

Advanced Practice Nurses' Perceptions of the Lived Experience of Power

by

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ABSTRACT

“Power” is a concept that has been discussed by nurse scholars and leaders within the nursing literature. The literature surrounding power concurs that power is necessary within the practice of nursing so that nurses are able to support patients and move the profession of nursing forward. There is a scarcity of research, however, regarding nurses’ perception of power within their own practices. Advanced practice nurses (APNs) are in positions in which they apply graduate education, specialized knowledge, and expertise to improve health care outcomes. Therefore, a qualitative study using an interpretive hermeneutic phenomenological approach was undertaken to discover APNs’ lived experience of power within their practices. In-depth, tape-recorded interviews were conducted with eight APNs from a large tertiary care facility. All of the participants agreed to a follow-up interview to review the summary of the study results. van Manen’s (1990) approach was used to analyze the data by subjecting the transcripts to a thematic analysis and reflective process. The overarching theme of the interviews is “building to make a difference” and the APNs’ perceived that this happened by “building on,” “building with,” and “building for.” The APNs *built on* their knowledge and expertise, *built with* others in relationships and *built for* the capacity to make a difference. Power was a part of the everyday practices of these APNs and was described as “soft power,” a power that they shared to bring about change for the better. This shared power was reflected back on them resulting in increased power within their practices, a process described by the APNs as power creep.

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CHAPTER ONE: INTRODUCTION

1.1 Introduction

Power, within nursing literature, has been acknowledged as necessary to effect change within the practice and profession of nursing (Benner, 1984; Bradbury–Jones, Sambrook, & Irvine, 2008; Doering, 1992; Polifroni, 2010; Ponte, et al., 2007; Roberts & Vasquez, 2004). Although power has complex effects on nursing practices, the relationship between power and practice is not well understood among nurses (Blanchfield & Biordi, 1996; King, 1981; Manojlovich, 2007; Roberts & Vasquez; Sieloff, 2003). Nurses need to use power in their practice to effect change and to support patients, health outcomes, and the profession as a whole (King, Manojlovich, Ponte et al., Roberts & Vasquez; Wilson & Laschinger, 1994).

Kagan and Chinn (2010) discussed the need to educate nurses about power. In their view, nurses had untapped and unacknowledged informal power that they could use to advocate for the well being of those for whom they cared. Kagan and Chinn supported the need to explore how nurses perceive the concept of power in their practice.

Power has intrigued me throughout my nursing career. As a novice nurse, I often thought about power and its connection to learning. My sense of my own power derived from my ability to improve the health of my patients in a Burn and Intensive Care Unit and to identify early on potential complications. Although I was aware that I had power within my practice and that my knowledge contributed to this, there were times when I felt that I did not have power. In these moments, I lacked situation-specific knowledge. The desire to increase my sense of power through knowledge attainment resulted in a commitment to lifelong learning.

During my first course on nursing theory, in the Master's program in nursing, I began to question the concept of power as it applied to my own practice and that of other nurses. Learning about feminist theory and the view of nursing as women's work stimulated me to examine my understanding of what power was within the practice of nursing. Exploring the role of advanced practice within a course entitled: 'Advanced Nursing Practice in Tertiary Health Care' further highlighted the need to better understand power. During the clinical portion of this course, I worked with an advanced practice nurse (APN) in trauma. Observing her interactions with patients, family members, and others and listening to accounts of how she had been able to influence patient outcomes augmented my reflections and brought new questions to bear. This APN did not use the word *power* in the descriptions of her practice, yet it was evident to me that she had the power to change outcomes.

1.2 Background

Various researchers have explored power as the ability of individuals to effect change (Earle, 1997; Laschinger, Sabiston, & Kutzcher, 1997; Ponte et al., 2007; Richard, 1993; Upenieks, 2003; Weston, 2006; Wilson & Laschinger, 1994). The effect of power on and within individuals and society has been a focus of scholarship in sociology, psychology, philosophy, religion, and languages. For example, Foucault (1980) regarded power as a flexible entity that changed with the acquisition of knowledge and contended that power and knowledge were intertwined. Polifroni (2010) discussed power and how it is situated in practice, stating that knowledge alone does not result in power. Rather, according to Polifroni, the application of knowledge activates power.

Spross and Hanson (2009), along with Benner (1984) and Chinn (2004), attributed positive power in nursing to the nurses' expertise and knowledge, which could lead to improved health outcomes of patients. If knowledge and expertise are related to power then nurses with these attributes should perceive themselves as having power. It is expected that advanced practice nurses (APNs) will improve outcomes through their clinical expertise, and knowledge (Bryant–Lukosius, DiCenso, Browne, & Pinelli, 2004; Canadian Nurses Association [CNA], 2008; Spross & Hanson). However, there has been a paucity of studies examining how APNs actually perceive power and what supports and hinders power in their practice.

1.3 Study Purpose and Questions

The purpose of this study was to explore APNs' perceptions of the lived experience of power within their practice in an acute care setting. Questions that served to guide this exploration included the following: (a) How do APNs view power in their practice? (b) What factors support power within the APNs' practice? and (c) What factors hinder power within the APNs' practice?

CHAPTER TWO: LITERATURE REVIEW

In order to study perceptions of power from the perspective of Advanced Practice Nurses, this chapter first reviews the literature examining theories surrounding power and personal sources of power. It then includes a synthesis of nursing research on power, a discussion of power versus empowerment, and a description of advanced practice nursing as defined by the CNA (2008). The chapter concludes with a summary of the literature surrounding power.

2.1 Search Strategy

A literature search used the following key words associated with power and nursing—*nurse, nursing, nurses, advanced practice nurse, clinical nurse specialist, perception, power, empowerment, powerlessness, authority, and autonomy*, was completed using CINAHL, Medline, PsycINFO, Scholars Portal, Embase, and Sociology Sage databases. Through this search, literature was found related to empowerment and power within the nursing profession as well as for individual nurses. However, there was a paucity of research on power within the practice of APNs.

2.2 Operational Definitions

Power is derived from the Old French *pouvoir*, a noun derived from the infinitive meaning “to be able,” and earlier from the Vulgar Latin *potere* and from Latin *potis*, meaning “powerful” and “potent” (Harper, 2001). Power is defined by the *Canadian Oxford Dictionary* (2004) as the ability to do or act, characteristically involving authority or influence.

An Advanced Practice Nurse for the purposes of this study is a nurse who practices clinical nursing at an advanced level, maximizing the use of graduate education,

in-depth nursing knowledge, and expertise in meeting the healthcare needs of selected populations (CNA, 2008). At this time the CNA includes Clinical Nurse Specialists (CNS) and Nurse Practitioners (NP) under the APN umbrella.

2.3 Power in the Literature

Nurse scholars regard the concept of power as both positive (“power with”) and negative (“power over”) (Benner 1984; Chinn, 2004). Benner posited that nursing power was based on caring practices that were built within the nurse-patient relationship. Power within the profession of nursing has often been referred to as “power over,” which has negative connotations, rather than the power “to be able,” that is, to support patients, which would shed a positive light on power (Hawks, 1991).

Power in nursing has been studied from three major perspectives: theories of power, types of power, and sources of power (Bradbury–Jones et al, 2008; Doering, 1992; Kuokkanen and Leino–Kilpi, 2000; Roberts and Vasquez, 2004).

2.3.1 Theories of power

Social theories examine how society affects an individual’s perception of power and powerlessness. For example, power and the oppression of groups, such as ethnic minorities, homosexuals, immigrants, and women by social institutions and other administrative units have been explored (Bradbury–Jones et al., 2008; Kuokkanen & Leino-Kilpi, 2000). Feminist theory has influenced understandings of power through increased awareness of societal views of power and the affect these views have had on the power of nurses. For example, an assumption inherent within feminist theories is that the oppression of women is the result of male-dominated power relations (Doering, 1992). Nursing relationships are often viewed as hierarchical and competitive, and nurses

could exhibit bullying and horizontal violence consistent with the behaviours of oppressed groups (Bradbury–Jones et al., 2008).

Organizational theories address the issue of power distribution within organizations, examining power from a top–down perspective with the assumption that those with power have the ability to empower those working for them (Bradbury–Jones et al, 2008; Kuokkanen & Leino–Kilpi, 2000; Manojlovich, 2007). Proponents of management theories view power from the perspective that those in authority should share knowledge, resources, and support in order to empower others (Kanter, 1977; Laschinger et al., 1997). In Kanter’s (1993) theory of structural power in organizations, she “locates the responsibility for the behaviours people engage in at work and their fate inside organizations in the structure of the work systems themselves” (p 10). She posits that there are people who have advantages in organizations because they have access to opportunity which creates more opportunities for these individuals adding to their power within the organization.

Social psychological theories argue that an individual’s sense of power is connected to his or her knowledge. Kuokkanen and Leino–Kilpi (2000) reveal that as individuals develop knowledge, it shapes how they view their impact, competence, meaningfulness and choice leading to a feeling of empowerment. Ultimately empowerment leads to an increase in self-esteem, which these authors describe as contributing to professional growth and development. Benner (1984) examines the clinical knowledge embedded in nursing practice and its impact on nurses as they moved from novices to experts. Inferred within Benner’s research is that power in nursing is visible in nurses’ practices as knowledge gained through clinical experience. It is

interwoven with caring and enacted in the nurse-patient relationship to empower patients. Both Kuokkanen & Leino-Kilpi and Benner connect the knowledge each nurse has to nurses' feelings of empowerment and power. Benner as well as Chinn (2004) agree that the use of power is necessary in nursing to develop knowledge and policy, as well as to empower patients to change their health status. Benner and Chinn both emphasize the need to use power in caring and collaborative ways.

King (1981), a nurse theorist, states that power exists in relation to a situation or an organization and that it is an essential element in social systems. King indicates that power is the capacity or ability of a person or a group to achieve goals and guide, direct, control, and change the behaviours of individuals and groups. Polifroni (2010) cites that it is the belief of individuals that they are able to bring about change. Power also can be used negatively, as when abuse and oppression are employed to effect change (Benner, 1984; Chinn, 2004; Daly, Speedy, & Jackson, 2004; Grohar-Murray & DiCroce, 2003). Barrett (2010) defines power as the capacity to knowingly participate in change. She explains that power is in how we use it, for purposes of control or freedom, and everyone has power. Barrett speaks to relationships and their effect on the outcomes of power.

Bradbury-Jones et al. (2008) support the work of Kuokkanen & Leino-Kilpi (2000) who examine power and empowerment from the perspectives of critical social theory, organizational theory and social psychological theory but also propose using a post structural approach drawing on the philosophy of Michel Foucault as another framework to examine power and empowerment in nursing. Bradbury-Jones et al. focus on two core elements of Foucault's philosophical beliefs: disciplinary power and knowledge/power relationships. These authors believe that power should be studied from

a bottom–up approach because they contend that power does not reside in a position but within an individual. They describe power as occurring in three variations: power from within, power over and power with, which corresponds to self-esteem, domination and shared power. Bradbury Jones et al. propose a direct connection between knowledge and power, that nurses knowledge of health care and the needs of those they care for should increase their power and ability to empower others.

Foucault (1980) describes power as the name given to a complex strategic relation in a given society. Power changes depending upon the context in which individuals find themselves. For example, nurses might feel powerless to change organizational policy when they are at the bedside but might find they have the power to change policy by involving themselves on committees that can bring about change. Foucault explains that power needs to be examined not simply from the view of who has access to power or the implications of power but as the ability of individuals to generate power

2.3.2 Sources of power

An individual can possess many sources of power. French and Raven (1959) identify five personal sources of power: reward, coercive, expert, referent, and legitimate. *Reward power* derives from the ability to provide incentives, whereas *coercive power* is the ability to sanction an individual in a negative way. One obtains *expert power* through knowledge, expertise, and recognition. *Referent power* is acquired by networking with those who have power. For example, support from powerful leaders, such as physicians and those in management, influence nurses' power by association. *Legitimate power* is based on legal, cultural, or symbolic authority and one's position. Structures that support autonomy enhance nurses' legitimate power. Willey (1987) identifies a sixth source of

power, *charismatic power*, which is the ability to attract and maintain the attention of others. An understanding of all these sources of power and how to develop them adds to an individual's power (Willey).

Roberts and Vasquez (2004) describe two sources of organizational power available to individuals. The first, connection power, is expressed through the effective use of networking, charisma and referent power as well as group decision making, which involves the ability of a group to come to an agreement. The second source of power is a combination of personal and organizational sources, which is referred to as informational power and is expressed as an individual's access to specialty information.

2.4 Nurses' Perception of Power

Only a few studies have examined nurses' perception of their own power (Earle, 1997; Ponte et al., 2007). In a qualitative study, Ponte et al. interviewed 11 nurse leaders from universities and hospitals to identify characteristics that the leaders felt indicated power in nursing practice. The nurse leaders included a clinical nurse specialist, nurse manager, vice president, program manager, nurse scientist, dean, chief retention officer and a nurse faculty member. These nurses were asked a series of questions to discern what power meant to them, how they saw it within their own practice and throughout their organization in the practices of nurses. A powerful professional nursing practice was identified as one in which nurses acknowledged their role in patient care, committed themselves to ongoing learning, were professional in their practice, took an active part in decision making, encouraged and supported peers, and show a commitment to nursing.

Earle (1997), in a phenomenological study, interviewed 7 nurse participants and observed them as they worked in a 24-patient telemetry unit at an acute care facility. She

found that the nurses often felt powerless because they were unable to influence policy changes on their units. Earle revealed that the nurses did not have an understanding of the concept of power nor did they perceive their personal or expert knowledge as adding to their power. Rather nurses' understanding of power was limited to the notion of positional power. Earle noted that nurses could identify changes in their patients' conditions and intervened to provide optimal care, supported colleagues' practice, and worked collaboratively with physicians but the nurses did not value this knowledge and expertise. Although they were able to affect patient outcomes, they did not perceive this ability as power. Nurses felt that they had support from their unit manager, but they were not aware of the ways in which upper management affected their practice. They were able to identify powerlessness as their inability to influence others and to change policy within their unit. They did not approach their manager with all of their concerns, as they felt that these concerns would not be addressed. Nurse leaders, on the other hand, recognized power in staff nurses' practice that the nurses themselves did not identify.

These studies provide views of power from the personal experiences of the staff nurses in Earl's 1997 study and from the perspective of what nurse leaders in Ponte's (2007) study consider to be characteristics of powerful nursing such as; supporting patient care, working collaboratively, and having knowledge and expertise within their specialty. Although Earl identified these same characteristics in the staff nurses in her study the staff nurses did not see themselves as powerful.

2.5 Power and Empowerment

Empowerment, a concept discussed by many nurse scholars, has been interwoven with power in some of the literature (Bradbury-Jones et al., 2008; Kuokkanen & Leino-

Kilpi, 2000). For example, Kuokkanen and Leino–Kilpi, emphasized the need to study power in order to understand the meaning of empowerment. They examined the concepts of empowerment and power within critical social theory, organizational theory and social psychological theory. For these authors, empowerment is seen as rooted in social action whereas power is often viewed in terms of coercion and domination. Chinn & Kramer (2008) concur that empowerment is generally viewed more positively than power and is often associated with the nurses' ability to "give power" to patients.

Kanter (1977, 1993) addresses structural factors such as opportunity for advancement, access to information, support, and resources as significant in order for individuals within an organization to be empowered. Her theory has served as the theoretical basis for multiple nursing studies (Finegan & Laschinger, 2001; Laschinger, Havens & Sullivan, 1996; Laschinger et al., 1997; Richard, 1993; Sarmiento, Laschinger & Iwasiw, 2004; Upenieks, 2003; Wilson & Laschinger, 1994). For example, Laschinger, Havens & Sullivan utilized the Conditions of Work Effectiveness Questionnaire which measures the sources of work empowerment identified by Kanter as information (knowledge which enables individuals to enact their role), support (strong alliances between nurses and those they work with), resources (funding, day to day supplies, mentors), and opportunity (ability to gain more knowledge, contribute to nursing practice). In 2001, Laschinger, Finegan, Shamian, and Wilk used a short form of the Conditions of Work Effectiveness Questionnaire II developed by Laschinger that linked structural empowerment with psychological empowerment. This research supported Kanter's claim that social structural factors in the workplace are important conditions for empowering employees and improving job satisfaction. Sarmiento et al., found that

workplace structures such as increasing access to information, support, resources and opportunities had positive effects on individuals by increasing their feelings of empowerment. Other studies have revealed that strong unit leadership had the greatest effect on nurses' perception of empowerment in practice (Laschinger, Havens & Sullivan; Laschinger, Wong, McMahon & Kaufmann, 1999; Wilson & Laschinger).

2.6 Advanced Practice Nursing and Power

There is a large body of literature that discusses the development of advanced nursing practice and advanced practice nurse roles. Nurses in these roles are expected to use their expert knowledge to interpret and incorporate new knowledge into clinical practice to meet the health needs of all those with whom they work (CNA, 2008; DiCenso et al., 2010). The CNA has identified core competencies of advanced nursing practice as: clinical practice, research, leadership, consultation and collaboration. The education competency is threaded throughout the other four competencies. Within the nursing literature reference is made to APNs having skills in expert coaching and guidance, consultation, research, clinical and professional leadership, collaboration, and ethical decision making (Bryant-Lukosius & DiCenso, 2004; Bryant-Lukosius, DiCenso, Browne & Pinelli, 2004; DeGrasse & Nicklin, 2001; Hamric, 2009). The literature on advanced practice also has identified concerns in the following areas: role definition, understanding of the APN role by stakeholders, implementation of the APN role, and role evaluation (Bryant-Lukosius & DiCenso; Bryant-Lukosius et al.; Cummings, Fraser, & Tarlier, 2003; Gardner, Chang, & Duffield, 2007; Stark, 2006).

2.7 Summary

The literature on the concept of power in nursing indicates that nurses need to understand power and the effect it can have, both positive and negative, on their practices and the health outcomes of those patients for whom they care. Embedded within the literature on power is the need for individuals to possess knowledge and to bring about change. Understanding how power works in society, organizations and relationships from various theoretical perspectives is important in understanding how power is embodied by individual nurses and the profession as a whole.

Although Kanter (1993) and other scholars such as Laschinger et al., (1997) identified the structures within organizations that support nurses' perception of power, only Earle (1997) explored nurses' lived experience of power within their practice. Nurses in the APN role are expected to apply specialized knowledge, skills, judgment, and personal attributes to improve healthcare outcomes. However, there are no studies related to understanding the perception of power by APNs. Therefore, research on APNs' perception of power is warranted.

CHAPTER THREE: METHODS

This chapter contains a description of the study design, methodological assumptions, sample, procedures for participant selection, setting, procedure for data collection, data analysis, methods to enhance rigour, and ethics.

3.1 Study Design

A qualitative design was chosen for this study. Qualitative research explores human behaviour and seeks an understanding of it (Polit & Beck, 2008). An interpretive hermeneutic phenomenological approach (Heideggerian) was selected in order to develop a better understanding of APNs' perceptions of their lived experience of power. Heidegger (1981) supported the philosophy that each person's experience of a phenomenon is unique and is integrated with past experiences and future expectations. Phenomenology involves the examination of the individual in the context of the everydayness that informs practices and meanings (Darbyshire, Diekelmann, & Diekelmann, 1999; Heidegger). Those who adopt the Heideggerian approach to phenomenological research consider themselves as part of the research process and believe that rather than suspend their beliefs about a phenomenon, researchers must acknowledge and present these beliefs within their work (Polit & Beck; Rapport & Wainwright, 2006).

In phenomenological research, the meaning assigned to data collected through interviews emerges from the interaction between the researcher and the participants directed by the research question (Wimpenny & Gass, 2000). The researcher requires skills in reflection, clarification, requests for examples and descriptions, and listening (Polit & Beck, 2008; Wimpenny & Gass). The "deeper goal" that is always the thrust of

phenomenological research remains oriented toward ascertaining the nature of this phenomenon as an essentially “human experience” (van Manen, 1990, p. 62). As van Manen states, “to do research is always to question the way we experience the world, to want to know the world in which we live as human beings” (p. 5).

In a phenomenological study, one must consider context, personal interpretation, and time. Context as it relates to a phenomenological study is what van Manen (1990) would refer to as “the world in which we as human beings live” (p. 53). In this study, the context is the world in which the APN works, which includes the APN program/specialty, the acute care organization, the profession of nursing, and the population for which the APN provides care. A description of this world is provided within the sections on participants and setting. In a phenomenological inquiry, the researcher accepts that each individual interviewed will describe his or her experience in an individualistic fashion. The way in which participants present their stories is also linked to “time.” In this study, the APNs’ interpretations of their experience are influenced and shaped by their present and past experiences and future orientation.

3.2 Methodological Assumptions

This study examines the concept of power within the lived experience of APNs. As Moules (2002) explicates, hermeneutics’ attentiveness to language involves recognition of sameness, place, and belonging so that one is able to recognize the interpretation of a concept. The interpretation of the data by the researcher is influenced by his or her relationship with the participants and the world in which each resides. As Moules states, “in these relationships others start to recognize not only something of themselves, but also of the world; they recognize something old and something new”

(p. 3). The presence of the researcher is not removed (or bracketed) from the research process but is readily acknowledged and accepted as an integral component of the research.

3.3 Participants

Purposive sampling was used to select the participants for this study. The target population was APNs working at one large tertiary-care organization in Canada. Twenty-one APNs were employed in a variety of specialty clinical areas, such as community, geriatric research, acute pain service, trauma, and the stroke program. Each of these APNs held graduate degrees in nursing or a related discipline. They reported to a clinical director, as well as the chief nursing executive. In some cases they also reported to nurse managers in units with which they were associated. According to the APN role description at this institution, they were expected to foster clinical excellence in specialty areas, contribute to an academic practice environment for nursing services, provide consultative services to assist clinical programs, and take part in the evaluation of new APN roles.

Eight APNs volunteered to participate in the study. Polit and Beck (2008) have indicated that in phenomenological studies, samples are intentionally small (i.e., 10 participants or less) because of the richness of the data obtained with in-depth interviews. The richness of the data obtained from these interviews supported the sample size. To protect the participants' identities, demographic characteristics were reported in aggregate format. The average age was 40 years. All eight participating APNs were female and represented a variety of specialties. Their level of experience within the APN role varied; but they had an average of 5.5 years of practice as APNs. Past experiences

differed greatly among the APNs; all had postgraduate education, with the majority of the participants having 10 years of nursing experience previous to their role as APNs. The participants for this study met the inclusion criteria, as each (a) had worked as an APN for at least 1 year, (b) was comfortable describing her experiences using the English language, and (c) held a graduate degree. Although the majority of participants held a graduate degree in nursing some had obtained a graduate degree in education and business.

All of the practices of the APNs within this organization incorporated core competencies of: clinical practice, consultation, education, research, leadership/administration and in addition, they each had a management component. The management component differed significantly from one APN to the next depending on the context of the work (i.e., population, setting). Some were responsible for one or two individuals; others were responsible for as many as 30 nurses. Each APN was responsible for a large or small budget and for decisions regarding the nurses within her practice. Some of the APNs were responsible to a specialty unit/program, while others were situated within a more corporate setting. The participants constituted a diverse group, but common to all was the commitment to “become” an APN.

3.4 Setting

The organization at which these APNs worked provides patient-centred health services with an emphasis on tertiary and specialty care. More than 1,000 inpatient beds are distributed across three campuses. A wide variety of educational opportunities are available across all healthcare disciplines through multiple partnerships with universities, community colleges, and training organizations.

3.5 Data Collection

Approval was obtained through the organization's Research Ethics Board (see Appendix A). The senior VP for professional practice, chief nursing executive, as well as the clinical directors were contacted for permission to access the APNs. The chief nursing executive in the organization took responsibility for establishing initial contact with the APNs via an e-mail flyer in French and English (see Appendices B & C) to determine whether they were interested in participating in the study. Interested APNs contacted the researcher by email to negotiate a time and place to meet for the interview

Data were collected through one-on-one audio-taped interviews with the APNs in their offices. The guiding questions were open-ended and conversational, so participants could introduce anything that was important in their experience (see Appendix D). Prompts such as "Can you give me an example," "Can you share a particular experience," and "Tell me more about that" were used in an effort to encourage the participants to speak with as much specificity as possible about their own experience and to clarify what they meant. Field notes were completed immediately after the interviews and complemented the data.

The consent form was signed at the time of the first face-to-face interview (see Appendix E). Each interview ranged from 45 minutes to 1.5 hours. All 8 APNs accepted the opportunity for a follow-up interview to discuss the findings of the study, which helped ensure that the generative nature of the interpretation was honoured and kept in play (Rashotte & Jenson, 2007). The follow-up interviews lasted 5 to 35 minutes. Each of the APNs reviewed the summary of the findings. Their comments regarding the summary were also audio-taped and transcribed verbatim.

3.6 Data Analysis

van Manen (1990) identified themes within phenomenological research as structures of experience or the lived experiences of the individual that contributed to the construction of a phenomenon. Data from the transcribed interviews were analyzed guided by the thematic analysis approach outlined by van Manen. A hermeneutic phenomenological approach involved three principal activities: (a) segmenting the data (each whole case) into manageable parts that would be comprehensible by themselves; (b) naming the data segments; and (c) understanding and describing the relationships within and among the data segments across cases as well as within and among whole cases. First, the transcribed interviews were checked and rechecked for accuracy and to identify significant statements. The process of transcribing, reading, and rereading offered the researcher intimate knowledge of the data. Common words and thoughts from the participants were identified and colour coded during the reading of every interview. Significant statements were then compiled from each of the APNs' stories. These statements formed the subthemes that were voiced by the APNs. The subthemes identified were then formed into themes. The relationships between the themes were examined within and between each of the interviews.

Although the participants' experiences remained the principal source of data in this research approach, other sources of data assisted in the analysis. As part of the analysis, etymological sources were traced (van Manen, 1990). The understandings revealed were then integrated into an exhaustive description of the experience of power.

3.7 Methods to Enhance Rigor

Rashotte and Jensen (2007) examined the ethics of relationships within the context of validity in hermeneutic phenomenology. These ethics, they explain are complex and develop through questioning each step in the progression of research. In this study, it is necessary to consider the relationship that develops between the researcher and the APNs, the data, and the readers of the research. It is through these relationships that others can participate in the meanings revealed by the participants and interpreted by the researcher (Rashotte & Jensen).

Credibility, dependability, confirmability, and transferability have been identified by various researchers as factors that contributed to rigor in qualitative studies (Koch, 1993; Lincoln & Guba, 1985; Maggs-Rapport, 2001; Polit & Beck, 2008). Credibility refers to the trustworthiness of the data and the interpretations of the data. The research team in this study consisted of experts in qualitative data methods, particularly phenomenology. They independently reviewed the transcripts and came to consensus regarding the themes and subthemes. A summary of the findings was presented to the participants by the researcher to determine whether their experience was accurately reflected. Moules (2002) suggests that the credibility of qualitative research is based upon the reader's ability to follow the interpretation of the data by the researcher. This might not result in the reader agreeing with the researcher but might result in an understanding by the reader of how the interpretation is reached. All eight APNs stated that the summary captured their perception of power in practice.

Dependability is established when another researcher can clearly follow the decision trail used by the researcher (Sandelowski & Barroso, 2003). Dependability is

assured through journal entries that record the decision-making process as the research progresses.

Confirmability is the process of ensuring that the participants' voices are reflected in and not superseded by the voice of the researcher (Lincoln & Guba, 1985). The research committee, experts in qualitative data analysis provided ongoing feedback related to the analysis of the data. In addition, reflective journaling kept interpretations of the data in view in order to prevent personal feelings and experiences from overshadowing the experiences of the participants (Lincoln & Guba).

Transferability requires that a researcher provides sufficient contextual information to make similar judgments possible by others. To support transferability, details related to the context of the work environment of the APNs have been provided within this chapter. It is the responsibility of the research consumer to determine the applicability of the research findings to other contexts (Lincoln & Guba, 1985).

3.8 Ethics

Prior to commencing the study, ethical approval was sought through the organization's Research Ethics Board. All potential participants were provided with an information sheet and consent form (Appendix E). Upon meeting with the participants, the researcher provided information regarding the purpose of the study, the potential risks and benefits of participating, confidentiality and the use of direct quotations, as well as participants' right to refuse participation and to withdraw at any time from the study. Participation or nonparticipation did not affect future performance appraisals of the participants.

Participant confidentiality and anonymity were maintained by assigning code numbers to the data; the names of the participants were not attached to any written records of the interviews. The code list was kept separate from the transcripts. All participant information, demographic data, consent forms, original transcripts, and audio taped interviews were stored in a secure cabinet in the thesis supervisor's office. The data transcribed from the interviews were protected using encrypted computers and memory sticks.

CHAPTER FOUR: FINDINGS

4.1 Introduction

This chapter contains the findings of this study, including the themes and subthemes revealed within the participants' descriptions of their perceptions of power. Factors that hindered and supported power have been identified in the experiences of the APNs and are included within the themes. The findings are supported by direct quotes from conversations with the APNs.

4.2 Overview

The overarching theme "building to make a difference" identified that APNs' perception of power concerned "building on," "building with," and "building for." Participants *built on* their knowledge and expertise, *built with* others in relationships, and *built for* the capacity to make a difference. In their experiences, these APNs articulated a passion to facilitate changes in practice, in order to improve patient care.

Power was an aspect of everyday APN practice but it was to be used "softly" to build change for the better. As one APN explained, "It's about being empathetic and being caring and all those things, which are not really power words. Inherent in that is a sort of soft power, if you will" [3]. They shared power with others in a variety of relationships in order to bring about change. APNs connected the building of power to interactions with others: patients, families, nurses, and members of the inter-professional team. The relationships that APNs built were reciprocal and resulted in the sharing of power through exchanges of knowledge and support, which improved desired outcomes. Recognition by others and the successful development of medical directives, programs, policies, and clinical pathways increased the APNs' confidence.

APNs' perceived their power to increase over time as they became comfortable enacting the role. As one APN explained, "In the APN role you have a lot of power inherently, and as you develop that role, and develop your expertise, and people become more aware, then your power increases" [3]. As they became more confident and comfortable in their ability to make a difference, their perception of power increased through a process called "power creep", as one APN explained:

So I think I have become more competent in using power a different way, understanding where to go with it. And I think if you write and you get known in your organization, the power creeps. There is a certain amount of recognition power that gets attributed to you that you should use wisely with all of your colleagues. [1]

This process of "power creep" was also evident as the power they shared returned to them and they saw their power increase within their practices.

4.3 Building On

The theme "building on" concerned building on knowledge and expertise to lay a strong foundation for practice. This theme had two subthemes: "being seen as having clinical expertise" and "being comfortable in the role: developing confidence and competence."

4.3.1 Being seen as having clinical expertise

"Building on" knowledge and expertise was paramount to the APNs' perception of power. They brought to their role a strong foundation of knowledge and expertise; experiential knowing from years of clinical experience, and theoretical knowledge garnered from advanced learning at graduate school. They viewed having knowledge and expertise as contributing to power within their practice as noted in the following quote:

Certainly knowledge is power. So I certainly understood that if I wanted to be accepted as an APN I had to walk with some knowledge. So reading and keeping up to date and being on the leading edge of best practices. [1]

Others health professionals did not tend to consult with APNs until they first recognized the APNs' knowledge and expertise. Consequently, APNs had to learn how to "live that expertise" so that others could see how their specialized knowledge could contribute to the development of interventions to improve care. As one APN explained, "So they see me, and I probably have influence and power along the pieces of what I have been able to demonstrate, that I can bring to the table from a clinical perspective" [2]. Once this recognition occurred, APNs were in a better position to bring about needed changes.

Indeed, without recognition of this knowledge and expertise, other health professionals did not support changes or suggestions offered by APNs. For example, nursing staff within one APN's practice had refused to accept changes that she suggested would have improved the nurses' ability to report a patient's condition to physicians. As the APN recognized, she had attempted to implement the change before she had established her credibility:

You can't have power that works unless people recognize that you have that. So you have to have the credibility. You have to have knowledge. You have to have other people recognize you for that. Maybe that's a bit what it was when I tried to implement that reporting program when I first came in.... because I had been gone for 6 months and came back to a totally new group that didn't know me. I didn't have that power and they weren't willing to allow that [change] until I proved I had the knowledge and expertise and the vision, to be able to say "yes, this is something that will help you develop in the [specialty] unit. It's not about taking away from you; it's about giving to you." [3]

Although APNs brought knowledge and expertise to their role from previous experience and postgraduate education, they experienced a learning curve in their new

position. It took time for them to demonstrate their credibility and for others to approach them. One APN recalled her coordinator asking her whether people had started to come to her yet. At the time, she had been unsure what this comment meant. However, once colleagues began to ask for her opinion and expertise, she reflected on this comment in a new way: “It’s recognition that your role as an APN is working and that’s recognition that you have the power, you have the knowledge to help make decisions and you have the power to help make it happen” [3].

4.3.2 Being comfortable in the role: Developing confidence and competence

APNs spoke of the importance of feeling comfortable in the APN role, as contributing to their perception of power in practice. They linked their own competence and confidence to feeling comfortable as they became APNs. In the beginning, the new role brought with it a feeling of discomfort: “You can give me a job description, but so what! You know ... it doesn’t tell me what to do day to day” [4]. These nurses had to “figure out” what they needed to do to “be” APNs. This role required them to develop competence by incorporating new knowledge as they integrated the components of education, research, management, leadership, and consultation into clinical practice. “So I sort of took all of the information I gathered and then started to create my own role based on the need of the [specialty] department” [4]. They built on previous strengths while developing new competencies required for the role. They demonstrated competence through their ability to identify the needs of those they worked with and to collaborate with others to build new programs, policies, and medical directives to improve outcomes. The success of these programs and input from others contributed to the APNs’ confidence in their role. One APN recalled, “So just talking with people and

getting their feedback and having them listening to what I was saying, I found a very positive experience” [8]. In turn the recognition from others that they were making a difference in practice increased the APNs’ confidence. As others included them in projects and on committees, and acknowledged their contributions to positive outcomes, the APNs’ perception of their own power increased contributing to the process of “power creep.”

Ultimately, it was the APNs’ belief that they could competently identify needs and develop interventions to change outcomes that led to their development of comfort within their role. As they became comfortable, they were able to “see” what needed to be done and were able to share their knowledge. In the words of one, “So that is what you have to do as an APN. You have to be comfortable enough in yourself to be able to give away your knowledge”. [6] The ability to share knowledge and make a difference was perceived by the APNs as holding power in their practice.

The APNs needed time to develop this feeling of comfort in their role and in their various competencies of consultant, researcher, leader, educator, and practitioner. One APN recounted, “So it probably took me a year I would say to feel comfortable doing the clinical consultant piece. I would say another year to really feel comfortable within the role itself with all its various components” [7] The APNs linked feeling comfortable to a sense of confidence in themselves as they were able to apply their knowledge and expertise in practice to make a difference in patient care. Once the APNs were comfortable they looked for opportunities to use their knowledge in practice as this APN explains, “So just taking the lead in that whole process was empowering for myself,

because it was a new experience, it helped to build your confidence...”[8] They were then able to take the lead in developing programs, policies and research.

Competent application of knowledge, skill and critical thinking to develop and successfully implement positive change built the APNs’ confidence. One APN used her knowledge and expertise to address the needs of the patients and others who would be caring for them. After planning and implementing one specialized program, she received positive feedback from families, patients, nurses, and others. This feedback gave her the confidence to move forward with other projects. The positive outcomes from each subsequent project gave her more confidence to speak up regarding other issues in order to support and enhance patient care, thus demonstrating another aspect of power creep.

You get that kind of reinforcement from the comments they (patients and families) make to you. I am starting to learn something here and know what I am talking about and that it just helps you to feel more confident, and that you are making a difference. [8]

Incorporating the comments from others with self reflections on how they had been able to make a difference in practice enhanced feelings of confidence. Each change contributed to “power creep” as they recognized within themselves the ability to effectively improve patient outcomes. Once the APNs “knew” what they “need to do” and “can do” within their role, they felt comfortable and excited about the changes they could bring about in practice.

The APNs in this study linked competence, confidence, and comfort to their perception of power. The feeling of discomfort they experienced upon first assuming their role was replaced with a feeling of comfort in their ability to bring about change in their ever-evolving capacity as APNs. A feeling of comfort in the role signified the APNs own belief in their ability to enact the role of APN to use and apply their knowledge and

expertise in ways that worked to bring about positive change for all those with whom they worked.

4.4 Building With

APNs indicated that they placed high value on the power of relationships based on their concern for others, be they families, patients, nurses, or others connected to their practice. “Building with,” as one perceived form of power, related to the APNs’ desire to maintain and enhance the relationships they had developed throughout their nursing careers as frontline clinical nurses, nurse educators, and/or clinical managers while continuing to expand their network as APNs. They understood the need to connect with others socially and to build relationships in order to make the kind of difference everyone needed and desired. APNs recognized that “building with” took time and was rooted in working on mutually beneficial projects. Embedded in “building with” was an understanding of how to build relationships and trust, as well as how to give and receive support within these relationships. When APNs implemented “building with” strategies, they perceived their power as being enhanced such that they could make necessary changes. APNs believed that “building with” others by sharing experience, knowledge, and resources resulted in the accomplishment of much more than what they could accomplish alone or through traditional hierarchical power structures. In other words, “building with” others brought to the fore the APNs’ belief in collaborative practice. Four subthemes constituted the theme of “building with”: building networks within and outside the organization, sharing power: receiving and giving support, building trust, and having versatility and flexibility.

4.4.1 Building networks within and outside the organization

If I think of a powerful APN, it's an APN who, when she picks up the phone, people want to talk to her; they want to work on her or his project; they are very powerful. They have the ear of senior administration. They have those linkages. They have those networks. That's the kind of power you have as an APN. If you can build a strong network of people you can call for both support and advice.... A lot of the power within the APN role comes from relationships, being able to know your relationships and use them well, not overtax anyone. [2]

Being involved in projects and building linkages with those who could help bring about change were aspects of the power of networking within the APNs' practices. As APNs learned how to bring people together to work on issues in the clinical setting, they recognized that knowledge of organizational practices and the ability to organize groups were essential skills. As one APN stated, "So I used my ability to put committees together to get people to participate. Then I took that and I used my knowledge of organizational practices to drive it in the right direction" [1]. In the development of policies, the APNs perceived it as essential that others see the value of the changes being initiated. As one APN explained,

Your power comes from your ability to influence people. Your power comes from the ability to get people on board with you to move forward.... Often, I think, for power, for myself, it means the ability to demonstrate the value of something and have the people come along with me to do it. [6]

For the APNs, relationships often extended beyond the boundaries of the employing organization. For example, one APN described how she established a critical pathway that changed the quality of life for the patients within her program, which would not have been possible without the relationships she had built both within the organization and the community:

So again we have sort of changed things, but I think it was the close relationship that we had with Community Care Access Centre (CCAC) and saying to CCAC, "OK, here is what we need." We sort of did a critical path of what we needed to have in place. [7]

The APNs also had a peer network that they could call upon to share and acquire information and to make connections, which, as another element of power creep, enabled them to empower others just as they were empowered to make a difference through the help of their colleagues. This network was cited by one APN as follows:

So what we are trying to do is connect them up with community-based types of programs. And there is one through the [type] help line that has been highly recommended to us from another APN that I work with at the hospital. [4]

4.4.2 Sharing power: Receiving and giving support

The APNs understood power as much in terms of what it was not as in terms of what it was. Power, as perceived by APNs, did not mean being domineering. Rather, holding power entailed empowering others and being empowered by others through the act of sharing. APNs shared their power by allowing others to facilitate change. They, in turn, received support from directors, managers, and the chief of nursing. Having others as resources and support was important to the development of power in this role because it enabled APNs to develop standards of care, medical directives, educational programs, and mentorship for those within and outside their programs.

I empower the bedside nurses by standardizing care and creating medical directives. So I am empowering them like my director ... empowers me by allowing me to go where I feel I need to go with certain things, and you know he's not always telling me what to do. And I feel that's empowerment... [4]

Another illustration involves an APN who wanted to develop a fellowship within her specialty but did not know how to undertake this effort. In discussing this with her director, she was encouraged to apply for a fellowship program through the Registered Nurses Association of Ontario, which resulted in a successful program that offered nurses the opportunity to gain more knowledge and expertise within the specialty. This APN's collaboration with and support from her director as well as her own desire to bring

educational opportunities to other nurses ultimately resulted in improved patient outcomes.

APNs described working with others and encouraging them to grow as “soft power,” which was perceived as a constructive form of power. They believed that one’s advanced expertise could and should be shared with others in order to create and build changes in practice in a mutually beneficial way.

So that’s what I mean by a soft power, a power that works for both parties who are involved in it. And it works because of the knowledge and expertise that one party has that can help the other party to develop and to figure what’s going to work for them. And so that’s what I mean by power not being a domineering power but a constructive kind of power. [3]

Constructive power was perceived as a collaborative process—a process of “building with.” One APN described her vision of such power as follows: “So I see the power coming from underneath and lifting and not power coming from on top and pushing down” [2]. Indeed, APNs used the words *teaching*, *mentoring*, *encouraging*, *recognizing*, and *acknowledging* to describe how they lifted or elevated co-workers, helping them to build a sense of confidence in themselves and thus enabling them over time to bring about the changes they desired, offering another illustration of “power creep.” For example, APNs taught others how to deliver presentations and assessments and how to develop standards for patient care. The following anecdote illustrates this process.

Occasionally the nurses would attend a conference but not present. When I came I gradually worked with them and said I was very comfortable with presenting. So I said, “I will help you, but my mandate is you can attend a conference but you need to submit an abstract. It doesn’t matter if it gets accepted or not.” But thus far we have had very, very few that haven’t been accepted. So I will help them write the abstract and then submit it and then help them with their presentation skills. [7]

This APN also encouraged nurses to share their own expertise with others by conducting in-services and interacting with all members of the healthcare team. The act of coaching helped the nurses to be recognized for their expertise and to move their ideas forward.

Just building that confidence level. And I encourage them instead of myself always doing the teaching... I do a lot of teaching in the hospital around [program] management, and [specialty issues]. If they are approached by one of the nurses on one of the units to do an in-service, then I encourage them to do that. I've also encouraged them [by saying] that any interaction with any team member is an opportunity to teach. And because it is a teaching hospital, often it is with the physicians, the med students, the residents, or with the nurses. [7]

The APNs recognized the knowledge and skills that nurses brought forward when collaborating with others and their positive effect on the care of patients. From the APNs' perspective, nurses were the "pulse" of patient care and, as such, they explicitly acknowledged nurses' expertise, thereby supporting the nurses' desire to make changes that would address the priority issues of specific patient populations.

To move our program forward from a nursing perspective, I see [nurses] as being the leaders, and I see me as being the resource person and the mentor and the person who can kind of move and support them in doing that. Because they're the ones who are now doing what I did as a liaison nurse, and they're the ones who are seeing the big bulk of what's happening, and they're the ones who can tell me clinically what are the priority issues. [2]

APNs used the word *leverage* in discussing their perception of power. Just as one might use a lever, a building tool, to both lighten a load and lift something up, APNs used their specialized knowledge, communication skills, and unique position within the organization strategically to lighten the workload for themselves and others, and to lift others' confidence and competence as leaders within their practice. Through the act of leverage, team members were brought together so that all could contribute collectively to change.

I don't think my perception of power of leverage has changed. But it's my ability to enact it that has probably changed. It is my techniques and my strategies and my communication approaches. And you know, my understanding of how to use it, I suppose that has changed. But because of experience and understanding, you know how to better move these things forward based on that power of leverage as opposed to a railroad approach. It really is walk softly but keep going in one direction as best you can and identify those things that are required and will benefit your patients. [5]

4.4.3 Building trust

Trust was fundamental to building relationships within the APNs' practices.

Embedded within the subtheme of "building trust" were four elements: 'being accessible and visible', 'listening to and recognizing others' contributions,' 'sharing values and vision', and 'advocating for others.'

Being accessible and visible was related to the APNs' physical placement in the organization as well as their availability to others. All but one APN had an office situated within the specialty unit for which she was responsible. The APNs spent time on their units with nurses, patients, families, physicians, and other members of the healthcare team. One APN stated,

I see that they trust me. I believe that they respect that I am there for their best interests and the patients. I very much have an open door approach. I feel that they can approach me and that I am approachable. [5]

APNs were "visible" to others not only through their physical presence on the unit, but also through their participation on committees, involvement in staff education, and attendance at conferences and professional organizations. They made an effort to be visible and involved not only in their organization but as well in the community and at the provincial and international levels. APNs used a variety of communication strategies to enhance their accessibility, including current technologies such as e-mail, texting, and telephone, as well as by being physically present for one-on-one dialogue. Being

accessible to others facilitated sharing of information to move projects along. One APN described her ability to share information with those in the community as follows:

I had already been involved with Community Care Access Centre (CCAC) very much because of my regional roles. I had very good relationships, and so we were able to do all the planning, we did it alongside them and shared everything. I think it's because I'm also a person that shares.... For example, we sent one of our [program] patients to Toronto. She went down for a specialized surgery, and so we had a call last week and they said, "Well, we don't know what to do." I said, "What's your e-mail?" and I e-mailed her our policy and whatever else she needed. We have done that a lot, so I think it's that sharing with the community. [7]

Listening to others and acknowledging their contributions strengthened the trust between the APNs and others. APNs respected the staff nurses' viewpoints and recognized that they needed their input before moving forward with any project. Combining their own knowledge and expertise in the specialty with others' expertise provided APNs with greater insight into what needed to be changed to improve patient care. One APN provided the following example regarding "building with" through communication practices that established trust:

For the most part, I always consult with the nurses around what we have to do. And I'm thinking of doing this or that, or there's this and I'm thinking of doing it for these reasons. And I really rely a lot on their feedback and their responses to what it is I'm going to propose and what it is that I'm thinking. Because often, they'll make me see things in a way that I hadn't necessarily thought of, or ... at the end of the day we might still do the same thing but how we implement it, how it looks when we implement it, will always look differently. [2]

Easy access to APNs gave others the opportunity to bring their concerns forward and encouraged interaction. This open communication allowed the sharing of values and vision between the APNs and others. APNs acquired a clearer understanding of how their beliefs fit with those of the organization and found ways in which they could work within the system to influence outcomes in a rapidly changing healthcare environment. They had

a vision of what they could do in their role to move change forward that they shared with staff. This shared understanding became the means for change, as identified in the following excerpt:

Every year we also do a [program] team retreat. We just did it a couple of weeks ago, where we used it as an opportunity to implement the inter-professional model of care. But we take one day and we go away and we always do kudos about what have we accomplished in this past year and being proud of what we've done. And then we talk about any issues and how we can do things better. So it's really looking at that continuous quality improvement type model about how could we do things better. The nurses, it's almost like a little family, we are so close. [7]

Staff and patient advocacy was another strategy for building trust to enhance care.

To obtain others' trust required not only recognition of others' concerns, but also the ability to change outcomes in ways that others supported. Indeed, APNs shared how they were able to "see" the needs of others and how others trusted that they would be their voice, advocating for their needs both internally at the organizational level and externally when they represented the organization. "And just the trust that's put in me, that when I represent the hospital in the various committees, I will update them on what's going on and I will represent the hospital appropriately" [3].

By working closely with nurses, APNs were able to recognize the enormous amount of emotional and physical energy that it took for them to care for complex patients. For example, the nurses on a unit were having difficulty caring for a patient and did not know how to improve the situation. They were able to discuss their concerns openly with the APN, who then met with them to provide support. The nurses trusted the APN to put the patient at the forefront and to translate their input into changes.

Then I brought all the nurses that were on for two different days together—that is, all the nurses on two shift changes. I said, "You know you are driving yourselves crazy because you feel you are not meeting the needs, and meanwhile that gets

translated into no one wanting to go into the room. So let's look at how we can turn that around.” [5]

The APNs were able to see the concerns of the nurses and support them in bringing about changes in care that benefited patients, families, and nursing staff. For example, connections were established with other organizations within the community to meet family needs. Forming relationships with families, patients, and communities gave APNs the ability to advocate for interventions for families.

4.4.4 Having versatility and flexibility

APNs employed the terms *versatility* and *flexibility* in their descriptions of building relationships within the organization and moving projects forward. They were versatile in utilizing the various competencies of the APN role to bring about change, and were flexible in how they operationalized their role. The APNs described versatility and flexibility as contributing to their perception of their power in practice.

4.4.4.1 Versatility

The APNs' role within this organization encompassed all the CNA (2008) competencies for advanced nursing practice: clinical practice, research, leadership, consultation, and collaboration. Education is threaded throughout these competencies as has been the direction in the CNA document. APNs had the additional dimension of management. Once the APNs had “built on” their knowledge and expertise and developed comfort in their role, they demonstrated versatility in how they enacted these competencies. For example, they could focus on the research competencies or the consultant competencies depending on the project. As one participant noted in discussing what percentage of time she allocated to each of the competences expected in her APN

role, “just having those five hats or whatever you want to call it that I can wear, I can really play around with that. I can do 20, 20, 20—I can do 5 and 40 [percent]” [4].

APNs brought a multifaceted skill set and level of expertise to the role that gave them the versatility required to enact all of the competencies. One APN commented,

It goes back to what we were talking about earlier ... as an APN being able to have a more versatile role with the five categories. With what I am doing and being able to be involved in various things like clinical education, I think that’s big. That’s what [power] means to me is to make a difference on various levels. I feel like I can make a difference clinically with families or creating medical directives or eventually doing research. [4]

APNs acknowledged that the versatility of their role enabled them to develop their own practices in terms of using their strengths, developing in areas needing growth, and exploring their interests to address patient and program needs. As noted by one APN,

So as an APN, I mean it’s with the team, and the program’s needs, and the patient’s needs that we identify what the clinical focus is. But it also gives me the opportunity, based on my strengths and weaknesses, to kind of forge forward wherever and develop whatever needs to be done, based on my strengths and my interests as well. [5]

The APNs were required to communicate their program’s needs to many different people. As this required expert communication abilities, they adapted their conversation to articulate their needs, gather information, and present ideas to all those within their practices, highlighting versatility with language. APNs demonstrated versatility through their ability to present information in various ways. They noted, for example, that when speaking to management personnel, they translated clinical issues into a business case and presented data in such a way that the problem would be viewed as fitting within the organization’s bigger picture. As one APN explained, she was frequently consulted because others recognized that she had “the political language to make it stick” or “had

the words we need to use to have this issue or this initiative fit into the hospital big picture” [2].

Communicating, collaborating, and bringing forward what the issues are and providing rationale behind why these changes need to be made. Getting buy-in, knowing who the stakeholders are, knowing who to talk to, knowing how to present it, knowing how to write it down, knowing how to develop a business case, you know it includes all these things. Knowing how to bring forth that information from the bedside caregivers or healthcare providers from your team, so you really are a liaison, in that sense. [3]

Similarly, when holding conversations with nurses or physicians, APNs reverted to medical language and clinical context. Just as APNs converted a clinical problem into a business case when necessary, they also used their language versatility to convert business cases into clinical scenarios. For example, APNs used language effectively to articulate how their ideas could improve patient and nursing outcomes. In this way, they were empowered to translate a need for change into an action for change supported by frontline care providers.

Using the language to make it fit and people buy into, oh yes, we need to support that because it fits into this. Versus if you are trying to move something forward and it’s like an island over here. And it’s totally irrelevant with all the other issues that are going on. It’s kind of, why would we want to invest time into supporting something like that now when we have all these other things going on? [1]

In other words, the power of APNs’ versatile language use was in their ability to bridge the divide between clinical and administrative practices—that is, to help each side be less isolated from the other.

4.4.4.2 Flexibility

The APNs demonstrated flexibility in their willingness to adapt and change in order to bring innovative ideas forward to improve outcomes. Developing flexibility in the role took time and was related to the experiences each APN had prior to, and within, her present practice. Embedded within the subtheme of flexibility was the ability to work

within the system by seeing the bigger picture, navigating around traditional power structures, operationalizing the management role, and positioning themselves both at the table and behind the scenes.

Knowledge of their specialty and the organization gave them insight into what others valued so that they were able to work with others toward common goals. They were able to be flexible and fit their projects into initiatives already underway in addition to presenting their needs in such a manner that others were able to see the benefits of their actions. One APN likened her work to kayaking. APNs must be able to work around “rocks” such as funding issues, resource constraints, and organizational plans that block their ability to move change through the organization.

And it’s kind of like paddling a kayak, and this is how I explain it to new APNs: “You have a choice: You’re in a river with a lot of white water. You can use the power of those waves and of those eddies and all those things to propel yourself forward really well. But if you decide to fight each rock and each boulder and each bit of white water, you will expend an incredible amount of energy.” [6]

“Seeing the bigger picture” was related to knowledge of the organization that APNs developed over time. APNs knew which initiatives were being supported by the organization and how their clinical and program priorities would fit in among them.

I think one of the skills of an advanced practice nurse is—how does this issue that you are trying to drive forward fit into the clinical priorities, the program priorities, and whatever initiatives are going on in the organization?... Or knowing how to make it fit.... And so sometimes it’s worth trying to fit it into the big picture or to say this here aligns this way and it’s on a trajectory that will be more relevant in a few years. [1]

They spoke of power in terms of “being innovative,” “being able to think outside the box,” “looking at things in a different way,” and then moving innovative ideas forward with greater momentum. One APN explained that her program was able to decrease the patients’ length of stay by adapting another organization’s model of care and

bringing in community resources to support patients and families. She shared her joy over the success of this program in the following excerpt:

It was fun; it was sort of cutting edge; it was innovative. And it worked so well, and patients were happy because why stay in hospital when you can go home and have attendant care come in and provide the services? And so that was one big factor in terms of getting patients out of hospital who otherwise wouldn't have been able to get out of hospital. [3]

APNs also perceived that power was associated with flexibility in navigating around barriers or traditional ways of doing things to bring about change. When needs within a specific program did not fit with organizational needs and priorities, APNs still found the ways and means to move practice forward. They blended others' priorities with their own to affect positive outcomes, as one APN explained:

So you use and understand your environmental contacts, and I thought the time is right for [best practice]. And in our place [best practice] is a good choice because we are an acute tertiary. So does everyone want to learn about [symptom] first?.. probably not first, but I can tease them in with [best practice] because then you can't screen out [symptom]. I'll get them that way, you know. [1]

Flexibility was associated with APNs' ability to adjust to the needs within their programs and organization, and to work either independently or in collaboration with others to accomplish goals. As one APN asserted,

You have to be able to be flexible and know where to get your resources. Because the key to a very competent experienced APN is the ability to be flexible, understand where to get her resources and understand when to put them into play. [1]

Within this particular organization, the APNs also carried management responsibilities, which were defined as activities associated with the leadership competency of advanced nursing practice. APN management responsibilities manifested themselves in a number of ways including the number of staff they supervised and the size of their budget they managed. On the one hand, the management component of the

role augmented APNs' access to organizational committees as well as other resources. The management role positioned the APNs in such a way that they had a more intimate understanding of organizational issues, thus enhancing their flexibility in moving their own initiatives forward within the organization. The APNs perceived themselves as positioned between the teams they partnered with closest to the point of care and those with whom they partnered at an administrative level. Indeed, the APNs' management responsibilities afforded them the flexibility necessary to look at other options to initiate change in their clinical practices. One APN described how she used the power of flexibility to position herself in such a way that she could bring issues from the frontline level to influence program development at an organizational level,

It's where you position yourself. So if I am reporting to the chief of nursing, that's pretty good. So I will just position myself as a quality project. So we'll co-chair, so even though the APN is bringing the knowledge, quality is housing it. So it works very dynamically in a partnership, and I do that today. [1]

On the other hand, APNs also experienced internal conflict as a result of their management responsibilities. Hiring staff and disciplinary responsibilities were associated with more traditional forms of hierarchical power, which were incongruent with power viewed as "building with" or relational power of being an APN. As one APN stated,

I don't see power as in me being the person saying, You are going to do this and you are going to do that, and you're going to do it this way and that way and on this day. So I don't see power in that capacity at all. [2]

Power as "building with" was perceived as collaborative, with benefits for all.

I have experienced individuals who have used their power or leverage inappropriately or unethically in an aggressive manner as opposed to a soft-spoken, collaborative way. [5]

APNs also perceived power as the ability to be flexible in positioning themselves strategically when working with others. At times, APNs saw that they could not move change forward by themselves and thus aligned themselves with those who were “quite powerful” and willing to help them “get the job done.” This form of alliance reduced the “expenditure of energy it would have required.” At other times, APNs purposely took the lead on committees and implemented programs. Sometimes, they chose to work behind the scenes to support others in leadership roles, as indicated in the following quote:

I’m comfortable working behind the scenes, and that’s what a good APN does sometimes. Actually, they may not be the powerful person out front. They’re the powerful person behind the scene making things happen. [6]

APNs worked behind the scenes in order to allow others to develop leadership expertise and to acquire recognition for being capable. The APNs worked with the nurses to build their knowledge and expertise within the specialty by obtaining specialty certifications, gaining expertise in writing abstracts, presenting in-services, teaching patients, performing consults, and interacting with the inter-professional team. APN’s support of nurses increased the nurses’ confidence in taking the lead in patient care, as one APN explained:

And it is a great opportunity for learning because the physicians have developed a very good rapport with the nurses, where they will say, “What do you want to recommend? Well, then the nurses will say, “Well, this is what I want to recommend.” [7]

Paradoxically, sharing power and involving others in the leadership role in order to bring about practice change had a negative impact on the organization’s recognition of the role of the APN in terms of achieving outcomes particularly when outcomes were measured in traditional ways.

Looking at measuring outcomes is difficult. So positively the sign to me, I believe, of a good APN is the belief that innovative practices are shared by others. So the APN may be bringing practices forward, but she offers the knowledge to others to build an innovative practice to suit a patient population or a system. And everyone gets the credit. The difficulty with that is—can you say, for example, did these rates decrease because the outcome belongs to me as the APN? Even though underneath it all, you may have driven all the innovative practice. But you, as someone who did that, you share your power, and you made sure it was reflected on the group. [1]

In sharing knowledge and supporting others, APNs were not always recognized as the individuals responsible for driving a change forward. Although the APNs agreed that their power resided in their ability to share with others, the lack of recognition of their essential role was a potential threat to their value in the organization.

The power of being flexible also included APNs “being at the table.” The APNs’ education, experience, expertise, role responsibilities, relationships, and recognition earned them “a seat at the table” where they could have input regarding issues arising from practice. APNs used their knowledge of the organization, their clinical expertise, and their relational skills to influence the issues to be addressed and the manner in which those problems were solved.

You cannot change the system from the outside. You can only change the system from the inside. You have to have enough power and influence to be at the table, where the important discussions are happening. You have to have enough power and influence, that when you open your mouth and your voice is heard, it can cause other people to change their minds. You have to be there. You have to be present. You can’t do that as an outsider. [6]

Although APNs described how flexibility and versatility had contributed to their power, they indicated that these qualities also presented barriers to them in their role. For example, the constant shift in how they enacted their role sometimes resulted in others being unclear as to what was the actual role of the APN. As one APN explained,

I think you have to clarify it a lot, actually, because there are five domains. For example, you have the education domain, the research domain, the clinical, consult, and leadership [domains]. The educator is supposed to spend the bulk of their time on education, either development or delivery of education. But if you have an educator that has been with the program for a very long time, they feel that the clinical, because they are an expert in this patient population, should be part of their role. Or they feel part of the leadership should be part of their role. So that's where some of the conflict comes in is when it's not clear within the program whose role and responsibility things are. [6]

Clarification of the role was most often necessary when new APNs were becoming established within a specialty. The need to explain their role to others decreased as APNs built their practices and others recognized the outcomes of their work. Established APNs also spoke of others not understanding what they could contribute within the organization, as one APN explained: "Often times people truly don't understand what the role is. So we get left out of things that we probably need to be in the loop about and other times get included when we don't really need to be included" [7].

Thus, "building with" others through relationships was key to the APNs' perception of their power, without which they could not have made needed changes. They developed networks, shared power, and built trust with their colleagues, patients, and families. The various competencies of the APN role enabled versatility, and they utilized flexibility in how they operationalized the role which contributed to their sense of power in accomplishing the goal of "building with."

4.5 Building For

The theme "building for the capacity to make a difference" is concerned with the desire to make a difference in clinical practice. When APNs were able to realize this goal, they felt empowered, which is the goal of power from the APNs' perspective. As one APN noted,

That you have been able to demonstrate improvements in patient care, I find it also for me is empowering. Knowing that you have done something that is going to benefit the patient, and setting standards that this is what is, in the [specialty] clinic, expected. The fact that everyone was agreeing with that I found helpful, and that was empowering, is having people listening to you and that was going to help improve the patient outcome. [8]

“Building for” is concerned with spheres of influence of the APN that included patients, nurses, the organization, and beyond.

One of the reasons I enjoy the role [is] because I know I can influence what’s going on and I know I can influence not only at the [organizational level], and not only within my team, but regionally and much more so in the last couple of years provincially, nationally that kind of thing, so ... To me that’s exciting as well to be able to contribute to that. [7]

APNs perceived power as building for others, that is, in order to make a difference at multiple levels—that is, at the level of the individual, the specialty or program, the organization, the profession, and even healthcare policy. For example, the APNs improved care for individual patients and families within their specialty, developed programs for the organization as a whole, and were involved in regional, national, and international projects. “Building for” others at one level often resulted in “building for” others at another level; that is, their influence moved multi-directionally, thus influencing not only within the team, but, “regionally ... provincially, nationally” [7]. The following example of one APN’s work with best practice guidelines demonstrates her influence from a local to a provincial level, a form of power creep:

I took a best practice that I was chairing in Toronto for the whole province, writing all those, and I said, “If I am writing them in Toronto, shouldn’t we be doing them here?” So I used my ability to put committees together to get people to participate. Then I took that and I used my knowledge of organizational practices to drive it in the right direction until now this year it is a corporate practice. [5]

By using their influence, the APNs were able to “build for” others in ways that reach beyond their specialty and the organization, affecting practice provincially and internationally through the development of medical directives, educational materials, programs, and policies. Their use of influence resulted in “power creep,” as change in one area of practice often caused a ripple effect that improved outcomes throughout the organization and the community.

I realize with time, forget doing this on your own because it’s like just too exhausting. How can you do this as a group, and how can you also look at what’s happening? How can you make one pebble have multiple ripples and have it influence different things? And how can you take one project [and] link these projects together so that the momentum goes from one thing to the next? And you just continue riding that wave for a bit, push it to the end. Versus starting one thing and then going onto another project that is totally irrelevant. [2]

4.5.1 Having influence at multiple levels

APNs influenced others to work with them in moving new practice forward. In the words of one APN, “You learn the strategies of negotiating with people and trying to influence by working with, as opposed to working against, not trying my way or no way approach. You don’t get far with that” [8]. They saw influence as a “softer” type of power that did not involve wielding “power over” others, and as such they presented their ideas to others in such a way that others saw the benefits of their programs in terms of patient care. To influence others effectively, the APNs demonstrated knowledge and expertise within their specialty and were able to confidently enact their role.

APNs engaged in various role competencies to make a difference in their patients’ lives and those of their families. For example, in the clinical practice area, they “listen to [the families] and hear their concerns and [are] able to respond based on the experience they have gained” [3] Moreover, they were able to build for multiple patients and

families through the development of educational materials that were made readily available to all patients within their specialties.

I am finding I can do other things and I can have an impact at the patient level in a different way than I did. So even though before I had a huge impact clinically with each individual patient, now my impact is with the patient population.... Because having the same patient asking you the same questions or wanting the same information and knowing, if I just had time to develop this booklet it would just help them so much better. So you ended up talking on the phone with 15–20 women about the same issue. But you know, you need to be able sometimes, just to put the individual patient aside in order to develop the materials so that those 15 people have a resource to go to. So this role allows me to be able to do that. [2]

APNs were also able to build for patients and families through their engagement in research. One APN commented on a research project in which she was involved, which entailed the implementation of programs that would support patients and families within their specialty. She remarked, “just to understand a bit more about what they are going through and to look at the possibility of putting programs into place to help them is pretty exciting” [3].

APNs identified gaps in nurses’ or others’ knowledge and took steps to influence their practices through one-on-one interaction. For example, they looked for teachable moments in order to help others “build on” their own knowledge, skills, and critical judgment by “building with” them in their clinical practices. As one APN explained, “So you use your opportunities to work and perform the clinical practice whenever you get a nurse beside you and any other profession because you work inter-professionally” [1]. Similarly, APNs were able to influence other’s practices positively by acting as role models for nursing practice. Although this was perhaps a more insidious strategy for change, it also appeared to be a potentially powerful one, even when it went unrecognized.

There are other times [when] I have frontline nurses say things to you where you never realized the influence that you have on them, in a positive way, because of the way you handled certain situations that they observed you doing. So in that sense being a role model to the frontline staff. Sometimes, you don't always recognize that you are doing that and the potential, I guess, of influencing them can be another source of power within the role that may not always be recognized. [8]

The APNs made every effort to “build for” nurses, to help them make a difference in their own professional growth and development either in their clinical practice or in leadership development.

So if I can influence their practice, influence the way they ask questions, influence the way they do assessments, influence the way they uptake research into their practice; you know, when I notice there's a gap in some part of their practice, if I can influence the way they practice and help that uptake, help that knowledge from research get into practice, then I've done my job. [3]

APNs recognized the potential long-term impact of developing expertise in the practice of nursing and its enhancement of patient care. For example, they encouraged nurses to become certified in their speciality.

I think really by enabling the nurses to feel autonomous and working to their full scope. First of all, encouraging everyone [nurses within the speciality] to become certified. Canadian certification in both (specialty) nursing and (second specialty) nursing, right now every member of the team is certified in one or the other, and I think there is only about 3 or 4 out of the 9 nurses that are not certified in both. [3]

APNs also strove to “build for” nurses to help them make a difference in their own practices. For example, they were able to support nurses by “standardizing care and creating medical directives” [4]. This enabled nurses to make care decisions in a more timely fashion, thus improving the delivery of care and patient outcomes and nursing satisfaction as a result of working to broaden the scope of practice.

So I still feel like I do quite a lot of clinical. And I feel like I have an important influence in the clinical role even though it's a lot less than I am used to. But I was talking to some of the nurses today, and they love that they are starting to get medical directives and protocols that standardizes practice and helps both the

doctors and the nurses, and how to do things. So I think that's one of the good things that I like about my role that I get to do all of those other things. [2]

The APNs often influenced care beyond their organization, as others recognized how they had benefited patient outcomes by developing and implementing programs, educational materials, and clinical pathways. One of the APNs talked about how changes within her program for a specific group of patients had influenced care in centres across Canada as she shared information with them,

We were one of the three or four centres in Canada that ... first started sharing this information with other people, and so other centres came here in [city name] to see how we were implementing this policy and so this one thing kind of had ripple effects and it became really big in the sense of my scope of influence got big. [6]

As APNs became confident in their ability to bring about change within the organization, they were often recognized by others as leaders and were then able to influence change within the community, as well as at provincial and international levels. Some of the APNs were members of national and international organizations within their specialties, which offered them the opportunity to present their ideas and programs. As they developed successful initiatives, others asked for their support and input in developing their own programs. One of the APNs developed a programme to improve the quality of life of those patients within her practice and was able to bring these changes to other centres. She explained,

And I think a lot of it also depends on the reputation you develop over time where you are identified as somebody who can move it forward and who can communicate and who can advocate and liaise and do it in a fashion that will actually get something done. [5]

APNs were also able to attain a broader sphere of influence by publishing articles and speaking at conferences on initiatives they had developed. As one APN observed,

When we did the best practice guideline project we are a spotlight organization now, one of the guidelines, [specialty] was the one I was involved with, so we did a [symptom] resource nurse program, and we published that just now. Actually we just got asked to write something for the International Society of Nurses newsletter on it. [7]

The capacity to make a difference in practice was seen by the APNs as integral to their power in practice. The dedication that the APNs had to improving care within and outside the organization brought with it the recognition by themselves and others that they could change practice. In the words of one APN,

One of the reasons that I enjoy the role is because I can influence what's going on and I know I can influence not only within my team but regionally and much more so in the last years provincially and nationally. [3]

The APNs were involved with many projects that involved various aspects of their role. When they began to influence outcomes at multiple levels and make a difference, they perceived that they had greater power. Changes they were able to implement within the organization often had a ripple effect within the community and beyond as others recognized the benefit of change and incorporated them into their practices within their organization. The successful development of programs, policies, critical pathways, medical directives, educational materials, inter-professional collaboration and best practice guidelines contributed to the process of “power creep” within the practices of these APNs.

4.6 Confirming the Results

All eight participants took part in a follow-up interview to review the summary of the study findings. After each participant read the summary of the findings, she was asked whether it reflected her perception of power within her practice. All of the APNs felt that the findings supported their perception of power in practice. One APN reflected

on the overarching theme of ‘building to make a difference’ by ‘building on’, ‘building with’ and ‘building for’ as follows:

I like the way ... it’s actually very clever, building on and building with. I am very impressed with the building for, it is really a nice way to put it. It frames the discussion well. I don’t see anything missing from what we discussed when we had our one-on-one interview earlier in the year. [1]

Another APN stated, “I did find those three different areas did make it comprehensive in terms of how APNs see their power. I think it is very reflective of the experience we have” [4].

The APNs also agreed that their perception of power changed over time and with experience. As one APN explained,

It is true that as you become more comfortable in your role and more competent in your abilities, as other people see you growing in the role as well and in what you can contribute, it does make you feel you have more power to make positive influences or changes [5]

Making a visible difference was essential so that others would know who they were.

Because not everybody knows, because if you don’t do any presentations, if you don’t see patients or if you don’t produce any medical directives or protocols, then nobody will know who you are. So you have to produce something in order for people to know who you are and to make a difference. [2]

The participants confirmed the findings that APNs used “soft power.” As one APN explained,

I liked the quote about soft power, because I think, truly that’s what it is... and the fact that it’s not power over. But it’s more power to influence change and move practice forward, and to create best practices and focus on outcomes. I really liked it. [7]

CHAPTER FIVE: DISCUSSION

This chapter contains a discussion of the study's findings with support from the relevant literature. Implications for practice, education, and research are examined. The chapter concludes with limitations of the study.

5.1 Introduction

This study explores APNs' perceptions of the lived experience of power within their clinical practice. Power is described as the ability to make a difference by "building on" knowledge and expertise, "building with" others, and "building for" the capacity to make a difference in the lives of patients and nurses. APNs in this study express the belief that power should be shared with others to improve patient care. The use of words such as *walking beside*, *sharing*, *helping*, *working with*, and *supporting others* describes their use of soft power rather than a dominating type of power over others. Their relationships enable them to change practice and to make a difference by sharing their knowledge, beliefs, and values. The power they share with others through relationships as well as their knowledge and expertise results in an increase in power within their own APN practices, the process they describe as "power creep."

5.2 Building On

Of great importance to the perception of power of the APNs in this study is the clinical knowledge and expertise they bring to their role and continue to develop as they advance in their practice. This expertise stems from their previous clinical practices prior to becoming an APN and continues to develop in the enactment of the competencies of advanced practice. Their knowledge and expertise gives them the credibility they require to be seen as clinical experts. They express the idea that as APNs they must walk with

knowledge and be on the leading edge of practice in order to be viewed as clinical experts. Many authors have established the relationship between clinical knowledge and power (Benner, 1984; Chinn & Kramer, 2008; Daly et al., 2004; Kanter, 1977; Spross & Hanson, 2009). For example, Chinn and Kramer explain that knowledge, within a discipline, “represents what is collectively taken to be a reasonable and accurate understanding of the world as it is understood by the members of the discipline” (p. 2). Other scholars indicate that in order to be successful in their professional role, APNs require advanced education and expert knowledge of the specialty (Bryant-Lukosius, DiCenso, Browne, & Pinelli, 2004; CNA, 2008; Gardner, Chang, & Duffield, 2007; Tracy, 2009). For example, Tracy states that knowledge from sources such as graduate education, experience with specific patient populations, professional reading, continuing education, and exchange of information with colleagues provides a foundation for the expert clinical thinking associated with the APN role. Based on this body of scholarship the CNA contends that the effective use of knowledge and expertise characterizes advanced practice.

The APNs in this study use their power to make positive changes to the profession of nursing, patient care, and practice outcomes. Positive outcomes such as those identified by the APNs in this study have been recognized in the literature examining the APN role and are attributed to the application of expert knowledge (DiCenso et al., 2010). Polifroni (2010) describes expert power as knowledge few others have and which can be activated and implemented. The activation of knowledge discussed by Polifroni is related to the ability to know what to do and then doing it. The APNs in this study use

expert power to identify the needs of those within their specialties and to develop interventions that improve care.

Power through knowledge develops over time. Knowledge and expertise contribute to the APN's development from novice to expert APNs. The APNs describe a progression from novice APN to expert APN that takes time, akin to what Benner (1984) described in the practices of the nurses in her research, that it took time, required new knowledge and reflective practice to proceed.

The APNs indicate that in their early practice, they did not feel that they had power until others recognized the knowledge and expertise they possessed. As Benner, Tanner, and Chelsea (1996) explain to become an expert, one must possess innate ability and have the opportunity to acquire sufficient experience. As the APNs build on their role and are able to demonstrate their ability to improve patient care, others recognize them as a valuable resource, both informally (by asking them for information) and formally (by inviting them to participate at committees and conferences). Through experiences in working with others and developing the competencies of the APN role, they are seen as experts in their specialty as they effectively implement change to improve patient care, thus affecting others inside and outside the organization.

Building on their previous knowledge and expertise, the APNs develop additional competence and confidence within themselves. The ability to identify the broad range of needs of others adds to the APNs' competence in their practices, and the implementation of successful change increases their self-confidence. The APNs discuss the connection among competence, confidence, and comfort in their role. They reflect on how they have learned experientially. The ability to reflect on practice to increase knowledge has been

discussed by Spross and Hanson (2009). Taking risks and reflecting on outcomes led them to gain self-confidence, leading to a feeling of comfort in the role. As Spross and Hanson stated, “The willingness to take a chance, to try, and to fail occasionally is the mark of a true leader” (p. 265)

Rashotte and Jensen (2010) examined the nature of the lived experience of being and becoming nurse practitioners (NPs) in acute care settings and addressed the transformation that new NPs underwent as they developed competence and confidence in their role. Their research connected the concept of comfort to the NPs’ development of competence and confidence in practice. The APNs’ competence as seen in this current study is related to the knowledge and expertise they develop within their professional role as they continue to learn and stay on the leading edge of practice. As their knowledge increases, they are able to identify needs within their specialties and implement successful programs, policies, and educational materials that improved outcomes. In this way, their confidence increases and they become more comfortable in the advanced practice role.

Building competence by nurses in the role of NP as researched by Rashotte and Jensen (2010) supports the experiences described by the APNs within this study, in that knowledge, expertise, and reflection on practice help them to build competence. Application of their expertise and knowledge through the development of policies, programs, best practice guidelines, and medical directives contributes to their confidence as they see these changes result in improved outcomes. As the APNs gain competence and confidence they experience a progression in comfort in the role adding to their perception of power. Ponte et al. (2007) posits that nurses who are competent and

confident in their knowledge and ability to change practice are powerful. They conclude that knowledge is connected to competence and confidence, but they did not formally investigate how nurses built knowledge in their practice. In this current study, the APNs identify needs within their specialties as a consequence of their experience and expertise and are, therefore, able to implement changes that result in positive outcomes. When they feel competent and are seen by others as being competent, they are then able to move forward not only in taking on new projects but also in building their relationships with others within and outside of the organization. Their confidence increases through their competence to make things happen and they begin to feel comfortable in the role. Knowledge and expertise precipitate the process of power creep, inherent in the APNs' perception of power. However, there was no reference in the literature to this process of power creep, what it is or how it works.

5.3 Building With

The importance of relationships is paramount to the APNs' perception of power. Ponte et al. (2007) explain that the abilities to lead, to be part of a team, and to partner with others are essential elements of a nurse's power base. Polifroni (2010) proposes power as something that does not rely on control but is based on individuals working together in a process of "power of" and "power to". Manojlovich (2007) explains that for nurses to use power to improve patient care they need an environment that empowers them, believe in themselves that they have power, and acknowledge that there is power in the relationships and caring they provide.

To build relationships Fletcher (2006) explains one must engage in meaningful dialogue, lead from the heart, and bring humanity to leadership, sentiments reflected in

the stories of the APNs. The significance of establishing relationships has been identified by authors such as Hamric, (2009), Kuokkanen and Leino-Kilpi (2000), Manojlovich (2007), and Rashotte and Jensen (2010). Kuokkanen and Leino-Kilpi describe nursing as being grounded almost entirely on human relations and Manojlovich extends this view that there is power within the relationships nurses build in their everyday practices. However, little has been written in the literature regarding the ways in which APNs specifically build relationships in practice. Spross and Hanson (2009) state that to be able to build strong relationships to bring about change APNs must demonstrate characteristics of effective leadership by being good listeners, and hearing others' viewpoints. Manojlovich supports the importance of relationships and refers to relational theory as the basis for building interpersonal connections.

The APNs believe that power should be shared to benefit others; they do not believe they should use power over others to bring about change. The APNs feel that they do not have power by themselves; instead they see it developing through their ability to build strong relationships. They see the power in their relationships reflected back to them, thus allowing them to build a more powerful practice. Manojlovich (2007) suggests it is a feminist perspective that brings a relational context to power by emphasizing the active development of relationships through interactions with others. This view of power is supported by the work of Chinn (2004), who describes power in terms of the acronym PEACE (praxis [thoughtful reflection and action], empowerment, awareness, and cooperation and evolvment [commitment to change that is conscious and deliberate]) (p 7). PEACE powers are person oriented and focus on the establishment of trust and communication in relationships. The concept of PEACE powers arises from a feminist

ideal of power in which there is a shift in emphasis from a hierarchical view of power as “power over” others to power that is value driven and translated into action (Chinn, 2004). Chinn’s PEACE powers are apparent when people are aware of their values and follow through with them in practice by sharing values and beliefs, working collectively, balancing power within a group, and working toward a shared vision. All of the APNs in the study are women which may affect their belief that their power is a “soft power” as being the type of power they want to share with others in their practices.

Benner (1984), Chinn (2004), and Manojlovich (2007) address the power of relationships in forming a common bond built upon reflection in practice, an understanding of personal values and beliefs, and respect for the values and beliefs of those with whom one works. The APN’s experiences are consistent with these ideas. The APN’s relationships are based upon trust and the sharing of values and beliefs centered on patient care.

The ability of the APNs to build and maintain relationships may be related to their emotional intelligence. Goleman (1998) describes the five components of emotional intelligence as self-awareness, self-regulation, motivation, empathy, and social skill. The APNs are aware of their beliefs and those of others, they are able to build trust, are empathic to the demands on nurses, patients and families, and they were able to reach out to others through networking and day-to-day interactions. Leaders who have emotional intelligence are able to inspire by engaging emotions, passions and motivation to achieve goals that may not have otherwise be possible (Cummings, Hayduk & Estabrooks, 2005). The APNs are able to develop standards of care, medical directives, clinical pathways, and educational programs to improve outcomes that require collaboration and effective

relationships. Studies by Cummings, Hayduk and Estabrooks, and Lucas, Laschinger, and Wong (2008) found that emotionally intelligent leaders were able to enhance teamwork improve quality of care and increase empowerment of frontline nurses. Lucas et al. suggest that “emotionally intelligent managers may have the ability to understand the emotional ability of their staff and manage them by providing the support, feedback or guidance they require” (p 971). The APNs demonstrate emotional intelligence through their ability to develop interventions that support the needs identified within the relationships they develop in practice.

The APNs build relationships from the ground up. They emphasize that they need to build relationships before they can advocate for change. MacDonald (2007) conducted a synthesis of qualitative studies that focused on nurses’ experience with advocacy in practice. Her findings support the results of this study in that it is the ability to connect, engage, and build relationships founded on trust that support the APNs’ ability to advocate for those within their practice. Power in this context involves empowering others and being empowered by others through relationships. The APNs discuss the importance of developing an understanding of what others believe and value in order to respect others’ perspectives. This gives them knowledge of what others need, and the APN role supports their ability to advocate for new interventions, programs, policies, and medical directives to make a difference in health outcomes. It is through the development of relationships with patients, families, nurses, inter-professional team members, community organizations, and provincial and international contacts that they are able to influence change in many spheres of practice.

APNs stress the importance of receiving support for the enactment of their role. Their support comes from inside and outside the organization. They have access to opportunities and information from their peers, colleagues, nurses, managers, community organizations, and professional bodies. In addition, all of the APNs comment that they feel that they have support from and access to their chief nursing executive. Laschinger, Wong et al., 1999 in their research identified leader empowering behaviors as influencing employee's perceptions of formal and informal power. Bryant-Lukosius et al. (2004) stress that administrative support for the APN role results in APNs having "greater role satisfaction, role autonomy, role clarity, role innovation, and fewer problems related to role conflict and role overload" (p. 526). Therefore support from various levels is a key component of the perception of power.

APNs' ability to collaborate, network, and build relationships appears to be one of the most significant factors contributing to their power in practice. They describe how they could not bring about change alone and rely upon the support of others through the relationships they have built. Anderson and O' Grady (2009) describe collaboration as a dynamic, interpersonal process that evolves over time as supported by the APNs in this study. Through these connections, the APNs are able to collaborate with patients, families, and all members of the inter-professional team to bring about positive change. Collaboration results from the APNs acting as connectors. As defined by Gladwell (2002), connectors are people whom everyone seems to know. Collaborators, meanwhile, are individuals who move between groups and connect one person to another. The APNs are able to connect one group to another and collaborate to achieve change by sharing ideas, knowledge, and expertise. Roberts and Vasquez (2004) reinforce the need for

connection power in collaboration and state that such power often is a combination of referent power, charismatic power, and expert power.

The importance of collaborative relationships in the development of power was discussed by Ponte et al. (2007), who carried out discussion sessions with 11 nurse leaders on the concept of power and what a powerful nurse's practice should resemble. They discovered that an individual nurse could have an impact on patients, families, organizations, interdisciplinary colleagues, and the profession of nursing. Ponte et al., asked nurse leaders how they defined power, which they then described as individual nurses' knowledge, expertise, and use of such to develop a collaborative, interdisciplinary effort focused on patients and families. The stories of the APNs in this study support the findings of Ponte's research in that it is their ability to collaborate and share knowledge that increases their perception of power in practice supporting the concept of "power creep".

Another facet of the APN role that is reflected in the participants' stories is the ability to share knowledge and expertise with others informally in daily conversations and formally in the development of programs, policies, medical directives, conference presentations, and educational materials. To do this, the APNs recognize and acknowledge coworkers, encouraging them to bring about their own changes, thereby contributing to power creep within others' practices. Anderson and O'Grady (2009) describe the sharing of knowledge by APNs in terms of providing expert coaching and guidance. Dias, Chambers-Evans, and Reidy's (2010) qualitative study of the consultation component of the CNS role connects the CNS's ability to share knowledge with others to improve care as an integral part of the consultative process. The APNs in

this study demonstrated effective communicative ability and were able to improve health outcomes through collaboration by sharing knowledge and expertise.

The APNs illustrate how they serve as role models for nursing staff, take part in inter-professional practice, and work with community partners to change outcomes through the sharing of knowledge and ideas. Sparacino and Cartwright (2009) discuss the ability of the APN to cross boundaries by working with inter-professional teams to bring about change. The APNs in this study speak of the need to, as Hanson and Spross (2009) put it, “build bridges” that enable them to partner with professionals in other disciplines such as pharmacy, physiotherapy, and dietary to implement best practices that improve health outcomes. The APNs understood the boundaries of their practices and sought to extend them by involving others in the development and implementation of changes to improve patient care. Dias, Chambers-Evans and Reidy’s (2010) research also reveals that the CNS expertise enabled them to negotiate across disciplines and settings to impact nursing practice, resources program development and consultation as did the APNs in this study.

The APNs speak of using leverage within relationships to increase the knowledge of others by supporting them in pursuing change through mentoring, coaching, encouragement, and role modeling. Nurses working with the APNs gain confidence as leaders. The use of leverage to lighten the load of others has not been discussed in the nursing literature on power. “Bringing others on board” is a skill developed by the APNs that lightens their own load in accomplishing outcomes. Getting people on board is a form of leverage. Gladwell (2002) refers to mavens as people who are socially motivated to collect information and share it with others. The word maven comes from the Yiddish

and it means one who accumulates knowledge (Gladwell, p 60). In a sense, the APNs act as mavens in recruiting others to their efforts by being socially connected and sharing knowledge with others.

Binns' (2008) research examined leadership and stated that, "flesh and blood leaders both men and women are sometimes compassionate and sometimes instrumental, sometimes vulnerable and sometimes tough, sometimes empathetic and sometimes judgmental" (p 616). Binns' describes behaving ethically as being conscious of the effects of power inherent in leadership relationships and using self-reflection to minimize the risk of one's own actions harming another. Relational ethics can be applied to the APNs perception of power. They describe their ability to build relationships in practice through a shared understanding of what needs to be accomplished to improve patient outcomes and nursing. They are able to communicate their beliefs and listen to others, which results in the development of a unique understanding for each participant.

Gadow (1999), in discussing the role of relational ethics in the nurse-patient relationship, cites, "the valuing of persons requires perception of each one's uniqueness, and perception involves engagement" (p 63). Engagement with others is the most significant aspect of the APNs' practice. They understand the need to form relationships that are ethically sound, whether with patients, families, nurses, managers, directors, or other members of the inter-professional team.

The APNs are able to build trust by being accessible and visible, listening to and recognizing others' contributions, sharing values and vision, and advocating for others. The APNs talk about how they develop trust in their relationships by supporting others and responding to their needs. They have a vision of what they can do in their role to

move change forward, which they share with staff. Being visible and accessible to others contributes to the relationships they build. The APNs' presence at the bedside helps them to understand the issues nurses face as well as the program issues. Tracy (2009) cites that within the first year of practice, the clinical nurse specialist (CNS) must establish credibility by providing direct patient care and building organizational and system relationships.

The APNs need to demonstrate their worth in order for others to understand the importance of their role. The APNs discuss sharing knowledge and influencing others as manifestations of soft power. However, they are not always seen as the particular individual who brought an innovative practice forward. Rather, recognition for change is shared, resulting in positive outcomes not always being attributed to them in the role. This loss of recognition connected to the APNs' use of soft power has not been discussed in the literature. The resulting increase in others' power reflects the APNs' efforts to develop strong relationships, but these efforts are not always formally documented. Thus, increasing others' power by sharing knowledge, thereby allowing others to change practice and take a leading role, is not always seen by the organization as a formal outcome of the APNs' work. However, the APNs also understand the importance of being acknowledged for their own contributions to practice and the impact of such acknowledgment on their perception of power.

One dimension of building relationships involves the characteristics of versatility and flexibility. The various competencies of the role enable versatility. Their role requires them to exhibit the competencies of research, clinical practice, leadership, consultation and collaboration. In addition, most of the APNs at this institution are in a

management role. They describe their practices as being similar and at the same time unique in relation to those of their peers. The individuality with which each APN acts out the role demonstrates the uniqueness of how the APNs operationalize each of the competencies of their own practices and is part of the power of the role.

The APNs speak of the need to explain their roles to others, especially when they first begin their practices. In their research into CNS and NP practices in Canada, DiCenso and colleagues (2010) discussed concerns similar to those identified by the APNs in this study regarding role ambiguity. Although the organization has developed a comprehensive job description and organizational support for its APNs, the individual APNs' enactment of the competencies resulted in practices that were unique to the individuals involved. Role ambiguity was one of the major challenges of the CNSs in a study by Dias et al. (2010) and was attributed in part to the constantly changing demands of the health care system that required the CNSs to adapt to how they enacted their role. Bryant-Lukosius & DiCenso (2004) developed the PEPPA framework which is based upon a participatory, evidence based, patient focused process for APN role development, implementation and evaluation. Charbonneau-Smith, McKinlay, and Vohra (2010) review the use of the PEPPA framework to optimally develop and implement APN roles as it promotes an increased understanding of the APN role and optimal use of APN expertise by involving stakeholders in identifying the need for the role and shared goals. The use of the framework in implementation of the APN role helps to decrease role ambiguity and build a greater understanding of it by all those connected with the practices of the APNs.

Versatility is demonstrated through the APNs' ability to present information in different ways that communicate their ideas and concerns regarding patient care. The APNs explain that they communicate in ways which allow them to be understood by specific audiences. For example, they discuss business cases, budgets, and staffing when speaking with management, and they discuss medical directives, standards of care, best practice guidelines, and improving patient outcomes when speaking with the inter-professional team. They are able to use language understood by patients and families when discussing plans of care and the support that patients need to improve their health outcomes. Their use of specific language to present their needs for their specialty to all members of the health care team takes experience and an understanding of what others value and see as needed interventions. Sparacino and Cartwright (2009) explain that the ability to influence is an outcome of excellent communication. The word versatility is not mentioned in the literature on power, yet these nurses give many examples of its importance in their perception of power.

Flexibility is essential to these APNs and is manifested in their knowledge of how to work within the system by seeing the bigger picture, positioning themselves effectively, and utilizing their management role. Knowing the goals of the organization gives the APNs the ability to develop a program for their specialty and fit it into the organization. For example, the management role gives them knowledge of the organization so that they can see the big picture. French and Raven (1959) describe this ability as informational power, which is present when a person understands how a system works. The APNs know whom they need to work with to bring about change; they can position themselves on committees as lead members or support others in stepping

forward. With knowledge of how the organization works, the APNs are able to position themselves behind the scenes, at the table, and in the lead. By positioning themselves effectively, they bring issues to key individuals and groups to bring about change. This phenomenon is consistent with the findings of Ponte et al. (2007), which revealed that a characteristic of powerful nurses is their ability to position themselves to provide direction, input, and information regarding decisions affecting their practices.

Power is related to being able to navigate the system, which requires the flexibility to navigate around obstacles to achieve goals for patient care. The management component of the APN role puts the APNs in a position of power over others, but they find ways to work with others to come to decisions that involved shared power. Their belief in sharing with and supporting others gives them the ability to establish relationships with others based upon a mutual understanding of needs. The APNs management responsibilities vary, but all of them are placed in positions of authority that conflict with their belief in power with others. They want power with, not power over, others. They feel that power should be shared and that decisions should be made collaboratively. The ability to be flexible in their view of power enables them to develop solutions to improve practice together with others.

Little has been written on the management role of APNs because these competencies do not exist in many forms of APN practice and are not identified as a component of the APN role in the CNA (2008) position statement. A literature review by Shawler, Stepler, and Kinnaird (1990) concerning the role dimensions of the CNS, clinical nurse manager (CNM) and staff development instructor (SDI) show similarities and differences in the roles, but they conclude that the integration of these can be

beneficial to the organization. A study by Duffield, Pelletier, and Donoghue (1994) used a questionnaire to determine the overlap between management and CNS roles. They concluded that burdening the CNS with management responsibilities might lead to a decrease emphasis on patient care. They conclude that burdening the CNS with management responsibilities might lead to a decrease emphasis on patient care. Their conclusion was supported by Arford and Olson (1988), who examined the placement of the CNS and nurse manager in three different organizational models and concluded that the roles should not be integrated but that a collaborate relationship be developed between nurse mangers, CNSs and staff nurses to provide the best outcomes. These studies provide support for and against integrating management responsibilities into the CNS role. The concerns and benefits brought forward in these studies are recognized by the APNs within this current study and identify a need for further research into how a management component affects the role of APNs and their perception of power in practice.

As they describe power in their practices, the APNs emphasize the importance of using power wisely, asserting that it should be shared rather than used as a domineering type of power. Interestingly, it is the very act of sharing power that the APNs see as contributing to the process of power creep within their practices. As they build their knowledge and develop relationships to influence change in practice, they recognize how their power grows. They do not work alone but through collaborative practice that involves those within and outside of their practices. The APNs' power increases as they develop relationships. As Hanson and Spross (2009) note, the ability to collaborate and network needs to be based upon clinical competence, common purpose, and effective

personal and communication skills, all of which the APNs in this study describe in their stories about their perception of power. As relationships are built and networks expand, the ability of the APNs to bring about change is enhanced within the organization and beyond, again contributing to the process of power creep.

5.4 Building For

The participants use their knowledge and expertise and their ability to build strong relationships to “build for” their capacity to make a difference in practice. They use the term *influence* when discussing how they bring about change. Manojlovich (2007) explains that one needs power in order to influence individuals and groups. The influence of the APNs affects all spheres of practice: patients and families, nursing, the inter-professional team, the organization, the community, the province, the nation, and the international community. Sparacino and Cartwright (2009) state that understanding each sphere of influence and mastering competencies is essential to the success of APNs. Polifroni (2010) refers to influence as power but pays little attention to how it is used within the APNs’ practices.

The APNs explain that they must take a leading role in bringing change to practice in order to sustain and build the APN role in the organization. In their article on the development, implementation, and evaluation of the APN role, Bryant-Lukosius et al. (2004) stress the importance of documenting positive outcomes directly linked to the APN in making a case for the implementation and sustainability of the APN role. Kleinpell (2007) notes that the APNs’ contribution to patient care is often invisible, despite yielding significant outcomes to patient care and nursing practice. As such, APNs must be able to show how they have contributed to improving the health outcomes of the

populations with which they work. MacDonald-Rencz and Bard (2010) and Bryant-Lukosius (2010) in their discussion of NP and CNS roles in Canada remark that more is needed on the direct impact of the CNS role. Others have to “see” the outcomes of the APNs’ practices in order to sustain the role. Kleinpell states that outcomes related to length of stay, patient and nursing satisfaction, and contributions to education should be examined before the role of the APN is implemented in specialty areas as well as after implementation. Improvement of health outcomes is demonstrated within all of the stories of the APNs within this study. They have implemented programs that have decreased patient hospital stays, improved quality of care for patients in hospital and in the community, established educational programs for patients and staff, improved support for frontline nurses through medical directives, best practice guidelines, critical pathways and established standards of care just to name a few of the changes these APNs have developed. They work with others modeling care, providing consultation, and encouraging and supporting others in increasing their knowledge and expertise through, for example, attendance at conferences and fellowships, formation of groups and committees to develop change, and establishment of networks through relationships with others both within and outside the organization.

Shirey (2008) examines influence as a prerequisite for change. Influencers are described as individuals who did not use forceful methods to produce change; rather, they create either new experiences or new motives to influence change. The research of Dias and colleagues (2010) links the CNSs’ power of influence and negotiation to their expertise, leadership, reputation within the organization, ability to verbalize health issues, and past success in negotiating innovative care modalities. Their research supports the

findings of this current study that the APNs' perception of power is directly related to their ability to change practice.

Ponte et al. (2007) identified eight behaviors of powerful nurses: (a) acknowledging their unique role in the provision of patient- and family-centered care; (b) committing to continuous learning; (c) developing professional comportment; (d) demonstrating the value of collaborative practice; (e) influencing decisions; (f) being inspirational, compassionate, and credible; (g) having a sought-after perspective; and (h) supporting the profession of nursing. The stories of the APNs in this study reveal that they hold a belief that these characteristics are encompassed in powerful practices

5.5 Summary

This study contributes to our understanding of power within APN practice. APNs in this study acknowledge that they perceive that they have power within their practices and that such power is directly linked to their ability to *build on* their knowledge and expertise, *build with* others through relationships, and *build for* the capacity to make a difference. They view their power as soft power that they share with others. They build relationships upon a shared belief in improving patient outcomes. As the APNs are able to make a difference in patient care, their perception of power increases, resulting in what they describe as a power creep.

The APNs are able to influence nurses' practices through role modeling, education, coaching, and support. For these APNs, the ability to influence others develops as they accumulate new knowledge and assimilate previous knowledge, develop comfort in their role, are recognized as experts, and are able to develop relationships based upon common beliefs surrounding patient care.

It is their ability to see the needs of those within the specialty and identify interventions that enables APNs to bring about positive outcomes. They are able to shape their role to fit the needs of those in their practices. Successful implementation of changes such as new policies, programs, critical pathways, medical directives, best practice initiatives, and educational programs adds to their perception of power in practice, supporting the process of power creep.

The APNs state that their connections and ability to build relationships constitute the source of their power. They strive to reflect on their use of power in relationships so that they do not exercise power over others. Their use of words like sharing, walking beside, teaching, and supporting, as well as their belief that strong relationships are essential to their ability to change outcomes, supports their development of relationships in practice. They build strong relationships that cross the boundaries of their practice as they involve others in bringing about change. Their power is not static; it changes as the APNs change. They acknowledge having power in their practices but are cautious in how they implement it. They understand the negative view of taking “power over” others and reflect on how they enact soft power within their relationships.

5.6 Implications of the Study Findings for Practice, Education and Research

5.6.1 Implications for practice

For these APNs, power arises from their own knowledge and expertise; their ability to form trusting relationships; and their ability to make connections with others at the patient, organization, community, province, and sometimes international levels to influence care and change outcomes. These findings indicate that one should support APNs in continuing to gain knowledge and expertise, forming relationships with others,

and increasing awareness of APNs' role and the impact they have on practice outcomes within and outside the organization.

The APNs do not specifically identify how they develop competence in each of the competencies of their role in their practices. They refer to the competencies in terms of which ones they feel they have experience with, and which they do not. All of the APNs stated that they had gained expertise in clinical practice before entering the APN role. Some also gained experience in education, some were more involved in research, and others did not feel that they were ready yet to conduct research. All the APNs stated they were able to develop the consultation component of their role as they gained experience. Support for competency development within the role needs to be addressed for each APN within the organization. This support could be accomplished formally through structured professional development sessions and informally through peer mentoring. Research also needs to be done examining the rate of competency development. For example does the research role develop at a slower rate than other competencies?

Comfort in the role was essential, but initially, there was some discomfort. The APNs commented that they had a job description, but did not always have knowledge of how to enact the competencies, and that it took time to develop their own role in their area of specialization. They informally asked other APNs within the organization how they had developed their roles. Formal mentoring of new APNs by senior APNs would be supportive and allow new APNs time to identify their own needs in building knowledge and expertise regarding each component of the role.

The need for formal and informal support for APNs to develop competency in advanced practice nursing roles is necessary (Dias et al., 2010; Doerksen, 2010). Mentorship by practicing APNs or CNSs was identified as contributing to the development of the competencies (Doerksen) of new APNs. The APNs in this study stated that although the organization was developing a formal mentorship program, it was not in place at the time of the interviews. Professional development sessions to address the needs of APNs could be formally implemented to support their learning needs and concerns. The APNs in this study communicated with each other informally, but there may be a need for more formal forms of communication such as newsletters or regular meetings. O'Connor and Ritchie (2010) found that regular, reflective practice sessions enhanced CNSs' competencies related to conflict management and system-level change.

Clarity of roles needs to be enhanced to avoid role confusion. As DiCenso et al. (2010) pointed out, several factors contributed to healthcare teams and the public not understanding advanced practice nursing roles. The ability of CNSs in their study to define their practices based upon the needs of their particular patient population, nursing staff, and the organization resulted in each practice looking unique, making it difficult for others to see the commonalities within each practice. Donald et al. (2010) identified that the lack of role clarity and title confusion among health care members themselves posed barriers to implementation of NPs and CNSs roles (APNs in this current study). Specific recommendations from Donald et al. were: development of a vision statement that clearly articulates the role across settings; use of a systematic planning process to guide role development and implementation; strategic communication plan to educate healthcare teams and the public; attention to inter professional team dynamics when introducing new

roles; and the inclusion of components that address inter-professionalism. The results from this current study suggest that APNs could take part in new staff orientations to explain their role within the specialty and organization, thereby increasing the APNs' visibility and accessibility. Public information sessions would give the APNs an opportunity to outline their practices and how their role impacts health outcomes. Monthly newsletters reporting outcomes in patient care resulting from collaboration within the APNs' practice might help APNs gain recognition for driving innovative practices forward. Public awareness of how APNs can support health outcomes could be increased through posters displaying changes to patient care and practice that the APNs have identified and implemented within the organization.

It is important to support the development of relationships within APN practices by encouraging inter-professional practice and knowledge of relational ethics. This goal could be accomplished by supporting the APNs' contributions to various committees and interest groups within and outside the organization. In large organizations, there needs to be a venue for open communication among all members of the healthcare team. Use of social media within the organization may offer new opportunities. This might not be an easy task, but electronic communication may have some role to play in connecting professionals with similar interests. Supporting APNs in connecting with others and establishing trusting relationships should contribute to the APNs' sense of power to effect change.

As relationships were built and networks expanded, the ability of the APNs to bring about change within the organization and beyond contributed to power creep. The phenomenon of power creep was not mentioned in the literature related to power that was

reviewed for this study, but it was identified by the APNs. Power creep was connected to all of the themes identified by the APNs and occurred as they were able to enact all of the competencies of their role and build relationships to influence positive patient outcomes. More work is needed on this phenomenon they described as power creep.

5.6.2 Implications for educational settings

The findings of this study indicate a need for additional formal education surrounding the competencies expected of the nurse in an APN role. The APNs indicate that they feel that they have knowledge of some of the APN competencies, but not of others. It is often up to them to develop knowledge and expertise by seeking out others who have relevant experience, attending educational conferences, and asking for mentorship support from colleagues. The difficulty they experience is that not all of their colleagues' practices resemble theirs. They have to build their practices based upon the needs of those within it. Formal education at the graduate level that directly addresses the development of these competencies is required to support the knowledge and expertise of APNs and thereby set the stage for powerful practice. This could be accomplished through structured clinical experience with established APNs in a formal clinical placement setting in the context of graduate education. Stark (2006) suggests that education at the graduate level addressing the specialized needs of the CNS and NP roles would give nurses expert knowledge to practice in diverse roles to meet the needs of health care consumers. Nurses who have expert knowledge of their roles may contribute to a decrease in role ambiguity. Implications for education should be directed at preparing nurses to enter the APN role with a solid understanding of the responsibilities of the role and how individual nurses can build powerful practices. Formal education programs that

clearly identify the competencies of the role and offer clinical experience to develop them are needed.

Knowledge and expertise is noted by the APNs as a significant factor in establishing relationships with coworkers. The credibility of the APNs is developed as they demonstrate their knowledge of the specialty by identifying the needs of others and developing interventions to improve health outcomes. Graduate programs need to recognize that attempting to prepare students who do not possess sound clinical experience will result in graduates not ready for APN roles and create challenges for nurses in APN positions trying to supervise students with little or no clinical experience.

The APNs use the term “soft power” to distinguish how they view power. They understand the more negative connotation of “power over” and take steps to share power through relationships. For nurses the traditional sense of “power over” can still prevail and therefore nurses need more education about the concept of power and how nurses use it to influence health care. Kagan and Chinn (2010) indicate that nurses need to be concerned with power so that their voices are heard. They believe nurses have untapped informal power that they can use to advocate for patients and families. Schools of nursing need to explore how they examine power at the undergraduate and graduate level. For example, Polifroni (2010) suggests that power be viewed through a Foucauldian perspective in which truth and knowledge are not fixed but are interwoven with power wherein an individual’s power is ever changing and is not a result of position.

Martin-Misener et al. (2010) address educational issues for APNs in Canada and include these criteria: education at the graduate level for all APNs, addressing the specific educational needs of APNs, mentorship for the development of specialized knowledge,

examination of the length of programs and type of delivery (onsite vs. distance), cost of programs, and continuing education for APNs.

5.6.3 Implications for research

The APNs' comfort in the role added to their perception of power in practice as they became competent and confident in their ability to bring about change. Qualitative research is needed to examine the transformational process of becoming an APN. The APNs within this study spoke of a process of power creep that they connect to their development in the role, their ability to establish relationships, and the influence they have to bring about change. Research examining the process of power creep may give more insight into how nurses' perception of power in practice changes as they gain knowledge and expertise, build relationships and influence practice.

Flexibility and versatility are identified by the APNs as being connected to their knowledge of the role, organization and all those they work with and results in an increase in their perception of power. Little is written in the literature in regards to how flexibility and versatility skills are developed and implemented in practice. More research needs to be conducted regarding the development and application of flexibility and versatility in the role of APN.

Research on how APNs develop and maintain relationships in practice is needed. This study reveals how APNs develop relationships to support the nurses within and outside their practices by mentoring, coaching, developing educational programs, conducting in-services, and role modeling with the goal of sharing. The APNs support staff nurses in the development of their own practices and facilitate their empowerment

through clinical pathways and medical directives. More research could be conducted on the impact of APNs on staff nurses' practices and staff nurses' empowerment.

All APNs feel that they are developing leadership roles, but within this organization leadership also contains a management component. More work is needed examining the impact of the management role on APN practice because there has been limited literature related to these competencies.

The role of administrative support in the perception of power by APNs could be further researched. Weston (2006) examined the antecedents of control over practice and found that nurse managers who encouraged leadership among nurses, stimulated nurses' intellectual discussion, and involved staff in decision making on the unit increased nurses' control over practice. Although Weston's study was concerned with staff nurses, the influence of the nurse manager on the APNs enactment of their role could be explored.

5.7 Limitations of the Study

In discussing the limitations of a qualitative study, it is important to recognize that the purpose of a qualitative inquiry is not to produce findings that are generalizable to an entire population but to gain a deeper understanding of lived experience. As such, the findings of this study are not reflective of the lived experience of all APNs or even all those within the selected institution. In addition, because this study was conducted in a large tertiary care facility, the findings may not be reflective of APNs working in community hospitals or in primary care or community settings. Because the APNs held management positions, it is unknown if this contributed to a greater sense of power in practice.

Limitations of the study are related to the recruitment of APNs from one organization and one geographical region. The APNs also self-identified their participation in the study. Therefore, the responses reflect only those APNs who wished to discuss their practice. In addition, all of the participants are women, so the experience of being a male APN is not reflected in this study. Further research would need to be conducted to address the possibility of gender differences. Another limitation is that all of the APNs are Caucasian and English-speaking. It is possible that the cultural background of nurses may have an impact on their experience of being APNs.

The limitations of this study are balanced with the willingness of the APNs to share their stories in the depth required in a phenomenological study. The researcher cannot claim that the experiences described here capture the entire experience of power within APN practice. However, this study does provide an interpretation of the experiences of eight APNs, and research consumers will ultimately determine whether this study is relevant to their own experience.

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APPENDIX A: APPROVAL LETTER FROM ETHICS



Ottawa Hospital Research Ethics Boards / Conseils d'éthique en recherches

751 Parkdale Avenue Suite 106, Ottawa, Ontario K1Y 1J7 613-798-5555 ext. 14902 Fax: 613-761-4311
<http://www.ohri.ca/ohreb>

Friday, May 15, 2009

Re: Protocol # 2009231-01H Advanced Practice Nurses' Perceptions of the Lived Experience of Power

Protocol approval valid until - Friday, May 14, 2010

Thank you for your letter dated May 7, 2009. I am pleased to inform you that this protocol underwent expedited review by the Ottawa Hospital Research Ethics Board (OHREB) and is approved to recruit only English-speaking participants. No changes, amendments or addenda may be made to the protocol or the consent form without the OHREB's review and approval.

Approval is for the following documentation:

- English E-mail flyer received April 15, 2009
- French E-mail flyer received May 7, 2009
- English Information Sheet and Consent Form for Advanced Practice Nurses (version 1) dated April 24, 2009

The validation date should be indicated on the bottom of all consent forms and information sheets (see copy attached). If the study is to continue beyond the expiry date noted above, a Renewal Form should be submitted to the OHREB approximately six weeks prior to the current expiry date. If the study has been completed by this date, a Termination Report should be submitted.

The Ottawa Hospital Research Ethics Board is constituted in accordance with, and operates in compliance with the requirements of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans; Health Canada Good Clinical Practice: Consolidated Guideline; Part C Division 5 of the Food and Drug Regulations of Health Canada; and the provisions of the Ontario Health Information Protection Act 2004 and its applicable Regulations.

Yours sincerely,

Ottawa Hospital Research Ethics Board

Encl.

/cb

APPENDIX B: E-MAIL FLYER IN ENGLISH

ADVANCED PRACTICE NURSES:

WOULD YOU LIKE TO BE INVOLVED IN A RESEARCH PROJECT?

You are being invited to participate in a qualitative study exploring your perceptions of power within your practice. The study is being done by (name) a Master's of Nursing student at Ottawa University under the supervision of (name), Full Professor in the School of Nursing.

What is involved?

You will be asked to take part in two interviews: the first will be 1-1 ½ hours, and a second interview that will be 30-45 minutes with the researcher (name). The interview will be done at a time and place convenient to you and will be audio taped. If you are interested in participating please contact:

Your participation in the research may contribute to an understanding of power in Advanced Practice Nursing.

Thank you for taking time to consider taking part in this research study.

APPENDIX C: E-MAIL FLYER IN FRENCH

Pratique avancée des soins infirmiers

Êtes-vous intéressé(e)s à participer à un projet de recherche?

Vous êtes invité(e)s à participer à une étude qualitative portant sur vos perceptions du pouvoir exercé à l'intérieur de vos fonctions. Cette étude est dirigée par, (nom) une étudiante qui fait présentement sa maîtrise sous la supervision du, (nom) professeur de la faculté des soins infirmiers à l'Université d'Ottawa.

Qu'est-ce que cela implique?

On vous demande tout simplement de participer à deux entrevues avec (nom) : La première, d'une durée de 1 heure 30 minutes et la deuxième, d'une durée de 30 à 45 minutes. Vous pourrez décider vous-même du temps et du lieu qui vous convient le mieux pour ces rencontres. Il est à noter que les entrevues seront enregistrées pour les besoins de la recherche entreprise par (nom).

Si vous êtes intéressé(e)s à participer à cette étude, veuillez contacter :

Votre participation à cette étude sera une importante contribution aux efforts de compréhension du pouvoir exercé dans la pratique avancée des soins infirmiers.

Merci à l'avance de votre intérêt et de votre disponibilité à prendre part à cette recherche.

APPENDIX D: GUIDING QUESTIONS

Question Guidelines for Research Interviews with Advanced Practice Nurses

What were your nursing experiences before your position as Advanced Practice Nurse (APN)?

Could you tell me why you chose to be an APN?

How long have you worked as an APN? (Prompts: How many years, and where? Where did you get your preparation to be an APN?)

Can you tell me what being an APN means to you? (Prompt: Can you share examples of this with me from your practice?)

Can you think of an experience where you felt there was support for power within your practice? (Prompts: What did it feel like for you to have power? What were the factors in this situation that influenced you feeling this way?)

Can you think of an experience where you felt there was no support for power within your practice? (Prompts: What did it feel like not to have power? What were the factors in this situation that influenced you feeling this way?)

Has your perception of power changed over time? Tell me more about that.

Are there factors within your practice that affect how you feel about power in your practice?

Benefits

It is possible that you may develop an enhanced understanding of power within your position as an APN and how this affects your practice.

Withdrawal from the Study

You may withdraw from the study at any time or choose not to answer any questions without any effect on your working relationship at the Ottawa Hospital. If you choose to withdraw from the study, all data gathered until the time of withdrawal will be destroyed by the researcher.

Confidentiality

All personal health information will be kept confidential, unless release is required by law. To ensure confidentiality you will be given a code number. This code will be attached to your interview. Fake names will be used on interview transcripts. The list of fake names, consent forms, audiotapes and transcriptions will be kept in a locked cabinet at the researcher's thesis supervisor's office for a period of 15 years after termination of the study. After the retention period has ended the paper data will be shredded and electronic data deleted. Information generated from this study will be analyzed and written into a report. You will not be identifiable in any publications or presentations resulting from this study. No identifiable information will leave the Ottawa Hospital. The investigator _____ will have access to the tapes for transcription and analysis.

_____, will have access to the raw data from the transcribed tapes. The Ottawa Hospital Research Ethics Board and the Ottawa Health Research Institute may review your relevant study records for audit purposes.

Voluntary Participation

Your participation in this study is entirely voluntary. Your decision of whether or not to participate will in no way affect your working relationship at the Ottawa Hospital.

Questions about the Study

If there are any questions or concerns about this study, you may contact the researcher _____

_____. If you have any questions about your rights as a research subject, you may contact the Chairperson of the Ottawa Hospital Research Ethics Board at _____



Consent Form

The Advanced Practice Nurse's Perception of their lived experience of Power

Consent to Participate in Research

I understand that I am being asked to participate in a research study about my perception of power within my practice. The study has been explained to me by _____

I have read the three page information and consent sheet. All my questions have been answered to my satisfaction. If I decide at a later stage in the study that I would like to withdraw my consent, I may do so at any time.

I voluntarily agree to participate in this study.

A copy of the signed information sheet and consent form will be provided for me.

Signatures

Participants Name (please print) _____

Signature _____ Date _____

Investigator Statement (or Person Explaining Consent)

I have carefully explained to the research participant the nature of the above research study. To the best of my knowledge, the research participant signing this consent form understands the nature, demands, risks and benefits involved in participating in this study. I acknowledge my responsibility for the care and well being of the above research participant, to respect the rights and wishes of the research participant, and to conduct the study according to applicable Good Clinical Practice Guidelines and Regulations.

Investigator/Delegate Name (please print) _____

Signature _____ Date _____

(Valid until May 14, 2010)

Version **date April 24, 2009**
1053 av. Carling Avenue
Ottawa, Ontario K1Y 4E9

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