advanced practice nurses are required to have a master's degree in nursing and have completed certification courses in basal heart-lung resuscitation (BHLR), advanced heart-lung resuscitation (AHLR), trauma nurse core course (TNCC), or advanced trauma life support (ATLS). Researchers found that these advanced practice nurses perform complex tasks daily and determined that characteristics such as ensuring continuity of care, paying attention to detail, and flexibility defined them. They saw that trauma nurse practitioners coordinated trauma patients' treatment; were responsible for adequate inter-team communication; gave support, information, and guidance to patients and patients' families; and were also responsible for follow-up after discharge. The trauma nurse practitioners were furthermore seen to be responsible for the overview and coordination of patients' nursing and treatment plans (as needed) between interdisciplinary teams and in ensuring good discharge. While the researchers saw that trauma nurse practitioners' highest priority was patient care, they noted that patient education came in strong second place (Lome et al. 2010).

To develop patient care and treatment and make care activities more effective, good teamwork is needed (Gaarde et al. 2019). To facilitate collaboration with physicians in the care team, it is important to develop a flexible system (Lindblad et al. 2010). In an acute care setting, advanced practice nurses are a resource and can even act as advisors for other interdisciplinary team members. The advanced practice nursing role involves contributing to the development of models and guidelines, performing audits, belonging to committees, and participating in the development of services. In comparison to their colleagues who hold special functions, advanced practice nurses update procedures more often, use surveys more often to measure satisfaction, and are more engaged in the development of services (Begley et al.

2013). In the role of supervisor, advanced practice nurses can contribute to increasing their colleagues' knowledge and competence (Begley et al. 2013; Li et al. 2013; McDonnell et al. 2015). An acute care unit staffed by advanced practice nurses can ease physicians' workload (Lindblad et al. 2010; Li et al. 2013). While most other healthcare staff are generally positive to the implementation of the advanced practice nurse role in acute care, general practitioners make up the exception; they appear to be less positive to the implementation of this role in acute care than other nurses or acute care physicians (Griffin and Melby 2006).

8.2 Advanced Practice Nursing Outcomes in Acute Care

8.2.1 Care Quality

Advanced practice nursing has been shown to have a positive effect on care quality and patient safety (Jennings et al. 2015; McDonnell et al. 2015; Gaarde et al. 2019). Advanced practice nursing clinics are seen to be of high quality. When compared to physician-led or other nurse-led practice, advanced practice nurses (both nurse practitioners and clinical nurse specialists) are seen to provide safe and equivalent or even better care. Some researchers have found that advanced practice nurses have better care outcomes than physicians (Begley et al. 2013; Newhouse et al. 2011; Sakr et al. 2003). Other researchers have found that advanced practice nursing in an acute setting leads to fewer significant process (care) errors when compared to medical staff (Sakr et al. 2003). Still others have seen that advanced practice nurses reduce patients' risk for harm by providing routine guidance on, e.g., the use of medications or whom to contact if more help or guidance is needed (McDevitt and Melby 2015).

8.2.2 Patient Satisfaction

Advanced practice nursing in acute care has been shown to have a positive effect on patient satisfaction (Begley et al. 2013; Byrne et al. 2000; Jennings et al. 2015; McDevitt and Melby 2015; Tye and Ross 2000). Senior nurses in acute care perceive that the number of complaints decreases when advanced practice nurses are involved in patient treatment (Li et al. 2013). Patients are overall more satisfied with the treatment provided by advanced practice nurses than with the treatment provided by physicians (Cooper et al. 2002; McDevitt and Melby 2015; Seale et al. 2005). Patients find advanced practice nurses in acute care easier to talk to, perceive that advanced practice nurses have enough time to discuss things fully, and experience they are given sufficient information about accident, illness, injury prevention, injury advice, use of medications, possible medications side effects, and whom to contact for further help (Gaarde et al. 2019).

Investigating patient satisfaction with emergency nurse practitioners in an acute care setting (A&E) by comparing treatment provided by advanced practice nurses

(emergency nurse practitioners) with treatment provided by a nurse-physician team, Byrne et al. (2000) saw that patients seen by an advanced practice nurse were less worried about their health and were significantly more likely to have received health education and first aid advice, to have been given written instructions, to have been told whom to contact if more help was needed, and to have been given advice following discharge. They also found that most patients perceived that they were given sufficient time to discuss their situation when seen by an advanced practice nurse; 15% of those seen by a nurse-physician-led team felt they still had something they would like to discuss.

8.2.3 Patient Flow and Wait Times

Advanced practice nursing in acute care has been shown to have a positive effect on wait times (Jennings et al. 2008, 2015) and can also reduce length of treatment (Newhouse et al. 2011). Researchers in several studies have shown that wait times for advanced practice nurses are shorter than wait times for physicians (Cooper et al. 2002; Jennings et al. 2008; Sakr et al. 2003; Tye and Ross 2000; Gaarde et al. 2019). When comparing wait times between clinical nurse specialists, clinical midwife specialists, and advanced practice nurses in Ireland, wait times were seen to be longest for the advanced practice nurses. Nonetheless, the advanced practice nurses were seen to have a quicker patient flow than their colleagues, because they could make more independent clinical decisions (Begley et al. 2013). Evaluating the quality of emergency nurse practitioner services (advanced practice nurses in acute care) for patients with minor injuries in the United Kingdom (McDevitt and Melby 2015), researchers found that wait times for the advanced practice nurses were much shorter than average national wait times. Still, contrary to other studies, they even found that longer wait times did not affect patient satisfaction. Looking at the impact of advanced practice nurses on care delivery in acute care settings in Australia (Li et al. 2013), researchers found that senior nurses perceived that patient flow was improved when advanced practice nurses were involved in care and that wait times decreased for patients with less serious injuries. Leaders for the acute care settings in that study perceived that the improvement of patient flow was linked to the correct (i.e., sufficient) number of advanced practice nurses in the setting.

8.2.4 Cost Efficiency

Advanced practice nurse practice can reduce costs (Newhouse et al. 2011). However, researchers in Australia (Li et al. 2013) found that leaders for acute care settings questioned whether advanced practice nurse practice leads to cost efficiency, because advanced practice nurses spent more time on each patient visit than physicians. Even other researchers (Tye and Ross 2000; Seale et al. 2005) have seen similar results; advanced practice nurses treat fewer patients than physicians because they spend more time with each patient. Researchers (McClellan et al. 2013) have

even found that overall costs increase because advanced practice nurses incur greater indirect costs, such as those associated with follow-up visits and subsequent primary care visits. Still, cost-wise, advanced practice nurse visits were seen to be equivalent to routine care.

8.2.5 Approach

The approach that advanced practice nurses employ during a visit can be experienced as being more caring than a physician visit, where diagnostic and medical treatment is the primary focus (Jennings et al. 2008; Li et al. 2013; Tye and Ross 2000; Gaarde et al. 2019). Even compared to clinical nurse specialists and clinical midwife specialists, advanced practice nurses are considered to provide more holistic care (Seale et al. 2005; Begley et al. 2013). Advanced practice nurses also act as leader figures in clinics and are seen to make more independent decisions than clinical nurse specialists and clinical midwife specialists. Advanced practice nurses can refer patients to other health services, and other colleagues, including physicians, refer patients to advanced practice nurses and even confer with them. Like their specialist colleagues, advanced practice nurses are good communicators and are perceived by patients as being open, humorous, and encouraging. Advanced practice nurses spend more time on explaining illnesses/health problems, processes, and follow-up treatment and are seen to take patients' socioeconomic circumstances into account (Li et al. 2013).

8.3 The Adult-Gerontology Acute Care Advanced Practice Nurse

Older patients with acute health problems constitute a large patient group who seek both primary and specialist acute care in emergency departments. While the advanced practice nurse role can vary in the acute care setting, the overall objective of such care is to diagnose and manage disease and promote the health of patients with acute, critical, and complex chronic health conditions across the continuum of healthcare services (Hravnak et al. 2019).

A group of Nordic researchers found that top-level managers and politicians anticipate a multifaceted scenario in relation to optimal future care (Finnbakk et al. 2012). Older people will have significant, acute, and complex needs, but resources will be limited. The top-level managers and politicians in that study believed that medical treatment and nursing care for older people on both the advanced and specialized levels in primary healthcare will be needed. Advanced practice nurses with special competence in gerontological care could be one solution for such future healthcare challenges.

The American Association of Colleges of Nursing (2016) delineated population-specific competences linked to what they term adult-gerontology acute care nurse practitioners. The first and most central competency encompasses health promotion,

health protection, disease prevention, and treatment. This includes assessment of health status, diagnosis of health status, and plan of care and implementation of treatment. The second competency is the nurse practitioner-patient relationship, where the use of a collaborative approach is central and enhances the effectiveness of care. The third competency is the teaching-coaching function. This includes skills linked to interpreting and individualizing therapies through advocacy, modeling, and teaching. The fourth competency is the professional role. This includes emphasis on the importance of a personal commitment to the implementation and evolution of the advanced practice nurse role for gerontological care. The fifth competency is managing and negotiating healthcare delivery systems. This includes the development and implementation of system policies affecting services. The sixth competency is monitoring and ensuring the quality of healthcare practice. This includes ensuring quality of care through consultation, collaboration, continuing education, certification, and evaluation.

In 2008, the Board of Directors for the American Association of Colleges of Nursing (AACN) endorsed the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education (www.ncsbn.org/Consensus_Model_for_APRN_Regulation_July_2008.pdf). In a 2012 position statement from the Gerontological Advanced Practice Nurses Association, a gerontological nurse practitioner is described as a certified nurse practitioner with advanced specialty education in health issues that impact older adult (www.gapna.org). This includes having competence in the diagnosis, treatment, and management of acute and chronic conditions (and their resultant consequences) that often lead to functional decline or which require interventions to restore or maintain an optimal level of function.

Common tasks that advanced practice nurses in gerontological care perform include patient stabilization for acute and life-threatening conditions, trying to minimize and prevent complications for the patient and promoting physical and mental well-being. Furthermore, advanced practice nurses should employ a focus on the restoration of maximum health potential, providing palliative, supportive, and end-of-life care, as well as observing possible risk factors in achieving these outcomes.

According to Schretzman and Strumpf (2002), older adults need health assessments that are multidimensional and interdisciplinary. An age-appropriate approach should be used when assessing the health of older adults, e.g., when taking a health history and performing a physical examination. The assessment of functional status is even a key part of a comprehensive geriatric assessment. When caring for and treating older patients, advanced practice nurses should be sensitive to atypical symptoms; nonspecific and/or vague complaints may be signs of serious disease, and older patients can exhibit milder symptoms than younger patients. Advanced practice nurses need strong competence in understanding age-related physiology, because age-related changes have many clinical implications. Polypharmacy is an increasing and alarming trend among older patients. When working with vulnerable older persons, advanced practice nurses should use an age-appropriate approach to provide meticulous medication management to minimize pharmacology-related problems. Also older patients with hip fractures are a care-intensive and vulnerable group. In addition to other problems, this patient group demonstrates a high

occurrence of delirium, both pre- and post-operatively (Juliebø et al. 2009; Krogseth et al. 2011, 2013).

Lastly, the importance of health promotion realized through person-centered guidance and coaching cannot be overestimated. For example, the treatment of a critical illness can require many complex treatments. To promote the patient's ability to self-care, advanced practice nurses can teach and support to the patient and her/his family. Even discharge can be a critical phase for older patients, who may need special guidance and coaching (Schretzman and Strumpf 2002).

Allowing advanced practice nurses to manage patients' entire care, from health history forward, facilitates responsibility and the follow-up of good practice, through which a focus on the diagnosis, prevention, and treatment of older patients' health problems can be facilitated.

8.4 Developing New Advanced Practice Nursing Models in Norwegian Acute Care

In Norway, emergency care crowding is a problem that could be alleviated by implementing advanced practice nursing models. In March 2015, a 6-year action research project funded by the Norwegian Research Fund and entitled, "Providing person-centered healthcare—Development of new models of advanced practice nursing in cooperation with patients, clinical field and higher education," and led by Professor Lisbeth Maria Fagerström was started (Boman et al. 2021a). The setting for the project was an emergency department in a region in Norway with approximately 168,000 inhabitants that provides 24-h care for patients with medical, surgical, or orthopedic diseases or injuries (equivalent to a level 3 trauma center). In 2018, 31,636 patients were admitted to this setting, and the majority had medical (35%), surgical (22%), or orthopedic (37%) health concerns/illness/injuries. To date, three studies have been included in the overall research project, described in more detail below.

In a qualitative interview study (Boman et al. 2019), researchers explored registered nurses' understanding of how an advanced practice nursing role could contribute to meeting patients' needs in the emergency care context and nurses' perceptions of the implementation process. The respondents perceived the advanced practice nursing role as being autonomous and suitable for non-urgent patients but also as being diffuse and a possible threat to colleagues and organizational structures. The researchers found that the advanced practice nursing role could help meet current challenges in the emergency care context and that the management team plays an important role in making implementation successful, by leading change and engaging co-workers in the process.

In a second, qualitative interview study (Boman et al. 2020a), researchers investigated the differences and similarities in scope of practice between registered nurses and nurse specialists at the same emergency department setting in Norway and a similar setting in Finland. The objective was to clarify scope of practice and nursing roles on different levels and shed light on inconsistencies, to thereby

encourage nurses to work to their full potential. The researchers saw no differences between the registered nurse and nurse specialist roles as linked to professional accountability and responsibilities in the studied contexts, although the level of nursing competence differed. The researchers recommended that management teams should invest in reviewing nurses' competence in relation to different expertise levels both before and after consensus on uniform competence standards for different professional nurse groups is reached. They also recommended the use of strategic recruitment to ensure that current health needs in emergency departments are met.

In a third study, participatory action research was used to develop advanced practice nursing in emergency care (Boman et al. 2021a). More specifically, the PEPPA (*p*articipatory, *e*vidence-informed, *p*atient-centered *p*rocess for *a*dvanced practice nursing role development, implementation, and evaluation) framework was used to develop a new model of care and the advanced practice nurse role in an emergency department in Norway, where the role is in its infancy. Using the PEPPA framework, the current model of care was mapped, and stakeholders and respondents were identified. Together the respondents determined the need for a new model of care, identified priority problems and goals, and defined the new model of care and the advanced practice nurse role. The slow treatment of patients with non-urgent conditions was defined as the priority problem, and it was decided that advanced practice nurses would care for a specific group of non-urgent conditions, defined in the project as patients with minor orthopedic injuries and older patients with hip fractures. The objectives identified were (1) orthogeriatric patients will undergo comprehensive assessment, and adherence to care guidelines for hip fracture patients will be improved, (2) wait times for non-urgent patients will decrease without compromising patient safety, and (3) the person-centered approach will be strengthened, including the improvement of the information given to patients and patients' significant others. These decisions were made in cooperation with the respondents during discussions.

In a fourth, non-inferiority (outcome) study (Boman et al. 2020b, 2021b), the aim was to evaluate the implementation of advanced practice nursing for patients with minor orthopedic injuries, including comparison of outcomes in relation to advanced practice nurse versus standard (physician-led) care models (Boman et al. 2021b). In total, 335 cases were included. The researchers found that diagnostic and treatment accuracies were high in both care models, and the advanced practice nurse care model was non-inferior. The new advanced practice nurse model, regarding quality of care, was seen to be as good as the standard, physician-led model. Still, the development process of new advanced practice nursing models was seen to be somewhat complicated and a demanding and time-consuming process.

Organizational factors, such as the reorganization of a unit, planning of a new hospital—or even a pandemic—all have a clear impact on the implementation of new advanced practice nursing models. As such, new advanced practice nursing models are still evolving.

In the Norwegian healthcare system, in which a "gatekeeper" system is used, patients experiencing acute health problems first visit a general practitioner and

then a primary healthcare out-of-hours (OOH) clinic, after which a patient can be referred to a pre-hospital emergency department. Researchers found that about 72% of all patients who visited an out-of-hours clinic in Norway from 2007 to 2018 were registered as non-urgent admissions, 24.5% as urgent, and 3.5% as acute (Holm Hansen et al. 2009). The age groups with the highest rate of contact were the oldest adults and the youngest children. In another study, 28% of observed consultations in out-of-hours clinics were partly or totally spent addressing minor ailments (Welle-Nilsen et al. 2011). Abdominal pain, respiratory infections, skin cuts, lower urinary tract infections, and general health problems were the most frequently used single diagnoses in 2017 (Eikeland et al. 2019).

In 2018, a new research project entitled, "Innovation project in xxx out-of-hours emergency health clinic—Implementing Nurse Practitioners for safer and more efficient patient care," funded by the Oslo Regional Research Fund and a collaboration between a regional university and a Norwegian out-of-hours clinic, was started (Holm Hansen et al. 2020). The first survey study was a pilot study conducted in 2019 with the aim to identify challenges in the current model of care and the possible benefits of implementing nurse practitioner services in an out-of-hours clinic, from both care providers' and patients' perspectives (Holm Hansen et al. 2021a). Long wait times and a lack of patient information were identified. General practitioners at the setting were skeptical to task-shifting, while the registered nurses and patients were more positive. All groups agreed that nurse practitioners could perform advanced assessment, and possible new tasks were stitching wounds, referral to radiography (X-ray), and treating lower urinary tract infection. A qualitative focus group study with staff (registered nurses, advanced practice nurse master's-level students, and general practitioners) was conducted with the aim to define possible advanced practice nursing roles. The researchers concluded that the registered nurse role can be expanded to a more autonomous advanced practice nurse role, but that clear descriptions of the task-shifting required must be first developed and then thereafter accepted by the team (Holm Hansen et al. 2021b/in manuscript).

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9 Advanced Practice Nursing in Primary Care

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Abstract

The actual and future challenges part of providing healthcare services in primary care are strong motivations for expanding nursing roles. In this chapter, an international overview of the development of advanced practice nursing in primary care is presented. This includes a description of possible advanced practice nursing roles and work duties, as well as the impact that such roles have had, emanating from research results. In systematic reviews and international evaluations, researchers find that nurses working in advanced roles provide a high quality of care. The advanced practice nurse workforce in primary care is evolving worldwide. One international trend is the increasing use of nurse role expansion as a

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strategy to improve access to health services; improve quality of care; provide new, time-intense services (primarily for patients with chronic conditions); and/or improve efficiency in service delivery.

Keywords

Primary care · Evaluation · Outcomes · Advanced practice nursing · Nurse practitioner · Work models

Already today there is a clear shortage of health professionals in primary care in many Organisation for Economic Co-operation and Development (OECD) countries or in rural and remote regions (OECD 2008, 2016; Ono et al. 2014). The worldwide population is ageing, and this brings with it increased rates of chronic conditions and multimorbidity that require complex and time-consuming healthcare services. As such, there is a strong motivation to develop new work models in healthcare. Throughout the world, the care workforce is changing in numerous ways. An increasing number of physicians, nurses, and other care providers from the so-named "baby-boom" generation are reaching retirement age. A new generation, born between 1980 and1990 and often called "Generation Y," appear to display different priorities regarding how they structure their work-life balance. Generally speaking, members of Generation Y appear to want to work fewer hours overall than previous generations, and this trend is particularly evident among the physician workforce. Researchers predict that the current shortage of nurses will worsen as more baby-boom generation nurses retire, and it has already been shown that young nurses' interest in working in elderly care is often weak.

The need to strengthen human health resources is receiving increasing levels of political attention globally. For decades, primary care provider models in many Organisation for Economic Co-operation and Development countries have been focused on acute care and/or physician-centered care in the form of solo- or small group practices. During the last decade, however, task-shifting and skill-mix reforms have been met with widespread interest among those who decide on health workforce policy, and such reforms have been sought as solutions to ease provider shortages, improve access to people-centered care, and reduce costs (Maier et al. 2016). Advanced practice nurses are a rapidly growing workforce with high levels of advanced practice potential in primary care. It has been assumed that by developing new and more advanced roles for nurses, access to care in the face of a limited or diminishing supply of physicians can be improved. From literature reviews, researchers have extrapolated that advanced practice nurses will be able to provide 67–93% of all primary care services in the near future. Still, more evidence is needed (Maier et al. 2016).

Task-shifting and skill-mix reforms can be considered the first step toward the development of clearer (more well-defined) advanced practice nursing roles. A wide range of terms are used to refer to models where nurses (and/or other care providers) engage in activities previously considered to belong to the traditional medical model

(profession), e.g., task-shifting, task-sharing, task reallocation, and physician substitution (WHO 2007, 2008). The term "skill-mix reform" is used to refer to the strategies that alter the mix and skills of different healthcare professionals so that the skills align with changing requirements for specific diseases or general service provision (Laurant et al. 2005).

9.1 The Development of Expanding Nursing Roles in Primary Care

In many countries, advanced practice nursing is a new concept and a new professional role in primary health and care services, and there is a growing interest in the concept. However, new advanced practice nursing roles are often introduced without clear professional duties having first been defined (Henni et al. 2018; Bing-Jonsson 2019; Holm Hansen et al. 2020). For example, in sub-Saharan Africa, the clinical nurse specialist role is well developed and has contributed to the development of HIV management and prevention for these vulnerable populations (ICN 2020). During the past few years, several comprehensive studies have been undertaken on the development of advanced practice nursing roles in primary care.

Countries worldwide are seeking to strengthen their primary care workforce to ensure that all citizens have access to high-quality health services, but many countries face workforce challenges in primary care. These challenges are multifactorial and vary by country but can be generally described in terms of provider shortages, geographical imbalances, efficiency, and performance-related challenges (Buchan and Campbell 2013). Healthcare professionals in primary care organizations face increasing demands, not only due to ageing populations, increasing rates of chronic diseases, and multimorbidity, but even because they often work in fragmented healthcare systems where the need for care coordination is increasing (Garin et al. 2016). New models of care have emerged to improve coordination, integration, and team work, and policy-makers and healthcare managers are seeking strategies whereby to optimize the skill-mix of their health workforce, including the nursing workforce (Delamaire and Lafortune 2010; Kroetzen et al. 2011).

The Organisation for Economic Co-operation and Development has for some time placed a special focus on the development of advanced nursing roles. A decade ago, an Organisation for Economic Co-operation and Development Working Paper was published in which researchers described and evaluated experiences of new advanced nursing roles from 12 countries (Delamaire and Lafortune 2010). In that paper, researchers reviewed the development of advanced practice nursing in primary care, with a particular focus on roles in the following countries: Australia, Belgium, Canada, Cyprus, Finland, France, Ireland, Japan, Poland, the Czech Republic, the United Kingdom, and the United States of America. The researchers found that the development of new nursing roles varied greatly. The so-named "nurse practitioner" role was established in Canada and the United States of America as early as the mid-1960s, whereas development of the role in England started first in the mid-1980s. The establishment of both higher education programs and posts

for advanced practice nurses has been very lively in Australia and Ireland during the last few decades. However, in other countries, formal recognition of the advanced practice nursing role was still a decade ago in its infancy, even though (what can be considered) “unofficial” advanced practice nursing roles do exist.

While interest for advanced practice nursing has increased during the last few years, there still remains a need for stronger policies and regulatory systems that support advanced practice nursing roles (Seitio-Kgokgwe et al. 2015). For example, in Botswana nurse practitioners provide primary care in outpatient departments, clinics, industrial settings, schools, private practice, and nurse−/nurse practitioner-managed clinics. Even though there is success in the country, stronger policies and regulatory systems are needed.

In 2016, the Organisation for Economic Co-operation and Development Health Division organized a workshop in Paris entitled, “Towards a more efficient use of health human resources: What lessons can we learn from innovations across OECD countries?” (DELSA/HEA 2016). The aim was to synthesize the evidence on recent developments on new, advanced roles for nurses in a total of 37 European Union and OECD and countries: all 28 European Union countries plus Australia, Canada, Iceland, Israel, New Zealand, Norway, Switzerland, Turkey, and the United States of America. Two concepts inherent to new advanced roles were focused on. The first was task-shifting (physician substitution), where nurses assume responsibility for some tasks that physicians had previously performed and/or either fully or partially substitute for physicians, with the aim to alleviate physician shortages and/or improve access to care. The second was the introduction of new nursing roles (supplementation), where nurses work in advanced, complementary roles to physicians, such as case managers, liaison roles, eHealth monitoring, and lifestyle advice (Laurant et al. 2005; DELSA/HEA 2016). As seen in an Organisation for Economic Co-operation and Development report from the workshop, the following countries have experience in integrating advanced practice nursing roles into their healthcare systems: Australia, Canada, Finland, New Zealand, the Netherlands, the United Kingdom, and the United States of America.

In a cross-country comparative study (Maier et al. 2016), researchers analyzed the extent of task-shifting in primary care and policy reforms in 39 countries. A total of 93 country experts from Australia, Canada, New Zealand, the United States of America, and the European Union were included. The researchers saw that task-shifting had already been implemented in two-thirds of the countries encompassed by the study ($N = 27$, 69%). Eleven countries (Australia, Canada, England, Finland, Ireland, New Zealand, Northern Ireland, Scotland, Wales, the Netherlands, and the United States of America) were seen to have extensive task-shifting, 16 countries were seen to have limited task-shifting, and 12 countries were seen to have no task-shifting. The researchers concluded that a high number of policy, regulatory, and educational reforms have facilitated the trend toward task-shifting in primary care. They found that the maximization of workforce capacity was one of the primary reasons given for the implementation of task-shifting. They even saw that during the early stages of implementation, countries seemed to primarily reform their educational systems. The researchers recommended that standardized definitions and

minimum educational and practice requirements be developed, particularly in the European Union countries, because these will help facilitate recognition procedures in increasingly connected labor markets.

Large variations in nurses' advanced roles and responsibilities in primary care are seen between the various Organisation for Economic Co-operation and Development Member countries. Advanced practice nursing roles can be organized into three categories: (1) nurses working in advanced roles as generalists, to ease physician shortages or geographical imbalances, (2) nurses primarily working with health promotion and disease prevention, and (3) nurses working in advanced roles as single-disease "specialists," to improve the treatment and monitoring of a specific, often high-prevalent chronic condition (e.g., diabetes, coronary heart disease; DELSA/HEA 2016). In the report from the previously mentioned Organisation for Economic Co-operation and Development Health Division workshop (OECD 2016), researchers concluded that regulation is a prerequisite for expanded practice. The authors of the report noted that without the official authorization of new, advanced clinical scope of practice and definitions, nurses cannot officially and legally practice in advanced roles.

In a 2017 Organisation for Economic Co-operation and Development Health Working Paper, mentioned briefly previously above and entitled, "Nurses in advanced roles in primary care" (Maier et al. 2017), researchers presented four main trends that emerged from their analysis of nurse role developments and reforms in Organisation for Economic Co-operation and Development and European Union countries:

1. The development in several countries of specific advanced practice nursing roles at the interface between the traditional nursing and medical professions.
2. The introduction of various new, supplementary nursing roles, often focused on the management of chronic conditions.
3. The rise in educational programs to train nurses to the required skills and competencies.
4. The adoption of new laws and regulations in a number of countries since 2010 to allow certain categories of nurses to prescribe pharmaceuticals (including in Estonia, Finland, France, Poland, Spain, and the Netherlands).
   (Maier et al. 2017)

In that paper, researchers found that the reasons underlying countries' introduction of advanced practice nursing roles were related to improvement in access to care or quality of care and/or cost reductions. They discovered that the data to routinely monitor the deployment of advanced practice nurses was only available in certain countries (Australia, Canada, Ireland, New Zealand, the Netherlands, and the United States of America), which they concluded hampered routine monitoring of this growing workforce. Analysis further revealed that the data available in these countries showed large variations in advanced practice nurses' work settings and the degree to which the advanced practice nursing role had been implemented.

In a descriptive, cross-country analysis of the advanced practice nurse workforce in six countries (Maier et al. 2016), researchers analyzed data from national nursing registries, regulatory bodies, statistical offices, as well as Organisation for Economic Co-operation and Development health workforce and population data from 2005 to 2015 and data from a literature scoping review. The aim was to compare the absolute and relative number of advanced practice nurses per population in the six included countries: Australia, Canada, Ireland, New Zealand, the Netherlands, and the United States of America. The United States of America showed the highest absolute number of advanced practice nurses per population (40.5 per 100,000 population), followed by the Netherlands (12.6), Canada (9.8), Australia (4.4), and Ireland and New Zealand (3.1, respectively). Annual growth rates were high in all countries, ranging from 6.1% in the United States of America to 27.8% in the Netherlands, and found to be between three and nine times higher than annual growth rates for physicians.

Emanating from the reports and studies described above, one can draw the conclusion that advanced practice nursing roles in primary care are increasing and thereby that advanced practice nurses constitute an expanding professional group in many countries. Nevertheless, it is difficult to obtain an exact overview of the total advanced practice nursing workforce and advanced practice nurses' scope of practice.

9.2 Summary of Advanced Practice Nursing Outcomes in Primary Care

As discerned from international research, there is an expectation that the implementation of the advanced practice nursing role in primary care can:

- Increase the quality of services traditionally provided by physicians.
- Safely replace services traditionally provided by physicians, thereby reducing the need for physicians.
- Reduce service costs (based on the assumption that costs associated with advanced practice nurses working as substitutes are lower than those associated with physicians).
  (Laurant et al. 2014)

In the previously mentioned 2017 Organisation for Economic Co-operation and Development Health Working Paper ("Nurses in advanced roles in primary care"; Maier et al. 2017), researchers synthesized evidence on the effectiveness and efficiency of nurses in advanced practice nursing roles in primary care. Emanating from a large number of systematic reviews in which the clinical effectiveness and quality of care of nurses working in advanced roles were compared to physicians, the researchers concluded that advanced practice nurses provide at least equivalent quality of care when compared to general practitioners. The evidence that this conclusion was based on was primarily composed of randomized controlled trials.

There, advanced practice nurses were seen to work in various roles, the extent of advanced practice nurses' (additional/further) education varied, and advanced practice nursing settings were linked to patients with acute and chronic conditions in multiple countries: among others, Australia, Canada, South Africa, Sweden, Switzerland, the Netherlands, the Russian Federation, the United Kingdom, and the United States of America. The researchers discerned that in many studies, patient satisfaction tended to be higher and mortality in many settings lower for nurse-led care when compared to physician-led care. However, the researchers found no evidence of differences between clinical parameters for most variables investigated. Thus, the researchers concluded that evidence related to the question of advanced practice nurse efficiency as compared to physician efficiency was inconclusive. Furthermore, in relation to cost savings, the findings were also mixed. In some studies, cost savings associated with the advanced practice nursing role were seen, linked to lower salaries for advanced practice nurses. Still, the researchers noted that in many studies it was mentioned that advanced practice nurses tend to have longer patient consultations and more return visits, which was seen to negatively affect advanced practice nurses' productivity level (and thereby cost savings) in comparison with physicians. The researchers even found that advanced practice nurses' holistic way of working, in which health promotion during patient consultation is emphasized, may increase costs.

Overall, the researchers found that advanced practice nurses provided at least equivalent quality of care compared to general practitioners when adequately trained. They concluded that advanced practice nursing roles can reduce hospital (re)admissions and lead to higher patient satisfaction. Their conclusion on cost savings was that the issue was unclear (mixed results) and that savings were dependent on factors such as productivity and remuneration differentials between advanced practice nurses and physicians. They saw similar barriers to implementation of the advanced practice nursing role across countries, e.g., opposition from certain stakeholders (medical workforce), outdated regulatory barriers, financing and reimbursement schemes not recognizing new advanced practice nursing roles, or slow uptake on the organizational level due to weak leadership and/or poor management of change.

In a recent Cochrane review (Laurant et al. 2018), researchers explored the delivery of primary healthcare services by nurses as compared to delivery by physicians. The aim was to investigate the impact of nurses working as substitutes for primary care physicians in relation to patient outcome, process of care, and utilization (including volume and cost). The researchers concluded that care provided by nurses probably generates similar or better health outcomes for a broad range of patient conditions. They found that nurse-led care can lead to slightly fewer deaths among certain patient groups, slightly improved blood pressure outcomes, and slightly higher patient satisfaction. However, they found little or no difference between nurse-led and physician-led care in a number of prescriptions, attendance at accident and emergency units, tests and investigations, hospital referrals, or hospital admissions. Like many other researchers, they noted that they could not draw any conclusions on the relationship between nurse-led care and care costs because certainty of the evidence was very low.

9.3 Examples of Advanced Practice Nursing Roles in Primary Care

What advanced practice nursing roles are there in primary health and care services? Below follows a brief presentation of the various models where advanced practice nurses can utilize their simultaneously generalist and specialist knowledge for patients' and their colleagues' best in primary care, with a specific focus on care for older people. Some of the advanced practice nursing models presented have been developed in specialist care but can be transferred to primary care services such as nursing homes (long-term care homes), primary healthcare clinics, geriatric care clinics, or municipal acute inpatient clinics (Bing-Jonsson 2019). In all these models, advanced practice nurses use both their broad, general competence and their specialist competence for patients', patients' families, and their colleagues' best in community health and care services. Common to the different work methods are that advanced practice nurses engage in direct patient care; make systematic, clinical assessments, evaluations, and decisions; and work with greater autonomy than "traditional" nurses, but still in close collaboration with, among others, nurses and physicians (Bing-Jonsson 2019). Many of these work methods require case management competency, research competency, or development and leadership, e.g., competence in leading professional development and teaching/instructing and guiding colleagues.

9.3.1 Patient Flow and Continuity of Care

Using advanced practice nursing to safeguard transitions between different levels of care promotes continuity (Bing-Jonsson 2019). Many countries today seek to minimize both patient care times in hospital and readmissions to hospital. In many countries, the objective is to shorten the length of hospital stays and readmissions to hospitals and (attempt to) solve most health problems as close to the patient as possible, i.e., in primary care. Advanced practice nurses use transfer protocols, which include systematic evaluations of patients and patients' families, to predict the need for healthcare services in a community. Advanced practice nurses also collaborate with other healthcare professionals to create individualized discharge plans, as well as educate and guide nurses in engaging in such practice as well (Henni et al. 2019).

As an example, advanced practice nurses make home visits to patients and patient's families (Bing-Jonsson 2019). As part of their competency, advanced practice nurses are capable of initiating measures based on own clinical assessment. The advanced practice nurses were asked to maintain a detailed log on the measures and interventions they performed during these home visits, which enabled the researchers to discern in retrospect how the advanced practice nurses had worked. The advanced practice nurses were seen to take responsibility for patients' discharge process and planning of services in the municipality and were also seen to engage in immediate follow-up after discharge. The advanced practice nurses can be considered to have acted as "case managers."

In this advanced practice nursing model, advanced practice nurses use their specialist competency to engage in systematic, clinical assessments and decision-making, documentation, interprofessional collaboration, and case management. Such a model has been shown to consistently decrease readmissions and lower costs for complex medical follow-up related to medications and surgery (Bourbonniere and Evans 2002).

Another example can be taken from Norway (Eidsberg kommune 2015). The restructuring of healthcare services in Norway through legislation such as the Coordination Reform and the Act on Municipal Health and Care Services has led to the shifting of duties from specialist healthcare services to municipal services for the follow-up and assessment of home-dwelling, older people with multiple conditions. To this end, a municipality in Norway organized the introduction of a so-named *virtuell avdeling* (the virtual unit) in their municipal home healthcare services, to facilitate the follow-up of vulnerable older people with multiple conditions who were discharge (from hospital) ready but still needed healthcare services. This virtual unit was overseen by an advanced practice nurse with a master's degree in advanced geriatric nursing, who was responsible for ensuring the implementation and follow-up of this measure. Overseen by the advanced practice nurse and in collaboration with physiotherapists, prior to inclusion in the "virtual unit," a comprehensive geriatric assessment (CGA) was used to evaluate new admissions (patients). Continued follow-up occurred in collaboration with a general practitioner, home healthcare staff, physiotherapists, and ergotherapists.

9.3.2 Holistic Home Rehabilitation

The objective of this advanced practice nursing model is to provide holistic, interdisciplinary care to home-dwelling older patients with complex medical and rehabilitation needs. The service provided as part of this model is nurse-led, and the care team includes geriatric specialists, physiotherapists, occupational therapists, ergotherapists, speech therapists, social workers, psychiatrists, and advanced geriatric specialists and/or advanced geriatric mental health specialists (Bing-Jonsson 2019). Advanced geriatric specialists perform physical examinations and psychosocial assessments and follow-up on nursing measures/interventions, which includes teaching patients and patients' families and coordinating the patient-centered services that the care team provides. Advanced geriatric mental health specialists work with identifying and intervening in relational, behavioral, or mental health problems that hinder effective rehabilitation. Researchers have found that this advanced practice nursing model leads to patients' improved functional ability, a decrease in hospital admissions, and that older patients with cognitive impairments benefited from rehabilitation (Bourbonniere and Evans 2002). In this model, advanced practice nurses use their specialist competence to engage in systematic clinical assessments, in terms of somatics, psychiatry and social conditions, professional nursing follow-up, interdisciplinary collaboration, the education of patients and patients' families, case management, and, not least, interdisciplinary collaboration.

9.3.3 Geriatric Mental Health Nursing

The high incidence of depression and delirium among hospitalized older patients has led to the development of advanced practice nursing models where advanced geriatric mental health specialists advise hospital healthcare staff on older patients with psychiatric symptoms (Bourbonniere and Evans 2002). Advanced geriatric mental health specialists assess older patients who show symptoms of, e.g., depression or delirium. When providing care for older patients diagnosed with depression or delirium, advanced geriatric mental health specialists collaborate with other healthcare and nursing professionals on measures/interventions and direct, patient-centered care. This includes evaluation, follow-up, supportive therapy, guidance of other healthcare staff, review of medications, familial support, and the initiation of a delirium protocol. Researchers have found that this advanced practice nursing model leads to a reduction in depression and delirium at discharge from hospital. Healthcare staff who received guidance from advanced geriatric mental health specialists perceived that they benefited from such guidance cognitively, emotionally, and behaviorally (Bourbonniere and Evans 2002). In this model, advanced practice nurses use their specialist competence to engage in systematic assessments/screening, guidance of and collaboration with other healthcare staff, professional nursing follow-up, interdisciplinary collaboration, and systematic documentation (Bing-Jonsson 2019).

9.3.4 Person-Centered Care Used to Reduce Restraining Measures

Advanced practice nurses can contribute to the reduction of restraining measures (restraint) used with frail older patients in nursing homes and hospitals (Bing-Jonsson 2019). In this advanced practice nursing model, advanced practice nurses educate and guide other healthcare staff in the use of person-centered care so that they learn to avoid the use of restraint in care. Advanced practice nurses assess patients' needs and prevent and manage patient behaviors that can trigger carers' use of restraint. In this manner, advanced practice nurses can contribute to a reduction in the use of restraint without the need for increased healthcare resources (staff), use of medications, or serious fall accidents (Bourbonniere and Evans 2002). In this model, advanced practice nurses use their specialist competence to engage not only in education and leadership but also systematic documentation that creates the foundation for research on and the documentation of the effect of this advanced practice nursing model.

9.3.5 Identifying Delirium and Improving Functional Ability

Advanced practice nurses can contribute to improving the functional ability of hospitalized older patients who are discharged from hospital into primary care units or

home healthcare services (Bing-Jonsson 2019). The primary objective in this advanced practice nursing model is the identification and treatment of delirium (Bourbonniere and Evans 2002). Advanced practice nurses teach other healthcare professionals about the cognitive, physical, sensory, and environmental conditions that should be taken into consideration when caring for hospitalized older patients, to prevent delirium. In this model, advanced practice nurses consult with patients' families, physicians, and other healthcare staff and even engage in direct patient care during the systematic evaluation of patients. They furthermore initiate treatment interventions and collaboration with physicians regarding assessment of the need for medications. In this manner, advanced practice nurses use their specialist competence to act as "case managers" or leaders, with an emphasis on "timing," expert communication skills, capacity to negotiate, and self-confidence. In this model, advanced practice nurses use their specialist competence to engage in systematic clinical assessments, professional nursing follow-up, interdisciplinary collaboration, and leadership.

9.3.6 Home Healthcare Oncological Nursing

Advanced practice nurses can act as case managers for cancer patients receiving care as part of home healthcare services (Bing-Jonsson 2019). In this model, advanced practice nurses engage in standardized, systematic assessments and create guidelines for patients and patient's families on decision-making and patient-centered care. Advanced practice nurses' work can be specifically linked to patient education, assessment of patient's need for healthcare services, follow-up of patient's physical and emotional status, provision of psychological support, and coordination of necessary services (Bourbonniere and Evans 2002). In this model, advanced practice nurses use their specialist competence to engage in systematic clinical assessments, professional nursing follow-up, and interdisciplinary collaboration.

9.3.7 Continence Nursing

The objective of this advanced practice nursing model is to provide the assessment and treatment of older patients with different types of incontinence in different service forms in community healthcare services (Bing-Jonsson 2019). In this model, advanced practice nurses engage in collecting complete health histories (anamneses) and performing physical examinations with a focus on the urinary system. Advanced practice nurses can use a number of non-surgical interventions to help patients regain continence, including behavior-oriented interventions and teaching and guidance. In this model, advanced practice nurses can enjoy various levels of autonomy: some can diagnose, prescribe treatment, and refer patients to other services. In this model, advanced practice nurses use their specialist competence to engage in systematic clinical assessments and initiate independent interventions.

9.4 Advanced Practice Nurses as Compliments to Physicians in Nursing Homes

In this more "general" advanced practice nursing model, advanced practice nurses engage in quick but systematic assessments and initiate treatment for patients in nursing homes, a setting where physicians are seldom available (i.e., available on-site less than 2 h per week). In this model, advanced practice nurses directly intervene and treat patients when patients' health conditions deteriorate, which improves care; there is no need to wait for a physician to answer a phone call or come to the nursing home and no need to send a patient to the hospital. In this model, advanced practice nurses belong to the medical team responsible for care at the (nursing home) setting and coordinate care between the various care settings and healthcare professionals (the nursing home physician, hospital-based physicians) involved in patients' treatment. Researchers have found that this advanced practice nursing model leads to a reduction in hospital admissions and emergency room transfers (Christian and Baker 2009). In this model, advanced practice nurses use their specialist competence to (especially) engage in systematic clinical assessments, medical interventions, nursing professional follow-up of own decision-making, and interdisciplinary collaboration with, among others, physicians (Bing-Jonsson 2019).

9.4.1 Integrated Nursing Teams

In this advanced practice nursing model, a team of advanced practice nurses engage in coordinating and leading health promotive and disease preventative activities throughout the entire patient pathway (Bing-Jonsson 2019). The advanced practice nurses are responsible for patients receiving the correct interventions from the correct individuals at the correct time. This occurs through the coordination of services and referrals to other professional groups. For example, in New Zealand, there is a team of mental health nurse practitioners who provide mental health services in rural areas (Hughes and Clark 2002). In this model, advanced practice nurses use their specialist competence to engage in systematic clinical assessments, treatment, health promotion, case management, and coordination of patient care, especially in collaboration with general practitioners.

9.4.2 Advanced Practice Nursing Clinics

Advanced practice nurses have the capacity to work independently and refer patients to other healthcare professionals as required (Bing-Jonsson 2019). Advanced practice nursing clinics can take the form of independent clinics, clinics part of a medical practice, community-based clinics, or specialty services/clinics. Common to all advanced practice nursing clinics is that the advanced practice nurses engage in own practice

where their services are made available to all. Advanced practice nurses are experts in, among others, health promotion and rehabilitation linked to specific health problems. This advanced practice nursing model is dependent on public acceptance of advanced practice nurses' expertise and the general public's belief that advanced practice nurses can meet patients' health needs. For example, in New Zealand (Hughes and Clark 2002), advanced practice nursing is used in specialty care for two patient groups identified as having an especial need for new services: patients with chronic heart failure and patients with renal disease. As part of what are termed "nurse practitioner specialty services/clinics," advanced practice nurses are responsible for the following:

Advanced Practice Nursing Specialty Clinic Measures for Patients with Chronic Heart Failure

- Case management of "at-risk" patients following discharge until stabilized on effective long-term treatment (average approximately 90 days).
- Monitoring, reviewing, and prescribing treatments for heart failure and associated conditions until the patient's condition is settled and/or treatment stabilizes.
- Collaboration and cooperation with the interdisciplinary healthcare team.
- Education of patients and families to support patient self-care.
- Management of multiple medications/medication regimens as required, particularly for older patients.
- Providing a heart-failure resource service based on current recommended evidence-based treatments to coordinate the medical management of patients from primary healthcare and hospital-based physicians.

Advanced Practice Nursing Specialty Clinic Measures for Patients with Renal Disease

- Maximize the patient's time on dialysis to assess, diagnose, monitor, and treat symptoms and manage diseases.
- Prescribe and adjust medications and treatment on a regular ongoing basis.
- Order diagnostic and monitoring tests and refer to other specialist services.
- Collaborate with other health specialists and coordinate patient care across all specialist services.
- Educate the patient and the patient's family in self-care, disease management, and prevention.
- Anticipate and prevent disease progression and complications in the patient and the patient's family.
- Liaise with, coordinate, and support the other health professionals involved with the patient (e.g., general practitioner, dialysis and diabetic staff, specialists, and the healthcare team).
- Facilitate the development of nurses and other health professionals in the care of patients with both diabetes and renal disease.
- (Hughes and Clark 2002)

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The Right to Prescribe Medications as an Advanced Practice Nurse

10

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Abstract

The concept of "non-medical prescribing" refers to the expansion of prescriptive authority for non-physician professional groups, i.e., nurses, midwives, physiotherapists, etc. In this chapter, the research, documentation and foundation for nurse prescribing are presented. Throughout the chapter the term "nurse" is used to represent all nurses with further education who are afforded prescriptive authority in a specific country. In many countries, prescriptive authority is given to advanced practice nurses. Today, following many years of experience of non-physician prescriptive authority (non-medical prescribing), the key question is not whether nurses should be allowed prescriptive authority but rather to what extent nurse prescribing has been established.

Keywords

Prescriptive authority · Advanced practice nursing

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In international literature on prescribing, the concept of "non-medical prescribing" is often used (Bhanbhro et al. 2011). In the international context, two main models for nurse prescribing can be discerned (Kroetzen et al. 2011; Tranmer et al. 2015). In the first model, independent nurse prescribers are responsible for clinical assessment, diagnosis, and medical treatment. In this model, nurses have either limited prescriptive authority (authority to prescribe certain medications) or full prescriptive authority (no restrictions in authority to prescribe medications). In the second model, supplementary nurse prescribers prescribe within an agreed and specific clinical management plan agreed in partnership with, e.g., a physician or dentist. This means that in collaboration with a physician and following an initial assessment and diagnosis, a nurse can prescribe medications, usually from a specified list. For example, supplementary nurse prescribers can prescribe medications already included in a patient's treatment plan, e.g., patients with chronic disease in a stable phase (Hall 2005).

10.1 International Overview

Prescribing has been defined as "the steps of information gathering, clinical decision-making, communication, and evaluation which results in the initiation, continuation or cessation of a medicine" (Cahin et al. 2015: 8). Four different models of nurse prescribing have been proposed in the International Council of Nurses (ICN) monographs: independent authority, dependent/collaborative authority, group protocol/patient care directives, and time and dose prescribing or patient-specific protocols (Buchan and Calman 2004; Ball 2009).

In the first model (independent authority), nurses are autonomous and have independent authority as a prescriber. Nevertheless, limited or open medication lists (formularies) may also be used. Nurses are responsible for clinical assessment, establishing a diagnosis, medications, and/or therapeutic decisions (Ball 2009; Kroetzen et al. 2011; Schober 2016). Usually this model requires legislative changes. In the second model (dependent/collaborative authority), nurses act in accordance with specific written instructions (directives) about what medications may be administered and in what situation. Directives are applied to patient groups and not individualized. Any deviation requires physician consent. In the third model (group protocol/patient care directives), nurses are semi-autonomous. They work in collaboration with independent prescribers and usually prescribe from a limited or open formulary, but typically do not make the initial assessment or diagnosis. In the fourth model (time and dose prescribing or patient-specific protocols), nurses are dependent on physician supervision and must follow patient-specific orders/protocols.

Despite already being introduced to a certain extent in the 1960s in the United States of America, nurses' prescriptive authority is far from being established throughout the world. The system and principles of nurse prescribing vary significantly internationally and are contingent on many different circumstances. Expanded nursing practice that includes prescription rights can be perceived to

intrude on physicians' professional role, and it would seem that a debate arises in all countries where nurse prescribing is considered, because physicians can feel threatened.

Another hotly debated subject is the right to diagnose, occurring in countries where nurses seek to expand their clinical rights. Schober and Affara (2006) describe making an initial diagnostic decision as "informed and educated decision-making by a healthcare professional with and on behalf of a patient or family." Yet, for example, advanced practice nursing scope of practice in Finland is limited; diagnosis remains solely based on the traditional and medical model, i.e., physicians diagnose.

In a systematic review of the literature on nurse prescribing in Western Europe and Anglo-Saxon countries in which 124 publications were included, Kroetzen et al. (2011) found that various external and internal factors influence the development of nurse prescribing. They also saw great differences between countries regarding the legal, educational, and organizational conditions under which nurses prescribe medications. In another systematic review of literature on prescribing in primary care, Bhanbhro et al. (2011) saw that when efficiency was considered a dimension of healthcare quality, expanded prescriptive authority was often given to nurses. They found that non-medical prescriptive authority, i.e., nurse prescribing, was necessary to improving access to nursing, care, and treatment, primarily in community healthcare, and that nurse prescribing contributed to safe nursing, care, and treatment.

Nurses have prescriptive authority in at least 25 countries throughout the world (Drennan et al. 2009; Bhanbhro et al. 2011; Kroezen et al. 2012). This includes Western and Anglo-Saxon countries such as Australia, Canada, Georgia, Holland, Ireland, Spain, New Zealand, the United Kingdom, and the United States of America (Kroezen et al. 2012) and African countries such as Kenya, Namibia and South Africa. Each state and country that allows nurses' prescriptive authority determines whether that authority is independent or limited. Restrictions can be linked to, e.g., education, diagnosis groups, patient age, or parts of the healthcare system. In many cases, the introduction and development of nurses' prescriptive authority are first started by allowing nurses' dependent or limited authority, where nurses can prescribe from a limited formulary. Scotland, for example, first allowed nurses limited prescriptive authority, which has now developed into independent authority with an open formulary on par with physicians.

The development of nurses' prescriptive authority first started in the United States of America in 1969, and while most American states have adopted nurse prescribing, some differences between states still exist. In Europe, the United Kingdom has been a pioneer in this area and has since 1992 developed a clear system for non-medical prescribing. In 2006, new legislation was introduced in the United Kingdom allowing "nurse independent prescriber to prescribe any licensed medicine including some Controlled Drugs, for any medical condition within their clinical competence" (Department of Health 2006). Ireland has a clear system that provides for the registration, control, and education of nurses and midwives in accordance with a regulatory framework for nurse or midwife prescribing.

The development of nurses' prescriptive authority first started in Australia in 1981 through the Drugs, Poisons and Controlled Substances Act, followed in 2000 by the Nurse Amendment Act (Bhanbhro et al. 2011). Using a descriptive electronic survey, researchers found that 78% of nurse practitioners in Australia reported prescribing medications as part being of their practice (Buckley et al. 2013). The medications most frequently prescribed were analgesics, psychotropics, and from cardiovascular, musculoskeletal, genitourinary, and gastrointestinal classifications. Also, the medications prescribed were comparable to the medications most frequently prescribed by all those with prescriptive authority in Australia, which the researchers interpreted as indicative of the diversity of advanced practice nurses' scope of practice.

Since 2001, advanced practice nurses in New Zealand have had prescriptive authority in community healthcare, i.e., their defined area of clinical practice, but were previously required to register as either a prescribing or non-prescribing nurse practitioner (Schober 2016). In 2014, the nurse practitioner scope of practice was expanded to include and facilitate the transition from non-prescribing to prescribing, made possible through two different pathways: qualifications that include a pharmacology course and supervised prescribing practice (100 h) and competence assessment by a medical mentor/nurse practitioner; nurse practitioners without appropriate qualification must complete certain pharmacology papers and supervised prescribing practice (100 h), competence assessment or supply a portfolio that demonstrates knowledge and skills, as well as a panel review (Nursing Council of New Zealand, Schober 2016).

Canada is composed of provinces and territories, which has hindered the development of a standardized nurse prescribing model. At the beginning of the twenty-first century, discussion on prescriptive authority increased in the country, in part because a debate began in the province of Ontario about whether to allow advanced practice nurses' independent prescriptive authority (Reis Bellaguarda et al. 2015). The College of Nurses of Ontario (CNO) governs nursing services in the province and as part of the reorganization of public healthcare instituted the Regulated Health Professions Act in 1991, which set out the governing framework for health professions in Ontario. As part of that framework, nurse practitioners were made responsible for the entire care process: health assessment, diagnosis, and prescription of medications. Due to the differences that existed throughout the provinces and territories, in 2015 the Canadian Nurses Association (2015) introduced the Framework for Registered Nurse Prescribing in Canada. There the vision for the principles of and the key elements considered important for nurse prescribing in Canada are delineated. Comprehensive educational programs and continuing professional development are recommended to ensure safe, secure patient treatment. Post-generalist registered nurse prescriber educational programs should:

- Be accessible. Flexible and transferable.
- Reflect national core competencies.
- Be grounded in the nursing profession's values, knowledge, theories, and practice.

- Be responsive to diverse client needs.
- Reflect the principles of adult learning.
- Promote critical thinking and diagnostic reasoning.
- Combine elements of theory and practice.

(Canadian Nurses Association 2015)

10.2 Examples of the Development of Nurses' Prescriptive Authority in the Nordic Countries

10.2.1 Sweden

In 1994, as the first Nordic country to do so, Sweden introduced limited prescriptive authority for registered nurses. This applied to registered nurses who had further education (ten credits) and worked in regional or municipal primary healthcare services or care for older people. The requirements for other nurses were that they worked in service homes or home healthcare for older people or people with disabilities or community healthcare or a comparable organization funded with public money. Registered nurses were allowed to prescribe medications from a limited formulary that encompassed the following areas: mouth and throat, stomach and intestines, nutrition, wound treatment, skin infections, eczema, face and scalp, skin, infection, urinary tract and genitals, maternity, ear-nose-throat, eyes, and others. The formulary from which registered nurses could prescribe was last updated in 2011 (Socialstyrelsen 2011). Midwives are allowed to prescribe contraceptive medications, provided that their degree was awarded after January 1, 1974, or upon completion of a contraceptive guidance training course for at least 30 h (Socialstyrelsen 1996).

Prescriptive authority in Sweden is mainly linked to non-prescription medications and, for example, some antibiotic ointments and eye creams. In a follow-up study on how nurse prescribing was realized, researchers found that most medications prescribed were linked to dry skin, constipation, mild pain, or eye infections. The nurse participants in the study expressed their dissatisfaction with the limited formulary and stated they wished to expand the medications that could be prescribed to include antibiotics for urinary tract infections and medications for patients with chronic disease (diabetes, high blood pressure, etc.) who are in a stable phase (Socialstyrelsen 2004).

In a small but interesting study set in Sweden (Rangel and Svensson 2013), researchers sought to describe registered nurses' experiences of prescriptive authority in home healthcare. The researchers found that nurse prescribing supported daily work and had a positive impact on nurses' competency. The nurse participants experienced that functional Information Technology (IT) systems were required to write prescriptions and noted that most of the medications they could prescribe were available even without a prescription. The researchers concluded that an expanded formulary was needed.

10.2.2 Norway

In 2002, Norway introduced a new scheme whereby registered nurses and midwives were given the right to prescribe contraceptive medications (contraception). This scheme has gradually been expanded since then. Previously, the right to prescribe contraception was limited to care services provided in school or healthcare center settings, and the patient group was limited to female patients aged 16–19. From January 1, 2016, forward, the previous limitations related to setting and patient group were lifted, and registered nurses and midwives were given expanded rights that encompassed the right to prescribe contraception for all female patients aged 16 and older. To insert contraceptive implants or intrauterine devices, registered nurses and midwives are required to have practical training. Physicians still retain the right to prescribe contraception for female patients younger than 16 years of age.

In 2012, the first master's-level advanced practice nursing educational programs were started in Norway, and new programs are being introduced. However, to date, the expansion of nurses' prescriptive authority has not yet been seriously discussed nor raised on the official or national level.

10.2.3 Finland

In 2010, to meet the need for a more efficient division of duties and improved interprofessional collaboration, limited prescriptive authority was introduced for several non-physician professional groups (STM 2015). This included nurses, opticians, and specialist dental hygienists. Initial requirements for nurse prescribing were as follows:

- Authorization as nurse.
- Employment relationship with a municipality/joint municipal authority (phased out in 2019).
- Work experience of 3 years and regulated postgraduate education on nurse prescribing (45 ECTS), provided at universities of applied sciences in cooperation with universities (medical and pharmaceutical education).
- Authorization from the physician-in-charge (STM 2015).

National specificities and restrictions are seen in the Finnish legislation on the regulation of nurse prescribing. As noted above, nurses were given limited prescriptive authority in 2010. The formulary for nurses was linked to specific, pre-defined vaccines, prescription medications, and certain patient groups. For example, nurses were allowed to renew a patient's medication on the condition that there was a written care plan drawn up by a physician for the patient (cf. Act on Health Care Professionals, legislation 559/1994; Finlex 1994). For patient groups, the conditions included that (a) the patient has a written care plan, (b) a physician has made the medical diagnosis, and (c) patients are diagnosed with, e.g., hypertension, type

2 diabetes, or asthma, and are in a stable phase. Nurses must be able to immediately consult a physician with regard to their work. Furthermore, the type of treatment encompassed by nurse prescribing must be noted in the patient's written treatment plan.

In 2019 (Finlex 2019) the prescription rights for nurses took an important step forward, when Health Care Act (legislation 1326/2010) was amended in 2019 (legislation 534/2019) to enable cost reimbursements to employers for education related to nurse prescribing via the national (Finnish state) budget; reimbursement can be applied when the nurse has been given the right to prescribe and the amount of the reimbursement is defined by decree. The 1994 Act on Health Care Professionals (legislation 559/1994) was also amended in 2019 to include limited prescription rights for nurses (legislation 533/2019). Even the 2010 Decree on Prescribing Medication (legislation 1088/2010; Finlex 2010) was even amended on January 1, 2020 (legislation 992/2019; Finlex 2019). As of today, nurses with prescribing authority can prescribe medications in centralized emergency units, outpatient hospital care, and home care settings; prescribing authority is also given to nurses working in private health services that provide health services for municipalities or joint municipal authorities, on the basis of agreements.

Today nurses with prescribing authority are allowed to start medical treatment autonomously and also prescribe medications for acute infections. A licensed healthcare professional may, in accordance with his/her training, experience, and job description, initiate treatment based on the patient's symptoms and available information, as well as initiate an assessment of the need for the treatment the patient is taking. A nurse may prescribe medication in the case of (1) prophylactic treatment (e.g., contraceptive medication), (2) continuation of medication prescribed by a doctor, or (3) medication based on the need for treatment identified by the nurse (limited prescription).

Valvira, the National Supervisory Authority for Welfare and Health in Finland, grants and maintains the register for professional practice rights and as such maintains the register of nurses who have limited prescriptive authority (Valvira 2016). Prior to registering a healthcare professional, officials at Valvira check that the conditions specific to the profession are met and issue an identification code that must be used in both written and electronic prescriptions. It is not possible to write a prescription without an identification code. In the event of a widespread pandemic, the Finnish government has the right to give nurses temporary prescribing rights in relation to medications that can prevent and treat the actual infectious disease.

Nurses' limited prescriptive authority has been evaluated by the Ministry of Social Affairs and Health in Finland in a study including document analyses and questionnaires and interviews with nurses, physicians, leaders, and patients (STM 2015). At the time of that study, about 200 nurses had prescribing rights. The findings were positive, and the recommendation was made to expand nurses' prescriptive authority to include specialist healthcare and private healthcare settings. The recommendation was also made to expand the formulary to include prescribed medications for common diseases in primary healthcare.

In 2012 and 2013, researchers conducted a qualitative study with the aim to describe the facilitators and barriers linked to the growth of nurse prescribing competence in Finland, seen from the perspective of nurses enrolled in a prescribing program (Hopia et al. 2016). The facilitators found that supported nurse prescribing included learning how to perform a clinical examination of the patient, networking with peers, support from the workplace and supervisors, physicians' positive attitudes toward nurse prescribing, and being able to directly apply one's competence to nursing practice. The barriers that they found inhibited nurse prescribing were unclear job description, incomplete care plans, and concerns about how the physician consultation will be organized and realized.

Between 2011 and 2020, about 500 nurses in Finland have completed the post-graduation educational programs required for them to register as advanced practice nurses, which includes limited prescriptive authority (Vallimies-Patomäki 2019). During the last years, about 100 nurses with prescription rights have been registered yearly at Valvira. In a 2019 study for the Finnish Institute for Health and Welfare, researchers found that 42% of health centers in Finland had adopted nurse prescribing, covering 51% of the population (Syrjä et al. 2019). The researchers concluded that this expansion of nurses' prescriptive authority is expected to improve access to treatment, facilitate the start of treatment, support patients' self-mastery of own health problems, and promote a rational and effective division of duties between health professions.

10.3 What Are the Benefits of Nurse Prescribing?

Over the past decade, many researchers have shown the positive effects of nurse prescribing. Discussed in more detail below, this is linked to improvement in access to care and medications, patient satisfaction, efficient division of duties, making the nursing profession more attractive, more efficient healthcare services, and economic benefits.

Improvement in Access to Care and Medications Both patients and nurses have reported that access to nursing, care, treatment, and necessary medications has substantially improved, especially in community healthcare services, where access to physicians is not on the desired level (Laterankirken et al. 2005; Delamaire and Lafortune 2010; Fairman et al. 2011). When nurses are given prescriptive authority, patients can quickly access the medications that they require without additional wait times and/or physician visits, and this simultaneously hinders the unnecessary deterioration of the patient's health condition. With prescriptive authority, nurses can solve patients' need for medications without unnecessary waits. Nurses can provide holistic care and include patients in the decision-making associated with treatment, which can also improve collaboration in the nurse-patient relationship (Bradley and Nolan 2007).

Patient Satisfaction Studies show that patients are as satisfied with or even more satisfied with nurse-led than physician-led treatment (Delamaire and Lafortune 2010; Gielen et al. 2014). Nurses in independent clinics usually spend more time on each patient, which is a possible reason underlying such results. Patients in mental healthcare also report high satisfaction with nurse prescribing (Ross et al. 2014). Mental healthcare patients found a stable care relationship with the same person over time and improvement in access to treatment and medications to be particularly valuable.

Nurse Prescribing Meets the Standards of Good Practice The usefulness of nurse prescribing is considerable, despite some problems, e.g., prescribing errors (Latter and Courtenay 2004; Darvishpour et al. 2014). Nurses' manner of prescribing and their clinical practice in this area has been investigated, and studies show that nurses' prescribing of various medications is stable, e.g., over a 3-year period, and that nurses fulfill current medication selection and dosage requirements (Latter et al. 2005; Buckley et al. 2013).

No statistically significant differences have been seen between nurse and physician prescribing in relation to, e.g., type of medications and dosage (Running et al. 2006; Gielen et al. 2014). Yet nurses are seen to offer patients other forms of treatment instead of medications (Running et al. 2006). Studies in mental healthcare settings have also shown that nurses have the competence to prescribe and that equally good outcomes linked to nurse and psychiatrist prescribing are seen (Hemingway and Ely 2009).

In a study investigating non-medical prescribing in accident and emergency and sexual health settings, Black (2013) compared 764 nurse prescribers' case notes with 490 case notes from nurses who could not prescribe. Over 53.5% of prescribers' patients were given medications with 99.8% considered clinically appropriate. Analgesia was most common in accident and emergency, and antibiotics in sexual health. The conclusion was drawn that nurse prescribing facilitated safe, appropriate, and independent prescribing practice. Similar results were seen in another study (Black and Dawood 2014).

In a retrospective cohort study in Canada (Tranmer et al. 2015), researchers found that the number of advanced practice nurses prescribing for older adults increased from 12.9% to 62.4% between 2000 and 2010 and that the number and proportion of medications prescribed for chronic conditions increased (nine out of ten medications in 2010). They also saw substantial variation between the number of nurses prescribing for older adults across provincial networks and concluded that nurse prescribing was significant in the provision of nursing, care, and treatment of older people.

Efficient Division of Duties Duties can be efficiently divided through specialization, expansion, delegation, or creation of new expanded work tasks. Expanded work tasks can be classified in two groups: (1) nursing and treatment previously provided by physicians, taken over by nurses who provide equivalent nursing and treatment, and (2) new work tasks for nurses that supplement and complement existing healthcare services (Delamaire and Lafortune 2010). Nurses' expanded work

duties can also be classified in accordance with the educational level. The transferal of duties also occurs within the nursing profession, from higher to lower levels, e.g., specialist nurse to nurse.

Making the Nursing Profession More Attractive Prescriptive authority has a positive influence on nurses' knowledge and skills in pharmacology and even on work motivation: provided one's work becomes more independent (Latter et al. 2005; Bradley and Nolan 2007; Sehic et al. 2012). Prescriptive authority is an extended responsibility for nurses, and this leads to new career opportunities. This together with increased motivation can have a positive effect on the attractiveness of the nursing profession.

More Efficient Healthcare Services The new division of duties between healthcare staff can make various parts of healthcare services more efficient and can improve a patient's treatment pathway. Because nurse prescribers can give patients a complete nursing and treatment package during a first visit and personal and holistic care from start to finish, unnecessary obstacles and delays can be avoided (Socialstyrelsen 2004; Bradley and Nolan 2007; Sehic et al. 2012). At the same time, nurse prescribers can inform and initiate dialogues with patients and their families about treatments, medications, and medications' effects and possible side effects. In this manner, nurse prescribing can contribute to involving patients in decisions concerning own treatment (user involvement).

In a survey of 868 qualified independent extended or supplementary nurse prescribers in the United Kingdom, 87% were found to use independent extended prescribing and 82% worked in primary care (Courtenay et al. 2007). The researchers found that supplementary nurse prescribers primarily treated patients with chronic conditions such as asthma, diabetes, or hypertension. Up to a third of nurse prescribers were unable to access continuing professional development, which was considered necessary to the expansion of the number of nurses with independent prescriptive authority.

Economic Benefits Despite international researchers' recommendations, there are few studies in which the economic benefits of nurse prescribing have been investigated (cost impact analysis). Increased costs have been associated with nursing clinics, where more time is spent per patient. Still, the information and guidance that patients receive during such visits have a great impact on patients' health and self-mastery, which in turn has a positive effect on healthcare service costs overall.

10.4 Factors That Inhibit Nurse Prescribing

A lack of knowledge of and understanding for nurse prescribing can hinder its development (Courtenay et al. 2007). Nurses with more independent responsibilities can feel as if they are alone with their responsibilities, and thus both support from own colleagues and leaders is important (Hall 2005). Clinical guidelines for

different patient groups and data programs that help support decision-making processes linked to prescribing are an important resource. Role clarity, a clear nursing perspective, support from leaders, and legislative support also contribute to facilitating the expansion of nurses' prescriptive authority so that it can achieve its full potential (Forschuk and Kohr 2009). Because nurses' responsibilities increase, nurses' total workload should be evaluated when prescriptive authority is expanded. It is important to take time as a factor into consideration and even that greater responsibility should result in greater remuneration (Creedon et al. 2015).

There has been discussion in mental healthcare about the barriers to the implementation of nurse prescribing in that setting. In a mixed methodology study set in Scotland (Ross and Kettles 2012), researchers found that 60% of nurse prescribers were not prescribing. This was attributed to concern about how prescribing impacts the therapeutic relationship, role conflict, lack of support, inappropriateness of prescriber training, remuneration, qualifying to prescriber time, supervisions, and clinical governance and nurse management. The researchers concluded that until the barriers to prescribing have been identified and addressed, nurse prescribing cannot reach its full potential and therefore cannot be effectively developed in healthcare services.

10.5 Conclusion

Legislative changes related to the regulation of nurses' prescribing authority are needed on the national level and are absolutely necessary if advanced practice nursing is to reach its full potential and accountability. The first evaluations of advanced practice nurses' experiences in Finland (Glasberg et al. 2009) and physicians' experiences of advanced practice nursing in Sweden (Lindblad et al. 2010) clearly show that if advanced practice nurses are not given prescriptive authority (nor given the right to refer patients for radiographic or laboratory tests), this limits advanced practice nurses' abilities to provide effective nursing, care, and treatment. It also leads to unnecessary waits for signatures from physicians part of advanced practice nurses' healthcare teams. Subsequently, advanced practice nursing models cannot work as smoothly and efficiently as they could. Nevertheless, experience also shows that advanced practice nursing roles are not entirely dependent on the expansion of prescriptive authority. Even without prescriptive authority, advanced practice nursing models and functions are of great benefit to nurse-physician collaboration in a healthcare team, because such collaboration is based on trust.

Even if nurses do not have prescriptive authority, the implementation of new advanced practice nursing models should not be delayed. Trust in the nurse-physician relationship is necessary for the development of nurse prescribing (Bowskill et al. 2013). More advanced practice nursing models will be developed, step by step, as has already occurred in many countries. Based on other countries' experiences, clear health policy decisions and strategic leadership on different levels are important to the development of nurses' prescriptive authority on an advanced level. If nurses are granted prescribing rights, then the implementation of new

advanced practice nursing models can be promoted, and such models implemented more effectively. If advanced practice nursing graduates are not given prescriptive authority, there is a risk that the development of new advanced practice nursing models will cease. New advanced practice nursing models will then have difficulty "breaking through," and it will be difficult to demonstrate the difference and benefit to patients that advanced practice nursing models have in comparison to nurses' (hitherto) "normal" practice.

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11 Core Factors for the Sustainable Development of Advanced Practice Nursing

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Abstract

In this chapter, the importance of planning and leadership during the development of new advanced practice nursing models is presented. The PEPPA (*p*articipatory, *e*vidence-informed, *p*atient-centered *p*rocess for *a*dvanced practice nursing role development, implementation, and evaluation) framework is also presented as a method whereby organizations can work strategically, systematically, and in a goal-oriented manner when implementing new advanced practice nursing models. The systematic evaluation of advanced practice nursing roles is needed to ensure sustainable development. Research shows that inconsistent professional and organizational support leads to problems and challenges in the development and implementation of new advanced practice nursing models. Consequently, clear support for new demanding nursing roles is needed from leaders and professional and trade organizations, alongside professional regulation.

Keywords

Action research · Implementation · Advanced practice nursing · PEPPA framework · Leadership · Roles

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What can one learn from other countries' experiences of implementing new operating models, where nurses are given a new role and several independent functions? International research shows that the introduction of new advanced practice nursing models involves radical change to how duties and responsibilities are shared between various professional groups. The delineation of roles and functions, demonstrated usefulness, good outcomes, as well as continuous support for advanced practice nurses who take on an expanded responsibility for patients, are the keys to the successful implementation of the advanced practice nurse function in healthcare services (Micevski et al. 2004). In a newly published scoping review of 76 publications, researchers found that team factors were simultaneously the most frequently reported facilitator and barrier to the implementation of advanced practice nursing in primary care settings (Torrens et al. 2020). Frequently reported facilitators were individual factors, supervision and leadership, and other factors (e.g., funding, planning for role integration), while barriers were individual factors, lines of responsibility, and other factors (e.g., funding). The researchers concluded that building collaborative relationships with other healthcare professionals and negotiating the advanced practice nursing role are critical to the success of implementation of the role and even noted that team consensus on the role and how it is integrated into the wider teamwork were also essential.

Other promoting factors/facilitators for implementing new advanced practice nursing roles in low-income or lower-middle-income countries are the relatively lower costs associated with educating advanced practice nurses, in comparison to medical providers, and the improved outcomes associated with advanced practice nurses' delivery of care in both primary and specialty healthcare settings.

The sustainable and long-term development of the advanced practice nursing function requires good planning prior to actual implementation and continuous follow-up and evaluation throughout the entire process. The development of advanced practice nursing functions requires strategic leadership on all levels. To these means, the development of strategic documents on the organizational and national levels and concrete goals on the unit level are essential. To ensure the sustainable development of the new, clinically demanding nursing role, clear support from leaders and professional and trade organizations, alongside professional regulation, are needed.

International experiences reveal the evident need for evidence-based approaches and methods during the development, implementation, and evaluation of the advanced practice nursing function (Bryant-Lukosius et al. 2004; McNamara et al. 2009; Serena et al. 2015; Doetzel et al. 2016). If professional or trade organizations are unable to clearly identify the objectives of and the need for advanced practice nursing and possible barriers to the development of new advanced practice nursing roles, it will be difficult to implement change. Research shows that inconsistent professional and organizational support leads to problems and challenges in the development and implementation of new advanced practice nursing models (Micevski et al. 2004). Nevertheless, the continuous evaluation of new operational models can prevent problems.

11.1 Effects of the Inadequate Planning of New Advanced Practice Nursing Models

A common problem during the implementation of advanced practice nursing models is that leaders, other healthcare staff, and politicians do not have complete knowledge of what advanced practice nursing is (Bryant-Lukosius et al. 2004). Such a lack of knowledge hampers communication and the development of new advanced practice nursing models. Common problems include that the objectives and purpose of the advanced practice nursing role are vaguely formulated, role description and distribution of responsibilities are unclear, and expected outcomes are not formulated nor described. Spreading information and knowledge to nurse leaders, other healthcare leaders, prospective team members (colleagues), politicians, and patients about what the advanced practice nursing role entails and the benefits and outcomes that advanced practice nurses can bring to patients and healthcare services is of great importance.

The implementation of advanced practice nursing entails changes in both role understanding and collaboration between physicians and other healthcare staff. Unless these changes are discussed and anchored in both leadership and work groups, problems and conflicts can arise. If such occurs, advanced practice nurses' competence and skills may not be fully utilized.

Inadequate planning has led to resistance, lack of acceptance among staff, role conflicts, and advanced practice nurses' increased work burden, which in turn effects both well-being and job satisfaction. In the long term, this leads to the risk that the advanced practice nurse quits and new staff must be recruited. The inadequate planning and implementation of outcomes lead not only to advanced practice nurses' clinical competence not being fully utilized but also extra costs because of the inefficient use of resources and, in the worst case, poor care quality and patient safety (Bryant-Lukosius et al. 2009).

Poor planning when implementing new advanced practice nursing roles can lead to undesired effects for an organization, such as:

- Poor stakeholder acceptance of the advance practice nursing role.
- Role conflict.
- Role overload.
- Poor advanced practice nurse job satisfaction.
- Difficulty recruiting and retaining qualified advanced practice nurses.
- Impaired quality of care and patient safety.
- Lost opportunities for innovation and to benefit from advanced practice nurse expertise (for patients, health providers, the overall healthcare system).
- Ineffective use of limited healthcare resources.
- Negative impact on long-term role sustainability.

(Bryant-Lukosius et al. 2004, 2009).

11.2 Leadership's Importance for Implementation

Support from different levels is essential to the effective implementation of advanced practice nursing in clinical practice. A supportive environment can deliver maximum outcomes for patients, various healthcare team members, the healthcare organization, and society in general (Canadian Nurses Association 2008). To succeed in starting and driving models of advanced practice nursing, strategic leadership is needed on all levels of healthcare services, including the community healthcare level.

The word "why" is central in all development. It is not enough to know "what" or "how" in relation to the development of new advanced practice nursing models. Having clear justifications and visions for why the healthcare sector needs new advanced practice nursing care models (Peters and Roodbol 2020) are most important. Having a clear "why" entails formulating a vision for the entire development process, because without a clear vision there is a risk that leaders "give up" when faced with adversity and/or resistance. Resistance to more independent nursing roles seem to be extremely common, due to historical power hierarchies.

Guidelines in strategy documents whereby future activities are delineated are necessary but not enough on their own. Specific and clear strategies should be delineated and activities/service planned to realize the outlined objectives of advanced practice nursing. Nursing resources should be allocated to the implementation process, and the continuous evaluation of outlined objectives should be initiated. If guidelines are not anchored on various levels to concrete activities, both in health policy and with strategic stakeholders, the guidelines and strategies become mere "declarations of will" without significance for or effect on the development of healthcare services.

Systems should be developed so that the right to refusal linked to advanced practice nursing duties is anticipated and incorporated. Experiences from other countries show that when introducing more independent nursing roles, including expanded nurse responsibility, prevailing power structures and ingrained notions of professional boundaries are "threatened" (OECD 2010). Such changes can spark opposition from colleagues or other professional groups. Consequently, advanced practice nurses need both personal and organizational support from their closest leaders.

To create new positions for advanced practice nurses, leaders must have a long-term and clear strategy. For the implementation of advanced practice nursing roles to succeed, both the advanced practice nurses themselves and their leaders must actively influence and drive the process forward.

Clear leadership and support from professional organizations are also necessary for the sustainable development and implementation of advanced practice nursing on the organizational level. National nursing associations and organizations (whether regional, national, or international) should therefore engage in strategic decision-making regarding the development of advanced practice nursing, especially regarding the definition of concepts, standardization, legitimization, and certification of advanced practice nurses.

11.3 The PEPPA Framework and the Development and Evaluation of Advanced Practice Nursing

The implementation of new roles and functions is demanding. In healthcare, many different parties and stakeholders should be included in such a process. International experiences of difficult and at times failed implementation processes reveal that there is a need for a reference framework for the introduction and evaluation of new advanced practice nursing roles and functions. A research group in Canada developed the PEPPA framework to guide this implementation and evaluation. The assumption underlying the framework is that the advanced practice nursing role can maximize, maintain, and restore patient health through new nursing innovations and in all healthcare practice (Canadian Nursing Association 2008). PEPPA stands for:

- *P*articipatory.
- *E*vidence-informed.
- *P*atient-centered.
- *P*rocess for *a*dvanced practice nursing role development, implementation, and evaluation.

The goals of the PEPPA framework are to:

- Use the best evidence and relevant sources of data to identify the need and establish goals for a clearly defined role.
- Support the development of a nursing orientation to practice that is characterized by patient-centered, health-focused, and holistic care.
- Promote the full integration and use of advanced practice nursing knowledge, skills, and expertise in all role dimensions related to clinical practice, education, research, organizational leadership, and scholarly/professional practice.
- Create practice environments that support advanced practice nursing role development by engaging stakeholders in the planning process.
- Promote ongoing role development and model of care enhancement through monitoring and rigorous evaluation of progress in achieving pre-determined outcome-based goals (Bryant-Lukosius et al. 2009).

The use of the PEPPA framework facilitates a systematic approach to the development of advanced practice nursing roles that are founded on patients' actual healthcare needs. The PEPPA framework has been developed from a foundation consisting of the principles of action research and the "structure-process-outcome" approach recommended by Donabedian for evaluating healthcare services. The objective underlying the framework is that it should serve as guidance for researchers, healthcare staff, administrators, and health policy-makers, whereby the optimal development and dissemination of advanced practice nursing roles are promoted (Bryant-Lukosius et al. 2009). The importance of the continuous development of

advanced practice nursing roles through all phases (from planning to implementation) is emphasized in the framework.

The PEPPA framework consists of nine steps. In the various steps, there are descriptions of how the stakeholders involved in deciding whether there is a need for new advanced practice nursing roles

can identify common objectives and effective strategies for planning, introducing, and integrating the roles in healthcare overall (Bryant-Lukosius and DiCenso 2004; Canadian Nurse Practitioners Initiative 2006; Bryant-Lukosius et al. 2009). The PEPPA framework also includes guidance on both the short-term and long-term evaluation of whether new advanced practice nursing roles correspond to delineated needs and objectives.

In steps 1–6, focus is placed on establishing structures for the new role, including decision-making processes in the various parts of the healthcare system and planning of the new operating model. In step 7, the actual introduction of the new advanced practice nursing role is described. In steps 8 and 9, both short-term and long-term evaluation are described.

- *Step 1: Define the patient population and describe the current model of care*

  Identification of the priority patient population should occur at the start of the process. It is important that various interests and parties are heard. Professional teams should together discuss, seek to understand, and describe the current model, i.e., how, when, and who the patient population meets in the care pathway. Professional, organizational, and geographical perspectives should be taken into consideration.
- *Step 2: Identify stakeholders and recruit participants*

  Individuals from key stakeholder groups involved in the nursing, care, and treatment of the patient population should be identified and invited to participate in the reformulation of the patient population's care pathway and treatment process. It is important to include various perspectives on how the patient population's treatment is integrated/involved. The views of patients and their family members should also be included in the process.
- *Step 3: Determine the need for a new model of care*

  The strengths and weakness of the current model of care regarding the ability to meet the patient population's healthcare needs should be assessed emanating from the various stakeholders' perspectives. Collected data on the scope, severity, and need for care relevant to the patient populations' healthcare needs should be evaluated, and it should be decided whether the current model of care fulfills the patient populations' needs and/or whether change is needed.
- *Step 4: Identify priority problems and goals to improve model of care*

  The participants should come to an agreement on what the most important healthcare needs not being met in the current model are. When identifying problem areas, new outcome-based objectives can be set through which the model of care and patient pathways can be improved.
- *Step 5: Define new model of care and APN role*

Strategies and solutions through which the determined objectives can be meet should be identified. What must be changed should be identified and determined, related to the realization of nursing, care, and treatment (i.e., the nursing measures, interventions, and procedures that should be changed) as well as the division of responsibilities between health professionals. Available advanced practice nursing model alternatives should be analyzed. If a new advanced practice nursing function is implemented, a clear work position description should be provided.

- *Step 6: Plan implementation strategies*

  Participants should develop a plan to ensure that the new model can be implemented in the organization. Possible barriers should also be identified. The following factors should be evaluated: need for (advanced practice nurse and stakeholder) education, information and marketing, recruitment, reporting systems/structures, funding, and the development of necessary documents. Also, timelines for role implementation and the evaluation of the implementation process should be developed.
- *Step 7: Initiate APN role implementation plan*

  Implementation of the new advanced practice nursing role begins. It is important to be aware that full implementation of the new model is a time-consuming process that can take between 3 and 5 years. The progression and development of the process must be continuously documented, modified, and changed as needed during implementation. The implementation process is a continuous process that is influenced by many factors in the actual context.
- *Step 8: Evaluate APN role and new model of care*

  The systematic evaluation of the new advanced practice nursing function, including its structure, process, and outcomes, is recommended as a strategy whereby continuous role development can be promoted. This can reveal both what hinders and what promotes the advanced practice nursing function. An evaluation of the outcome-based objectives is both necessary for and important to continued development. Furthermore, continuous evaluation of whether other support and measures are needed to further develop the role should occur.
- *Step 9: Long-term monitoring of the APN role and model of care*

  Continued follow-up and documentation of how the advanced practice nursing function and model have been developed are necessary so that continuous changes can be made in accordance with new patient needs, treatment principles, and healthcare system challenges. A prerequisite for sustainable development is the use of a long-term perspective in follow-up.

The PEPPA framework has been now used in several contexts. Experiences show that the framework can facilitate the development of new advanced practice nursing functions and roles (McAiney et al. 2008; Robarts et al. 2008). The PEPPA framework has been used to support leaders, planners, and administrators in introducing new advanced practice nursing roles in primary care (Canadian Nurse Practitioner Initiative 2006). The PEPPA framework has also been used on both regional and national levels throughout the world to support the development of

new treatment models and to inform and develop the strategic governance documents and action plans necessary for effective implementation. The PEPPA framework has even been used in the introduction of new advanced practice nursing models in various settings, including oncology, acute care, and the treatment of patients with chronic disease in primary healthcare (Bryant-Lukosius et al. 2009; Doetzel et al. 2016). The PEPPA framework has moreover been shown to work well in the introduction of advanced functions for physiotherapy and radiography. The PEPPA framework has additionally been used in Canada, when the specialized nurse practitioner role was introduced, and in Switzerland, in the implementation of advanced practice nursing for patients with lung cancer (McNamara et al. 2009; Serena et al. 2015).

Seeking to address the gap in the evidence-based information required to support the development of the advance practice nursing role in Switzerland, Bryant-Lukosius et al. (2016) developed a framework for the evaluation of advance practice nursing roles that was found to be sufficiently generic to allow application in developed countries throughout the world and can be used for systematic evaluation as well as research. Actual literature and the aforementioned PEPPA framework were analyzed. The evaluation framework that emerged can be used for evaluating different types of evolving advance practice nursing roles, and the framework matrix presented included key concepts that can be used to guide evaluations across three stages of advanced practice nursing role development: introduction, implementation, and long-term sustainability.

During the introduction stage, the determination of stakeholder needs that can be met by advanced practice nursing roles and the promotion of advanced practice nursing role clarity among stakeholders are central. Promotion of role clarity is achieved by ensuring that a new role meets the identified needs. During the implementation stage, the ensuring of appropriate resources whereby various advanced practice nursing roles can be supported in different practice settings; the improvement of understanding on how advanced practice nursing roles impact patients, organizations, and surrounding society; and the optimal utilization and implementation of advanced practice nursing roles by monitoring trends in practice patterns are central. During the long-term sustainability stage, demonstrating the long-term benefits and impact of advanced practice nursing roles to various stakeholders (healthcare consumers, providers, organizations, overall healthcare system) and ensuring that advanced practice nursing roles meet the needs of the healthcare system are central.

To facilitate the application of the evaluation framework, serial tools were developed. Through these, among others, the objectives, i.e., answers to the questions related to the examination of advanced practice nursing role structures, processes, and outcomes from different perspectives (e.g., patients, providers, managers, policy-makers), can be mapped. A more detailed proposed framework for evaluation, the PEPPA Plus, was published and introduced in 2015 (see Fig. 11.1; Bryant-Lukosius et al. 2015, 2016).

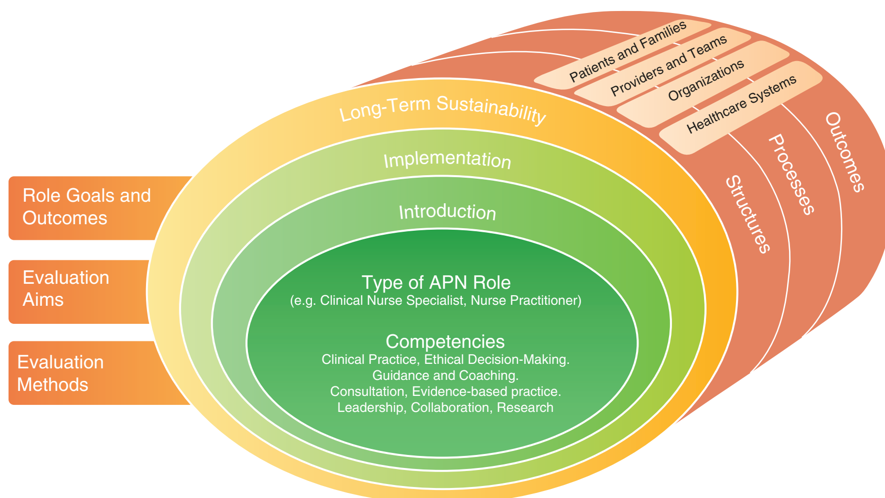

Fig. 11.1 Evaluation framework matrix-key concepts for evaluating advanced practice nursing roles (Bryant-Lukosius et al. 2016)

11.4 National Guidelines and Certification Schemes

In a mapping of nurses in advanced roles in 12 developed countries (OECD 2010), deficiencies in educational systems, legislation, and the regulation of healthcare professionals' work and duties were seen to be factors that inhibited the introduction of advanced practice nursing. The recommendation was made to develop (on the national level) guidelines for national standards for the education of advanced practice nurses and develop systems for the certification and recertification of advanced practice nursing competence. Schober (2016) emphasizes the clear importance of professional regulation for advanced nursing practice. Professional regulation consists of the rules and policies through which an advanced practice nurse is recognized and given official certification (credentials) for practice. Through rules and policies, a profession and its members are defined and the scope of practice determined. Regarding advanced practice nursing, standards of education and the determination of what constitutes ethical and competent practice should be determined, as well as systems of accountability. Through legislation and professional regulation, a distinct title designation and protection for the advanced practice nursing role should ideally be provided. Clear authority to carry out a range of activities in advanced practice nursing should be delineated in national systems, and a formally authorized institution or agency is recommended. Formally authorized institutions should oversee a clear regulatory system whereby the advanced practice nurse role can be legitimized, the public protected, and individual healthcare professionals' practice and behavior monitored.

Changes to laws and regulations governing the rights of nurses in professional practice are essential to advanced practice nursing being developed to its full potential. Studies on the first evaluation of advanced practice nurses' experiences of working post-education in Finland (Glasberg et al. 2009; Wisur-Hokkanen et al. 2015) and physicians' experiences of the advanced practice nursing role in Sweden (Lindblad et al. 2010) clearly reveal that if advanced practice nurses are not given prescriptive authority or the right to order radiographic or laboratory tests, this limits the realization of their effective nursing, care, and treatment. This in turn leads to unnecessary wait times for, e.g., a physician's signature. When such occurs, an advanced practice nursing model does not work as smoothly and efficiently as it might otherwise. Experiences also simultaneously show that the advanced practice nursing role is not entirely dependent on, e.g., prescriptive authority or the right to order radiographic/laboratory tests. Despite limited prescriptive authority, a new advanced practice nursing role can benefit patients if nurse-physician collaboration is well functioning and based on trust. There should be no delay in the introduction of new advanced practice nursing models, even if the optimal rights to implement autonomous functions do not exist. Still, experience from Norway (Holm Hansen et al. 2020) shows that the lack of professional regulation can impede the sustainable development of new advanced practice nursing roles. There, nurse practitioners with a master's degree in advanced practice nursing have found it difficult to clarify and organize their roles in the preexisting work models. There was consequently a risk that they were unable to fully use their competence, because knowledge of what advanced practice nursing is was lacking.

As seen in many countries, the development of advanced practice nursing models occurs step by step. Experiences show that clear health policy decisions, legislative changes, professional regulation, and strategic leadership on various levels are all necessary for the successful expansion of nurses' rights.

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Leading Change When Implementing Advanced Practice Nursing

12

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Abstract

The healthcare services of many countries are undergoing major changes, which require clear leadership. The introduction of new advanced practice nursing roles is a big change that affects all the healthcare staff involved, and such change be met with resistance. Accordingly, visionary leadership and a leader's ability to lead change become central to the process. Change is not a clear-cut concept but has instead many different dimensions. According to Kotter (Leading change, Harvard Business School Press, Boston, MA, 1996), the change process as seen in organizations can be described in eight steps. In the three-dimensional model for leading change in healthcare, leading change in a clinical context is to lead relationships, processes, and cultures, with the patient's best as the primary objective. In all change processes, the change leader's dialogue with staff about a common vision and concrete objectives is a prerequisite for success. Advanced practice nurses often shoulder leadership responsibility and therefore have the possibility to contribute to the development of healthcare services that truly benefit the patient and the patient's needs and desires.

Keywords

Change management · Leadership · Advanced practice nursing · Vision

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The healthcare services of many countries today are undergoing major and profound changes on both the primary and specialist healthcare service levels, which often entails an increase in the demands placed on healthcare staff's competence and skills. Implementing change is no easy task for healthcare service leaders, where "human resources" in the form of professionally skilled staff are the most central resource for services and their outcomes. Leading the development of competence in staff-intensive healthcare organizations is a demanding task, because healthcare organizations are traditionally often characterized by (inter)professional group hierarchy. By the very nature of the services offered, patients themselves already make great demands on healthcare services, and these demands and needs will increase in the future. Consequently, the development of new healthcare service and treatment forms are needed. The introduction of advanced practice nursing into an organization, with its expansion of nurses' professional practice, necessitates changes in established professional roles. This in turn requires a change in the organization's thinking, actions, cultures, and values. Those who lead change (change leaders) therefore need not only both the knowledge and will to lead these changes but also a vision and purposeful willingness to implement them.

Leading change in a clinical context is to lead relationships, processes, and cultures, with the patient's best as the primary objective (Fagerström and Salmela 2010; Salmela 2012). In all change processes, a condition for success is the change leader's dialogue with staff about what the common vision and concrete objectives for the change are.

12.1 Advanced Practice Nursing as Management's Vision

The introduction and implementation of new advanced practice nursing models require not only a change in traditional interprofessional boundaries but also a change in inter-gender boundaries. The nursing profession continues to be female dominated, and nurses are often expected to play an assistive role, primarily for those trained in medicine (e.g., physicians), in traditional models. Traditionally, physicians make the decisions related to patient care, while nurses provide the care and assist the physicians. The introduction of the advanced practice nursing function changes how healthcare services are delivered and organized and thereby also requires that changes be made to organizational and treatment structures. In the advanced practice nursing function, care and clinical decision-making related to patients' nursing and treatment are combined into a new functional whole, which leads to "added value" for patients. Yet the advanced practice nursing function also requires a radical change in thinking in terms of attitudes: in the nursing profession, in other healthcare professional groups, among healthcare service leaders and the general public.

Healthcare services are often described as complex, interdisciplinary, and highly specialized knowledge organizations, with a structure and leadership steered by politics, administration, and various professional groups. In complex organizations,

collaboration is by virtue both necessary and a condition for good outcomes (Brommels 2001; Norbäck and Targama 2009). To implement advanced practice nursing models, both the decision and will to actively work on changing healthcare service roles are required: among nursing leaders, organizational leaders, and politicians.

The expansion of nurses' independent professional practice involves utilizing the (resource) potential to eventually reduce or shorten hospital stays (cf. Keeling 2009). The increased efficiency and availability of services, everyday cost savings, and the release of medical resources can also be noted here, all of which benefit patients with more challenging medical problems (Lindblad et al. 2010). Nevertheless, the expansion of nurses' professional role gives rise to discussion, both within the profession and among other professional groups. According to Norbäck and Targama (2009), this is about daring to ask questions and revaluating work methods to change established professional roles and ingrained traditions. The introduction of advanced practice nursing entails a change in habits and practice, and, as with all other changes, such changes will most likely be met with resistance. Realizing the vision of advanced practice nursing will be a major challenge for leaders in today's healthcare systems. Only once leaders take their responsibility and "burn for" advanced practice nursing can one say that they are willing to fight for patients' better treatment, which can be realized through advanced practice nursing and advanced practice nurses' specialized knowledge and expertise.

During a change process, it is essential to have a clear and shared vision for those activities considered meaningful, and this vision should be based on key fundamental values. The vision can be considered a tool whereby an organization's management can motivate and inspire different professional groups and give guidance on and direction toward the objective being sought. Nurse managers advocate not only for themselves but also for other nurses and the nursing profession (Borthwick and Galbally 2001; Thorpe and Loo 2003).

The vision must be "brought down" to a concrete level, e.g., who does what and how, so that healthcare staff can contribute to the change process. To develop actions and changes, the vision must be anchored in the organization's management, in one's own profession and among other professional colleagues. This requires dialogue and information on the objectives and measures used to increase healthcare staff's engagement and sense of participation. This also requires monitoring of the follow-up of the change process and milestones part of the process (Salmela and Fagerström 2008; Fagerström and Salmela 2010).

12.2 Change as a Phenomenon and Concept

To realize change, both internal drivers, e.g., individuals or organizational groups that lead and drive individuals' interests, and external drivers underlying the changes are needed (Sveningsson and Sörgärde 2007; Norbäck and Targama 2009). External drivers can be changes in activities or services, new forms of knowledge, or various

technological, medical, medical, technological, and pharmacological advances. They can also be changes in economic, political, cultural, or demographical circumstances. Given that circumstances are continuously in flux, one must remember that it can be difficult to realize a planned change or development when the drivers also are changing.

Change as a *phenomenon* is difficult to classify or categorize (Sveningsson and Sörgärde 2007). A phenomenon has its starting point in subjectivity and is based on discretion. A phenomenon can also be understood as an extraordinary event. Change as a phenomenon follows a human being throughout his/her entire life. Human beings experience many changes and extraordinary events in their personal lives, and even own health and life situation change throughout one's life.

Change as a *concept is not clearly defined in nursing literature and therefore should be clarified. Change as a concept is value neutral in comparison to the concept of development, which often includes an appraisal of the purpose of the development. Koort's substance-oriented research methodology is one method used in nursing science research for concept analysis and conceptual investigations, through which the content and extent (dimension) of a concept can be investigated* (Koort 1975). In Koort's methodology, analysis consists of four parts: etymological analysis (examination of a term's genesis or original meaning and transformation), semantic analysis (examination of different dictionaries and thesaurus), discrimination analysis (exploration of closely related concepts; leads to a matrix phase, paradigm phase, and interpretive phase), and testability analysis. As part of the lexical investigation, i.e., those words and linguistic expressions linked to the meaning of the concept, material is taken from dictionaries published within a certain timeframe.

As part of a semantic analysis, researchers in a theoretical study applied Koort's methodology in light of Katie Eriksson's approach for concept determination to investigate the word "change" (Salmela et al. 2007). There the ontological determination resulted in two main contents of meaning (dimensions) for "change": transformation and shift (exchange or barter; Salmela et al. 2007). The most important concepts in the first dimension were "conversion," "change," "reform," and "development," whereas the most important concepts in the second dimension were "fluctuation" and "variation." The researchers concluded that change as a transformation entails that someone or something undergoes a reforming (a transformation or metamorphosis). This occurs through a transformation or renewal of something or through giving something another meaning. Change as development entails a divergent or altered pace for an action or thing that is characterized by instability. In the overall hermeneutic interpretation of the concept, and which can be used by nursing leaders, the researchers found that the concept of change can be understood as coming from either external or internal to an organization and that change as action requires a certain form. To realize lasting change, thought patterns must be changed through the transformation of thoughts, perceptions, and values (Salmela et al. 2007).

The results and analysis of the concept of change above can be compared to Ahrenfelt's (2001) model of change. According to Ahrenfelt, there are two different

types of change: first-order change and second-order change. In first-order change, no deeper changes occur. A relationship or situation changes without much thought being applied or without the solution to solving the problem being changed. This means that the old pattern of thoughts is still used. In second-order change, conversely, thoughts and perceptions of reality have changed, and because of such change, actions are changed. Reality is understood in a different way, and, using this new pattern of thoughts, new solutions to old problems are found. In Ahrenfelt's model, an organization is characterized by the fact that it is an open, living system undergoing continuous change and is influenced by the milieu and environment in which it exists. Also Alvesson (2001) highlights that a transformative daily life and transformation in daily life are a type of culture and, thereby, an activity.

12.3 Theoretical Perspectives on Leadership During Change

The objective of leadership during change, so-named change leadership, is to achieve good outcomes. Each change is unique, and a change leader should take into consideration the present circumstances and factors that affect the situation in the change context (Ahrenfelt 2001, 2013). As a change leader, conscious decision-making is needed if one is to truly realize lasting change, i.e., second-order change.

In Blake and Mouton's (1985) Managerial Leadership Grid, renamed the Leadership Grid®, a change leader should realize the objectives for a change process through others by mobilizing human resources in an integrated system. As seen in the *leadership grid*, to achieve an objective, a leader must adapt his/her leadership style to prevailing conditions or circumstances, i.e., to the tasks to be done and the individuals in the organization (Northouse 2007; McKee and Carlson 1999). The change leader must concentrate on steering outcomes, i.e., production and relationships (human beings) (Blake and Mouton 1985; Carlson et al. 2006). Relationships and tasks are equally important in achieving good outcomes (Northouse 2007).

Blake and Mouton's model was designed to help explain how organizations can achieve their objectives through two factors: concern for production and concern for people (Northouse 2007). Tasks and relationships are equally important in achieving good outcomes. In concern for production, one sees how important it is that the people/staff achieve the goals of the organization. In concern for people, the change leader cares and is concerned with the people/staff in the organization. This increases staff's engagement and creates trust that is based on respect.

Extrapolated to a healthcare system, the change leader's responsibility is to develop new healthcare services, realize policy decisions, follow decision-making outlines, and take responsibility for issues related to different types of processes (treatment and change) and staff workloads (Blake and Mouton 1985; Northouse 2007). The change leader should guide and facilitate the work being done to achieve the performance objectives while simultaneously maintaining and developing relationships and teamwork (Yukl 2006).

To gain insight into how an organization works, the change leader must also understand how staff think, follow, react, and act. It is the people in the organization who largely determine the outcome of change processes (Alvesson and Sveningsson 2007). To succeed in change and development work, the change leader must work closely with his/her colleagues. The change leader's role is to coordinate his/her colleagues in a targeted manner and with an emphasis on the purpose of the change.

A change, and especially a planned change, can be considered a process that includes a variety of events and measures that develop over a period. Leading change is to lead processes (Ahrenfelt 2001; Jacobsen 2005; Fagerström and Salmela 2010). In a process organization, which modern healthcare systems are, change leaders should focus on people, processes (Ljungberg and Larsson 2001), and the organization's prevailing culture and values. The cultural dimension plays an important role in change, which is not clearly seen in Blake and Mouton's Leadership Grid®. In other words, leading a culture is also an important dimension in the change process (Salmela et al. 2012).

12.4 The Eight Steps of the Change Process

The introduction of advanced practice nursing, with its new models and roles, entails profound organizational changes. How is one to succeed as a change leader in leading second-order change? As a well-recognized American professor at Harvard Business School and a specialist in change management and leadership, Kotter (1996) emphasizes the importance of the leadership role during the various phases of a change process. Leadership largely consists of communication, which must also be rooted in the vision of change (Kotter and Cohen 2002). The real challenge, however, lies in changing people's actions and activities and getting them to see reality so that it affects their actions. Kotter maintains that emotion is the real "heart" behind change.

Kotter created what he called the eight-step process for leading change, the steps that a change leader should take into consideration if they want to succeed in realizing change. Note that the order of these steps is interchangeable.

Eight-step process for leading change:

1. *Create a sense of urgency*. Through honest and open dialogue, staff should gain the feeling that there is a rush or a crisis. Compelling arguments can be used to help staff understand the need for change, and the importance of that something needs to be done to solve the problems delineated.
2. *Form a powerful coalition* (cf. PEPPA framework; see Chap. 13). Bring together a group of key individuals who have the right qualities and sufficient "power" to guide, lead, and manage the change. These key individuals should also have a trusting and dedicated approach to each other and the specific task they are given.

3. *Create a vision for change.* Create a compelling and clear vision through which a direction is clearly given. Steer efforts using a clear strategy that reveals how the vision is to be achieved but which nevertheless does not preclude flexibility.
4. *Communicate the vision*. Communicate/convey a simple vision that is repeated in many forms, to promote understanding and convince. The goal is to get as many people as possible to act in a manner that makes the vision become reality.
5. *Remove obstacles*. Barriers that block the desired actions/activities, both on the individual and organizational levels, should be removed. This can be done by developing structures, providing training, giving customized information, or developing staff systems that support the vision and by confronting those resisting the change.
6. *Create short-term wins.* Give people a "taste of victory" early on. Short-term wins can be small but can contribute to nurturing staff's confidence in the change. Such wins help reduce cynicism, pessimism, and skepticism. However, do not forget the long-term objective; remember to maintain the drivers behind the effort.
7. *Build on the change. From* short-term wins, the change will gain both direction and speed. Continue to implement changes one by one so that the vision becomes reality, despite perhaps unsolvable problems. Continue to seek new ways to maintain the pace of the change.
8. *Anchor the change.* Ensure that staff continue to act in the new (changed) way, despite eventual opposition from "tradition," by allowing new ways of working to take root in the reformed organizational structure. A new supportive culture creates the foundation for new ways of working.
   (Adapted from Kotter 1996)

12.5 The Three-Dimensional Model of Leading Change in Healthcare

Similar to other contexts, in healthcare change leaders should lead change processes both cognitively and emotionally and should create a framework for change by communicating it as a positive challenge. Change leaders' ability to effectively communicate change through all change processes is of great importance. Change leaders should lead relationships and work for the entire team and not, e.g., solely focus on individual advanced practice nursing roles. At the same time, change leaders should emphasize the change process and prevailing culture (Reay et al. 2003; Carter et al. 2010; Fagerström 2011; Salmela et al. 2012, 2013).

The three-dimensional model of leading change in healthcare is in part based on Kotter's theory of leading change and is in part a further-developed version of Blake and Mouton's (1985) Managerial Leadership Grid model, which is concerned with both production and people (Salmela 2012; Salmela et al. 2012). In the three-dimensional model, there is a focus on good patient care, and its three dimensions are leading relationships, leading processes, and leading a culture.

The change leader is responsible for leading performance, outcomes, and staff. To achieve a change process outcome, a change leader must work through others. Consequently, the model incorporates the view that human relationships are of great importance during a change process; the effective change leader should guide and facilitate efforts to achieve objectives while simultaneously maintaining relationships and teamwork (Fagerström 2011).

Because change can be considered a series of events that develop over a period of time, change can be seen as leading processes (Kotter 1996; Ahrenfelt 2001; Fagerström and Salmela 2010; Fagerström 2011). Each change is unique, so a change leader must take the circumstances and context into account. The change leader's leadership style should also be adapted to the unique time or situation, and change leaders must even be able to switch the role they play, especially in difficult times. Consequently, there are no universal tools or solutions through which change can be led; leading change is more about putting together the pieces of a puzzle (composed by knowledge and changes). Consequently, more than one solution or path to change exists (Yukl 2006; Fagerström 2011; Salmela 2012; Salmela et al. 2012).

When leading change in the form of leading relationships, results, and processes in the healthcare setting, change leaders' actions also stem from their core values, norms, assessments, and ideals (Blake and Mouton 1985; Fagerström and Salmela 2010; Salmela et al. 2012). Change leaders' leadership style should correspond to the ethics inherent to healthcare professions and, furthermore, to the history and culture of an organization (Fagerström and Salmela 2010; Salmela et al. 2012). Schein (2004: 20) defined organizational culture as:

> *A pattern of shared basic assumptions that was learned by a group as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught new members as the correct way you perceive, think, and feel in relation to those problems.*

A healthcare organization's culture is characterized by how those in the organization interpret the care reality, how they relate to the care work, and how they act and interact with others (Fagerström 2011). The culture reveals which frames of reference are relevant for the nursing staff's common thought patterns and values. Metaphorically speaking, the culture can be viewed as "social glue": which sticks things together and creates an identity through cohesion. Culture can also be understood as a compass that provides direction (Salmela 2012). One of the challenges that change leaders face during change is the maintenance of a clear and distinct ethos in the caring tradition. Aside from the change process, the change leader must support staff's ethical foundation and a caring culture that is based on charity and should further develop an evidence-based care culture (Eriksson and Nordman 2004; Lindström et al. 2006; Salmela et al. 2013).

The implementation of new advance practice nursing models affects the power relationships that exist between professions, because a change in work processes and functions can cause anxiety, uncertainty, and stress on all levels. Staff's reaction

to a change can be similar to the patterns seen with traumatic events, e.g., denial, anger, grief, and adaptation (Yukl 2006; Fagerström 2011). Change leaders often ignore the emotional aspect of change and how change can affect a person. Researchers have shown that a lack of education in leading change processes among nurse leaders is a barrier to implementing a new role in healthcare. Knowledge of change as a phenomenon is especially important for nurse leaders, as this enables them to understand and facilitate a change process (Salmela et al. 2013). Despite discontent and negative attitudes, the change leader should take into consideration staff's willingness to participate and should maintain relationships and teamwork by guiding, motivating, and demonstrating norms and standards. Change leaders must invite others to communicate and to engage in an open dialogue with mutual feedback and must create an atmosphere where reflection and discussion are taken into consideration. This helps create a sense of security and modulates possible feelings of uncertainty and/or resistance to change. It is in the change leader's fundamental attitude and in relation to both patients and healthcare staff that the change leader's ethics are reflected. They are even reflected in the change leader's responsibility to serve the cause of caring (Fagerström 2011; Salmela 2012).

The three dimensions of nursing leadership during change in healthcare can be illustrated through the following interpretative pattern (Salmela 2012: 56) (Fig. 12.1):

Advanced practice nurses lead change and contribute to change, which is part of the work inherent to the introduction of new models of care. Change leaders and advanced practice nurses as leaders must work with nursing staff to implement change. Advanced practice nurses are clinical experts and often in a position where

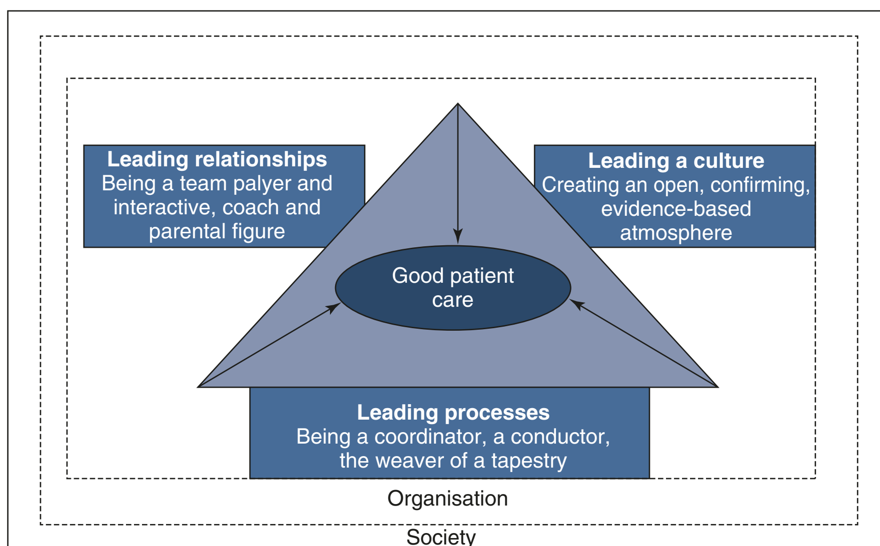

Fig. 12.1 Interpretive pattern:—a three-dimensional model of the main tasks and roles of nurse leaders during a changes process (Salmela et al. 2012: 429)

they can coordinate and lead interdisciplinary teams through restructuring processes in clinical practice (Saxe et al. 2007; Fagerström 2011; Elliott et al. 2013).

12.6 Understanding Change and Resistance to Change

Understanding is important to realizing a change process, but one must remember that resistance is also present alongside change. The change leader can encounter resistance, despite several individuals or more demonstrating understanding for the necessity of the change. Understanding for change acts like a driver for the change process, while resistance to change acts like a counterforce to the process. Nevertheless, resistance can also be used and transformed into positive engagement.

How each person interprets and perceives reality affects his/her actions in an organization and is dependent on the person's background, experience, and position. The basis for decision-making and actions is composed of a person's thought patterns and how he/she interprets which he/she experiences. Both emotions and cognitive aspects influence a person's thought patterns (Ahrenfelt 2001). Thought patterns can be considered a description of the reality that a person perceives as being the "true" reality. It is also possible to consider thought patterns to be patterns of understanding, which can differ between professional groups. One should therefore strive to (re)consider whether certain changes can be realized. Human beings' patterns of understanding are emotionally rooted, which can lead to difficulties with and resistance to change (Ahrenfelt 2001, 2013; Jacobsen 2005; Norbäck and Targama 2009).

For change to become something real, tangible, and adapted to a healthcare unit or organization, the initiative for the change must be "translated" and made concrete. The change leader should aim to identify both the drivers for and counterforces to the change prior to initiating the change, so that the drivers and active support can be steered and/or the counterforces and active resistance can be reduced.

Resistance to a change process is a normal and healthy reaction, i.e., it is a defense mechanism used when a person does not understand or encounters a threatening situation: a way to address fear and anxiety (Ahrenfelt 2001; Jacobsen 2005). Usually there is resistance to the social and psychological consequences that change can entail. The change leader can use the engagement of those who are critical to the change to their advantage, because such can be transformed into an active and positive engagement in the change.

The degree of resistance varies depending on how clear the initiative for the change is, its content and the size of the change, as well as the structure of the change and its timeframe (Ahrenfelt 2001, 2013; Jacobsen 2005). The change leader must actively listen, even to criticism, which can be very instructive. The objectives of the change should be communicated repeatedly, both to individual healthcare staff members and healthcare staff as a group. But this should be balanced with allowing staff to process and "digest" the information they are given and turn it into useful knowledge. The objective is to change both individuals' and the overall group's understanding of the task.

12.7 Advanced Practice Nurses as Change Leaders

To contribute to the development of healthcare services so as to benefit patients, advanced practice nurses often shoulder responsibility as change leaders. As change leaders, advanced practice nurses can influence their colleagues' thoughts, feelings, and values, by influencing and steering how reality is perceived and developed in accordance with a certain worldview. A change leader's influence over nursing staff's approach to tasks is dependent on time as an aspect (the timeframe for the change) as well as the organization's social and cultural contexts (Cutcliffe and Bassett 1997; McPhail 1997; Alvesson 2001; Chenoweth and Kilstoff 2002; Jacobsen and Thorsvik 2002; Jacobsen 2005; Carney 2006; Kane-Urrabazo 2006; Alvesson 2007; Alvesson and Sveningsson 2007). The change leader's explicit and implicit understanding of the change and his/her underlying worldview also influence the change itself (Shanley 2007).

Leading change and renewal are a part of advanced practice nurses' daily care work. Both the change leader and the advanced practice nurse can develop and create opportunities to implement a change through a realistic approach and sufficient preparation. The planning of a change includes defining how the change will be implemented and what is included in the change and identifying what is necessary to make the change successful. The timeframe for the planning and implementation of a change should also be focused on. The change leader should communicate how the change will impact services and activities and should communicate the objectives linked to the change. Both the change leader and the advanced practice nurse should therefore have knowledge of change as a phenomenon, knowledge of the emotions that change can give rise to, and knowledge of the most important factors that influence change (Kerfoot 1996; Cutcliffe and Bassett 1997; McPhail 1997; Jacobsen 2005; Engström 2009).

As noted previously in this chapter, there are no universal tools or solutions whereby change can be led to suit all. Again, it is more about putting together the pieces of a puzzle—the various skills and relationships the change leader and the advanced practice nurse have with their colleagues – because change processes can differ so greatly (Cutcliffe and Bassett 1997; McPhail 1997; Ahrenfelt 2001, 2013; Shanley 2007).

Change leaders must always take various factors into account, including the politics, administration, culture, and various professional groups that steer the organization's structure and leadership. Change leaders should continuously observe and assess healthcare staff's attitudes, actions, knowledge, and feelings. Differences between the change leader's, the advanced practice nurse's, and other staff's/colleagues' motivations for and understanding of a change can exist, especially when work tasks are reorganized. A so-named motivational gap can arise, which must be leveled out. It is therefore important that neither the change leader nor the advanced practice nurse project their own understanding onto others without first understanding how their colleagues have understood the information about and message on the change.

To achieve lasting change, the change leader's leadership style and attitude toward staff and services are important. The change leader should be brave, flexible, humble, be willing to learn, meet colleagues with respect, have humor, think critically, and address and resolve both challenges and resistance (Cohen 2006). The change leader's role also includes acting as an objective observer. The change leader allocates resources, develops new ideas, helps bring the process or action forward, and brings together those who seek to drive the process forward and those who seek to solve problems. The change leader challenges and acts as an advocate, educator, advisor, or coach, all according to need (Bennett 2003). Other healthcare staff, however, can take on different roles in the change process, and it is therefore important to identify these roles and, as a change leader, respond to them (Lorenzi and Riley 2000).

To achieve their objective, the change leader and the advanced practice nurse should work and develop the change in collaboration with their colleagues. As change leaders, in addition to their administrative and clinical work, both the change leader and the advanced practice nurse should unite and integrate their colleagues' resources and efforts. They should furthermore collaborate on guiding, motivating, and supporting their colleagues and setting norms and standards, all to develop evidence-based practice. Because all staff are affected in one way or another, a leadership that counteracts uncertainty and conflicts and which leads and steers during times of uncertainty is needed to succeed with a change (Salmela and Fagerström 2008).

The change leader and the advanced practice nurse should seek to meet the new requirements that emerge during the entire process and, despite worry and negative attitudes, work together to harness staff's willingness to participate and be engaged in the change. To achieve the desired outcome, the change leader should focus on the staff and lead the transformation (the change) emanating from ethical values. The unifying link between the change leader and the staff should be common goals and values. If needed, the change leader should defend the cultural ethos that is required for the realization of good healthcare services. To provide high-quality healthcare services, the change leader has a responsibility to create a culture characterized by care by focusing on patients' nursing and care needs (Fagerström and Salmela 2010).

The real challenge is to also collectively ask questions, criticize, and discuss which change leader has not seen or has not thought about regarding the change. Doing this can lead to lasting change. A living communication, where there is a dialogue and exchange of information between leaders, advanced practice nurses, and others in the healthcare team, is of greatest importance. Yet it is also important to create an atmosphere where reflection and discussion are valued. A respectful atmosphere tones down and reduces uncertainty and resistance (Fagerström and Salmela 2010).

Norbäck and Targama (2009) maintain that both the change leader and the advanced practice nurse face a challenge when implementing changes that benefit patients, i.e., when they develop activities that are based on patients' needs and perspectives. The change leader and the advanced practice nurse together must raise

awareness of and demonstrate the need for change, and they should support the change process in a credible and convincing way and on a broad front. The implementation of advanced practice nursing as a vision should be crystalized for the entire unit's staff and for all working in the overall organization. The implementation of advanced practice nursing roles can entail a dramatic change, and the process can periodically be perceived as being chaotic. Each change is a learning process. The change must even be anchored on a higher organizational level, so that it is possible to receive help and support from key persons in the organization when needed during the actual implementation (Carnall 2007).

In summary, the points presented in this chapter regarding how to lead change during the implementation of advanced practice nursing should be considered in light of the processes underlying change:

- Leading change in clinical contexts is to lead relationships, processes, and cultures, with the patient's best as the objective.
- Awareness of the need for change should be raised in a credible and convincing way.
- The need for change should be anchored with the organization's senior and upper management, own colleagues, and other professional groups.
- A common vision, an objective, and a strategy for change should be developed.
- Change is influenced by an organization's culture and common values, through which the patient, who is placed at the center of care, should be emphasized.
- The content, scope, timeframe, objective, and outcome of the change as well as the measures needed to achieve the change should be defined.
- Key responsible staff, who can act as drivers and catalysts, should be selected.
- All change is a learning process, and through a learning process, thought patterns can be changed. This in turn can lead to changed behavior.
- Create a forum for dialogue, follow-up, and the continuous evaluation of both milestones in the change process and the change process outcomes.

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Abstract

Today, there is an international consensus on advanced practice nursing educational programs that should be on the master's level. In each country or setting, how advanced practice nursing is defined, a population's health needs, and guidelines for health and educational policy comprise important starting points for the development of advanced practice nursing curricula. Master's-level advanced practice nursing education is characterized as "hands-on" education, i.e., an education where if students are to be capable of practicing on the advanced level, clinical competence must be practiced and theoretical and clinical studies should be optimally balanced. The OSCE (Objective Structured Clinical Examination), a type of examination commonly used to test clinical competence in advanced practice nursing, is presented as an applicable and useful examination form that can be used in master's-level advanced practice nursing education.

Keywords

Education · Master's in advanced practice nursing · Standards · Clinical competence

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Advanced practice nursing educational programs should provide nurses with the knowledge and skills they need to bear greater responsibility, and these should be more demanding content-wise than what is offered in bachelor's-level programs. An advanced practice nurse should be prepared for and have the capacity to bear independent professional responsibility for patients' health problems. The development of clinical competence is the result of a balanced mix of theoretical and clinical studies, i.e., a synthesis of knowledge (*epistêmê*), practical skills (*technê*), and practical wisdom (*phronesis*) (see Chap. 4). *In healthcare, the need for specially trained (advanced practice) nurses has increased over the past two decades. Medical developments have led to the increased need for specialized competence among both physicians and other healthcare staff. In an analysis of international literature and research, researchers find that clear and uniform recommendations for* advanced practice nursing educational programs do not exist (Gardner et al. 2006). Advanced practice nursing educational programs should be based on content that will provide the clinical competence needed for meeting the needs of patients, society, and a country's healthcare system. A program's faculty, i.e., the level and competence of instructors, is also crucial for the sustainable development of advanced practice nursing (Anathan et al. 2020). A strong healthcare workforce emerges from an education system in which both the quality and number of faculty allow for the preparation and effective teaching of the next generation of advanced practice nurses.

13.1 An Optimal Balance Between Theoretical and Clinical Studies

Specific to advanced practice nursing education is that it should be broad enough for students to be prepared to and have the capacity to diagnose unclear and new patient situations. Master's-level advanced practice nursing education can therefore largely be characterized as "hands-on" graduate post-secondary (advanced) education, but an optimal balance between theoretical and clinical studies is needed to achieve the learning outcomes. In advanced practice nursing practice, both "hands-on" and "hands-free" competencies are needed.

The specific "hands-on" competency needed is the ability to conduct a systematic clinical examination, including a holistic assessment of the patient's undiagnosed health problems and the determination of the nursing, care, and treatment that the patient needs. Furthermore, a master's-level education should give the capacity for knowledge of and the ability to engage in the teaching, leadership, research, and development tasks inherent to the advanced practice nurse's scope of practice, which can be considered "hands-free" competence.

When educating nurses to have the capacity for advanced practice clinical ability and bear greater independent responsibility, there are specific demands made on instructors' competence and the equipment used in the pre-clinical/simulation rooms. There are also new, specific demands made on the supervision that students receive during clinical practice, recommended at about 500 h per student (The University of Auckland, New Zealand 2016; Farley et al. 2016). As long as there are

no clearly defined advanced practice nursing roles, collaboration with physicians and other healthcare staff with expert competence is necessary, because they can provide supervision during advanced practice nursing students' clinical practice.

A very important starting point in the planning and development of an advanced practice nursing educational program is the use of the three-dimensional view of knowledge as an epistemological basis, where knowledge (*epistêmê*), practical skills (*technê*), and practical wisdom (*phronesis*) are synthesized (see Chap. 4). In the three-dimensional view of knowledge, the different parts of knowing are combined into a meaningful and fruitful whole, which can lead to independent clinical competence. The clinical competence developed includes theoretical knowledge from many different areas, an ethical and caring approach, and a practical ability to act in a correct and defensible manner. It is thanks to actual (physical) clinical experience that advanced practice nurses can meet each individual patient's health needs and desires and help the patient to a higher level of health and well-being.

13.2 International Advanced Practice Nursing Educational Programs

An important starting point in the development of advanced practice nursing educational programs is actual literature and research on the nurse practitioner/advanced practice nurse role and international guidelines and experience (Horrocks et al. 2002; Furlong and Smith 2005).

The development of the first advanced practice nursing educational programs in the Nordic countries (University of Skövde, Skövde, Sverige; NOVIA University of Applied Science, Vaasa, Finland; University of Oslo, Oslo, Norway) was influenced by European and international trends. Development in Finland and Sweden was influenced by a European Union project, the Thematic European Nursing Network (2003–2005). The aim of that project was to develop the nurse practitioner/advanced practice nurse role in Europe (Fagerström 2009). Included in the network were representatives from Cumbria University in England, where advanced practice nurse programs have been offered since the 1980s, and University College Dublin, where advanced practice nurse programs have been offered for more than 15 years.

At the beginning of the twenty-first century, the International Council of Nurses conducted an international survey on how advanced practice nurse educational programs were organized, with the aim to examine what was happening in the field of advanced practice nursing internationally (Schober and Affara 2006). It was concluded that a master's degree was the best possible way to academically attain an advanced level of knowledge, i.e., the best way to "progress" from the bachelor's degree level. Today, however, there is a debate about whether sufficient clinical skills are attainable through a master's degree. Internationally, discussions are ongoing about whether a doctoral degree (Doctor of Nursing Practice/DNP) would be more appropriate. There are currently more than 50 different doctoral-level advanced practice nursing educational programs throughout the world, and there is a trend toward a strong increase in such programs going forward. Schober and Affara

(2006), however, have pointed out that doctoral programs are an unrealistic goal for countries that are in an early stage of developing advanced practice nursing roles. For both economic and competence reasons, doctoral-level advanced practice nursing educational programs are not possible in many countries.

The International Council of Nurses' survey revealed that while advanced practice nursing education was taking place in about 20 countries, the scope and educational philosophy (content) of such programs varied. For example, the length of programs was seen to range from 12 to 36 months. Furthermore, admission requirements ranged from the need to (only) have clinical experience to the need to hold a bachelor's degree and have work experience. The delineation of national standards for advanced practice nursing educational programs was recommended, and this has occurred in, among others, Canada, New Zealand, the United Kingdom, and the United States of America (Schober and Affara 2006). The recommendation was also made that institutions and curricula should be nationally accredited. This however is not currently possible in all countries, e.g., the Nordic countries, and as such the International Council of Nurses' recommendations and other international guidelines on advanced practice nursing educational programs constitute a valuable resource.

The Nursing and Midwifery Board of Ireland (2017) recommends that curriculum design and development should reflect current evidence-based educational theory, healthcare policy, and advanced practice nursing. The recommendation is that a curriculum should be dynamic, be flexible, and allow for changes in advanced practice nursing and healthcare delivery and should facilitate the development of evidence-based professional advanced practice in response to educational, health, social, cultural, and economic change.

In the United Kingdom, the Royal College of Nursing renewed the standards for registered nurses working on the advanced level in 2018 (https://www.rcn.org.uk/professional-development/publications/pub-007038). As per these standards, registered nurses working on the advanced level should be registered as an independent prescriber on the Nursing and Midwifery Council (NMC) register and practice within four pillars: advanced clinical practice, leadership, facilitation of education and learning, and evidence research and development. They furthermore must be educated to the master's level (180 level 7 points), and this education must encompass the following core areas:

- Therapeutic nursing care.
- Comprehensive physical assessment of all body systems across the lifespan.
- History taking and clinical decision-making skills.
- Health and disease, including physical, sociological, psychological, and cultural aspects.
- Applied pharmacology and evidence-based prescribing leading to a prescribing qualification.
- Management of patient care.
- Public health, epidemiology, health education, and promotion.
- Research and service development.

- Organizational, interpersonal, and communication skills.
- Accountability—including legal and ethical issues.
- Quality assurance.
- Political, social, and economic influences on healthcare.
- Pathophysiology and genomics.
- Leadership skills.
- Theories and models of teaching and learning.

(Royal College of Nursing 2018)

Schober and Affara (2006) emphasize that no matter how well an advanced practice nurse role is defined in a country or region, it is of great importance that the content of an advanced practice nursing educational program reflects a well-defined advanced clinical practice in that country. Common challenges that faculty face are insufficient economic resources, lack of skills, inadequate equipment, lack of clinical internships, lack of access to role models and mentors for students, and overly broad curricula (Schober and Affara 2006).

13.3 International Standards for Advanced Practice Nursing Educational Programs

The International Council of Nurses' Nurse Practitioner/Advanced Practice Nursing international network (ICN 2004) delineated the following standards for advanced practice nursing educational programs about 15 years ago:

- The program should prepare a nurse with a bachelor's degree for clinical practice on an advanced level and provide students the possibility to expand their knowledge, experience, and skills to act competently in the advanced practice nurse role.
- The program should prepare students to fully practice and use their advanced practice nursing competency.
- The education should be provided by qualified instructors.
- The program should be accredited by a national body.
- The program should facilitate lifelong learning and ensure that advanced competence can be maintained.

In the International Council of Nurses' latest guidelines on advanced practice nursing, launched in 2020, the goal of graduate programs (master's or doctoral degrees) specifically identified for clinical nurse specialist (CNS) education is to:

> *…prepare the nurse to think critically and abstractly at an advanced level in order to assess and treat patients/families/populations as well as to teach and support other nurses and healthcare professionals in complex clinical situations. The educational program prepares the CNS to use and integrate research into clinical practice, regardless of setting or patient population. Educational preparation is built on the educational foundation for the generalized or specialized nurse in the country in which the CNS will practice. (International Council of Nurses 2020).*

According to the International Council of Nurses (2020), nurse practitioner education is inconsistent and varies internationally. A Master's degree on the postgraduate level is considered the minimum standard for entry-level nurse practitioner practice (CNA 2008, 2019; Fagerström 2009; Finnish Nurses Association 2016). In the United States of America, recommendations put forth in the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education include that to earn national certification and/or state licensure, an advanced practice registered nurse must complete a graduate nursing program that has been accredited by a nursing or nursing-related accrediting organization recognized by the US Department of Education and/or the Council for Higher Education Accreditation (The APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee 2008). A Doctor of Nursing Practice (DNP) degree is now recommended as an entry level for nurse practitioner practice in the United States of America. The International Council of Nurses emphasizes in their advanced practice nursing guidelines on nurse practitioner education that clinical competencies and common core elements of nurse practitioner clinical practice are the foundation for program and curriculum development. They maintain that the focus of nurse practitioner education programs must be placed on "the preparation of nurses to practice at an advanced level in clinical settings as NPs" and must include "supervised clinical practice or a clinical practicum, usually for a designated minimum number of hours with an experienced [nurse practitioner] or physician" (ICN 2020). They note that the minimum number of hours of supervised clinical practice varies between countries; the recommendation in Ireland is 500 clinical hours; in the United Kingdom, it is a minimum of 500 supervised (direct and indirect) clinical hours; in New Zealand it is 300 h; and in the United States of America, it is a minimum of 500 supervised direct patient care clinical hours. In their guidelines, the International Council of Nurses specifically note that:

> *All-purpose or nonspecific Master's degree nursing programs are not a recommended pathway for [nurse practitioners]. Master's degree education related to nursing management, nursing research or nursing education alone is not considered sufficient preparation for [nurse practitioners]. However, as the role evolves, existing Master's level programs may be adapted to include additional skills specific to [nurse practitioner] practice including advanced physical assessment, advanced clinical reasoning and diagnostic decision-making, pharmacology/pharmacokinetics, clinical and professional leadership, and practice-based research* (ICN 2020).

A population's health needs, the needs of a country's or region's healthcare and healthcare services, and available resources should all influence the development of the content of advanced practice nursing educational programs. This can be compared to the PEPPA (*p*articipatory, *e*vidence-informed, *p*atient-centered *p*rocess for *a*dvanced practice nursing role development, implementation, and evaluation) framework, which is presented in Chap. 11. Both theoretical and clinical master's-level programs should be designed to meet a population's health needs as well as align with (the relevant) society's view on the direction in which healthcare services should be developed.

Educational programs that incorporate a flexible structure and composition have been shown to work well (Schober and Affara 2006). Training programs based on

these principles can be easily developed or changed to meet the changing needs of a healthcare system, and all changes should be based on evaluation. According to Chan and Garbez (2006), while there are both similarities and differences between the clinical competencies of clinical nurse specialists and nurse practitioners as seen in emergency care, educational preparation for both groups overlap, and, therefore, certain elements of these curricula could be integrated in academic programs where feasible. Professional areas where overlap is seen include pathophysiology, pharmacology, differential diagnosis, and patient care management. They find that instruction in these areas can be shared and included in advanced practice nursing educational programs.

Gagan et al. (2002) presented a model for the revision of nurse practitioner curricula that was based on three components: curriculum goals, health policy and state regulation, and community needs and demands (primary, secondary, and tertiary levels). When determining a curriculum, one should primarily consider the prevailing regulatory structures and domains of advanced practice nursing competency and how the advanced practice nursing role is defined, because these are the recommended starting points whereby goals for educational programs can be determined (Schober and Affara 2006). This is illustrated in Fig. 13.1, in which the diversity of environmental factors and the relevant context(s) that influence the goals that an

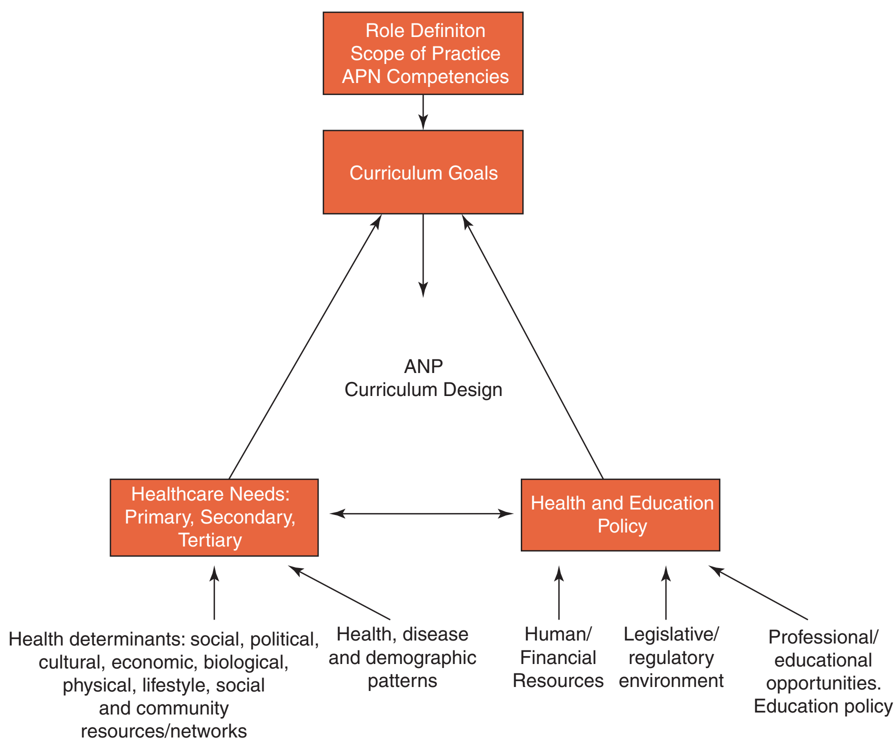

Fig. 13.1 Advanced practice nursing framework for curriculum development (Fagerström 2019, p. 258; Modified from Schober and Affara 2006)

educational program should seek to meet are shown. The determinants of health, i.e., the factors that influence health and disease, can be social, political, cultural, economic, biological, physical, and lifestyle-related. A society's demographic patterns, economic resources, and even educational opportunities also influence health. This range of factors influences a population's current and future health needs, which a healthcare system should be capable of meeting.

Farley et al. (2016) outlined a six-step process for the development of advanced practice nursing educational programs, the six-step curriculum process model. The steps part of their model include problem identification and general needs assessment, targeted needs assessment, goals and objectives, educational strategies, implementation, and evaluation and feedback. A continuous quality improvement process is inherent to the model.

13.4 Overall Structure of Advanced Practice Nursing Educational Programs

The curricula for advanced practice nursing educational programs are normally based on three larger units: key theoretical modules, clinical modules, and specialization modules. The way in which these three core modules are covered and/or included in a program should correspond to the stated goals of the program. Factors that can also influence the content of a program and/or the split between the aforementioned core modules include, among others, advanced practice nursing models, epidemiological factors, or a setting's/country's needs. The core modules should even be formed in accordance with any specific clinical focus (deepening of knowledge) that is either needed or desired. Flexibility in the form of alternative (elective) modules facilitates student choice based on interests and the actual advanced practice nursing model that they will work in after graduation.

The planning and design of the clinical practice that students engage in in an advanced practice nursing educational program are of great relevance to the clinical skills that students develop. As mentioned previously, direct/patient-centered clinical practice is the most important core competence for an advanced practice nurse. How practical clinical experience and learning in a clinical context are incorporated into an advanced practice nursing educational program can be considered to be of decisive importance for both the entire program and for students' development of clinical skills (Gardner et al. 2004). An important problem that should be solved is how students will gain relevant and necessary clinical experience during their education. According to Castledine (2003), the basis for learning in advanced practice nursing is that it should be well anchored in clinical practice. In a comprehensive analysis of nurse practitioner education in Australia and New Zealand (Gardner et al. 2006), researchers saw that a strong clinical learning component and in-depth theoretical education for one's clinical specialty practice are needed. They furthermore found that student-directed and flexible learning models were also important.

A comprehensive review of the education of advanced practice nurses in Canada was undertaken, with special focus on history, current state, interprofessional education, resources, and continuing education (Martin-Misener et al. 2010). The researchers found that advanced practice nursing educational program content should be based on the competence that advanced practice nurses need to meet the requirements of clinical practice. They also found that education by itself is insufficient; a good and balanced combination of education and clinical experience is necessary for students to develop the clinical skills needed.

In three different Canadian studies, researchers found that, when compared to postgraduate prepared nurses, self-identified clinical nurse specialists with a master's degree were more likely to implement all recognized domains of advanced nursing practice (Bryant-Lukosius et al. 2018; Kilpatrick et al. 2013; Schreiber et al. 2005). Clinical nurse specialists with a master's degree level of education were also seen to improve health outcomes on the population health level and contribute to innovation and improvement on the unit, organization, and systems levels, whereby access to and the quality of nursing and healthcare services were improved.

13.5 Assessment of the Development of Clinical Competence

In nursing education, assessment plays a major role in ensuring competent practitioners who can adequately take care of patients (Muthamilselvi and Ramanadin 2014). According to Walsh et al. (2009), objectively assessing and evaluating nursing students' clinical competence is one of the most challenging tasks in nursing education, due to healthcare system complexity and the dynamic, revolutionary nature of nursing itself.

Assessments of education should be reliable and valid. Peters and Roodbol (2020) conclude that properly developed tests can promote learning. They recommend a testing program consisting of four different phases:

1. Assessment policy—that describes the institution's plan for the assessment of the students, such as when, what, and how.
2. Assessment program—that the combination of assessments fits with the goals, content, and structure of the curriculum.
3. Assessment instruments—that each assessment is usable, reliable, and valid.
4. Assessment tasks—that each task or the assessment is relevant, objective, and distinctive and the difficulty appropriate for the level being assessed.

While instructors should assess students' competence during the courses part of an advanced practice nursing educational program, self-assessment of clinical competence can also be used with the aim to promote self-awareness of own professional development and educational needs. A sensitive instrument needs to assess and measure the development of clinical competence in advanced-level nursing.

Developed from the Nurse Competence Scale, the Professional Nurse Self-Assessment Scale (PROFFNurseSAS I) questionnaire, through which advanced practice nurses' core clinical competencies can be assessed, was developed (Nieminen and Fagerström 2006) in Finland and later validated in a study set in long-term and home-care contexts in Norway (Finnbakk et al. 2015). The theoretical framework of the PROFFNurseSAS I was based on the Caring advanced practice nursing model, which in turn is built on a modified version of the International Council of Nurses' (Schober and Affara 2006) and Hamric's (2009) definitions of advanced practice nursing central competence domains. The epistemological foundation of the PROFFNurseSAS I emanated from the three dimensions of knowledge described by Aristotle, epistêmê (nurses' theoretical scientific knowledge), technê (the knowledge in doing), and phronesis (practical wisdom), and that advanced practice nursing is based on the synthesis of these three dimensions (Nieminen et al. 2011; Fagerström 2019).

A revised version of the Professional Nurse Self-Assessment Scale (PROFFNurseSAS II) was used for data collection in a European cross-sectional survey (Wangensteen et al. 2018). The researchers sought to describe nurses' self-assessment of clinical competence and need for further training and explore possible differences between nurses in specialist versus master's-level programs. A total of 97 nurses in postgraduate programs from five countries were included. Highest competence was seen in relation to the items "taking full responsibility," "cooperation with other health professionals," and "acting ethically." The need for further training was seen in relation to the items "competence on medications, interaction, and side effects" and "differential diagnoses." For all items, nurse students in master's programs rated their competence higher than nurse students in specialist programs. Nurse students in specialist programs rated their need for further training in all items as being higher than nurse students in master's programs: for 47 of the 50 items, these differences were statistically significant.

The PROFFNurseSAS II was also used in a Norwegian study (Taylor et al. 2020), in which the aim was twofold: to describe and analyze advanced practice nursing students' self-assessment of clinical competence and need for further training and to analyze the possible predictive variables in the nursing students' self-assessment. A total of 99 students enrolled in a master's-level advanced practice nursing program in Norway participated in this cross-sectional study. The researchers found that the students gave the highest self-assessment ratings for clinical competence for the items "taking full responsibility" and "need for further training in medication effects and interactions." The students were seen to give low ratings for the item "use of electronic devices." The researchers furthermore concluded that clinical work experience as a registered nurse and previous higher education level were not significant predictors of clinical competence or the need for further training. It was concluded that self-assessment using the PROFFNurseSAS II instrument is appropriate for students in advanced practice nursing programs and that the PROFFNurseSAS II can be used in the longitudinal assessment of the development of students' clinical competence before, during, and after a study program.

13.6 Objective Structured Clinical Examination for Assessment of Clinical Competence

Originally designed for medical students, the Objective Structured Clinical Examination (OSCE) is an often-used assessment form used to assess advanced clinical competence. It is used to objectively assess a range of competencies that (medical) students are expected to have and realized in different stations with an examiner providing student assessment through checklists and rating scales (Harden 2016). While some have voiced concerns about the OSCE in relation to, e.g., cost and labor intensity (Palese et al. 2012), validity of simulation (Rushforth 2007), or student stress (Miller and Carr 2016), there nonetheless remains consensus on the OSCE as a valid and reliable assessment of clinical competence (Bagnasco et al. 2016; Barry et al. 2013; Najjar et al. 2016).

Some criticize the use of the OSCE in nursing education and maintain that its use of different stations during the assessment process leads to the fragmentation of holistic patient care (Rushforth 2007). In nursing education, there is a greater focus on an integrated assessment tasks approach (a whole patient consultation that conforms to real-life clinical settings), and the Objective Structured Clinical Assessment (OSCA) was developed for the nursing setting (Yanhua and Watson 2011). The OSCA is considered more in line with a holistic view of clinical competence that includes knowledge, skills, values, and attitudes. Because the OSCE includes simulated clinical situations and the assessment of advanced skills such as history taking and physical assessments, it can also be considered suitable for the testing of advanced practice nursing student's clinical competence. Note that a clear distinction between the OSCE and the OSCA does not exist, which could indicate the inconsistent use of these terms or even confusion about the different approaches and processes that they use to assess clinical competence.

Researchers have found little research on students' perceptions of the OSCE examination in nursing education, which is surprising because student engagement is integral to a student's overall OSCE performance (Johnston et al. 2017). In that study, undergraduate (bachelor's-level) nursing students found value in the OSCE but expressed concerns about the stress involved and the perceived validity of the exam from a student perspective. Other researchers saw that midwifery students were neutral/unsure about the use of the OSCE as an approach used to assess clinical competence (Muldoon et al. 2014). Still other researchers in a Norwegian study sought to expand knowledge of nurse practitioner students' and examiners' experiences of the OSCE (Taylor et al. 2019). Five focus group interviews, consisting of 15 nurse practitioner students and 5 individual interviews with examiners, were conducted and analyzed using thematic analysis. These researchers found that nurse practitioner students and examiners perceived the OSCE to be an appropriate method of assessment for advanced clinical competence, even though there were some challenges linked to its form. The researchers concluded that a course design that includes constructive alignment between the course and the exam, more training with real patients, use of formative and summative assessment, and a second exam with a real patient after the student's clinical placement could be

recommended. The researchers even concluded that the lack of a clear nurse practitioner role in countries with evolving advanced nursing roles can challenge the expected level of advanced clinical competence in an educational context.

For countries with evolving advanced practice nursing educational programs, the assessment of advanced clinical competence should be realized to meet the standards for advance practice nursing as delineated by the International Council of Nurses (2019): an expert knowledge base, complex decision-making skills, and clinical competencies for expanded practice.

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