

Nursing Professional Practice – An Evolutionary Concept Analysis

by

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A Project Submitted in Partial Fulfillment of the
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Supervisory Committee

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Abstract

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The aim of this project is to explore the concept of *nursing professional practice* from an ontological view and illustrate the significance of the concept from a disciplinary, practice, and ethical perspective through an evolutionary concept analysis (Rodgers, 2000). Through the process of evolutionary concept analysis, the *uses* of the concept of nursing professional practice (e.g. conceptual models, practice environment elements, and individual deportment) will be described, the twelve attributes of nursing professional practice from a Canadian context identified, and its definition articulated as a foundation for further inquiry (Rodgers, 2000). An exemplar for nursing professional practice will be illustrated based on the concept attributes identified as an outcome of the analysis. The implications suggested by the findings of the concept analysis for nursing practice – policy, administration, clinical practice, education, and research will be identified.

Key words: nursing, professional practice, evolutionary, concept analysis, attributes

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Forward

This project was guided by these two perspectives:

"The results are ...a starting point rather than an end." (Rodgers, 2000, p. 97)

"In this life we cannot do great things. We can only do small things with great love."

(Mother Teresa, nd)

Chapter 1

Introduction

This paper is a major project was undertaken as part of fulfilling the requirements of the Nurse Educator option of the Masters in Nursing (MN) program at the University of Victoria. The aim of this project was to explore the concept of *nursing professional practice* from an ontological view and illustrate the significance of the concept from a disciplinary, practice, and ethical perspective through an evolutionary concept analysis (Rodgers, 2000). Through the process of evolutionary concept analysis I will describe the *uses* of the concept of nursing professional practice (e.g. conceptual models, practice environment elements, and individual deportment), identify attributes of nursing professional practice from a Canadian context, and its definition as a foundation for further inquiry (Rodgers, 2000). An exemplar for nursing professional practice will be illustrated based on the concept attributes identified as an outcome of the analysis. I will conclude the paper by outlining the implications suggested by the findings of the concept analysis and the associated recommendations for nursing practice – policy, administration, clinical practice, education, and research.

The paper has been organized into four chapters. The first chapter will provide an introduction, background, and outlining the significance of the project and the concept analysis method. The second chapter identifies the concept, setting and method for collecting the data. The third chapter describes the six elements of the analysis and provides exemplars. The fourth chapter outlines the implications for nursing practice and concludes the paper.

Background to Project

My interest in nursing professional practice is a result of the exciting synergy I experienced in my multi-roles as a graduate student, Clinical Practice Consultant in a regional Professional Practice department and a board member of a newly forming nursing association. As I engaged in the process of praxis during this period, the experience of many seminal events, both personally and professionally, identified the salience of the concept of nursing *professional practice*. These events and the experience of having multi-roles gave me the opportunity to consider the concept of nursing professional practice through different perspectives – organizational, disciplinary, professional, and as a bystander to nursing care provided to a loved one. Therefore, what I came to understand is that the concept of nursing professional practice is important; it has multiple meanings and these are dependent on the context in which the term is used.

Organizational Perspective

Considering first the organizational context, Professional Practice departments are a recent component of organizational structures in health authorities within British Columbia. Early in the 2000s, these departments were created to support the work of the newly formed Chief Nurse Officer role in the province. Mathews and Lankshear (2003) identify these departments as being “accountable for promoting professional practice in the workplace” (p. 67). As a member of a Professional Practice department for five years, I gained a perspective of the intent of these departments in BC. The programs and services within these departments support health professionals by promoting professional standards, evidence based practice, and interprofessional collaboration. Examples of regional programs and services in the department

where I worked included the new graduate nurse transition program, professional practice councils, professional development workshops and practice consultation services. As a Clinical Practice Consultant providing practice consultation services with individuals and teams, I recognized there was complexity identifying the accountability for professional practice issues. As I gained experience in the role, I came to understand more clearly that the formal authority for elements of practice environments (e.g., skill mix, mentorship models) resided with operational programs (e.g., Home Health Program) or with individuals for their own competence (Mathews & Lankshear, 2003). I saw my role within the Professional Practice department to influence the professional practice of individuals or environments of teams (Lankshear, 2011). Therefore, it became important to me to explore the meaning of nursing professional practice in order to support my role in providing practice consultations as a core service of an organizational professional practice department. Storey, Linden, and Fisher (2008) identified the importance of moving the abstract conceptualization of what nursing is to what nursing does to resolve practice dilemmas. As resolving practice dilemmas was a key function of my role, analyzing the concept of nursing professional practice was highly relevant to my practice.

Disciplinary Perspective

My multi-role of student, Practice Consultant, and board member provided me the opportunity to consider the indistinctness of the concept of nursing professional practice through readings and activities within my Master's program in a disciplinary and professional context. Multiple nurse authors have noted the lack of clarity regarding the meaning and significance of the concept *professional practice* as reflected in the multiple ways the term is used in nursing professional and disciplinary discourse (Mark, Salyer, & Wan, 2003; Storey, Linden, & Fisher

2008; Hoffart & Woods 1996; Mathews & Lankshear, 2003). The influence of society's collective interconnected conceptualizations of nursing as a *practice profession* and *scholarly discipline* have also been well described in nursing literature (Donaldson & Crowley, 1978; Cody, 1997; Northrup et al., 2004; Parse, 1999, 2001; Schlotfeldt, 1989). Similarly, Gordon in an article with Nelson (2004) - "The Rhetoric of Rupture" - and a book with Buresh (2006) - *Silence to Voice* - asserted the power of nurses' discourse to shape the future professional practice of nurses and the influence of the disciplinary and professional contexts. I realized through my student-inspired process of praxis that there is a discourse within the discipline of nursing regarding the indistinctness of the concept of professional practice. Evolving the conceptual clarity of nursing professional practice is important as the discourse enables the development and strengthening of current professional and disciplinary support structures (Cronin & Coughlan, 2010; Tofthagen & Fagerstrøm, 2010; Ryle, 1971).

Professional Perspective

The discourse related to the concept of professional practice was also present within the context of my preceptorship placement at the Association of Registered Nurses of British Columbia (ARNBC). The inaugural board members of this newly forming association were nurses that intended to establish a provincial forum to create a new voice for registered nurses that will contribute to health and social policy and explore emerging health care and professional issues (ARNBC, 2011). The ARNBC is one piece of the mosaic of professional nursing in British Columbia (BC), rooted in history, legislation, and the evolution of the profession through research and scholarly inquiry (Thorne, 2010). This unique student placement gave me the opportunity to talk first hand with provincial and national nurse leaders about the organizational,

disciplinary, and professional structures necessary to support nursing professional practice. These rich dialogues helped me understand how historical events and the resulting nursing standards, regulations, and credentials reflect professional nursing practice and the establishment of a nursing epistemology. The conversations also highlighted the role of institutional groups and structures in strengthening and sustaining nursing professional practice. Examples of these groups include the CNA, CRNBC, Canadian Association of Schools of Nursing, and organizational professional practice departments. Examples of the structures include provincial legislation, standards of practice, curriculum and policy and practice support groups. The prevalent discourse I noted from this student placement was the influence of professional practice on quality client care through the quality of nursing practice environments. Nursing research conducted in BC identified that nurses experience moral distress and moral residue as a result of working in environments with limited or absent professional practice elements (Rodney, Hartrick Doane, Storch, & Varcoe, 2006; Rodney et al., 2009). Nurses have reported moral distress, when poor quality professional practice environments adversely impact their ability to provide safe, compassionate, competent, and ethical care (CNA, 2008; Rodney et al., 2006; Rodney et al., 2009). Therefore, further conceptual clarity regarding nursing professional practice has the potential to assist nurses to better understand the concept and recognize, acknowledge, improve, and sustain a healthy working environment; thus, demonstrate professional practice individually, within groups, and within their organizations to promote safe, compassionate, competent, and ethical care.

Bystander to the Nursing Care of a Loved One Perspective

The final context in which I experienced nursing professional practice was from the perspective of being a bystander to the nursing care of a loved one. The process of praxis - which I thought would have been informed only by my work and student roles - was unexpectedly influenced by my journey through the health care system with some of my family members who required care. As my enactment of this project is situated from my adoption of an interpretative paradigmatic perspective, my understanding of the concept of nursing professional practice and the areas of my life that inform this perspective, cannot be reduced and separated into parts (Monti & Tingen, 1999). Therefore, I accept the influence of this life experience on my understanding of the concept. As a family member, who is a nurse, I felt a sense of powerlessness, as meeting my family's health needs depended on other nurses. I attentively listened to my family members' descriptions of the attributes of nurses that positively influenced their health. I identified these qualities as elements of my concept of nursing professional practice – client centered evidenced based care. As our family's experience through the health care system progressed and intensified, I witnessed first hand how the individuals my family described as the “good nurses” influenced not only the health outcomes but also my family's experience of the care. Therefore, the important insight from my recent personal journey is how a nurse's professional practice directly influences the health outcomes and experience of care for clients and their families.

Significance of Project

The significance of this project is twofold. First, evolving the conceptual clarity of nursing professional practice contributes to the discourse on the meaning of nursing professional

practice. My experience of this concept and its uses in different contexts led me to identify the need for conceptual clarity for individual nurses and organizational professional group leaders. Nurse scholars have identified that conceptual clarity of nursing professional practice enables and strengthens the development of current professional and disciplinary support structures (Cronin & Coughlan, 2010; Tofthagen & Fagerstrøm, 2010; Ryle, 1971), which in turn influence nurses individual ability to demonstrate professional practice including provision of competent, ethical, quality care (Baumann et al., 2001; Bournes & Ferguson-Pare, 2007; CNA, 2008; Rodney et al. , 2006; Rodney et al., 2009). Second, this project provided a unique opportunity to contribute to the nursing discipline. Conceptual analyses on the topic of nursing professional practice were not identified in my literature search. Therefore, this analysis provides a foundation for further inquiry and research on the concept.

Concept Analysis

Overview of Concept Analysis

Concepts.

A *concept* has been defined as “a cluster of attributes” (Rodgers, 2000, p. 83). There is currently no consensus on the theory of concepts (Cronin & Coughlan, 2010). Rodgers identified two views of concepts – the entity view and the dispositional view. Individuals holding the entity view identify concepts as having essential elements that do not change (Rodgers, 2000). The entity view is associated with the logical positivism philosophical perspective and was reportedly held by such philosophers including Aristotle, Descartes, Locke and Kant (Rodgers, 2000). Cronin and Coughlan (2010) suggested that an implication arising from the logical positivism

perspective is that there is a relationship between concepts and objects. The entity view has been labelled the *classical* theory of concepts whereby the essence of a concept is clarified with a universal definition (Cronin & Coughlan, 2010; Rodgers, 2000; Tofthagen & Fagerstrøm; Walker & Avant, 1995). Individuals holding the dispositional view identify the elements of the concept dependent on the use and context of the concept (Rodgers, 2000). The dispositional view of concepts is associated with an interpretive or constructivist philosophical perspective as described by philosophers such as Wittgenstein (in his latter writings), and Price, Rye, and Toulmin (Rodgers, 2000). This perspective holds that a concept can have one name or term with multiple meanings (Cronin & Coughlan, 2010). Rodgers (2000) asserted that the belief that concepts are dispositional or dynamic is seen in the differing meanings of concepts in various disciplines.

Concept Analysis.

Aristotle legitimized defining and analyzing concepts as a scientific activity (Cronin & Coughlan, 2010). Similarly, nurse scholars have identified that concept development makes an important contribution to knowledge development (Rodgers, 2000). Types of concept development in nursing include concept synthesis, concept derivation and concept analysis (Walker & Avant, 1995). Concept analysis in health care has been linked with the responsibility of disciplines to have clear concepts based on a scientific epistemology (Weaver & Mitcham, 2008). “When a concept is defined, it to a greater degree becomes possible to describe the phenomenon and its characteristic manner in relation to the distinctive nature of the discipline (Tofthagen & Fagerstrøm, 2010, p. 22).

Through paradigmatic evolution, three approaches to concept analysis have developed in nursing – 1) Wilsonian-derived (Walker and Avant, 2004), 2) Pragmatic Utility (Morse, 2004) and 3) Evolutionary (Rodgers, 2000). Authors using Wilsonian-derived approaches utilize a positivistic perspective to determine characteristics of a concept that would be true in any circumstance (Weaver & Mitcham, 2008). Individuals utilizing a Pragmatic Utility approach utilize a critical theory perspective to determine the characteristics of a concept through critique of the literature to identify similar criteria that demonstrates usefulness for practice (Morse, 2000). From an evolutionary approach, individuals utilize a constructivist perspective to determine the attributes of the concept through common understood uses of it in practice (Rodgers, 2000). All three analytic approaches consider the literature to identify the attributes or characteristics of a concept (Rodgers, 2000). The main difference between evolutionary and other approaches is that researchers utilizing the results comprehend the results as a heuristic, that is, to assist and promote further research and inquiry (Rodgers, 2000).

Rodgers' Evolutionary Concept Analysis

Concept analysis is related to the process of concept development. Rodgers asserts that the concept development cycle considers the application, significance, and use of a concept (2000). Rodgers' (2000) evolutionary concept analysis involves the use phase of development. There are six iterative phases that include the following activities: 1) identifying the name and concept of interest and association expressions, 2) identifying and selecting the appropriate setting, 3) collecting the data 4) analyzing the data, 5) identifying an exemplar of the concept, and 6) identifying implications, hypotheses, and implications for further development of the concept. The intention of this type of inductive approach to concept analysis is to establish a

foundation for future development of the concept in contrast to a static, universal set of criteria (Rodgers, 2000). These six phases will provide the framework to guide the analysis of the concept of professional practice discussed in this paper.

Rationale for selecting Rodgers' evolutionary concept analysis.

The selection of Rodgers' (1989, 2000) evolutionary concept analysis to explore the concept of nursing professional practice was made for several reasons. As noted earlier, I believe the concept of nursing professional practice has evolved through contextual influences; therefore, Rodgers' approach would be congruent with the development of the topic to date. The heuristic nature of the method supports the intent of a master's program major project to provide a foundation for further inquiry into the concept. Finally, the dynamic and contextual nature of this method is congruent with the largely accepted perspective in nursing (commonly associated with the interpretive perspective) that humans are ever changing and interact with the environment to establish their health (Rodgers, 2000).

Chapter 2

Evolutionary Concept Analysis

Step 1: Identify the Concept of Interest and Associated Expressions

Rodgers (2000) described a concept as an “idea or the characteristics associated with the word” (p. 85) and not the word itself. The concept of interest I have chosen is *nursing professional practice*. Surrogate terms [words that say the same thing or have something in common with the chosen concept (Rodgers, 1989)] for nursing professional practice include “professional nursing practice”, “professional practice”, “nursing practice”, “professional” or “professionalism” and “practice”. These terms are considered antecedents in the analysis, but are discrete terms from the combined concept of professional practice. Another important initial decision of the evolutionary conceptual analysis process is to determine the direction or context of the analysis (Rodgers, 2000). I have chosen to explore the concept of nursing professional practice in the context of the Canadian nursing perspective.

Step 2: Identify and Select the Appropriate Setting

Rodgers (2000) defines the setting of an evolutionary concept analysis as the time period to be explored and the type of disciplinary literature to be included. I have selected nursing literature between 2005- 2011 as the setting. I have selected this period to ensure I am informed by literature with a recent health care context perspective. The type of disciplinary literature I have used includes peer-reviewed literature and grey literature. To obtain the peer reviewed literature sample for this concept analysis I searched the CINAHL and ERIC online databases. I selected these databases as they are recognized as repositories for nursing and education related

literature. The key words used for CIHAHL and ERIC included “professional practice” as title and “nursing” as a subject. To obtain grey literature sources I used Library and Archives of Canada, Google Canada as an internet search engine. Rodgers (2000) identified the use of grey or popular literature as a strategy to include in conducting a concept analysis. Grey literature are documents that are not formally published or research based but provide key information from a convergence of experience or ideas (RNAO, 2007). Grey literature sources selected for this project were from established government, health authority, professional association, union, and regulatory college websites.

Step 3: Collect the Data

Due to the fore mentioned indistinctness regarding the concept of nursing professional practice (Mark, Salyer, & Wan, 2003) a multi – step exploratory literature search was used to determine the limits which included articles from 2005- 2011 and the search terms “professional practice” as a title and “nursing” as a subject (Figure 1). The final step of the search using these limits revealed 75 citations. I determined which of the 75 peer reviewed literature citations and nursing grey literature were ultimately included in the concept analysis using the following criteria.

Inclusion criteria.

1. Nursing professional practice should be the focus of the article;
 - A definition of professional practice should be described in relation to the individual, environment, or as a concept
 - A tool, model, or structure of professional practice should be described

- Specific behaviours or attributes of an individual are labelled as professional practice are described
2. A definition of professional practice in a nursing context should be provided;
 3. The article should be published in English.

Exclusion criteria.

1. Professional practice not the primary focus of the article and/or a definition of the concept was not provided;
2. Professional practice described in a context which did not include nursing;
3. Professional practice described in relation to advanced practice nursing;
4. Professional practice described in relation to speciality nursing;
5. The article not published in English.

In addition, I included 18 articles published prior to 2005 that are considered well recognized and well cited (articles that have been cited at least twice in related articles). The 42 documents of grey literature were selected from established government, health authority, professional association, union, and regulatory college websites as related to nursing professional practice, scope of practice and posted job descriptions for positions titled “Professional Practice Leader. These additional strategies ensured current and relevant literature is included in the data analysis.

Twenty-two of the 75 articles were included based on the inclusion criteria. Eighteen articles were considered well recognized and well cited and also included in the analysis. Forty-two grey literature sources were included based on the latter search strategy. Of the 135 total articles reviewed in the literature search, 53 articles were excluded and 82 were included for analysis.

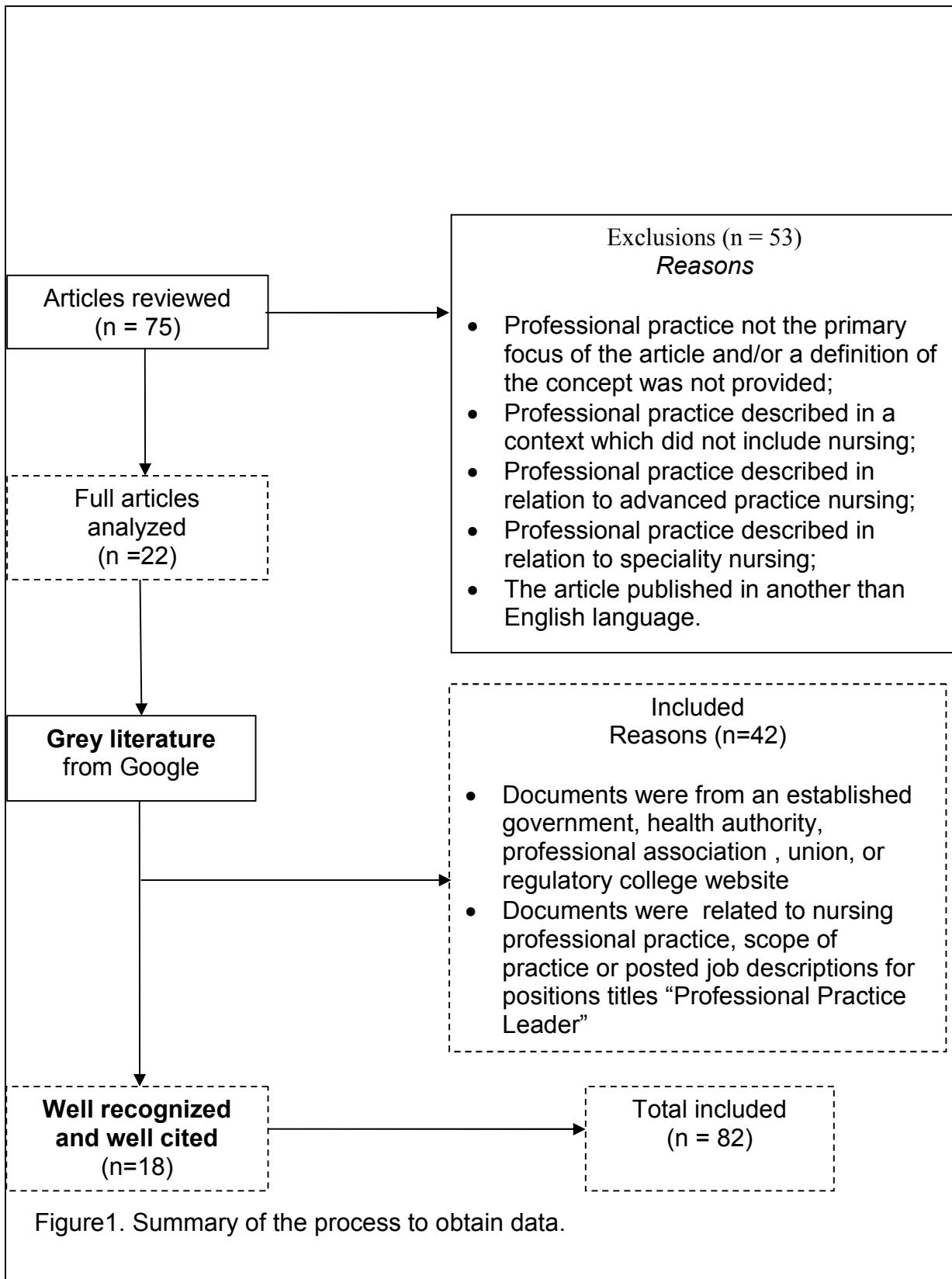


Figure1. Summary of the process to obtain data.

Chapter 3

Step 4: Analyze Data

Rodgers' (2000) evolutionary method of concept analysis includes a review of each of the articles retrieved from the literature for the purpose of identifying the following elements: 1) surrogate terms, 2) related concepts, 3) references, 4) antecedents, 5) consequences and 6) attributes. An inductive process of analysis [where generalizations are developed from specifics (LoBiondo-Wood & Haber, 2009)] began with a review of the 82 documents collected. Content fitting one or more of the six analytic element categories was extracted and then entered in to the appropriate column of an excel spreadsheet. I arranged the spreadsheet to horizontally have six columns for each of the analytic elements - 1) surrogate terms, 2) related concepts, 3) references, 4) antecedents, 5) consequences and 6) attributes. Vertically, the spreadsheet was arranged to list all literature documents by number, document title, year, author, inclusion/exclusion criteria. Next, I established a second table to support the next step in the analysis process whereby I documented key themes under labels [“major aspects of the concept” (2000, p. 95)], for each of the six elements. In other words, I used the process of *thematic analysis*, which is “a process of continually organizing and reorganizing similar points in the literature until a cohesive, comprehensive and relevant system of descriptors is generated” (Rodgers, 2000, p.95). Identification of the key themes was done by identifying selection criterion for each of the analytic elements. The criteria were used as a filter for the information in each column to identify the key themes. In the following section, I describe the detailed analysis and criterion for each of the six elements.

Surrogate terms.

Surrogate terms are words used with similar meanings or have commonalities with a concept (Rodgers, 2000). Rodgers highlighted the historical associations between concept development and language (2000). She asserted that a concept is more than a word or term (2000). Individuals with a dispositional view of concepts believe a term could have a dynamic meaning, which is dependent on the context and use of the concept (2000). Hence, the same word could be used but have a different meaning or in the case of surrogate terms, different words could be used to represent the same conceptual attributes. Therefore, consistent with Rodgers' evolutionary analysis framework, I identified five surrogate terms for nursing professional practice.

These terms were selected as surrogate terms because they were used in the literature to refer to the same attributes as the concept of nursing professional practice. These terms include “professional nursing practice” (Girard, Linton, & Besner, 2005; Laschinger, Finegan, & Wilk , 2009; Murphy, Hinch, Liewellyn, Dillion, & Carlson, 2011; Pearson et al., 2006) “professional registered nursing practice” (CNA, 2011), “professional practices” (RNAO, 2009), and “nursing practice” ARNNL, 2007; CARNA, 2003; CRNBC, 2010; CRNM, 2009; Noone, 2009; SRNA, 2007; YRNA, 2008) and “practice” (Newcomb, Smith, & Web, 2009; Paton, 2010). The terms “professional” (Hall et al., 2003), “professionally” (Sui, Laschinger, & Finegan, 2008) or “professionalism” (Berk & Costello, 2008; RNAO, 2009; Storey et al., 2008) were also used to describe more specifically the individual deportment of nursing professional practice.

Related concepts.

Related concepts are concepts that have some relationship with the concept, but do not have the same set of attributes as the concept (Rodgers, 2000). Tofthagen and Fagerstrøm (2010) provide the example of compassion as a related concept to empathy. The following criteria were applied to the chosen related concepts: 1) the term is considered a concept – has a set of attributes that have been relayed in a theoretical framework and 2) the concept has influenced the concept of nursing professional practice. There were six categories of related concepts of nursing professional practice – organization design, nursing human resources, culture, population care needs, care delivery, and practice education (Table A1). I will now describe each of the six categories.

The category titled *organization design* includes concepts in the literature related to the design and function of health care organizations. The related concepts are at system level and refer to multiple practice settings and potentially multiple facilities. The category titled *nursing human resources* includes concepts related to management of nursing positions within the health care system. The category titled *culture* includes concepts that reflect nursing as a unique culture. The term culture is used from an ethnographic perspective, where culture is defined as a “system of knowledge and linguistic expressions used by social groups” (Aamodt, 1991 as cited by Liehr, LoBiondo-Wood, and Cameron, 2008, p. 175). The related concepts in this category are not unique to nursing, but have unique historical meaning as reflected by the literature sources (e.g., conflict management as it relates to dynamics between nurses and physicians). The category of “population care needs” refers to the influence of current trends related to client care needs have on nursing professional practice. The category of *care delivery* includes concepts related to the

methods and skills of care to clients. These related concepts are not included under organizational design for two reasons – (1) organizational design literature refers to design of organizations at a system level, and while the care delivery literature refers to delivery of care services at a unit level and (2) the authors of the current literature are recommending that organizational design include designated care delivery models, suggesting this practice is innovative and not yet standard practice. The final category of *practice education* includes concepts which support nurses' continuing practice competence.

Table A1 is a complete list of related concepts, their relationship to the main concept of nursing professional practice, and related references for each of the six categories. The abundant number of related concepts highlights this writer's and other authors' assertions regarding the lack of clarity regarding the concept of nursing professional practice (Mark et al., 2003; Storey et al., 2008; Hoffart & Woods 1996; Mathews & Lankshear, 2003).

References.

References is the term Rodgers (1989, p. 334) uses to refer to the “events, situations, and phenomena” to which the concept has been applied. Nursing professional practice was referenced in four ways within the literature reviewed for this analysis – (1) as a model, (2) as a practice environment, (3) as individual nurse comportment, and (4) as nursing support structures (Figure 2). Each reference will be next described.

First, the concept of nursing professional practice is used in reference to a *model* or framework to guide health care organization redesign (Ashford & Zone-Smith, 2005; Danyluk, 2011; Erickson, Duffy, Ditomassi, & Jones, 2009; Hoffart & Woods, 1996; Ingersoll et al.,

2005; Mathews & Lankshear, 2003; Miles & Vallish, 2010; Newcomb et al., 2009; Murphy et al., 2011; Girard et al., 2005; O'Rourke, 2006; Story et al., 2008; Wolf et al., 1994; Wolf & Greenhouse, 2007; Wolf, Haden, & Bradel, 2004). Wolf and Greenhouse (2007) suggest that professional practice models schematically explain how professional nursing practice is accomplished.

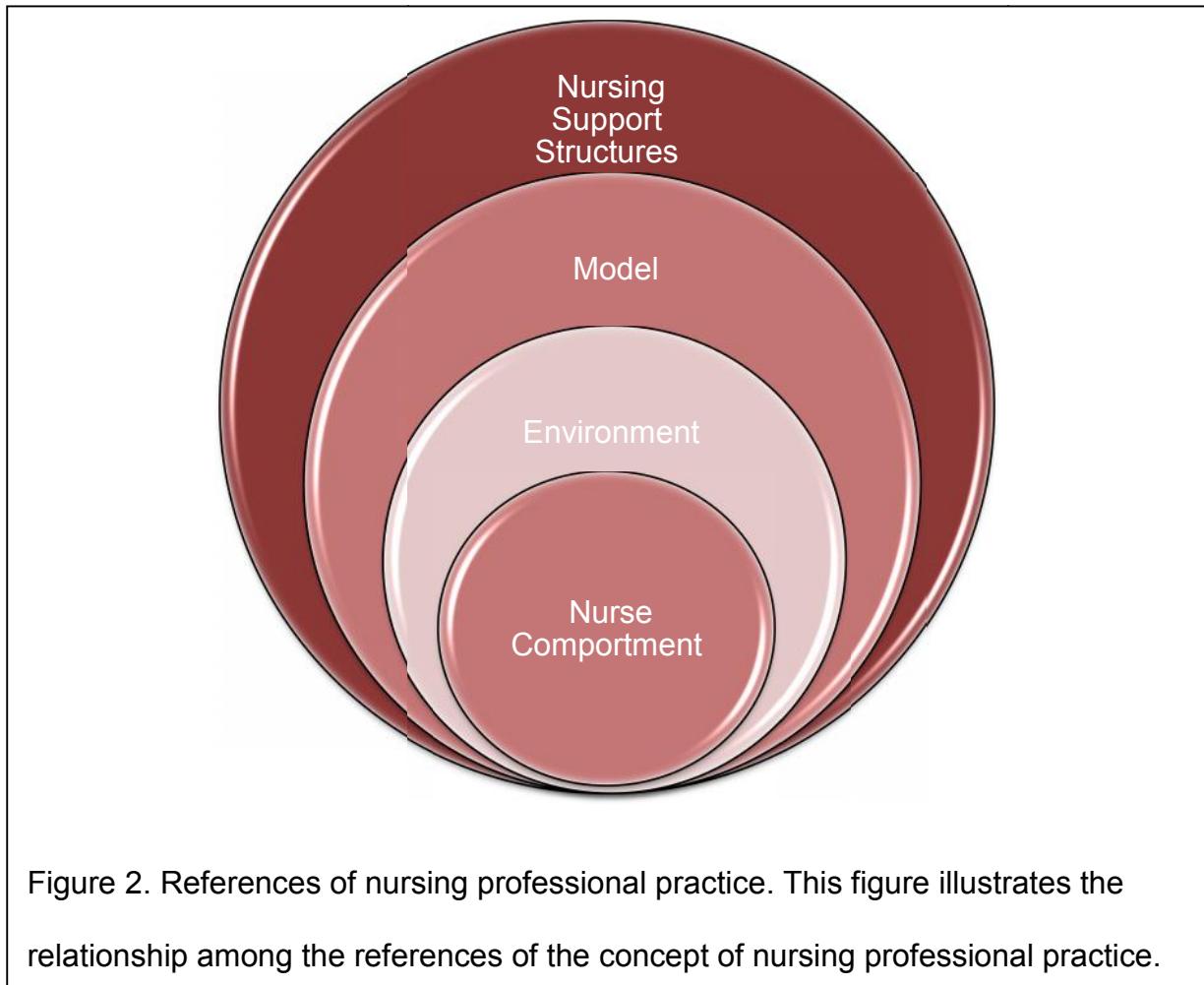
Second, nursing professional practice was also used in reference to *practice environments* (ARNNL, 2007; Ashford & Zone-Smith, 2005; Block & Sredl, 2006; CNA & CFNU, 2006; Lake, 2002; Laschinger & Leiter, 2006; Wolf & Greenhouse, 2007) describing the organizational characteristics “to promote safety, support and respect all persons in the setting” (CNA & CFNU, 2006, p.1). Researchers’ measurement of the degree to which these environments have these characteristics has been done with what is referred to as a professional *practice environment scale* (Ashford & Zone-Smith, 2005; Erickson et al., 2010; Halcomb et al., 2010; Kramer & Schmalenberg, 2008; Laschinger, 2008; Laschinger & Finegan, 2009; Manojlovich, 2005; Newcomb et al., 2009; Sui et al., 2008). The professional practice scale differs from the reference of a professional practice environment, as the scale is the operational definition of the former. Halcomb et al. (2010) outlined how the Professional Practice Scale (PPS) originally developed by Kramer and Schmalenberg (1988) evolved through various validation processes. Practice settings considered quality professional practice environments have been quantified in many studies using professional practice environment tools. These tools - Nursing Work Index (NWI) (Kramer & Schmalenberg), Revised Nursing Work Index (NWI-R) (Aiken & Patrician, 2000), Professional Environment Scale (PES) (Lake, 2002), Professional Practice Environment (PPE) (Erickson et al., 2004), Perceived Nursing Work Environment (PNEW) (Choi et al., 2004) - have evolved from foundational research regarding the attributes of a professional practice

environment that have become associated with magnet status hospital designation (McClure, Poulin, Sovie, & Wandelt, 1983; Kramer & Schmalenberg, 1988, 1991). The association between elements of quality professional practice environments and positive client outcomes has been demonstrated in nursing research (Aiken, Smith, & Lake, 1994; Baumann et al., 2001; Tourangeau, Giovannetti, Tu, & Wood (2002); McGillis Hall et al., 2003; Tourangeau et al, 2007; Laschinger & Leiter, 2006); Aiken & Patrician, 2000; Choi et al., 2004; Erickson et al., 2009; Pearson et al., 2006; Mark et al., 2003; Kramer & Schmalenberg, 1988; 2008; Lake, 2002).

Third, nursing professional practice is used in reference to nurses' *individual comportment* (ARNNL, 2007; CNA, 2011; CNA, 2010; CRNBC, 2010; CRNM, 2009; CRNNS, 2004; Selman, 2000; Paton, 2010; Levett-Jones et al., 2010; Wolf & Greenhouse, 2007; YRNA, 2008). Nurse comportment is the nurse's behavioural demonstration of the integration of nursing knowledge and ethics (Day & Benner, 2002). The CNA (2010) identified the comportment of professional practice within individual competencies for the Canadian Registered Nurse Exam.

Fourth, the concept of nursing professional practice has been applied to *nursing support structures* such as education methodology, apprenticeship (Noone, 2009), achievement programs (Borchardt, 2005), standards (ARNNL, 2007; CRNBC, 2010; SRNA, 2007), domains of nursing (RNAO, 2007), a pillar of a nursing organizational framework [ICN, 2011], organizational department and roles within department (BC Cancer Agency and Health Care Center, 2011; Fraser Health, 2011; Eastern Health, 2011; Interior Health Authority, 2005; Northern Health Authority, 2003; Providence, 2002; Royal Ottawa Health Care Group, 2011; St. Joseph's Health Care Center, 2011; Vancouver Island Health Authority, 2011). In summary, the concept of

nursing professional practice has been utilized in reference to theoretical models, environmental characteristics, individual behaviours, and professional support structures.



Antecedents.

Antecedents are the events or phenomena that occur prior to or have been previously associated with the concept (Rodgers, 1989). Tofthagen and Fagerstrøm (2010) provided an example of the antecedent for the concept of empathy as “the ability to communicate feeling” (p.26). In the following section, I describe the antecedents for the concept of nursing professional practice from a discipline, practice, and ethics perspective.

Being a professional as an antecedent to the concept of nursing professional practice.

Analysis of the literature revealed *being a professional* as an antecedent to the concept of nursing professional practice. A systematic review of the literature related to the professional practice of the nurse suggested there is no universal contemporary disciplinary definition of being a professional (Person et al., 2006). Northrup et al. (2004) noted the 1915 Flexner Report, which identified attributes of a profession, has been influential in the current understanding of the concept. The historical professional attributes include the following: altruistic service to society, autonomy and adherence to an ethical code, a body of knowledge, and education and socialization processes (Figure 3) (Pearson et al., 2006). Pearson et al. (2006) asserted their review of literature reveals that nursing does the criteria of a profession. These authors also identified opposing discourses within the disciplinary literature related to nursing's professional status. Proponents of one view suggest nurses are better served by focusing disciplinary efforts on the work of nursing than by aligning with the ideology of "professionalization" (2006, p. 226). Proponents of the opposing view believe that the elements of a profession provide a framework for professional practice. The majority of the literature reviewed for this concept analysis supported the latter view (Pearson et al., 2006).

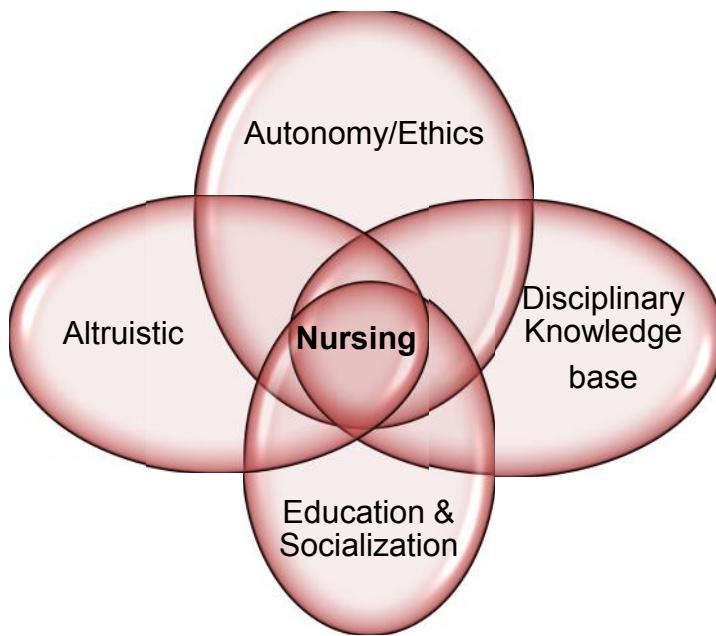


Figure 3. Attributes of a Profession. This figure illustrates the elements of a profession as described in Pearson et al. (2006).

Some of the nursing literature reviewed for this analysis identified being a professional or professionalism as a precursor (or occurring prior) to the concept of nursing professional practice. Review of the Canadian provincial and territorial nursing standards of practice documents identifies governmental legislation and regulation authorizing the practice of nursing. Four provinces used the word profession in the title of the related governmental acts (i.e., Health Professions Act) [CARNA, 2003; CRNBC, 2010; College of Nurses of Ontario (CNO), 2009; Registered Nurses Association of Northwest Territories and Nunavut (RNANWTN), 2006]. All of the provincial or territorial nursing association and/or nursing colleges (Quebec nursing standards not reviewed as document in French language) had developed a nursing standards document which referred to the standards that guide *professional* practice (ARNNL, 2007; ARNPEI, 2011; CARNA, 2003; CRNBC, 2010; CRNM, 2009; CNO, 2009; CRNNS, 2004;

RNANWTN, 2006; SRNA, 2007; YRNA, 2008). Similarly, documents published by Canadian nurses' unions also refer to the practice of nurses as being professional as (British Columbia Nurses' Union (BCNU), 2011; CNA & CFNU, 2000; CFNU, 2010; ONA, 20011; UNA, 2006). Further, national and international nursing groups have published documents that identify being a professional as an antecedent to nursing professional practice (CNA, 2004; CNA, 2007; CNA, 2007; CNA, 2010; CNA, 2011; CNA, 2009; CNA & CFNU, 2006; ICN, 2011). Therefore, the literature from provincial governments and nursing groups within Canada reflects being a professional as an assumption of nursing professional practice.

Self-regulating profession as an antecedent to the concept of nursing professional practice.

Self-regulation has been identified as an element of being a professional (Northrup et al., 2004) and as an antecedent to the concept of nursing professional practice. Self-regulation and the structures and processes to sustain this regulation influence the current understanding of what it means to be a nursing professional in Canada. As an antecedent, the literature related to the structures for Canadian nursing self-regulation influence both the understanding of the elements of being a profession and professional practice. The CNA (2007) position statement on the Canadian regulatory framework for Registered Nurses identifies the structures and processes necessary to support self-regulation. The structures for self-regulation are provincial colleges and/or associations. The processes carried out by these nursing bodies include the following: 1) legislative mandate, 2) title protection, 3) scope of practice, 4) requirements for registration, 5) standards of practice and ethics, 6) continuing competence, 7) professional conduct review, and 8) evaluation (ICN, 1985; CNA, 2007). The documents reviewed in this analysis included the nursing standards for each of the Canadian provinces and territories All of these documents

reflected the latter mentioned College or Association eight processes to support self –regulation (ARNNL, 2007; ARNPEI, 2011; CARNA, 2003; CRNBC, 2010; CRNM, 2009; CNO, 2009; CRNNS, 2004; RNANWTN, 2006; SRNA, 2007; YRNA, 2008). Therefore, the processes established as part of professional self-regulation ensures the public is protected and is congruent with the values within the CNA code of ethics (CNA, 2008).

Organizational commitment as an antecedent to the concept of nursing professional practice.

Organizational commitment was revealed as another antecedent of the concept of nursing professional practice. All the literature included in the analysis reflected that nurses practice within a practice environment. Many of the publications revealed a strong relationship between the practice environment and nurses' individual comportment of professional practice (CNA, 2007; Laschinger & Leiter, 2006; Statistics Canada, Health Canada, and Health Information, 2005; Tourangeau et al., 2002). Ashford and Zone-Smith (2005) suggested that organizational commitment is necessary to develop professional practice environments and professional practice models, which support the individual nurses' professional practice. Organizational commitment includes four dimensions: structural, political, cultural, human resource (Ashford & Zone-Smith, 2005). Organizational commitment as an antecedent to nursing professional practice was identified in other publications (Borchardt, 2005; Girard et al., 2005; Hall et al., 2003; Hoffart & Woods, 1996; Ingersoll et al., 2005, Kramer & Schmalenberg, 2008; Laschinger, 2008; Laschinger & Leiter, 2006; Mathews & Lankshear, 2003; Manojlovich, 2005; Murphy et al., 2011; Wolf et al., 1994; Wolf, Hayden, & Bradel, 2004). These authors identified organizational commitment as the resources and infrastructure to implement a specific professional practice model (i.e., the system structure, process, and outcome measurement

method for nursing professional practice). Organizations that implemented these models had implemented professional practice leader positions (e.g., Chief Nurse Officers) to lead the implementation.

There is an important cyclical interrelationship between individuals, organizations and the practice environments, and the structures and processes of self-regulation (Figure 4) (Ashford & Zone-Smith, 2005; Cornett & O'Rourke, 2009; Hall et al., 2003; O'Rourke, 2006; Wright, 2008). The elements of self – regulation influence the structures and processes necessary in practice environments within organizations. Organizational leaders' enactment of these structures and processes promote individuals ability to practice professionally. The quality of nurses' professional practice sustains the privilege of having a self-regulated profession. Therefore, the three antecedents have an individual as well as a collective influence on the concept of nursing professional practice.



Figure 4. Cyclical relationship between organizational commitment, self-regulation, and professionalism.

Consequences.

Consequences are the phenomena that result from the use of the concept (Rodgers, 1989).

For example, the suggested consequence of the concept of empathy was its impact on the assessment and management of pain (Tofthagen & Fagerstrøm, 2010). The criteria used to decide on the consequences of the concept of nursing professional practice were 1) temporally, the phenomena occurred after or as a result of nursing professional practice and 2) there was some level of evidence linking the consequence with the concept. Using these two criteria there were three consequences identified: 1) client outcomes; 2) nurse outcomes; and 3) organizational outcomes. Each consequence is described in the following paragraphs.

Client outcomes as a consequence of the concept of nursing professional practice.

Client outcomes were identified as a consequence of nursing professional practice. The CNA's definition of RNs identifies that the intended outcome of nurses' practice is to "enable individuals, families, groups, communities and populations to achieve their optimal level of health" (CNA, 2007, p.6). Client outcomes, including the achievement of an optimal level of health, are impacted by the degree to which practice environments possess nursing professional practice attributes (CNA, 2007). The types of client outcomes assessed within these environments include both positive and negative outcomes: mortality rates (Aiken et al., 1994; Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Tourangeau et al., 2002), satisfaction (Mark et al., 2003); number of falls (Mark et al., 2003), number of nurse assessed adverse events (Laschinger & Leiter, 2006), and occurrences of action taken to rescue (Aiken et al., 2008). Nurse leaders who have led organizational redesign initiatives associated with elements of professional practice environments have noted the measurement of client outcomes as important. Although the actual

outcomes are not revealed, the intent to influence and measure client outcomes related to the organizational redesign work is well documented within the literature (Ashford & Zone-Smith, 2005; Hoffart & Woods, 1996; Girard et al., 2005; Mathews & Lankshear, 2003; Miles & Vallish, 2010; Ingersoll, Witzel, & Smith, 2005; Laschinger, 2008; O'Rourke, 2003, 2006; Pearson et al., 2006; Story et al., 2008; Wolf et al., 1994; Wolf et al., 2004). Similarly, the expectation that nurses will positively influence client outcomes through their individual professional practice is clearly elucidated within provincial nursing standard documents (ARNNL, 2007; ARNPEI, 2011; CARNA, 2003; CRNBC, 2010; CRNM, 2009; CNO, 2009; CRNNS, 2004; RNANWTN, 2006; SRNA, 2007; YRNA, 2008). Therefore, the client outcomes as a consequence of nursing professional practice clearly emerges from the nursing literature reviewed within this analysis.

Nurse outcomes as a consequence of the concept of nursing professional practice.

Nurse outcomes were also identified as a consequence of nursing professional practice. These outcomes are the “internal goods” (Selman, 2000, pg. 28) or the personal feeling experienced from participation in nursing professional practice. As noted earlier, there is a cyclical interrelationship between individuals, organizations and the practice environments, and the structures and processes of self-regulation (Figure 4) (Ashford & Zone-Smith, 2005; Cornett & O'Rourke, 2009; Hall et al., 2003; O'Rourke, 2006; Wright, 2008). Recent nursing research has focused on the specific influence of the professional practice environment on nurses. Nurses have reported moral distress, when professional practice environments they consider are poor in quality, adversely impact their ability to provide safe, compassionate, competent, and ethical care (CNA, 2008; Rodney et al., 2006; Rodney et al., 2009). Moral distress is the feeling that results

when individuals cannot act on their moral choices (Rodney & Starzomski, 1993). Therefore, research related to nurses' experience of their practice environments is relevant to the concept of nursing professional practice. For example, the health care funding cuts of the 1990s influenced the emergency of an evolving shortage of nurses.

A variety of nurses' experiences and outcomes have been explored in the literature. Specifically, the experience of nurses' satisfaction compared with the quality of their professional practice environment was examined through seminal nursing research studies (Halcomb et al., 2010; Schmalenberg & Kramer, 2008; Laschinger, 2008, Laschinger & Leiter, 2006; Mark et al., 2003; Murphy et al., 2011; Newcomb et al., 2009; Person et al., 2006). Other nurses' experiences explored in comparison to the quality of their professional practice environments included nurses' physical and mental health (Person et al., 2006), empowerment (Laschinger, 2008; Laschinger et al., 2009), perceptions of quality care (Charalambous, Katajisto, Välimäki, Leino-Kilpi, Suhonen, 2010), and participation in professional development (Murphy et al., 2011). The *intent* to influence and measure nurse outcomes by nurse leaders who have led organizational redesign initiatives associated with elements of professional practice environments is also documented within the literature (Ashford & Zone-Smith, 2005; Hoffart & Woods, 1996; Girard et al., 2005; Mathews & Lankshear, 2003; Miles & Vallish, 2010; Ingersoll et al., 2005; Laschinger, 2008; O'Rourke, 2003, 2006; Pearson et al., 2006; Story, Linden, Fisher, 2008; Wolf et al., 1994; Wolf et al., 2004). As a result, nurse outcomes in this analysis are identified as a consequence of nursing professional practice.

Organizational outcomes as a consequence of the concept of nursing professional practice.

Organizational Outcomes were revealed as a consequence of nursing professional practice. The client and nurse outcomes noted earlier could be seen as a benefit to organizations, as these outcomes are often embedded in the organization's mission statement (Ingersoll et al., 2005). The organizational outcomes identified in this analysis are outcomes seen to sustain health care organizations. Examples of these types of outcomes measured by leaders of health care institutions include; nurse turnover rates (Laschinger et al., 2009; Mark et al., 2003; Murphy et al., , 2011; Pearson et al., 2006), low nurse absenteeism, illness and injury rates, low involuntary overtime rates, positive inter-staff relationships, low unresolved grievance rates, opportunities for professional development, low burnout and job strain reduction of length of stay, cost per case within an acceptable range, and the delivery of observable high-quality patient care (Pearson et al., 2006). The intent to influence and measure organizational outcomes by nurse leaders who have led organizational redesign initiatives associated with elements of professional practice environments is also documented within the literature (Ashford & Zone-Smith, 2005; Hoffart & Woods, 1996; Mathews & Lankshear, 2003; Miles & Vallish, 2010; Ingersoll et al., 2005; O'Rourke, 2006; Pearson et al., 2006; Story et al., 2008; Wolf et al., 1994; Wolf et al., 2004). These outcomes also included the following: reputation (user perceptions of the facility) (Hoffart & Woods, 1996 ;Wolf et al., 1994), cost savings (Miles & Vallish, 2003, Wolf et al., 2004), defined process for meeting goals (Wolf et al., 2004), integrated corporate strategic view (Mathews & Lankshear, 2003), professional practice culture (Mathews & Lankshear, 2003), productivity (CNA, 2007, CRNBC, 2010, Storey et al., 2008), innovative models of care (Ingersoll et al., 2005) decreased workplace injury (CRNBC, 2010), clear

accountability (PPNO, 2011), protection of the public (CNO, 2009), average length of client stay¹ (Ingersoll et al., 2005; Mark et al., 2003; Miles & Vallish, 2010). In summary, the nursing literature reviewed for the analysis demonstrated organizational outcomes as a consequence of nursing professional practice.

Attributes.

Attributes are key characteristics, which constitute a “real” definition of the concept (Rodgers, 2000, p. 91). Attributes of a concept contrast a dictionary definition that uses similar words to describe a term or word (Rodgers, 1989). Rodgers (2000) asserted that a cluster of attributes compose a concept. The attributes of the concept of *nursing professional practice* were identified through a thematic analysis process from an ontological perspective.

Ontology, a branch of metaphysical philosophy, focuses on the study of what exists (*The Oxford Dictionary of Philosophy*, 2008). This type of philosophical inquiry is characterized by questions of reality such as-what is nursing? Ontological inquiry promotes the exploration of the phenomena in the profession (Edwards & Liaschenko 2000; Flaming, 2004) and discipline of nursing (Reed, 1997). Paradigms are commonly used in ontological discourse (i.e., interpretive and empiricist (Monti & Tinggen, 1999). Kuhn (1970) describes paradigms as a “disciplinary matrix, the ordered elements which are held by the practitioners of a discipline (Monti & Tinggen, 1999). The ontological question as noted above, what is nursing? has been answered many times through the creation of metaparadigms [substantial focus of the discipline, i.e., nursing, person,

¹ Length of stay, as described in the literature reviewed in this analysis, is identified the number of days in hospital, often compared to organizational averages. In contrast, *readiness for discharge* or *client recidivism rates* seen as a client outcomes versus organizational outcomes as the evaluation of this indicator is conducted from a client perspective.

health, and environment (Reed, 1997)]. Through ontological discourse, nurses continue to consider whether these four elements remain the appropriate metaparadigm for nursing today (Holmes & Gastaldo, 2004; Reed, 1997; Sarter, 1987; Smith, 1988). In her article “Nursing: the ontology of the discipline” (Reed, 1997), demonstrated how ontological discussion can develop the epistemological and ethical perspectives of the discipline. Thus, the aim of this evolutionary concept analysis was to consider the question— what is nursing professional practice? from the interpretative paradigm. The stepped thematic analysis approach within the evolutionary method assisted in identification of ontological attributes due to the multiple uses of the concept within the literature.

Evolutionary concept analysis focuses on the use of a concept to understand its contextual aspects (Rodgers, 2000). This concept analysis of nursing professional practice has focused on the *use* of the concept from a disciplinary, practice and ethical perspectives. Many nurse authors have noted that the concept of nursing *professional practice* is used in multiple ways as reflected in the varied ways the term is used in nursing professional and disciplinary discourse (Mark et al., 2003; Storey et al., 2008; Hoffart & Woods, 1996; Mathews & Lankshear, 2003). As identified earlier, the concept was referenced in four different ways within this analysis – individual comportment, environments, organizational models, and professional nursing support structures (Figure 2). Therefore, to distil the attributes of nursing professional practiced from an ontological perspective, it is necessary to first identify the attributes of the primary uses of the concept. Four categories of conceptual uses were identified as macro categories in which references of the concept are situated – organization models, environments, processes (as reflected in nursing support structures) and individual comportment (Figure 5). The attributes of each of the uses is next identified.

Attributes of nursing professional practice organizational models.

1. Nursing professional practice organizational models include *structure, process, and outcomes* (Donabedian, 1980; Hoffart & Woods, 1996; Mark et al., 2003; Wolf et al., 2004; Miles & Vallish, 2010; Storey et al., 2008; Pearson et al., 2006; Ingersoll et al., 2005).
2. The philosophy of the organizational model is congruent with nursing professional ethics, standards, and legislation (CARNA, 2003; Pearson et al., 2006; Mathews & Lankshear, 2003; Miles & Vallish; Storey et al., 2008).
3. The nursing professional practice structure is integrated into organizational system (Providence, 2009, Ashford & Zone – Smith, 2005; Cornett & O'Rourke, 2006; Girard et al., 2005; Hoffart & Woods, 1996; Ingersoll et al., 2005; Mathews & Lankshear, 2003; Wolf et al., 2004).
4. The structure includes transformative leadership, collaborative practice, client care delivery system, and professional growth (Hoffart & Woods, 1996; Wolf et al., 1994; Wolf et al., 2004).
5. Processes established sustain nursing professional practice environments and nurses' professional practice (Hoffart & Woods, 1996; Mark et al., 2003; Wolf et al., 2004; Miles & Vallish, 2010; Storey et al., 2008; Pearson et al., 2006; Ingersoll et al., 2005).
6. The structure and processes reflect domains of nursing practice – clinical, education, administration, and research (CRNBC, 2010; O'Rourke, 2003, 2006; Miles & Vallish, 2010).
7. Outcomes of integrated structure include client, nurse and organizational outcomes, which are measured and inform the evolution of the structure and system (Hoffart & Woods, 1996; Mark et al., 2003; Wolf et al., 2004; Miles & Vallish, 2010; Storey et al., 2008; Pearson et al., 2006; Ingersoll et al., 2005).

Attributes of nursing professional practice environments.

8. Client care is provided through interprofessional teams (ARNL, 2007; Block & Sredl, 2006; CNA, 2007; CNA, 2010, CNA & CFNU, 2006; Erickson et al., 2009; Halcomb et al., 2010; Ingersoll et al., 2005; Schmalenberg & Kramer, 2008; Lake, 2002; Laschinger et al., 2009; Laschinger, 2008; Laschinger & Leiter, 2006; Newcomb et al., 2009; Valente, 2010; Sui et al., 2008; Wolf et al., 2008).
9. Client care from nurses is based on a nursing care delivery model (Lake, 2002; Laschinger et al., 2009; Laschinger & Leiter, 2006; Sui et al., 2008).
10. Nurses have autonomy over their practice (ARNL, 2007; Block & Sredl, 2006; CNA, 2010; CNA, 2007; CRNBC, 2010; CNA & CFNU, 2006; Erickson et al., 2009; Schmalenberg & Kramer, 2008; Laschinger et al., 2009; Newcomb et al., 2009).
11. There is access to nurses who hold organizational leadership positions (ARNL, 2007; CNA, 2019; CNA, 2007; CNA & CFNU, 2006; CRNBC, 2010; Charalambous et al., 2010; Halcomb et al., 2010; Hoffart & Woods, 1996; Ingersoll et al., 2005; Schmalenberg & Kramer, 2008; Lake, 2002; Laschinger, 2008; Laschinger et al., 2009; Laschinger & Leiter, 2006; Newcomb et al., 2009; Sui et al., 2008).
12. Professional development and continuing competency opportunities are provided (ARNL, 2007; Borchardt, 2006; CNA, 2007; CRNBC, 2010; Ingersoll, et al., 2005; Schmalenberg & Kramer, 2008; Newcomb et al., 2009; Wolf et al., 2004).
13. There are adequate resources and technology to meet client care needs (CNA, 2010; CNA, 2011; Halcomb et al., 2010; Lake, 2002; Ontario Nurses Association (ONA), 2011).

14. Nurses have opportunity to participate in decision making regarding care systems (Erickson et al., 2009; Halcomb et al., 2010; Lake, 2002; Laschinger et al., 2009; Laschinger & Leiter, 2006; Mathews & Lankshear, 2003; Sui et al., 2008; Wolf et al., 2004).

Attributes of nursing professional practice processes.

15. Flexible and non-siloed through a networked system (Danyluk, 2011; Hoffart & Woods, 1996; ICN, 2011; Miles & Vallish, 2010).
16. Identified practice authority (O'Rourke, 2006).
17. Linked to physicians and organizational leaders (Hoffart & Woods, 1996).
18. Include information technology knowledge management systems (CNA & CFNU, 2006; Mark et al., 2003; Wolf et al., 2008).
19. Present at a local or unit level (Erickson et al., 2009; Ingersoll et al., 2005).
20. Connected to larger community (CNA, 20011; Borchardt, 2006; Pearson et al., 2006; Storey et al., 2008; VIHA, 2011; Wolf et al., 2008).
21. Include students and mentorship opportunities (CNA, 2004; Borchardt, 2006; Block & Sredl, 2006; Borchardt, 2006; Danyluk, 2011; Ingersoll et al., 2005; ONA, 2011).
22. Consider the workload of nurses and other professionals (ARNL, 2007; CNA, 2007; CRNBC, 2010; Erickson et al., 2009; Halcomb et al., 2010; Lake, 2002; Laschinger, 2008; Laschinger et al., 2009; Laschinger & Leiter, 2006; ONA, 2011; Sui et al., 2008).
23. Establish decentralized decision making which includes nurses (Mark et al., 2003).
24. Utilize a model of quality improvement (Mark et al., 2003; Milles & Vallish, 2010).
25. Embed evidence-based practice and research (CNA, 2010; Halcomb et al., 2010; Providence, 2009; Mark et al., 2003; Milles & Vallish, 2010).

26. Recognize practice excellence (CNA, 2007; Borchardt, 2006; Ingersoll et al., 2005; Milles & Vallish, 2010).
27. Support client centered care (CNA, 2011; Borchardt, 2006; Charalambous et al., 2010; Erickson et al., 2009; Halcomb et al., 2010; Ingersoll et al., 2005; Schmalenberg & Kramer, 2008; Milles & Vallish, 2010; Wolf et al., 2008).

Attributes of nurses' nursing professional practice.

28. Utilize a professional knowledge base (ARNNL, 2007; ARNPEI, 2011; CARNA, 2003; CRNBC, 2010; CRNM, 2009; CNO, 2009; CRNNS, 2004; RNANWTN, 2006; SRNA, 2007; YRNA, 2008).
29. Demonstrate a spirit of inquiry (ARNNL, 2007; ARNPEI, 2011; CNO, 2009; SRNA, 2007).
30. Exhibit accountability (ARNNL, 2007; ARNPEI, 2011; CARNA, 2003; CRNBC, 2010; CRNM, 2009; CNO, 2009; CRNNS, 2004; RNANWTN, 2006; SRNA, 2007; YRNA, 2008).
31. Recognize and assert practice autonomy (ARNPEI, 2011; CRNBC, 2010; CRNNS, 2004; YRNA, 2008).
32. Demonstrate advocacy (ARNNL, 2007; ARNPEI, 2011; CARNA, 2003; CRNBC, 2010; CRNM, 2009; CRNNS, 2004; RNANWTN, 2006; SRNA, 2007; YRNA, 2008).
33. Include innovation and vision (ARNNL, 2007; ARNPEI, 2011; CRNBC, 2010; CNO, 2009; Interior Health, 2005; RNANWTN, 2006; YRNA, 2008).
34. Demonstrates collegiality and collaboration (ARNNL, 2007; ARNPEI, 2011; CARNA, 2003; CRNBC, 2010; CRNM, 2009; CNO, 2009; CRNNS, 2004; Fraser Health (FH), 2011; RNANWTN, 2006; SRNA, 2007; VIHA, 2011; YRNA, 2008).

35. Demonstrate congruent comportment with the professional code of ethics (ARNNL, 2007; ARNPEI, 2011; CARNA, 2003; CRNBC, 2010; CRNM, 2009; CNO, 2009; CRNNS, 2004; RNANWTN, 2006; SRNA, 2007; YRNA, 2008).
36. Demonstrate leadership (ARNNL, 2007; CNO, 2009; CRNNS, 2004; FH, 2011, Providence, 2009; Northern Health Authority, 2011; VIHA, 2011).

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| <i>Attributes of Nursing Professional Practice Organizational Models.</i> |
| Nursing professional practice organizational models include <i>structure, process, and outcomes</i> . The philosophy of the organizational model is congruent with nursing professional ethics, standards, and legislation. |
| The nursing professional practice structure is integrated into organizational system. |
| The structure includes transformative leadership, collaborative practice, client care delivery system, and professional growth. |
| Processes established sustain nursing professional practice environments and nurses professional practice. |
| The structure and processes reflect domains of nursing practice – clinical, education, administration, and research. |
| Outcomes of integrated structure include client, nurse and organizational outcomes which are measured and inform the evolution of the structure and system |
| <i>Attributes of Nursing Professional Practice Environments.</i> |
| Client care is provided through interprofessional teams. |
| Client care from nurses is based on a nursing care delivery model. |
| Nurses have autonomy over their practice. |
| There is access to nurses who hold organizational leadership positions. |
| Professional development and continuing competency opportunities are provided. |
| There are adequate resources and technology to meet client care needs. |
| Nurses have opportunity to participate in decision making regarding care systems. |
| <i>Attributes of Nursing Professional Practice Processes.</i> |
| Flexible and non-siloed through a networked system. |
| Identified practice authority. |
| Linked to physicians and organizational leaders. |
| Include information technology knowledge management systems. |
| Present at a local or unit level. |
| Connected to larger community |
| Include students and mentorship opportunities. |
| Consider the workload of nurses and other professionals. |
| Establish decentralized decision making which includes nurses. |
| Utilize a model of quality improvement. |
| Embed evidence-based practice and research. |
| Recognize practice excellence. |
| Support client centered care. |
| <i>Attributes of Nurses' Nursing Professional Practice.</i> |
| Utilize a professional knowledge base. |
| Demonstrate a spirit of inquiry. |
| Exhibit accountability. |
| Recognize and assert practice autonomy. |
| Demonstrate advocacy. |
| Include innovation and vision. |
| Demonstrates collegiality and collaboration. |
| Comportment is congruent with the professional code of ethics. |
| Demonstrate leadership. |

Figure 5. Summary of the attributes of the uses of nursing professional

The delineation of the attributes of the primary uses of the concept assisted to distil the attributes of nursing professional practiced from an ontological perspective. Ontological inquiry asks questions to explore and identify phenomena. In congruence with the ontological and thematic analysis approach, the question—*What is... the key attribute(s)?* – was applied and answered for each of the 36 preliminary conceptual use attributes. The answers to this question resulted in identifying the 12 ontological attributes of the concept of nursing professional practice. In other words, one or more of the 12 attributes of nursing professional practice can be applied back to the 36 preliminary attributes (Table A2). For example, the attribute of autonomy is the “key attribute” for preliminary conceptual uses attributes 4, 9, 10, 18, 23, and 31. The 12 attributes of nursing professional practice are next identified.

Attributes of nursing professional practice.

| | |
|--------------------------|---------------------------|
| 1. Accountability | 7. Disciplinary knowledge |
| 2. Autonomy | 8. Ethics |
| 3. Client Centered | 9. Innovation |
| 4. Collaboration | 10. Leadership |
| 5. Contextual | 11. Self-regulation |
| 6. Continuing competence | 12. Service |

Summary

Table 3 outlines the complete results from the data analysis for each of the 6 elements of the evolutionary concept analysis process. The concept of nursing professional practice has been

used in relation to organizational models, processes (i.e., within support structures and practice settings), and practice environments, and individual comportment [the behavioural demonstration of the integration of nursing knowledge and ethics (Day & Benner, 2002).] Analysis of the attributes of each of these primary uses resulted in the identification of the ontological attributes of nursing professional practice.

Table 3*Summary of Concept Analysis Results*

| Elements | Findings |
|-------------------------|--|
| Surrogate Terms | Professional nursing practice Professional registered nursing practice Professional practices Nursing practice Practice Professional Professionally Professionalism |
| Related Concepts | Organizational design Nursing human resources Culture Population care needs Care delivery Practice education |
| References | Model Practice environment Individual comportment Nursing support structures |
| Antecedents | Being a professional or professionalism Self-regulating profession Organizational commitment |
| Consequences | Client outcomes Nurse outcomes Organizational outcomes |
| Attributes | Accountability Autonomy Client Centred Collaboration Contextual Continuing competence Disciplinary knowledge Ethics Innovation Leadership Self-regulation Service |

In congruence with the constructivist paradigm and heuristic strategies within the evolutionary analysis method, a definitive definition of the concept was not expected (Rodgers, 2000). Instead, I interpreted the results of the analysis and developed a definition that contributes to the evolution and contextual definition of the concept. The intent of the definition is to highlight how this analysis revealed nursing professional practice as a concept with ontological attributes that can be applied to multiple uses. Nursing professional practice is next defined.

Definition of nursing professional practice.

Nursing professional practice is:

- 1) a *collection of traits* associated with the profession including self-regulation, ethics, autonomy, disciplinary knowledge, continuing competence and accountability; and
- 2) a *way of being* as a nurse that encompasses service, collaboration, leadership, and innovation in the context of client and environment; and
- 3) a *label applied to a practice environment*, which supports the practice of these traits and ways of being. These environments are characterized by interprofessional collaboration, a nursing care delivery model based on nursing research related to the context of practice, the nurses' ability to practice autonomously according to professional standards and ethics, access to nurses in leadership positions, opportunities for continuing competence development, and access to demonstrate leadership and innovation.

Step 5: Identify an Exemplar of the Concept of Nursing Professional Practice

Rodgers (2000) identified the goal of discovering an exemplar, as part of the concept analysis, is to describe the characteristics of the concept in the relevant context and “enhance the

clarity and effective application of the concept of interest" (p. 96). Exemplars are identified through the analytic process and are selected as a real versus constructed example of the concept. Three exemplars of nursing professional practice are presented to illustrate the significance of the concept from a disciplinary, practice, and ethical perspective. Building on the synergy in my multi-role role, I will share my own experiences during my role as a clinical practice consultant. As stated by Rodgers (2000), these experiences are not constructed, rather, they were carefully selected as real examples I have witnessed of nursing professional practice highlighting the 12 identified attributes.

Exemplar 1 - nursing professional practice: a disciplinary model promoting organizational transformation.

The Clinical Practice Model Resource Center (CPMRC) is a company that provides professional practice models, tools, and expertise to health organizations to support patient, staff and hospital outcomes (CPMRC, 2011). Bonnie Wesorick, founder, developed a nursing professional practice model in 1983 that evolved to a model to promote interdisciplinary care in 1997. The model was "designed to create healthy, healing cultures and integrated healthcare systems for recipients and providers of care" (CPMRC, 2011). The model is an example of nursing disciplinary knowledge - knowledge that reflects social commitment, nature of the service within the discipline, and an area of responsibility for future development (Newman, Sime, Corcoran-Perry, 1991). The model reflects the integrated relationship of nursing practice to the values and beliefs of the team members, structure and processes of the practice environment and required infrastructure and tools (CPMRC, 2009). The following exemplar will identify these interrelationships in detail.

The professional practice department where I worked collaborated with the CPMRC to support the development of a practice infrastructure in the health authority. I had the opportunity to attend two conferences where Bonnie Wesorick presented the professional practice model (framework) she developed. Many of these tools and strategies were embedded in the Professional Practice department's processes and resources for health authority staff. Most notably was the strategy of networking councils. A council is a group of individuals representing the team (i.e., individuals that provide direct and indirect care) that discuss the effectiveness and outcomes of the team and care. Councils "supplement traditional hierarchical systems" (Wesorick, 2002, p.30) "...by breaking silos, and connects people across shifts, units, departments, disciplines, and settings" (2002, p.30). The health authority where I work has established many councils which have a goal to promote the professional practice of both discipline specific and interdisciplinary teams. As a practice consultant, I had the opportunity to work with various health professionals to establish councils to support their professional practice.

A model was presented as a power point slide at the 2009 professional practice conference that featured Bonnie Wesorick and the CPMRC resources. The model or diagram on the slide illustrates the elements of a healthy culture (work environment). Ten interconnected elements are identified as composing a healthy culture. These elements are represented in the diagram as a stick person. The head in the diagram represents what health professionals need to know – the team's shared purpose, their individual scope of practice and competency as well as the integrated (or team) competency. The arms of the person illustrate what is done as a professional - dialogue, health relationships and hand offs (professional exchange report). The

legs of the person identify what is needed to support the knowing and the doing of health professionals – an infrastructure of councils and tools and resources.

As Clinical Practice Consultant, my departmental colleges and I used this model to influence the development of councils within the health authority. The councils were seen as the initial infrastructure necessary to develop and sustain the other elements of the model. Therefore, three types of departmental services were provided to staff in the health authority with the overall goal of council development. These services themselves reflected the elements of the health molecule. First, tools and resources were developed for staff to describe what a council is and how to establish this type of networked group within your practice setting. A DVD was created from video tape of the professional practice 2009 conference with Bonnie Wesorick. The video segments selected described the 10 elements of the health molecule model. In addition to the DVD, a guide was developed to lead new council members through each segment of the video with companion engagement activities. These activities assisted staff to apply the elements to their practice context. Second, clinical practice consultants provided consultation services to leaders who were interested in establishing a council in their practice setting. The consultant would review the tools and resources available with the leader and help them identify the role of the council in the practice context. Third, the professional practice department as a team, contributed to establishing tools, resources and consultation services for all the elements of the health culture molecule. I have provided three examples. The element of “tools and resources” was supported by the establishment a regional clinical policy office to lead development of clinical decision support tools. The element of “scope of practice” was supported by clinical practice consultants that collaborated with staff and regulatory colleges to establish health professionals scope of practice in the health authority. The element of “competency” was

supported through the provision of education pathways (e.g., workshops and courses) to support the competency of educators. To date, the professional practice department continues to support the development of councils and healthy culture of practice environments.

Table 4

Identification of Nursing Professional Practice Attributes within Exemplar I

| Nursing Professional Practice Attribute | Example from Exemplar |
|---|---|
| 1. Accountability | <ul style="list-style-type: none"> “The councils were seen as the initial infrastructure necessary to develop and sustain the other elements of the model. Therefore, three types of departmental services were provided to staff in the health authority with the overall goal of council development. These services themselves reflected the elements of the health molecule”. |
| 2. Autonomy | <ul style="list-style-type: none"> Scope of Practice is an element in the Healthy Culture Molecule Model. |
| 3. Client Centered | <ul style="list-style-type: none"> “The model was designed to create healthy, healing cultures and integrated healthcare systems for recipients and providers of care” (CPMRC, 2011). |
| 4. Collaboration | <ul style="list-style-type: none"> “Councils “supplement traditional hierarchical systems” (Wesorick, 2002, p.30) “...by breaking silos, and connects people across shifts, units, departments, disciplines, and settings” (2002, p.30). |
| 5. Contextual | <ul style="list-style-type: none"> “The video segments selected described the 10 elements of the health molecule model. In addition to the DVD, a guide was developed to lead new council members through each videos segment with companion engagement activities. These activities assisted staff to apply the elements to their practice context”. |
| 6. Continuing competence | <ul style="list-style-type: none"> “The element of “competency” was supported through the provision of education pathways (e.g., workshops and courses) to support the competency of educators”. |
| 7. Disciplinary knowledge | <ul style="list-style-type: none"> “Bonnie Wesorick, founder, developed a nursing professional practice model in 1983 that evolved to a model to promote interdisciplinary care in 1997”. The model identifies the interrelationship of the nursing practice to individuals’ way of being, the practice environment, and tools and resources (e.g., the interconnection of element “S-scope of |

| Nursing Professional Practice Attribute | Example from Exemplar |
|---|--|
| | practice” the other elements of the molecule). |
| 8. Ethics | <ul style="list-style-type: none"> “The arms of the person illustrate what is done as a professional - dialogue, health relationships and hand offs (professional exchange report)”. |
| 9. Innovation | <ul style="list-style-type: none"> “A DVD was created from video tape of the professional practice 2009 conference with Bonnie Wesorick. The video segments selected described the 10 elements of the health molecule model. In addition to the DVD, a guide was developed to lead new council members through each videos segment with companion engagement activities”. |
| 10. Leadership | <ul style="list-style-type: none"> “...clinical practice consultants provided consultation services to leaders who were interested in establishing a council in their practice setting. The consultant would review the tools and resources available with the leader and help them identify the role of the council in the practice context”. |
| 11. Self-regulation | <ul style="list-style-type: none"> “The element of scope of practice was supported by clinical practice consultants that collaborated with staff and regulatory colleges to establish health professionals’ scope of practice in the health authority”. |
| 12. Service | <ul style="list-style-type: none"> “Shared purpose is an element in the Healthy Culture Molecule Model...The model was designed to create healthy, healing cultures and integrated healthcare systems for recipients and providers of care” (CPMRC, 2011). |

Exemplar 2 - nursing professional practice: a nurse's comportment in practice

Not wanting to go home. I knew my mother had a nurse assigned to her tonight, but I did not want to leave her and go home to sleep. The emergency was its usual frenetic pace. Many thoughts were running through my mind - What if they go busy and were too busy to check in on her? Did they know that Mom did not always say what she needed? Would the night nurse accept that it was OK for her to take her some of her meds from home? She was really to short of breath to explain the whole story again.

Just as I was saying, “Mom, I’ll just stay a bit longer... ”, the nurse for the night shift walked in through the curtain. Although it was not uncommon to recognize the nurses working, having been in the community for over 30 years, I was surprised to see it was Maria². Maria and I worked together when I was a new graduate nurse at the hospital. Maria walked in and said “Hello Mrs. Smith. My name is Maria and I will be your nurse tonight.” Maria then turned toward me and we warmly acknowledged each other. Her focus quickly returned to my Mom – “So what brings you in here tonight?” She focused intently on my Mom’s answer. Next, she asked ‘how are you feeling now?’ I could see how Maria’s calm, confident, and sensitive approach was putting Mom at ease. Mom actually disclosed that she really was not feeling well at all and asked if the results of her blood work had come back. Maria said she would check, but explained how she would need to do her initial check on all her patients first and then would have a chance to check the results in the computer. Mom nodded. Next Maria explained what she was going to do for Mom tonight – she would like to listen to her chest, and take her vitals, and quickly looking at the IV, “I believe you have another dose due tonight, I will make sure your bag is good for the night”. She next asked if Mom needed help getting ready for bed, and I said I would help before left. She said OK, but encouraged me to go home after I was done to make sure I got some sleep.

Ten minutes later, Maria returned with the vital sign machine and stethoscope. Maria confidently moved through my Mom’s assessment, asking what results were considered “normal” for Mom. She used humour and empathy acknowledged in her conversation with my Mom respectfully acknowledged the challenges with self-care and chronic disease management.

² Maria (not real name) and my Mother gave permission to share this story.

After reviewing Mom's medications, she acknowledged that she did not know one of the medications and that she would need to "look that one up." She stated that she would follow up with the physician, but for Mom to continue to take her own medications that were not on the hospital formulary.

After she completed the assessment, she reinforced to Mom the importance of her ringing the bell if she did not feel well or if she needed something. Maria said she would now be able to check on the blood work and would come back to let her know the results. On her way out, Maria shared with me how she continues to mentor new graduate nurses in the emergency and that she was glad we re-connected after all these years. After a few minutes, I said goodnight the Mom. I had relaxed and felt relieved that Maria was taking care of Mom tonight. As I was saying goodnight, Maria poked her head in and said that the results were "not in yet", but she would "keep a watch for them".

Table 5

Identification of Nursing Professional Practice Attributes within Exemplar 2

| Nursing Professional Practice Attribute | Example from Exemplar |
|---|--|
| 1. Accountability | <ul style="list-style-type: none"> <i>Maria said she would check, but explained how she would need to do her initial check on all her patients first and then would have a chance to check the results in the computer.</i> |
| 2. Autonomy | <ul style="list-style-type: none"> <i>She stated that she would follow up with the physician, but for Mom to continue to take her own medications that were not on the hospital formulary.</i> |
| 3. Client Centered | <ul style="list-style-type: none"> <i>Her focus quickly returned to my Mom – "So what brings you in here tonight?" She focused intently on my Mom's answer. Next, she asked 'how are you feeling now?'</i> |

| Nursing Professional Practice Attribute | Example from Exemplar |
|---|---|
| 4. Collaboration | <ul style="list-style-type: none"> • <i>She stated that she would follow up with the physician...</i> |
| 5. Contextual | <ul style="list-style-type: none"> • <i>...asking what results were considered “normal” for Mom.</i> |
| 6. Continuing competence | <ul style="list-style-type: none"> • <i>After reviewing Mom’s medications, she acknowledged that she did not know one of the medications and that she would need to “look that one up.”</i> |
| 7. Disciplinary knowledge | <ul style="list-style-type: none"> • <i>Maria confidently moved through my Mom’s assessment...</i> |
| 8. Ethics | <ul style="list-style-type: none"> • <i>Next Maria explained what she was going to do for Mom tonight – she would like to listen to her chest, and take her vitals, and quickly looking at the IV...</i> |
| 9. Innovation | <ul style="list-style-type: none"> • <i>She used humour and empathy acknowledged in her conversation with my Mom...</i> |
| 10. Leadership | <ul style="list-style-type: none"> • <i>On her way out, Maria shared with me how she continues to mentor new graduate nurses in the emergency and that she was glad we re-connected after all these years.</i> |
| 11. Self-regulation | <ul style="list-style-type: none"> • <i>Hello Mrs. Smith. My name is Maria and I will be your nurse tonight.”</i> |
| 12. Service | <ul style="list-style-type: none"> • <i>After she completed the assessment, she reinforced to Mom the importance of her ringing the bell if she did not feel well or if she needed something.</i> |

Exemplar 3 -nursing professional practice: a regulatory quality assurance program supporting nursing ethics.

The College of Registered Nurses of BC has developed a new program focusing on quality assurance (CRNBC, 2009). The purpose of the program is to “promote high standards through a proactive to improving nursing practice” (CRNBC, 2011) demonstrating nurses’ responsibility for professional self -regulation. I had the opportunity to learn about the program in a collaborative meeting between members of the Professional Practice department and the

CRNBC. As a practice consultant, I welcomed the chance to learn more about the program in order to assist nurses integrate these requirements into their everyday practice. I was aware how this information would assist my role to demonstrate leadership by influencing the professional practice of individuals or environments of teams.

The CRNBC Practice Consultant³ reviewed the program details and implementation and evaluation plans. She explained that there are three components to program: continuing competency, multi-source feedback, and practice support. The first component, continuing competency program is an existing process whereby nurses are accountable to declare annually that they have participated in an autonomous, self-reflective process. This process includes peer feedback to establish a learning plan with documented learning outcomes demonstrating disciplinary knowledge. The second component of the program involves a multisource feedback system that establishes processes to assess nurses' competence. Peers and Clients have an opportunity to provide formal feedback regarding a nurses' professional performance through electronic survey. The third component provides practice support to nurses who "have identified gaps in knowledge, skills, attitudes, and judgement" (competence) (CRNBC, 2011). These nurses are provided further coaching, mentorship, and further assessment to ensure they are able to meet the standards of practice and provide safe, compassionate, competent, ethical care (CNA 2008). The consultant identified that the professional review process will remain in place to ensure nursing meets the responsibilities for self-regulation within the Health Professions Act (BC Ministry of Health, 2011). The professional review program has established processes were by CRNBC staff investigate complaints about nurses who reportedly are unable to meet

³ The CRNBC Practice Consultant gave permission to use share this story.

standards; and as necessary establish a consensual resolution or move to a formal disciplinary hearing where a reprimand or registration conditions or limits may be imposed.

The CRNBC consultant reviewed the implementation plan for the quality assurance program with the team. Substantial innovation was evident with the software with the multisource feedback survey system and the collaboration with various practice settings and patient groups. Individuals from professional practice team had many questions about the new program. The team agreed to continue to remain informed about the new program due to the impact on nurses' professional practice.

Table 6

Identification of Nursing Professional Practice Attributes from Exemplar 3

| Nursing Professional Practice Attribute | Example from Exemplar |
|---|--|
| 1. Accountability | <ul style="list-style-type: none"> <i>The first component, continuing competency program is an existing process whereby nurses are accountable to declare annually that they have participated...</i> |
| 2. Autonomy | <ul style="list-style-type: none"> <i>...declare annually that they have participated in an autonomous, self-reflective process.</i> |
| 3. Client Centered | <ul style="list-style-type: none"> <i>...Clients have an opportunity to provide formal feedback regarding a nurses' professional performance.</i> |
| 4. Collaboration | <ul style="list-style-type: none"> <i>...provides practice support to nurses who "have identified gaps in knowledge, skills, attitudes, and judgement".</i> |
| 5. Contextual | <ul style="list-style-type: none"> <i>...processes were by CRNBC staff investigate complaints about nurses who reportedly are unable to meet standards and as necessary establish a consensual resolution or move to a formal disciplinary hearing...</i> |
| 6. Continuing competence | <ul style="list-style-type: none"> <i>As a practice consultant, I welcomed the chance to learn more about the program in order to assist nurses integrate these requirements into</i> |

| Nursing Professional Practice Attribute | Example from Exemplar |
|---|---|
| | <i>their everyday practice.</i> |
| 7. Disciplinary knowledge | <ul style="list-style-type: none"><li data-bbox="463 382 1421 487">• <i>This process includes nurse peer feedback to establish a learning plan with documented learning outcomes demonstrating disciplinary knowledge.</i> |
| 8. Ethics | <ul style="list-style-type: none"><li data-bbox="463 530 1421 635">• <i>These nurses are provided further coaching, mentorship, and further assessment to ensure they are able to meet the standards of practice and provide safe, compassionate, competent, ethical care (CNA 2008).</i> |
| 9. Innovation | <ul style="list-style-type: none"><li data-bbox="463 677 1421 783">• <i>Substantial innovation was evident with the software with the multisource feedback survey system and the collaboration with various practice settings and patient groups.</i> |
| 10. Leadership | <ul style="list-style-type: none"><li data-bbox="463 825 1421 931">• <i>I was aware how this information would assist my role to demonstrate leadership by influencing the professional practice of individuals or environments of teams.</i> |
| 11. Self-regulation | <ul style="list-style-type: none"><li data-bbox="463 973 1421 1043"><i>The purpose of the program is to “promote high standards through a proactive to improving nursing practice”...</i><li data-bbox="463 1047 1421 1199"><i>The consultant identified that the professional review process will remain in place to ensure nursing meets the responsibilities for self-regulation within the Health Professions Act (BC Ministry of Health, 2011).</i> |
| 12. Service | <ul style="list-style-type: none"><li data-bbox="463 1241 1421 1347"><i>These nurses are provided further coaching, mentorship, and further assessment to ensure they are able to meet the standards of practice and provide safe, compassionate, competent, ethical care (CNA, 2008).</i> |

Chapter 4

Step 6: Identify the Implications for Further Development of the Concept

The final step of Rodgers' evolutionary concept analysis provides an opportunity to discuss the implications discovered through the process. The concept development cycle considers the use, application, and significance, of the concept (2000). As the analysis phase and the majority of this paper has focused on the *use* of nursing professional practice, this last step will consider the application and significance of the definition. Specifically, I will discuss the implications of the concept of nursing professional practice related to nursing practice – policy, administration, clinical practice, education, and research (CNA, 2007). These implications will include concept engagement strategies for nurses with a view to lessen moral distress by improving the quality of professional practice environments.

The approach I have chosen to outline the implications reflects the cyclical connectedness of the evolutionary concept analysis and concept development processes (Figure 6) (Rodgers, 2000). I will begin by outlining the implications for policy, as policy is a key driver the other four areas of nursing practice, in particular administration. The implications for clinical practice follow those for administration, as the administrative implications impact primarily clinical practice. The implications for education follow those for clinical practice due to the relationship between education and practice. The research implications are the final section, as the research implications inform nursing curriculum as well as nursing policy.



Figure 6. Cyclical connectedness of the implications of the definition of the concept on areas of nursing practice.

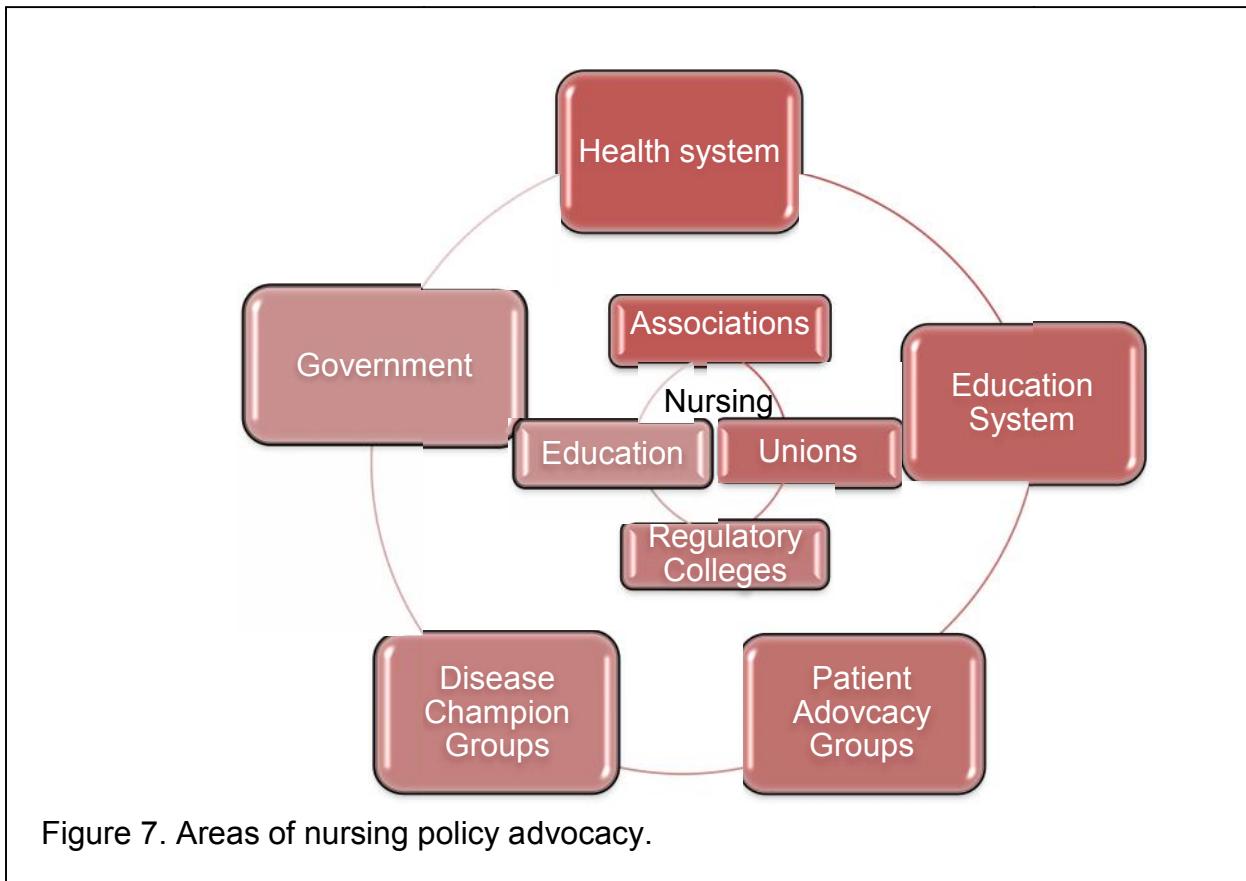
Implications for policy.

The results of this concept analysis of nursing professional practice have revealed implications for nurses involved in policy development and health care reform. The concept definition identifies the key attributes used by policy makers in *government, health authorities* and *nursing groups* when developing policy designed to influence nursing professional practice. Consideration of these three areas of policy is important as nursing is embedded within the social structures with formal power (e.g., the health care system, education system, provincial and national governments) as well as structures with informal power (e.g., disease champion groups and patient advocacy groups) (Figure 7). Nurse scholars have identified that conceptual clarity of nursing professional practice enables the development and strength of professional disciplinary support structures (Cronin & Coughlan, 2010; Tofthagen & Fagerstrøm, 2010; Ryle, 1971), which in turn influence nurses' ability to demonstrate professional practice including provision

of competent, ethical and quality care (Baumann et al., 2001; Bournes & Ferguson-Pare, 2007; CNA, 2008; Rodney et al., 2006; Rodney et al., 2009).

There are specific policy implications for non-nurse policy makers and nurse policy makers. Non-nurse policy makers within the governments and health authorities should promote policies that sustain and support the evolution of the nursing professional practice definition. Nurse policy makers within government and health authorities should 1) collaborate and collectively promote the attributes of nursing professional practice, 2) focus on strategies and means to individually influence non- nurse policy makers within the social structures and policy development, 3) secure seats at decision making tables for nurses (e.g., Chief Nurse Officer), 4) establish policy making/participating in policy making as another area of practice for nurses, and 5) sustain and evolve the existent structures to protect professional nursing practice. Nurse policy makers within the nursing groups (Figure 7) should 1) use the nursing professional practice definition when they develop policies, 2) sustain and evolve nursing structures to protect professional nursing (Villeneuve, 2010), 3) collaborate between provincial and national nursing groups, 4) influence other individuals who develop policies, 5) promote the role of policy advocacy as a role for individual nurse practice in all areas of practice (Carnegie & Kiger, 2009; Kilty, 2005), and 6) ensure that the attributes of the concept are sustained in policy development, which in turn, can influence the nursing professional practice. Interrelationship among individual nurses' professional practice, practice environments and professional structures are important for nurses' well-being. As research conducted in BC identified, nurses experience moral distress and moral residue as a result of working in environments with limited or absent professional practice elements (Rodney et al., 2006; Rodney et al., 2009). Therefore, policy that promotes and uses the

attributes of nursing professional practice can also contribute to lessening nurses' moral distress and residue.



Implications for administration.

This analysis of the concept of nursing professional practice has revealed implications for nurses and non-nurses working in administration in three specific ways. First, the implication for administrators is to promote their individual ability to practice through professional development. Nurse managers who understand and role model the attributes of nursing professional practice and are accessible to staff represent a key element of professional practice environments and positively influence recruitment and retention (Aiken et al, 2001). O'Rourke (2006) suggested formal accountability and rewards for nurses and nurse managers who promote

and display the attributes of nursing professional practice. The second implication for administrators is to implement nursing professional practice attributes in practice setting processes. O'Rourke (2009) identified the important role of nurse managers in promoting nursing professional practice through the establishment of key processes within practice environments. The thirteen attributes of nursing professional practice *processes* (Figure5) (e.g., linkages to physicians and organizational leaders, recognizing practice excellence) identified in the attributes section of this paper represent a synthesis of the literature reviewed for this analysis. These process attributes are examples of nurse leaders and managers who have used the attributes of nursing professional practice in practice setting processes. The third implication for administrators is to implement attributes of nursing professional practice in practice environments. Elements of quality nursing professional practice environments have been identified in research (Halcomb et al., 2010). These elements are important as there is an association between quality nursing professional practice environments and positive patient outcomes (Aiken et al., 1994; Aiken et al., 2008; Laschinger & Leiter, 2006; Mark et al., 2003; Tourangeau et al., 2002), and nurse outcomes (Halcomb et al., 2010; Schmalenberg & Kramer, 2008; Laschinger, 2008; Laschinger & Leiter, 2006; Mark et al., 2003; Murphy et al., 2011; Newcomb et al., 2009; Person et al., 2006). Mathews and Lankshear (2003) suggested that the integration of professional practice into the organizational vision requires dedicated resources and the delineation of professional practice as a distinct service within the organization (Lankshear, 2011).

Implications for clinical practice.

This analysis of the concept of nursing professional practice has revealed four implications for nurses in clinical practice. First, the delineation of nursing professional practice attributes will assist nurses to develop personal learning plans and meet provincial continuing competence requirements. Second, there is an opportunity for nurses to use the nursing professional practice attributes to advocate for quality professional practice environments and processes within their settings (BCNU, 2011; ONA, 2011). Third, the definition of nursing professional practice identifies nursing professional practice attributes in system uses (i.e., environment and processes as well as comportment by individual nurses). Fourth, participating in activities associated with continuing competence and strengthening of professional practice environments (e.g., local committees, nursing groups) may assist in the identification of pragmatic solutions to practice environment challenges. Nursing advocacy and self-reflection are strategies to begin to heal wounds from moral distress and moral residue related to professional practice (Marck, 2004).

From a societal perspective, there is an important role for individuals outside profession who understand the attributes of nursing professional practice. They have opportunity to 1) encourage individual practice of these attributes in their one on one interaction with nurses and 2) influence policy and resources through the systems and processes of a democratic society at municipal, provincial and national levels. Since the 1970s, there has been discussion regarding the establishment of national nursing standards (CNA, 1998). Analysis of the provincial and territorial nursing standards documents (Figure 5) identified similarities and difference among Canadian jurisdictions. Therefore, the definition of nursing professional practice contributes to

the current national discourse related to nursing standards of practice by delineating the conceptual attributes and uses for nurses and citizens of Canada.

Implications for education.

The key implications for education resulting from this concept analysis include the opportunity to integrate nursing professional practice attributes and uses into 1) nursing curriculum, 2) mentorship programs, and 3) student placements. The literature review for this analysis identified only one textbook that discussed nursing professional practice (McIntyre & McDonald, 2010). There is an opportunity to integrate the attributes of nursing professional practice and into nursing curriculum at baccalaureate, masters, and doctoral program levels. Considering the elements of Rodgers' (2000) concept development, the inclusion of nursing professional practice in nursing curriculum would include identification of the attributes uses as well as current conceptual application and significance. The purpose of the integration of the concept is threefold—(1) from a professional perspective – students become familiar with the attributes of nursing professional practice [socialization as part of being a professional (Pearson et al., 2006)], (2) from a discipline perspective – the use, application, and articulation of the significance of these attributes from a nursing context strengthens the “professional discipline” (Northrup et al., 2004) (in contrast to the use of corporate or medical taxonomies or perspectives), (3) from an ethical perspective – the various uses of nursing professional practice has positive outcomes for nurses, organizations, and clients. Mentorship programs and student placements provide an opportunity to assist nursing students with praxis through dialogue, sharing of wisdom, and role modeling of nursing professional practice from a nurse mentor

(Daloz, 1986). The attributes of nursing professional practice provide a framework for programs for mentors and student placements (e.g., attribute of leadership and innovation).

Implications for research.

This analysis of the concept of nursing professional practice has revealed five key implications for further research. First, identifying the organizational, nurse, and client outcomes related to nurses' professional practice and practice environments (Pearson et al., 2006). Second, exploring nurses' perceptions of how these attributes impact their practice, considering the definition of nursing professional practice and the identified interrelationship between nurse, environment, and self-regulation supports (Ashford & Zone-Smith, 2005, Cornett & O'Rourke, 2009; Hall et al., 2003; O'Rourke, 2006; Wright, 2008). Third, comparing the nursing definition of professional practice with other disciplines and interdisciplinary models would support the current use of the concept. This is important as recent professional practice models, although developed by nurses, are interdisciplinary (Mathews and Lankshear, 2003; Wesorick, 1997). Further, Rodgers (2000) identifies that cross discipline comparison of concepts not only assist with analysis but may assist with collaboration. Fourth, validating the Professional Practice Scale in other practice settings (e.g., community) and the determining the value in the development of tools for specialized settings versus validation of a tool for all practice settings. The research regarding the nursing professional practice environment was only completed in the acute care sector [NWI (Kramer & Schmalenberg, 1988), NWI-R (Aiken & Patrician, 2000), PES (Lake, 2002), PPE (Erickson et al., 2004), PNEW, (Choi et al., 2004)]. Fifth, discover how nurses' definition of nursing professional practice compares to the definition from the analysis. A

systematic review identified the value of further inquiry on the theoretical discourses related to professional practice (Pearson et al, 2006).

There are specific implications for research related to the temporal and setting features of evolutionary concept analysis process (Rodgers, 2000). Further inquiry into the concept when the nurse human resource shortage (Ashford & Zone-Smith, 2005; Block & Sredl, 2006; Borchardt, 2005; Bournes & Ferguson – Pare, 2007; CNA & CFNU, 2006; Halcomb et al., 2010; Smith & Kehl, 2009) is less an issue may provide interesting insights to the evolution of the concept. The setting for this concept analysis considered the literature in the last 5 years in Canada. The literature review for this analysis did not find evidence that an analysis of the concept of nursing professional practice had been previously undertaken. Therefore, there is an opportunity for further concept analyses with the same setting and a different time to compare the results.

Rodgers (2000) identified the importance of considering the *temporal* aspect of the evolutionary process in concept analysis. Similarly, changing the setting of the analysis to consider other countries would also provide further insights to the definition of nursing professional practice. These insights are important to the international implications of the profession and discipline as globalization is a grown 21st century trend (Benton, 2009). In keeping consistent with Rodgers' (2000) evolutionary process the outcome from this concept analysis of nursing professional practice is not intended to be a final definition of the term. “The results are ...a starting point rather than an end” (Rodgers, 2000, p. 97), for future inquiry in to this important concept for the discipline and the profession.

Reflection

I am fortunate to have experienced the exciting synergy in my multi-roles as a graduate student, Clinical Practice Consultant in a regional Professional Practice department, and board member of a new forming nursing association. The personal and professional events that created a sense of integrated praxis during this period were essential to identify salience of the concept of *nursing professional practice*. Friere (1970) describes praxis as “reflection and action upon the world in order to transform it “(p. 33). Therefore, there are a few actions in which I would like to engage as a result of reflecting and completing a concept analysis on nursing professional practice. First, as an advance practice nurse, I would like to influence health authority policy and program development to embed the attributes of nursing professional practice. Second, I would like to continue to engage with the forming provincial nursing association to promote the attributes of nursing professional practice in all areas of practice and to key stakeholders. Third, I am interested in conducting research to explore nurses perceptions of the attributes of nursing professional practice and compare the congruence with the attributes of this concept analysis. Finally, I will strive to demonstrate these attributes in my own nursing professional practice.

Conclusion

As part of this project, I undertook an evolutionary analysis of the concept of *nursing professional practice* from Rodgers. The concept was analyzed from an ontological view to illustrate the significance of the concept from a disciplinary, practice, and ethical perspective (Rodgers, 2000). Through the process of evolutionary concept analysis, I described the *uses* of the concept of professional practice in nursing (i.e., conceptual models, practice environment elements, and individual deportment) and the attributes of professional practice and definition as a foundation for further inquiry. Thus, nursing professional practice was defined as: 1) a collection of traits associated with professions including self-regulation, ethics, autonomy, disciplinary knowledge, continuing competence and accountability and; 2) a way of being as a nurse that encompasses service, collaboration, leadership, innovation in the context of client and environment and; 3) a label applied to a practice environment which supports the practice of these traits and ways of being. These environments are characterized by interprofessional collaboration, a nursing care delivery model based on nursing research related to the context of practice, the ability of nurses to practice autonomously according to professional standards and ethics, access to nurses in leadership positions, opportunity for continuing competence development, and access to demonstrate leadership and innovation. Three exemplars for nursing professional practice were also illustrated using the concept attributes as an outcome of the analysis. I concluded the paper by outlining the implications suggested by the findings of the concept analysis and the associated recommendations for nursing practice, education, administration, research, and policy advocacy.

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Appendix A

Table A1

Related Concepts of Nursing Professional Practice

| Category | Related Concepts | Relationship to Nursing Professional Practice | References |
|------------------------|-----------------------|--|---|
| 1) Organization Design | Organizational Design | Structure and processes of organizations influence practice environments and individual ability to enact professional practice. | (Ingersoll, Witzel, & Smith, 2005; Newcomb et al., 2009; Storey et al., 2008; Wolf, Boland, & Aukerman, 1994; Wolf & Greenhouse, 2007) |
| | Magnet Status | The 14 forces of magnetism associated with facility designation of magnet status have been linked with practice environments supporting professional practice. | (Arford & Zone-Smith, 2005; Halcomb, Davidson, Cadwell, Salamonson, & Rolley, 2010; Schmalenberg & Kramer, 2008; Laschinger & Leiter, 2006; Mathews & Lankshear, 2003; Miles & Vallish, 2010; O'Rourke, 2006; Smith & Kehl, 2009) |
| | Quality of Work life | Initiatives supporting quality of work life influence nurses' professional practice environments. | (Bournes & Ferguson – Pare, 2007; Hall et al., 2003; Laschinger, 2008) |
| | Quality Improvement | Processes and outcomes associated with quality improvement influence the quality of the professional practice of individuals and their practice environments. | (Halcomb et al., 2010; Miles & Vallish, 2010; Smith & Kehl, 2009) |
| | Economics | The optimization of financial resources has been associated with the implementation of | (Miles & Vallish, 2010) |

| Category | Related Concepts | Relationship to Nursing Professional Practice | References |
|----------------------------|---------------------------|---|--|
| | | professional practice models. | |
| 2) Nursing Human Resources | Nursing Shortage | Care delivery models as an element of professional practice models assists in the optimization of existing nurse resources. | (Arford & Zone-Smith, 2005; Block & Sredl, 2006; Borchardt, 2005; Bournes & Ferguson – Pare, 2007; CNA & Canadian Federation of Nurses’ Unions (CFNU), 2006; Halcomb et al., 2010; Smith & Kehl ,2009) |
| | Nurse Attrition/Retention | Limited nursing resources create a need to retain nurses through quality professional practice environments. | (Ashford &Zone-Smith, 2005; Bournes & Ferguson – Pare, 2007; Block & Sredl, 2006) Girard et al., 2005; Lake, 2002; Miles &Vallish, 2010; Newcomb et al., 2009) |
| 3) Culture | Nursing Discourse | Historical narrative and moral traditions influence the discourse related to nursing professional practice. | (Selman, 2000) |
| | Preceptorship | The enactment of professional practice is role modeled and encouraged through the process of preceptorship. | (CNA, 2004; Paton, 2010) |
| | Leadership | Leadership displayed by nurses in all roles influences professional practice environments. | (CNA, 2011; Sui et al., 2008) |
| | Profession | Societal and disciplinary understanding of the attributes of a | (CRNBC, 2010; Noone (2009)) |

| Category | Related Concepts | Relationship to Nursing Professional Practice | References |
|--------------------------|---------------------------------|--|--|
| | | profession influence what is understood as professional practice. | |
| | Empowerment | Empowerment has been identified as an important element of professional practice environments. | (Laschinger et al., 2009; Manojlovich, 2005) |
| | Conflict Management | High quality professional practice environments feature effective conflict management processes. | (Sui et al., 2008) |
| 4) Population Care Needs | Chronic Conditions | The complexity and intensity of chronic health care conditions place a demand on the health care system that requires optimized professional practice. | (Halcomb et al., 2010) |
| 5) Care Delivery | Client Care Delivery Models | The complexity and intensity of chronic health care conditions place a demand on the health care system including requiring optimized professional practice. | (Murphy et al., 2011; Newcomb et al., 2009; Wolf & Greenhouse, 2007) |
| | Interprofessional Care Delivery | Care delivery models that include collaboration of varied professionals have been associated with professional practice. | (Halcomb et al., 2010; Miles & Vallish, 2010; Sui et al., 2008) |
| | Client Centered Care | A focus on providing client-focused care has been associated with | (Smith & Kehl, 2009) |

| Category | Related Concepts | Relationship to Nursing Professional Practice | References |
|-----------------------|------------------|--|--|
| | | professional practice. | |
| | Competence | Professional practice has been associated with the ability of professionals to demonstrate their knowledge, skill, attitude and judgement. | Levett-Jones, Gersbach, Arthur, & Roche (2010) |
| 6) Practice Education | Best Practices | Access and enactment of care practices, which are evidence of informed, influence professional practice. | (CNA & CFNU, 2006; Noone, 2009) |
| | Specialization | In-depth education in one area of client care promotes professional competence and is congruent with the health care system taxonomy. | (Valente, 2010) |
| | Certification | Certification processes promote professional practice through demonstration of best practices in a specific nursing practice specialty. | (Valente, 2010) |

Appendix B

Table A2

Relationship between the Attributes of Nursing Professional Practice and the Conceptual Attributes

| Nursing Professional Practice Attribute | Attributes of the Uses of Nursing Professional Practice |
|---|---|
| 1. Accountability | 1, 2, 3, 7, 11, 13, 21, 24, 29, 30 |
| 2. Autonomy | 4, 9, 10, 18, 23, 31 |
| 3. Client Centered | 1, 3, 4, 8, 13, 25, 27, 34 |
| 4. Collaboration | 1, 3, 4, 8, 11, 14, 15, 17, 20, 22, 34 |
| 5. Contextual | 1, 3, 5, 7, 17, 19, 25 |
| 6. Continuing competence | 2, 4, 5, 12, 25, 29 |
| 7. Disciplinary knowledge | 2, 3, 4, 6, 8, 9, 23, 25, 26, 28 |
| 8. Ethics | 1, 2, 13, 22, 27, 30, 31, 32, 35 |
| 9. Innovation | 1, 3, 5, 7, 9, 14, 18, 24, 25, 26, 29, 33 |
| 10. Leadership | 1, 3, 4, 7, 11, 14, 16, 17, 20, 21, 23, 26, 29, 33, 36 |
| 11. Self-regulation | 2, 3, 14, 20, 22, 27, 35 |
| 12. Service | 1, 3, 5, 7, 13, 15, 17, 21, 32 |

Glossary

| Acronym of Jurisdictional Nursing Group | Name of Jurisdictional Nursing Group |
|--|--|
| ARNNL | Association of Registered Nurses of Newfoundland and Labrador |
| ARNPEI | Association of Registered Nurses of Prince Edward Island |
| CARNA | College and Association of Registered Nurses of Alberta |
| CNA | Canadian Nurses Association |
| CRNBC | College of Registered Nurses of British Columbia |
| CRNM | College of Registered Nurses of Manitoba |
| CNO | College of Nurses of Ontario |
| CRNNS | College of Registered Nurses of Nova Scotia |
| ICN | International Council of Nurses |
| RNANWTN | Registered Nurses Association of Northwest Territories and Nunavut |
| RNAO | Registered Nurses Association of Ontario |
| SRNA | Saskatchewan Registered Nurses Association |
| YRNA | Yukon Registered Nurses Association |