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The Professional Practice Leader: The role of organizational power and personal influence in creating a professional practice environment for nurses

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A thesis submitted in partial fulfillment of the requirements for the degree in Doctor of Philosophy

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by

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ABSTRACT

Professional Practice Leadership (PPL) roles were introduced in response to health care professionals' concerns about the loss of professional autonomy and other possible negative consequences on professional practice arising out of the widespread implementation of program management during health care restructuring. Despite the extensive implementation of the PPL role in Ontario, there is a paucity of empirical studies examining the impact of the PPL role. The main purpose of this study was to address this knowledge gap by determining the role of organizational power and personal influence in enabling the PPL to fulfill their role functions toward creating a positive professional practice environment for nurses. In this study a theoretically based model is tested that integrates PPL perceptions of manager support and organizational power with their own influence tactics to predict the achievement of PPL role functions and the impact these functions could have on nurses' perceptions of the professional practice environment.

This dissertation is comprised of four main components: 1) a review of the literature describing professional practice; 2) the application of a theoretical framework to describe the PPL role; 3) the development of an instrument to enable measurement of the PPL role; and 4) the empirical testing of a conceptual model depicting the proposed relationship of the PPL role and nurses' practice environments. Based on path analysis with the hypothesized model, organizational power had a direct and positive effect on PPL role functions and PPL influence. Although PPL influence had a direct and positive impact on PPL role function the proposed mediated effect of organizational power on PPL role function was not supported nor was the hypothesized moderated effect of manager support on PPL role function. Finally, there was a small but statistically

significant, positive relationship between PPL role function and aggregated nurse perceptions of the practice environment.

As this was the first known research study specific to the Nursing PPL role in Ontario, the evidence generated from this study can be used to inform current practices regarding the design, implementation and evaluation of the PPL role as well as future research regarding the impact of professional practice leadership roles on staff, organizational, and patient outcomes.

Keywords: professional practice leader role, nursing, professional practice environment, professional practice, organizational power, influence tactics, manager support, leadership, empowerment theory, instrument development, path analysis

DEDICATION

I dedicate this dissertation to my family: my husband Ken and children Meghan and Alex, who patiently supported my desire to return to university "one last time", survived countless dinners from the Crockpot, and who, over the course of this journey have become my greatest supporters and cheerleaders – despite the fact that they still aren't really quite sure what this was all about anyway! For all of this…I am truly Thankful!

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TABLE OF CONTENTS

LIST OF TABLES

Table

LIST OF FIGURES

Figure

LIST OF APPENDICES

Appendix

CHAPTER ONE

INTEGRATING CHAPTER: THE PROFESSIONAL PRACTICE LEADER: THE ROLE OF ORGANIZATIONAL POWER AND PERSONAL INFLUENCE IN CREATING A PROFESSIONAL PRACTICE ENVIRONMENT FOR NURSES

Introduction and Background

For health care facilities, the 1990's were characterized by significant organizational restructuring and the proliferation of program management. Program management, also described as product line or service line management, is defined as an administrative system to coordinate and control the work of those who are providing the services, structured around specific patient populations or clinical services provided by the organization (Bowers, 1990). The change processes experienced by hospitals were massive and often accompanied by the elimination of profession specific departments, which prompted many health care organizations across Canada to implement professional practice structures. These new structures were introduced to address concerns regarding loss of professional identity and the potential undermining of professional standards (Baker, 1993). Despite the widespread creation and dissemination of these new professional practice structures in health care organizations, very few evaluations have been done, particularly in relation to the leadership roles that typically accompany them.

Research examining the restructuring of health care work environments has highlighted the relationship between organizational structures and health care professionals' perceptions about the impact these structures have on their professional practice. Specifically, research describing nurses' experience within restructured organizations, most involving the introduction of program management, has reported decreased communication and coordination (Clifford, 1998), decreased sense of power

and opportunities for input into decisions impacting client care (Blythe, Baumann, & Giovannetti, 2001), decreased autonomy and loss of professional identify (Lankshear, 1996; Sharp et al., 2006), and decreased job satisfaction and opportunities for professional development (Young, Charn, & Heeren, 2006). In contrast to these results, a national study of nursing leadership structures in Canada revealed that senior nurse leaders and middle managers within a program management environment, reported greater organizational support, job security and greater support for professional practice than those working in traditional organizational structures (Laschinger et al., 2008).

In light of these concerns with the impact of organizational restructuring on nursing professional practice, the Ontario Ministry of Health & Long-Term Care received several reports outlining recommendations pertaining to the importance of structures enabling nurses to participate in decisions directly impacting patient care as well as the importance of nursing leadership at the senior management level (CNAC, 2002; Nursing Task Force, 1999; RNAO, 2000). The most common internal response to the introduction of program management in restructured organizations was the introduction of a professional practice department and/or a professional practice leader role to specifically address standards, credentials, and performance expectations specific to each profession (Heslop & Francis, 2005). When describing the key elements of a professional practice structure, Matthews and Lankshear (2003) noted that the *professional practice leader* (PPL) role was identified as a key element. The PPL is described as being responsible for the promotion and maintenance of the standards of practice for their specific profession (Miller, Worth, Barton, & Tomkin, 2001). Despite the extensive implementation of this role in Ontario (e.g., over 82 organizations have some variation of a PPL role in place), a scan of the health care literature reveals very

few publications focusing on the role (Adamson, Shacketon, Wong, Prendergast, & Payne, 1999; Chan & Heck, 2003; Comack, Brady & Porter-O'Grady, 1997; Lankshear, Laschinger, & Kerr, 2006; Matthews & Lankshear, 2003; Miller et al., 2001) and no empirical studies examining the impact or effectiveness of the PPL role.

Although PPL positions appear to vary widely from one organization to another, content analysis of existing PPL role descriptions reveals that the overall depiction of the PPL is commonly portrayed as the role accountable for addressing professional practice related issues within the organization, promotion of professional standards of practice, identification of professional development needs and implementation of evidenced-based practice. Despite the varying organizational approaches to the role, one common characteristic is the lack of any direct line or budget authority pertaining to the health care professionals the PPLs provides leadership to (i.e. nursing). The nurses report directly to their unit manager and do not have any formal reporting relationship to the PPL. Due to the lack of line and budget authority, the PPL functions in a similar fashion to that of an internal consultant by bringing forth recommendations regarding professional practice initiatives. Once the recommendations are presented, it is the ultimately the manager (or collective management team) who then decides whether the recommendations will be acted upon (e.g. allocating budgetary support, establishing performance expectations related to staff participation and/or compliance with PPL lead initiatives, supporting staff attendance at meetings and professional events through the provision funding and replacement staff). Therefore the success of the PPL role relies on the extent of organizational power ascribed to the role and the ability of the PPL to influence key stakeholders (i.e. Unit managers, senior nursing leadership and nursing staff) in order to achieve the outcomes associated with their role.

Purpose for the Research

The impetus for this research is drawn from my own personal experience as a Professional Practice Leader within several organizations, as well as my interactions with colleagues through the Professional Practice Network of Ontario. It is through these experiences that I became acutely aware of the tremendous diversity in how the PPL role is operationalized not only across organizations, but also by the individuals in the PPL roles. This ambiguity made it difficult to develop a common language for describing the PPL as well as uncertainty about its added value in the practice environment. If a role is not clearly understood, even by those in the role, and if its value-added contributions or outcomes are not well defined or known, there is a strong possibility the role could be eliminated, especially in an ongoing environment of severe fiscal constraints. Yet, there is also a strong possibility that the role could play an important part in the development of systems and structures to support professional practice, despite the lack of formal budget and line authority. If the original intent of the professional practice structures and roles was to address the concerns associated with professionals functioning within a program management environment, then the immediate challenge is to determine a way to better describe the PPL role and measure its impact on the practice environment of nurses.

This dissertation, therefore, is a result of the need to develop a common language for describing the PPL that could subsequently serve as the foundation for empirically measuring the functions associated with the role and the potential impact on practice environments. The primary purpose of this study is to determine the role of organizational power and personal influence in enabling the PPLs to fulfill their role functions toward creating a positive professional practice environment for nurses. The study tests a theoretically based model that integrates PPL perceptions of manager

support and organizational power with PPL influence tactics to predict PPL role functions and their impact on nurses' perceptions of the professional practice environment.

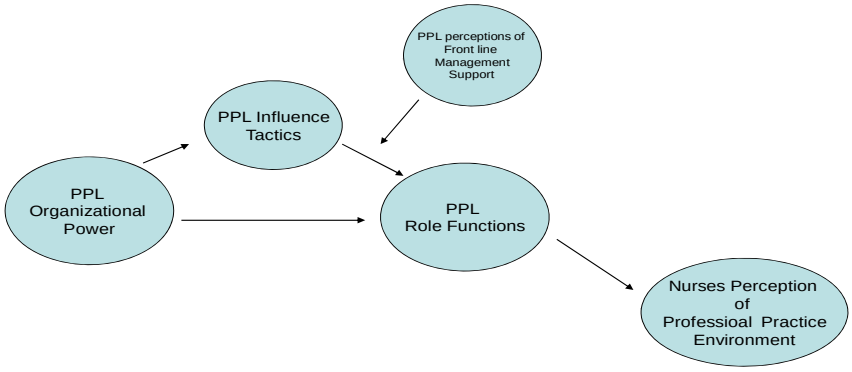

Figure 1. PPL Conceptual Model

Specifically, it is hypothesized that the degree of organizational power of the PPL and personal influence tactics used by the PPL will directly impact the degree to which the PPLs achieve their role functions and that the personal influence tactics used by the PPL will partly mediate the effect of organizational power. It is also hypothesized that the relationship between PPL influence tactics and role functions is moderated by PPL perceptions of manager support, thus ultimately impacting the extent to which nurses perceive their practice environment as being supportive of professional practice.

The knowledge generated by this research study will be of importance to policy makers, nursing leaders, senior administrators, health care providers, professional practice "practitioners" across the continuum of care, and researchers as the results of this study will provide much needed empirical evidence regarding the impact of the professional practice leader role on the practice environment of nurses.

Overview of Study Model Components

Professional Practice Leader (PPL)

The PPL role has been a part of the healthcare system for the past two decades, with literature describing the implementation of the role beginning to appear in the mid 1990's (Adamson et al., 1999; Bournes & DasGupta, 1997; Comack, Brady, Porter-O'Grady, 1997; Miller et al., 2001; Ross, MacDonald, McDermott, & Veldhorst, 1996). The PPL role was introduced primarily as a result of the implementation of program management and the elimination of profession-specific departments that occurred with that change process. It was introduced as a way to address concerns from professionals regarding a perceived loss of professional identify and the lack of development or input into organizational decision making that could impact practice (e.g. professional voice). The purpose of the PPL role has been described as being responsible for the promotion and maintenance of the standards of practice for their profession (McCormack & Garbett, 2003; Miller et al., 2001).

Common frustrations expressed by current PPLs about their varied roles include: the lack of clarity regarding the PPL role, even as defined among members of the Professional Practice Network of Ontario (PPNO); the challenges in demonstrating outcomes associated with the role; and the varying degrees of organizational support provided to PPLs such as lack of formal authority and time allocation for the role (Matthews & Lankshear, 2002). Although it is recognized that the unique needs and culture of individual organizations will determine how any role is operationalized, the significant variation in how the PPL role has been implemented is perhaps a reflection of the lack of a theoretical framework as a guide to implement these existing roles (Lankshear, Laschinger, & Kerr, 2006).

Organizational Power (Structural Empowerment)

Kanter's (1993) theory of organizational power provides a strong theoretical foundation for the model being tested in this study. Kanter describes *power* as the ability to mobilize resources to get things done. Power is achieved through formal and informal sources. *Formal power* results from job roles and functions which are considered extraordinary (i.e. not routine), have a high degree of visibility, are relevant to key organizational processes and goals and are identified with the solutions to organizational problems (Kanter, 1993). *Informal power* is achieved through peer alliances and the ability to connect with other parts of the system (Kanter, 1979). Individuals with both formal and informal power are viewed as having greater access to opportunities, information, support and resources (Laschinger, 1996). *Opportunity* refers to conditions that enable advancement and professional development. *Information* includes the knowledge (both formal and informal) required to do the work required, whereas *support* refers to the degree of discretion or exercising of judgment along with feedback. Finally, access to *resources* (or supplies) means having influence over the environment, such as access to the materials needed to accomplish desired goals. These materials may include time, money and prestige (Kanter, 1979; Laschinger, 1996).

Personal Influence & Influence Tactics

Yukl (2006) describes *influence tactics* as types of behaviours that are intentionally used to influence another person's behaviour and/or attitudes. Influence tactics are presumed to include: rational persuasion, apprising, inspirational appeals, consultation, collaboration, ingratiation, personal appeals, exchange, coalition tactics, legitimating tactics and the use of pressure. Various research studies (Yukl & Falbe, 1990; Yukl & Falbe, 1991; Yukl, Guinan, & Sottolano, 1995; Yukl & Tracey, 1992) have

demonstrated that, depending on who (i.e. what person or role) you are trying to influence; certain influence tactics are more appropriate and effective than others. For example, rational persuasion and consultation are often used when trying to influence superiors, whereas pressure tactics would not be appropriate or effective. When trying to influence peers, rational persuasion and ingratiation are more often used (Yukl, Falbe, & Youn, 1993). Research to determine the effectiveness of influence tactics on outcomes revealed that the use of core influence tactics (rational persuasion, inspirational appeals, and consultation) is significantly and positively related to target (i.e. manager) commitment and agent (i.e. PPL) effectiveness (Yukl, Chavez & Seifert, 2005; Yukl & Tracey, 1992). Due to the lack of line and budget authority assigned to the PPL role, the overall effectiveness of the PPL role includes their ability to influence those in the formal leadership roles at varying levels of the organization who do have line and budget authority, such as front line managers and senior nursing leadership.

Organizational Power, Personal Influence and the PPL Role

If the intent of the PPL is to promote and maintain the professional standards of their distinct profession and if the definition of power, as described by Kanter (1979) is the ability to get things done in a meaningful way, then the components of organizational power provide a strong theoretical foundation for the PPL role. As the internal representative (and perhaps advocate) for the profession, the PPL would require a certain degree of formal and informal power in order to adequately provide leadership for their profession. The direct reporting relationship of the PPL can either intentionally or unintentionally send a message regarding the importance of the role and its associated initiatives. For example, PPLs who report directly to the Chief Nursing Executive (e.g. member of the senior leadership team) are more likely to experience a higher degree of

formal and informal power, than PPLs who report to a unit manager (Kanter, 1993). As organizational structures become more flattened, this creates opportunities for those without formal positional power to exert upward influence and decision making power through their legitimate role as content experts regarding the core business of the organization. Support from the unit manager is also central to the success of the PPL role. The PPLs ability to access empowering structures (i.e., informal power) and use of informal power alliances within the organization (e.g. the manager group as a whole) will also contribute to the degree of manager support (Kanter, 1979; Laschinger & Shamian, 1994). The PPL must be able to influence the managers to support PPL related initiatives in order to garner support when influencing practice. If the PPL is not successful in influencing the manager to support the PPL related initiatives, this lack of manager support can act as a significant barrier to obtaining access to staff, the support for practice changes and the creation of an enhanced professional practice environment.

Professional Practice Environment

Lake (2002) describes the nursing practice environment as the organizational characteristics of the work environment that facilitate or constrain professional nursing practice. Within nursing, the link among organizational attributes, practice environments and nursing practice has been well established. Kramer and Schamlenberg (1988a, 1988b) first described the elements of nurses' environment that resulted in enhanced recruitment and retention in hospitals described as "magnet hospitals". Aiken, Sloane, Lake, Sochalski, and Weber (1999) took this research study further to demonstrate the impact of nurse's practice environment on patient mortality and demonstrated that the magnet characteristics of autonomy, control over practice and positive nurse-physician relationships contribute not only to positive nurse outcomes (i.e. increased job

satisfaction), but also to positive patient outcomes such as decreased mortality. Aiken et al. (1999) concluded the resources and policies that govern the work of clinicians in hospitals, factors that tend to receive scant attention in the growing literature on hospital performance, are important in determining the outcomes of patients. A review of the magnet hospital literature (Scott, Sochalski, & Aiken, 1999) reveals a growing body of nursing research demonstrating a link between the features of the practice setting and their impacts on professional nursing practice.

Overview of the Dissertation Papers

This dissertation is comprised of four main components: 1) a review of the literature describing professional practice; 2) the application of a theoretical framework to describe the PPL role; 3) the development of an instrument to enable measurement of the PPL role; and 4) the empirical testing of a conceptual model depicting the proposed relationship of the PPL role and nurses practice environments. The papers comprising this dissertation reflect the evolution of the activities and research conducted to further our understanding of the PPL role, the factors that enable or hinder the achievement of PPL role functions, and the impact of the PPL on the professional practice environment of nurses. The following provides a brief description of the four individual papers.

Paper 1: An Integrative Review of the Theoretical and Empirical Literature Describing Professional Practice

The aim of this integrative review is to synthesize the existing theoretical and empirical literature describing professionals and professional practice in order to develop a comprehensive understanding of the professional practice concept. The paper identifies the common attributes that have been used to describe professional practice over time and

in a variety of venues resulting in the development of a concise conceptual mapping or framework which will describe the core attributes of professional practice.

Paper 2: Exploring the Theoretical Foundation for the Professional Practice Leader Role

The aim of this paper is to contextualize the PPL role within Kanter's theory of structural empowerment in order to provide a common language for the various stages of the PPL role evolution (i.e. design, implementation, and evaluation). A content analysis of existing PPL role descriptions in Ontario was completed to demonstrate the applicability of Kanter's theory to the PPL role. The results of the content analysis supported the use of Kanter's theory of structural empowerment as an appropriate theoretical foundation for the PPL role. A version of this paper was previously published in the Canadian Journal of Nursing Leadership in 2006.

Paper 3: The Professional Practice Leader Questionnaire: Development and Psychometric Testing

The aim of this paper is to describe the development and psychometric testing of a questionnaire designed to measure the extent to which Professional Practice Leaders (PPLs) are able to achieve their role functions. The Professional Practice Leader Questionnaire (PPLQ) was developed using a three phased approach: item generation, pilot testing and additional psychometric testing. This questionnaire, which is interprofessional in nature, addresses the current void in the ability to empirically describe PPL roles, the main areas of responsibility often assigned to the role and the degree to which PPLs are able to achieve their role functions.

Paper 4: The Professional Practice Leader: The Role of Organizational Power and Personal Influence in Creating the Professional Practice Environment for Nurses

Building on the previous three papers, a theoretical model was developed depicting the relationships among organizational power, personal influence, manager support and professional practice role functions and their impact on nurses' perceptions of their practice environment. The study described in this paper tests the following hypothesized model: The degree of organizational power of the PPL will directly and indirectly impact the ability of PPLs to fulfill role functions, with this relationship mediated by PPLs' use of personal influence tactics. The relationship between PPL influence tactic and PPL role function will be moderated by PPL perceptions of the degree of front line manager support. Finally, PPL role functions are hypothesized to directly affect the way in which nurses perceive their practice environment (see Figure 1).

Significance to Nursing

As this was the first known research study specific to the Nursing PPL role, the study results will serve as the initial model for investigating factors contributing to PPL role functioning and how the role might impact nurses' perceptions of their practice environment. The evidence generated from this study can be used to inform current practices regarding the design, implementation and evaluation of the PPL role as well as future research regarding the impact of professional practice roles and/or portfolios on staff, organizational and patient outcomes.

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PAPER ONE

AN INTEGRATIVE REVIEW OF THE THEORETICAL AND EMPIRICAL LITERATURE DESCRIBING PROFESSIONAL PRACTICE

Introduction/Background

Despite its wide spread use in the everyday language of professionals and the prevalent (and yet diverse) use in the theoretical and empirical literature, there remains a great deal of ambiguity regarding the exact definition of *professional practice* and the associated attributes, characteristics and components that would therefore encompass this concept. This degree of variation and ambiguity becomes problematic for practitioners, administrators, researchers, and policy makers as they endeavor to describe, implement, evaluate and/or advocate for behaviors, resources and systems which are perceived to support excellence in professional practice and in the case of the health care industry, the provision of excellent patient care and the establishment of quality work environments.

This degree of ambiguity is based on the apparent lack of a clear universal definition or description of the term *profession* in the contemporary literature (Pearson et al., 2006). If there is no apparent universally accepted definition for the term profession (and therefore which occupations are in fact deemed to be professions), then it is not surprising that there is no collective understanding about what constitutes professional practice including the key characteristics of a professional practice structure, model, role or environment.

This lack of a common understanding is not due to a lack of theoretical and empirical literature on the topic. The topic of professions, professionalization and professional practice is evident in citations from the early 1900's and is still prevalent today. The theoretical literature describes the evolution of the profession, the

characteristics of professions, and describes the varying perspectives regarding the professional "status" (i.e. occupation, semi-profession or profession) of some groups such as nursing. The empirical literature provides a variety of research studies which describe the characteristics of professional practice structures, professional practice models, professional practice behaviors, professional practice roles, and professional practice environments and their impact on patient, staff and system outcomes.

Aim

The aim of this integrative review is to synthesize the existing theoretical and empirical literature describing professionals and professional practice in order to develop a comprehensive understanding of the professional practice concept and to identify the common attributes that have been used to describe professional practice over time and in a variety of venues. The exploration of the theoretical and empirical literature regarding professional practice will assist in the development of a concept map that can be used for the development, implementation and evaluation of existing professional practice models, structures behaviors and roles, as well as future initiatives.

Search Strategy and Methods

A variety of methods were used in order to maximize the amount of relevant material available for inclusion in the review. A systematic review conducted by Greenhalgh and Peacock (2005) revealed that the majority of citations included in reviews were obtained through citation tracking, review of reference lists, and through personal knowledge, contacts or through serendipitous findings, with only 30% of sources obtained through database and hand searches. The search strategy for this integrative review, therefore, followed a similar three-step process: citation tracking, review of reference lists and purposeful searches.

Key Words and Initial Search

The key words used for the search included: Profession, professional organizations, professional practice, professionalization, professionalism, and professional practice models, professional practice behaviors, professional practice environments, professional practice leader(ship), and Nurse or nursing. Boolean logic was used to combine broader terms to allow for greater focus to the search and the results. SCOPUS was utilized for the initial search as this database provides comprehensive coverage of health, physical, life and social sciences, with CINAHL then used for the more focused search regarding the key variables as they apply to health care, including nursing and allied health professions. Manual searches were conducted for books and other resources not available electronically. Purposive sampling was also conducted by searching for known seminal works (either by title or author), utilizing citation tracking to identify other seminal works and frequently cited titles, and reviewing the reference lists of retrieved articles.

Inclusion and Exclusion Criteria

The inclusion criteria for the theoretical literature included titles that described the processes and issues related to the identification of professions, the evolution of professions and professional status; the professionalization of groups and the professionalization of the workplace/ practice setting. The inclusion criteria for research studies (e.g. quantitative and qualitative) required that the research design referred to the term *professional practice* as the main phenomena of interest and/or the independent or dependent variable. Exclusion criteria for research studies and citations were those where the focus was a clinical treatment or intervention.

The initial search produced a total of 1,503 citations once duplications were removed. Citation abstracts were reviewed using the inclusion and exclusion criteria, which resulted in a total of 139 citations included for the review which included 29 research studies.. See Appendix A for search process and retrieval results. See Appendix B for a table describing the studies included on this review.

The Characteristics of a Profession

When reviewing the literature describing the criteria for a profession, it becomes very apparent that although there is no single commonly accepted criterion, there are commonalities in the various descriptions. This section will endeavor to provide a synthesis of the literature describing professions as a distinct group.

There is extensive literature describing the characteristics, criteria and qualities of a profession, with the majority of the descriptions including elements that can be traced back to the criteria for a profession initially proposed by Abraham Flexner (1910). Flexner's description of professions is derived from a study undertaken to review the quality of medical education in the United States and Canada. As a result of his observations, Flexner concluded that professions had the following characteristics: activities which were based on practical, intellectual pursuits and based on knowledge that could be taught and learned, a tendency for self- organization and the provision of altruistic service for others. Flexner felt that identifying professions through these criteria would enhance the quality of candidates who were entering medical schools.

Goode (1957) built upon Flexner's criteria by describing a profession as a community of members who were bound by a sense of identity, who demonstrate a life-long commitment to the work, display evidence of agreed upon values and role definitions, utilize a common language that is not well understood by outsiders, and has

power over its members through control over the selection and education of those entering the profession. Wilensky (1964) argued that any occupation wishing to attain professional status must, in part, convince the public that the services they provide are unique, in that they can be provided only by that occupational group and that the occupational group is trustworthy in the provision of that service. Wilensky's description of a professional occupation included "doing full time the thing that needs doing" (p. 142) , the establishment of dedicated training and schools at the university level, formation of a professional association, self-regulation, (i.e. licensing and certification), and the presence of a code of ethics. Although Wilensky's criteria contains many of the same attributes described by Flexner and Goode (i.e. specialized knowledge, and a degree of self-regulation) his was the first to specifically refer to the development of a code of ethics.

Greenwood (1957) also focused on the relationship between the occupation and the community they serve. Greenwood described five attributes of profession as knowledge that is based in theory, authority, evidence of community sanctions, body of ethics, and demonstrating a professional culture. This presence of a professional culture is reflective of Goode's description of the community with a common sense of identity. In a study of 1000 students representing eight occupations from nine universities within the United States (Forsyth and Danisiewicz,1985), professional services are described as being essential or important to the client, complex and non-routine, requiring the utilization of specialized knowledge and exclusive in that the occupation has a monopoly of the provision of the particular service(s). Professional power is described in terms of degrees of autonomy or the degree of decision making without external pressures or influences. This study provides the first description of autonomy as a source of power for

the professions and individual practitioners and thus identifies it as a key component of the concept of a profession. Yam (2004) continues the discussion by drawing from the works of a variety of sociologists in describing the traits of a profession to include: an extensive theoretical knowledge base, legitimate expertise in the field, altruistic commitment to service, unusual degree of autonomy in work, code of ethics overseen by a representative body, and a personal identity that stems from the chosen occupation.

Beyond the social science and sociology literature, the nursing literature includes many citations regarding the status of nursing as a profession. Melosh (1989) describes a profession as possessing an extended theoretical knowledge, commitment to service, autonomy, altruism, code of ethics, peer review, and self-regulation, standards for education and certification of new practitioners, and a strong professional identity. The criteria of a profession described by Keough (1997) include: specialized knowledge that is theory based, control of professional policy and activity (autonomy), presence of a code of ethics, education at the university level, and service to the public. In order to determine the extent of autonomy that has been achieved, autonomy is described as comprising three functions: independent, interdependent and dependent. Mellish and Wannenburg (1992), describes the independent functions of autonomy to include areas such as observation and assessment of the client, performing of procedures based on assessment findings, patient education and supervision of other nursing team members. The interdependent functions of autonomy refer to the relationship between the nurse and the members of the interprofessional team due to the inherent interdependent role. The dependent function of autonomy refers to the requirement to adhere to external educational, legislative and regulatory standards of the profession.

In a qualitative study designed to obtain nurses' views on the key elements of professional nursing practice, Girard et al, (2005) conducted 18 focus groups with nurses from a wide variety of sectors (i.e. hospital, public health and home care) and practice settings (i.e. clinics, hospitals and community based offices) within a large health region. The information obtained through the focus groups led to the description of professional nursing practice as "the commitment to compassion, caring and strong ethical values; continuous development of self and others; accountability and responsibility for insightful practice and demonstrating a spirit of collaboration and flexibility. It is with this definition that the concepts of caring, insightful practice, and flexibility are introduced as key elements of professional nursing practice as well as the commonly described components of continuous development, collaboration and commitment. In a systematic review conducted by Pearson et al, (2006), the characteristics of professional practice were described to include the procession of a unique body of knowledge, commitment to altruistic service, autonomy and ethics, extensive education and socialization. The results of this systematic review reinforce the common themes presented in previously discussed literature describing professional practice.

Upon review the various descriptions and criteria of professions presented here, common themes become apparent including: the utilization of specialized knowledge, a degree of autonomy, self-regulation, altruistic service, and the presence of a code of ethics. These initial themes will provide the foundation for the following sections as I further explore the common threads that describe the criteria of a profession, the work of professionals and the characteristics and challenges of the contexts in which they practice.

The Context of Professional Work

When considering the impact of the practice setting on professions and professionals, it is important to separate the content of the professional work from the context in which the professionals conduct their work (Leicht & Fennell, 1997). Leicht and Fennell suggest that it is not necessary to define professional work as a distinct entity, but rather to focus on the role that organizations play in either enhancing or inhibiting the work of professionals. Therefore, for the purpose of this review, professional work will be defined as those activities performed by practitioners that are reflective of and congruent with the criteria and characteristics of a profession. Based on this definition and the definitions for profession and practice stated earlier, professional work can be considered synonymous with *professional practice*. Brannon (1994) describes the features of professional practice as the complete responsibility for nursing care through the provision of unified tasks, and the unmediated relationship with the client. Unmediated relationship refers to the ability of the professional to function to optimal scope of practice without interference from organizational polices or procedures (e.g. organizational policy requiring a written physician order before a physiotherapist can assess a patient). Referring back to Freidson's (1973) assertion that it is the degree of autonomy that ultimately determines the professional status of any group, the context of practice can have a significant role in the degree of professionalization that can be operationalized. Practice environments can be described according to a continuum from bureaucratic to professional (Lake & Friese, 2006), with bureaucratic organizations having more centralized decision making and being more hierarchical in nature while in professional organizations, the decision making is more decentralized and relationships are more collegial than hierarchical.

Due to the complexities of providing health care, more and more professions are functioning within bureaucracies, thus becoming vulnerable to the loss of autonomy through administrative direction and control. Although control over the terms of work is lessened by being an employee, control over the content of professional practice does not. Weins (1990) views autonomy as not an issue of nurses' total control over their practice environment, but rather the ability to determine the situations when it is best to retain control over practice and when is reasonable to relinquish control over certain aspects of practice. The *content* of professional practice is determined first by the underlying educational preparation and the processes (i.e. standards and guidelines) established by the professional and regulatory bodies that govern the profession. When an occupation becomes a formalized profession, administration can control the resources connected with professional work but cannot control what professional workers do and how they do it (Freidson, 1973). As the professional is a member of two distinct organizations (i.e. the profession itself and the administrative organization), the issue for professional workers is to what degree they are able to exercise control over their work and the outcomes.

The context of professional work can have a significant impact on the ability of individual professionals to fully engage in the activities and attributes that define professions and professionalism. Organizations that enable professions' ability to exercise their full scope of practice, as described by relevant professional standards and legislation, and function autonomously in the development and delivery of patient care, without interference from organizational rules, are viewed as creating an optimal context for professional practice. As the majority of professionals provide their services within the context of an organization, professions and organizations both must come to terms on how this unique relationship and structure will function. This brings us to the topic of the

professional organization and the unique opportunities and challenges of professions functioning within bureaucracies.

The Professional Organization

Brock (2006) defines the professional organization as an organization primarily sustaining professionalized occupations (pg. 157). The literature provides a variety of frameworks for describing professional organizations. Weber (1947), defined a bureaucracy as an organization with a hierarchy based on authority, control by formal rules and regulation, division of labor that is based on functional specialization, impersonal relations and reward based on merit or competence. Bureaucratic control is the extent to which organizational rules affect the work and functioning of their employees

Mintzberg (1981, 1989, 1997) describes all organizations as being comprised of five components: the strategic apex (i.e. senior management team), the operating core (i.e. those hired to perform the services and tasks required of the organization), the middle line or managers, the technostructure (i.e. those that plan and control the work of the operating core) and lastly, the support staff (i.e. those providing indirect services to the operating core). A professional bureaucracy is defined as an organization where the majority of the workers are professionals and where members of one or more professional groups define and achieve the primary organizational goals (Montagna, 1968). In a professional bureaucracy the largest component is the operating core where professional staff provides direct client services without much interference from the strategic apex. Professionals are provided with a certain degree of autonomy and are trusted to function in the best interests of the client(s) and organization. High value is placed on autonomy, participation and collaboration in decision making.

Scott (1982) describes three models for managing professional work in health organization: autonomous, heteronomous and conjoint professional organizations. In an *autonomous* professional organization, the organization delegates to the professions the responsibility for defining and implementing goals and for setting and monitoring performance standards. In the autonomous model, the professionals are viewed as being capable of determining their own performance standards, monitoring the performance of colleagues and defining the nature and scope of their work. Although hospitals are included as an example of an autonomous professional organization, the argument can be made that this would not equally apply to all professions within the hospital. The prestige of a profession (e.g. medicine) can itself carry significant organizational weight, therefore, having a greater ability to self-determine professional practice and also provide direction to organizational service delivery (Leicht & Fennell, 1997).

In the *heteronomous* professional organization, professionals are viewed as being subordinates of the administrative hierarchy. As a result, the degree of professional autonomy is not determined by the profession but rather by the organization. This structure places emphasis on the power of the managers rather than the power of the operating core (i.e. professionals). In this type of professional organization, the power of the professional group(s) is dependent on whether or not the employing organization grants the desired degree of autonomy to the professionals (Forsyth & Danisiewicz, 1985). Nursing can be described as an occupation that has achieved professional status and an increased degree of professional autonomy, yet continues to struggle with their status as primarily employees of professional organizations (Brannon, 1994; Coburn 1988).

The *conjoint* professional organization is viewed as a possibility rather than a model that exists in today's complex environments. The conjoint professional organization is one where the administrators and professionals are *equal in power* and recognize the interdependent nature of their relationship. Although from a philosophical perspective, this model of professional organization would be the most preferred and assumedly provide the best outcomes, there are no obvious examples of any professional organizations which can claim to have this ultimate degree of partnership and shared power.

Despite the increase in the number of professionals functioning as the operating core of organizations and therefore their significant role in organizational success, the literature reveals a trend toward control over professional work moving more and more into the hands of the managers of the organization (Briscoe, 2004; Leicht & Fennell, 1997). This leads to concern about how professional employees of bureaucracies deal with the actual and potential conflicts between their desire to be autonomous practitioners and the rules of the organization and higher systems (Lake, 1999; Raelin, 1985). The following section will provide some empirical support for the importance of professional organizations that provide systems and structures that empower, rather than hinder, professional practice.

Importance of Organizational Context to Professional Practice

Lake (1999) describes the practice environment as the organizational features that undermine or facilitate the nurses' professional autonomy (p. 23). Although the professional's knowledge, skills and abilities are important features of professional practice, the environment and work arrangements that enable or hinder their practice are viewed as being equally important. Therefore, the extent of an individual's or group's

professional practice (i.e. clinical autonomy) can be viewed as being dependent on the work arrangements (i.e. organizational autonomy) specific to the context of their practice.

Hall (1968) explored the dimensions of professionalization across different occupations groups: lawyers, teachers, medicine, nursing, engineering, accountants and librarians. The six dimensions examined included degree of authority, division of labor, presence of rules and specifications, technical competency and relationships. Those professions with high scores in the autonomy dimension included medicine, law, and accounting. It was noted that even though physicians practice within the context of an organization (i.e. hospital), as a professional group they are generally free to determine their own work. The professional that ranked lowest on professionalism scales included nurses, teachers and librarians. These professions were then classified as being within a heteronomous professional organization and therefore subjugated to the rules and practices of others (Scott, 1982).

Aiken et al (1999) studied the impact of unit and hospital characteristics on patient satisfaction and mortality rates, with results indicating that 30 day mortality was lower in units where nurses had more organizational autonomy (e.g. control over bedside clinical care), more involvement in primary nursing (full responsibility for the provision of nursing care) and where there was a positive relationship between nurses and physicians. This description of organizational autonomy is similar to that of Brannon's (1994) description of the features of professional practice as the complete responsibility for nursing care through the provision of unified tasks, and the unmediated relationship with the client.

Research describing the impacts of the restructuring of work environments has highlighted the linkage between the design of professionals' work environments and the

enablement of professional practice. Laschinger and Havens (1996) conducted a descriptive correlational study involving 127 nurses from two US teaching hospitals for the purpose of determining the relationship between nurses' perceptions of work empowerment and control over practice. One component of work empowerment investigated was formal power (Kanter, 1977; Kanter, 1979), which includes roles that have flexibility (e.g. autonomy) and whose functions or outcomes are relevant to organizational goals. Those with sufficient power are deemed as being able to accomplish desired tasks and goals. Results indicated a strong, positive correlation between nurses' perceptions of work place empowerment and perceived control over nursing practice. This reinforces the importance of organizational factors (e.g. access to information, support, resource and opportunities) that can hinder or enhance professional practice

Blythe, Baumann, and Giovannetti (2001) utilized a thematic qualitative design to determine nurses' experiences with restructuring. Much of the restructuring described by the nurses, was the implementation of a program management organizational structure. Program management (product line or service line management) is defined as administrative system to coordinate services, structured around specific patient populations or clinical services provided by the organization (Bowers, 1990). Themes generated through the focus groups include: perceptions of fragmentation of relations, increasing uncertainty and disempowerment. Nurses described policies associated with restructuring as infringing on the nurse's ability to maintain professional standards resulting in perceptions that they could not fulfill their professional roles and dissatisfaction with the lack of opportunities for input into polices that would impact patient care. Clifford's (1998) investigation of the impact of hospital restructuring on

nursing leadership revealed that the absence of a specific nursing department within the organization (i.e. program management structure) was linked to concerns over the lack of a central place for addressing client care issues and standards, and the significant communication and coordination role the nursing "department" provided to the rest of the organization. Sharp, et al, (2006) conducted a mixed method study involving interviews with 125 Nursing Executives (NE) and survey results from over 11,000 nurses across 125 organizations within the Unites States. NE perceptions' of the overall impact of program management on nursing, included the loss of autonomy and professional identify. Positive aspects included increased presence of nurses involved in issues related to patient care and increased collaboration within nursing and allied health. Staff nurses in matrix organizations were less positive about the quality of patient care, whereas nurses in a pure service line model were more positive about quality of patient care. There were no significant differences in job satisfaction scores of staff nurses in the three organizational structures.

A longitudinal, qualitative study conducted by Lankshear (1996) described similar concerns regarding loss of professional identify and autonomy expressed by staff nurses within a newly implemented program management environment. Thematic analysis of data collected using focus groups, revealed that upon implementation of program management, nurses were most concerned with issues related to professional identify (e.g. devaluing of the profession by no longer requiring nursing background) and accountability (e.g. fears associated with the need for staff nurses to assume more leadership in practice issues). Main themes generated at eight and 18 months post implementation continued to reflect the earlier concerns of professional identify and accountability, but the focus shifted from the anger and fear to that of an increased sense

of ownership for practice (e.g. "we know that nursing issues are owned 100% by nurses"), but frustration at the lack of authority for practice (e.g. "they tell me I have this power, but sometimes I just don't see it").

A quantitative study conducted by Young, Charns, and Heeren (2004), revealed that the presence of a program management structure was significantly and negatively associated with both job satisfaction and professional development. In contrast, a national study of nursing leadership structures in Canada, revealed that senior nurse leaders (SNL) and middle managers (MM), within a program management environment, reported greater organizational support, job security and greater support for professional practice than those in traditional organizational structures (Laschinger et al., 2008).

The studies described above provide evidence regarding the impact of restructuring and the implementation of program management on the health care professionals practicing within these organizational structures. As the majority of the findings describe the negative impacts as perceived by the professionals, this can provide the foundation for the development of organizational strategies to mitigate these challenges. Heslop and Francis (2005) conducted a qualitative study to determine how seven health care organizations in Ontario responded to the introduction of program management. The intervention most frequently mentioned was the introduction of a professional department and/or professional practice leader role specifically to address standards, credentials, and performance expectations specific to distinct profession.

Professional Practice Environments

A professional practice environment can be described as the system that supports nurses' control over the delivery of nursing care and the environment in which care is delivered and the characteristics of an organization that facilitate or constrain

professional nursing practice (Aiken & Patrician, 2000; Lake, 2002). The impact of the work environment on professional practice has been described extensively in the nursing literature. The research on magnet hospitals (Kramer & Hafner, 1984; Kramer & Schamlenberg, 1988a, 1988b) provides the initial empirical evidence regarding organizational characteristics that facilitate professional nursing practice. The characteristics describing "magnet" hospitals include control over nursing practice, autonomy, visible, supportive nursing leadership, and collaborative relationships with physicians. Scott et al, (1999) conducted a review of the magnet research and the implications for professional nursing practice. Their review highlighted the importance of nursing leadership in the development of systems which support optimal patient care. Autonomy and control of nursing practice was also highlighted and described as nurses utilizing expert knowledge allowing for accountability and authority in decision making.

Laschinger et al. (2001a, 2003) demonstrated the link between nurses' work environments and nurse outcomes such as trust, burnout, quality of care, and satisfaction. Using Kanter's theory of structural empowerment, Laschinger has developed a program of research which highlights the importance of work place structures that allow for the ability to get things done (1996). This includes sufficient power and access to the necessary information, resources and support to achieve the desired outcomes. Armstrong and Laschinger (2006) demonstrated the link between magnet hospital characteristics, empowerment and patient safety. The exploratory study within a small community hospital revealed that nurses who perceived their environments to be empowering and, therefore, enabling professional practice, were more likely to perceive their environment as supporting a culture of patient safety.

Upenieks (2003) utilized a mixed method design to determine the relationship between organizational characteristics, nursing leadership and nursing job satisfaction, with results indicating that nurses within magnet hospitals reported greater perceptions of empowerment and experienced greater job satisfaction than nurses in non-magnet hospitals. This provides further support for organizational structures that enable nurses to operationalize the attributes of a profession, thus creating an empowered and satisfied professional work force.

A longitudinal design was utilized by Martin and Gustin (2004) to develop a database for the purpose of depicting nurses' perceptions of their work environment to support decision making and future organizational planning. Results depict nurses' perceptions as they related to organizational events over the 10 year time period; no significant changes in autonomy were noted over time, yet significant differences at certain data points could be attributed to internal organizational changes (i.e. an increase in autonomy that coincided with the implementation of shared governance model). The contribution of the study was the ability to link the impact of organizational innovations to nurses' perceptions of their work environment over a period of 10 years.

The challenges faced by professionals within organizations as described in this section can be linked directly to the criteria for professions described earlier. The attributes important to professions (i.e. autonomy, authority, utilization of specialized knowledge, and self-regulation) are those most identified as being challenged by the organizational context. Lack of input into decision making, inability to practice due to barriers created by rules and policies are just some examples experienced by professionals. These examples provide some empirical evidence of the impact of organizational structures on professionals. In the next section the available empirical

literature will be explored which endeavors to measure the various factors that enable (or hinder) professional practice.

Measurement of Professional Practice Environments

A variety of instruments have been developed to measure nurses' perceptions of their practice environment (Appendix C). The early magnet hospital research provided the foundation for the development of the Nursing Work Index (NWI), a five subscale, 65 item instrument developed by Kramer and Hafner (1989). The subscales included in the NWI include management style, quality of leadership, organizational structure, professional practice and professional development. Using the NWI as the foundation, Aiken and Patrician (2000) developed the Revised Nursing Work Index (NWI-R) to measure organizational characteristics associated with professional practice models. The NWI-R contains 55 items within four subscales describing areas such as: autonomy, control over practice, organizational support, and nurse-physician relationship. Cronbach's alpha for the entire scale was 0.96 with subscale alphas ranging from 0.75 – 0.91. As one of the initial and most extensively used instruments to reliably describe and measure nurses' practice environments, a review of other existing tools will reveal some degree of lineage back to the NWI-R.

Despite the extensive use of the NWI-R, there have been critiques of the NWI-R in terms of the validity of the tool, specifically item language, in the current nursing and health care context (Kramer & Schamlenberg, 2004, 2005), with the lack of a strong theoretical foundation as a possible explanation for poor structural fit (Cummings, Hayduk, & Estabrooks, 2006). Estabrooks et al. (2002) tested the psychometric properties of the NWI-R with a sample of Canadian nurses and determined that the

Canadian Practice Environment Index (PEI), a single factor, 26 item instrument provided a reliable, parsimonious measure of the practice environment.

Lake (2002) utilized the Nursing Work Index (NWI) as the foundation for the development of the Practice Environment Scale (PES). Survey data from existing samples were used to conduct a factor analysis of 48 items chosen from the original 65 items included in the NWI. Factor analysis using principal axis extraction and varimax rotation produced an instrument containing 31 of the original 48 items clustered within 5 subscales: Nurse participation in hospital affairs, nursing foundations for quality of care, nurse manager ability, leadership and support, staffing and resource adequacy and collegial nurse-physician relationships. Cronbach's alpha for the PES scale = 0.82; with subscale ranges of 0.71 – 0.84. Gajewski et al, (2010) conducted a multi-level confirmatory factor analysis (CFA) of the PES utilizing data from over 72,000 nurses from over 4000 patient care units. The results of the CFA confirmed the original 31 item, five factor structure of the PES (CFI = 0.90 and RMSEA = .042) and provided validity at both the individual (RN) and unit level of analysis.

Cummings et al. (2006) examined the validity of the subscales within the NWI-R, PES, and PEI using structural equation modeling (SEM) as well as the Chi-square test of model fit. Results indicated that factor models associated with each of the instruments had poor model fit (NWI-R: Chi-square=939.12, $p < .001$, $df = 50$, AGFI = .979; PES: Chi-square=17,872.73, p=.001, df=319, AGFI= .877; PEI: Chi-square=38,590.29, $p < .001$, $df = 229$, AGFI= .751), therefore raising questions about the validity of the instruments as measures of the nursing practice environment.

The Professional Practice Environment (PPE) Scale developed by Erickson et al. (2004) is a 38 item scale containing eight subscales including: Handling disagreement

and conflict, internal work motivation, control over practice, leadership and autonomy in clinical practice, staff relationships with physicians, teamwork, cultural sensitivity and communication about patients. Although the PPE is described as a theoretically grounded measurement, there is no theory specifically described to support the instrument. Cronbach's alpha for the 38 items PPE scale = 0.93 with subscale alpha ranges of 0.78 – 0.88. Erickson and Duffy (2009) conducted psychometric evaluation of a revised 42 item PPE, with the results of confirmatory factor analysis supporting the original eight factors and a total of 39 items. Overall scale reliability is reported as .93 with subscale alpha scores ranging from 0.82 – 0.87. Erickson and Duffy describe the benefits of the PPE as providing information regarding the practice environment beyond the original "magnet" characteristics to also include areas such as conflict work motivation and cultural sensitivity.

Additionally, in response to criticisms of the NWI-R, Kramer and Schmalenberg (2004) developed the Essentials of Magnetism (EOM) tool through consultations with nurses and onsite observations in 14 hospitals. The resulting instrument contains 57 items clustered within 8 subscales. The subscales are descriptive of: support for education, clinically competent, RN-MD relationships, autonomy, control over practice, adequate staffing, cultural values, and nurse manager support. Cronbach's alpha for each subscale ranged from 0.81 – 0.90.

Despite the variety in instruments used to measure practice environments, many of the items included in them can be traced back to the theoretical literature describing professions and the empirical literature describing the magnet hospitals. These common elements include: autonomy, control over practice, quality of care, leadership, collaboration, and professional development and competency. Understandably, these

themes are also reflective of the characteristics described for professions. Therefore the intent of these instruments is to determine the degree to which nurses perceive their context as either enabling or hindering their ability to function as a profession. The concerns expressed about the validity of the instruments highlights the complexity of practice environments and the need to advance theory as a base for instrument design and testing.

Professional Practice Roles

Although roles designed specifically to support professional practice are present in a wide variety of health care organizations, there is a paucity of research regarding the essential elements of these roles role and effectiveness. Unique to Canada, Professional Practice Leaders (PPLs) are described as being responsible for the promotion and maintenance of the standards of practice for their profession (Miller et al., 2001). Although the literature contains citations which describe the professional practice leader roles (Adamson et al, 1999; Bournes & DasGupta, 1997; Chan et al, 2003; Comack et al., 1997; Lankshear et al., 2007; Matthews & Lankshear, 2002; Ross et al., 1996), there is limited published research regarding this role. McCormack and Garbett (2003) employed a concept development approach to determine the characteristics of practice developer roles. Practice developers are described as professionals who have formal responsibility for developing practice in their organizations. Upon completion of a review of the literature, six categories were identified to describe the focus of the practice developer role: Promoting and facilitating change, translation and communication, responding to external influences, education, research into practice, and audit and quality. Many of the categories, specifically education, research into practice, audit & quality are reflective of the criteria for professions in that they address professional knowledge (education) and

service to the public (responding to external influences) and self-regulation (audit and quality).

The literature describing and evaluating the Nurse Consultant (NC) role implemented in the United Kingdom provides the best available evidence regarding roles designed to specifically support professional practice of nurses in a variety of environments. First introduced in 1999, the intent of the NC role was to advance practice, research, leadership and education in nursing (Alderman & Lipley, 2001; Coady, 2003; Higgins, 2003; Woodward, Webb, & Prowse, 2005). The domains of the NC role include: expert practice, professional leadership and competency, education, and practice and service development (Graham & Wallace, 2005; Ryan, 2006; Woodward, Webb, & Prowse, 2005). The role is distinguished from other advanced nursing roles (i.e. Clinical Nurse Specialists) in that the strategic nature of the NC, including the ability to influence people and policies required greater political and interpersonal skills (Redwood et al., 2007).

A growing body of research published within the United Kingdom provides empirical evidence of the characteristics of the NC roles, the factors (personal and organizational) that enhance or hinder the effectiveness of the roles and outcomes of the role at the nurse and patient levels. Woodward, Webb, and Prowse (2006) determined the organizational influences impacting NC role achievement. The two themes generated from data collected through interviews, identified support systems and National Health Service (NHS) influences as key factors to role effectiveness. In terms of support systems, NCs described the importance of networks and collaborative relationships as a significant factor influencing their overall role achievement. Support was described not only in terms of the support provided to them by others (i.e. managers, NC colleagues,

researchers and educational institutions), but also the support they were able to provide to others (i.e. empowering others through their initiatives). NHS influences included overarching policy direction of the NHS (i.e. the modernization initiative involving all NHS trusts) and the power bases within the NHS, specifically that the NC role had limited power and that the balance of power remained with the physicians. Recommendations generated from the study include the need for increased organizational awareness of the role and the supports required (i.e. access to information and resources), and to enhance the profile of the NC role as a valuable source of expert information regarding patient care and service delivery. These recommendations are reflective of the impact of context on the ability of professionals to achieve their desired outcomes. The limited power base (i.e. organizational autonomy) of the NC was shown to have a negative impact on role effectiveness and satisfaction.

Guest et al. (2004) conducted a comprehensive evaluation of the NC role incorporating both quantitative and qualitative methods. The aim of the study was to evaluate the impact of the nurse consultant role on service delivery and patient care and to determine factors associated with role effectiveness. A multi-method longitudinal design incorporated the use of interviews, focus groups, surveys and longitudinal phone interviews over 3 phases of data collection. They found that NCs were involved in the following main functions: leadership (86%), practice (48%), education (43%), and expert practice (33%). Only 15% of the NCs involved in the study indicated that they were heavily engaged in all four functions. The vast majority (73%) indicated satisfaction with the role despite ongoing challenges regarding role clarity, and the balance between accountability and levels of authority/power and supports for the role. This study provides the most comprehensive descriptions of the Nurse Consultant role as a unique

leadership position designed to support professional practice and patient care. The results of this study can provide valuable information and guidance in the design, implementation and evaluation of future professional practice leadership roles.

A systematic review conducted by Humphreys et al. (2007), presented the results from 14 studies describing the NC role and outcomes. The thematic analysis of the studies identified four themes within the literature: empowering colleagues to develop expert practice, service development, developing educational programs and use of theory to support practice. The levels of influence of the NC role are also described by McIntosh and Tolson (2008) as extending beyond service to the profession, across boundaries and having impacts at the individual, group, organizational and strategic levels. The research describing the Nurse Consultant role, functions, and outcomes provides a strong foundation for the describing the purpose and scope of the PPL role. The original intention of both of these roles is similar, in that they are both perceived as being accountable for the advancement of professional practice through research, leadership, and development of systems to support ethical client care.

In this section an overview of the relevant research describing the various aspects of professional practice and the impact of these attributes on nurse, patient, and systems outcomes was provided As demonstrated by the studies described here, the indicators or variables used to describe professional practice are consistent with the attributes used to describe professions (i.e. autonomy, control over practice, collaboration, quality patient care and utilization of professional knowledge). These indicators to measure aspects of professional practice were used consistently across a wide range of areas: organizations, environment, behaviors, roles, and models. The presence of these consistent themes and

elements provides strong support for the identification of common attributes that can be used to describe professional practice.

Conclusion: A Concept Map for Describing Professional Practice

The aim of this integrative review is to synthesize the existing theoretical and empirical literature describing professionals and professional practice in order to develop a comprehensive understanding of the professional practice concept and to identify the common attributes that have been used to describe professional practice over time. This information obtained through the review was then used to help compile the core attributes that can be universally applied to describe professional practice. Figure 2 summarizes the key outcomes of the review including the core attributes of professional practice. Although there is no commonly held definition of professional practice, this review of the literature has clearly identified the characteristics commonly used to define a profession and the impact of context on the professional practice of nurses. The contextual features included areas such as organizational structures, mechanisms designed for optimal delivery of patient care, and the characteristics of roles designed to support nursing professional practice.

Professional practice in health care can therefore be described as those professional activities and behaviors that are operationalized for the purposes of providing optimal effective and efficient patient care. The five attributes of professional practice identified by the review include: Self-regulation, knowledge-based activity, autonomy and control over practice, collaborative relationships and a demonstrated commitment to patient care. The five attributes described here provide a common foundation that can be applied to the diverse nature of nursing professional practice and the wide range of contexts in which nurses operationalize professionalism.

An important contribution of this review is the development of a common language which can be used when describing the concept of professional practice, as it relates to professions, professional organizations, and professional practice roles. The review of empirical and theoretical literature described here resulted in the identification of five attributes of professional practice which can be used to form the basis of a common understanding of the areas that are included when discussing professional practice. As demonstrated through the review of the literature, these five attributes (e.g. self-regulation, knowledge based, autonomy and control over practice, commitment to service, and collaborative practice) can be applied when describing professional practice as it related to individuals (e.g. performance expectations), structures (e.g. what is within scope for professional practice portfolios) and roles (e.g. areas of accountability). As a result, the following definition of professional practice in health care was developed: *"the utilization of specialized knowledge combined with the ability to exercise legitimate control over practice in order to provide collaborative, ethical, client centered care"* (Lankshear, 2011).

As there is often confusion or ambiguity regarding practice versus operational functions and accountabilities within organizations, these five attributes and the associated definition can be used to help clarify the areas that fall within the legitimate domain of professional practice portfolios and roles (i.e. standards of practice, credentialing, professional development) versus operations (i.e. fiscal planning, performance management), and the areas where there are implications for both practice and operations (i.e. care delivery models, skill mix, recruitment and retention).

The five attributes can also provide a useful framework for future research and program evaluation studies regarding the impact of professional practice structures and

roles on outcomes at the individual (i.e. health care professional) and organizational levels.

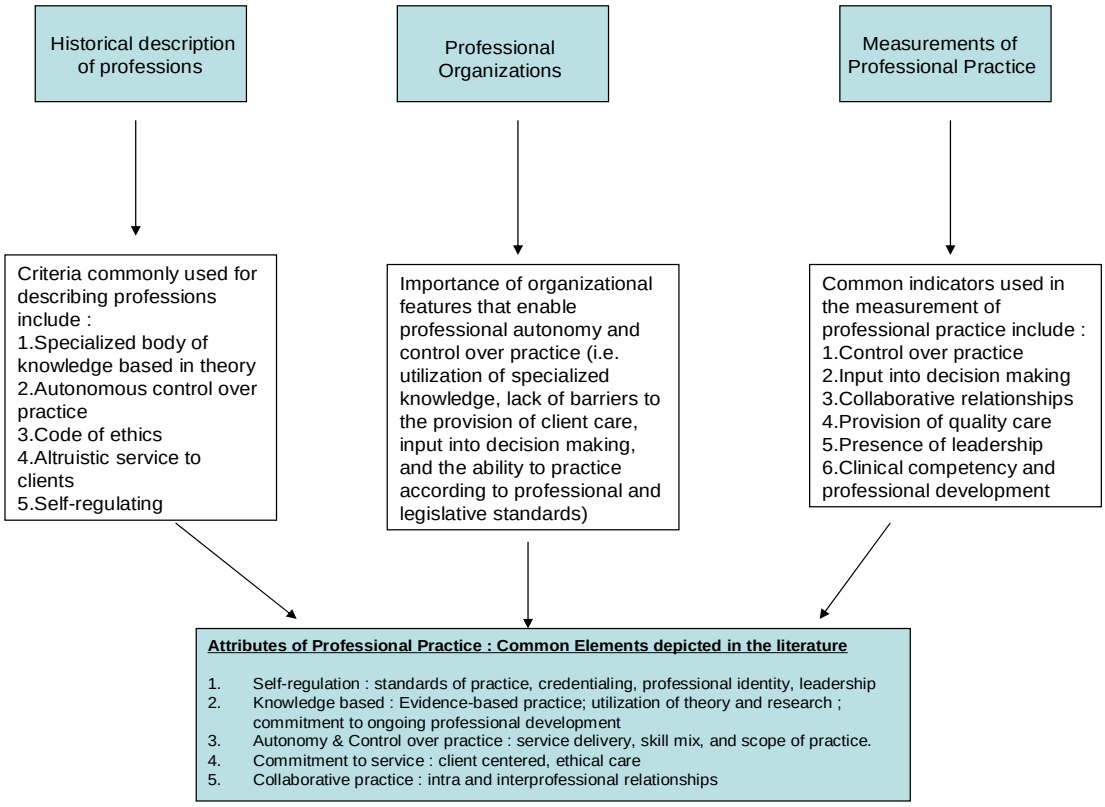

Figure 2. Professional Practice Concept Map

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PAPER TWO:

EXPLORING A THEORETICAL FOUNDATION FOR DESCRIBING THE PROFESSIONAL PRACTICE LEADER ROLE

Introduction

Faced with a climate of significant organizational restructuring, proliferation of program management and the elimination of profession specific departments, health care organizations across Canada, in the 1990's, were prompted to implement professional practice structures. These structures were introduced to address health care professionals' concerns regarding loss of professional identity and possible undermining of professional standards within a program management structure (Alexander & Robison, 1991; Baker, 1993). Matthews and Lankshear (2003) identified the professional practice leader role (PPL) as a key element of a professional practice structure. Despite the variation in how the role is operationalized, the PPL role is commonly described as the position responsible for the promotion and maintenance of the standards of practice for a distinct profession (Miller, Worth, Barton, & Tonkin, 1999). Although widely implemented (i.e. over 60 organizations in Ontario alone have some variation of a PPL role in place), a scan of the literature reveals relatively few publications on the topic and a lack of empirical studies regarding the impact of the PPL role (Adamson, Shacketon, Wong, Prendergast, & Payne, 1999; Chan & Heck, 2003; Comack, Brady, & Porter-O'Grady, 1997; Matthews & Lankshear, 2003; Miller, Worth, Barton, & Tonkin, 1999). This gap in the literature regarding specific *roles* to support professional practice is interesting when compared to the significant amount of research regarding the benefits of professional practice *structures* for nurse, patient, and system outcomes (Aiken, Clarke, Sloan,

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Sochalski, & Silber, 2002; Aiken, Sloane, Lake, Sochalski, & Weber 1999; Gleason Scott, Sochalski, & Aiken 1999; Laschinger & Havens 1996; Upenieks, 2002).

The concept of a magnet hospital has provided the foundation for a body of nursing research and empirical tools that directly link the characteristics of nurses' practice environment to nursing, patient, and system outcomes (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Aiken & Patrician, 2000; Kramer & Schamlenberg, 1988; Lake, 2002; Scott, Sochalski, & Aiken, 1999). In addition, Kanter's theory of structural empowerment (1979, 1993) has been widely studied as a significant contributing factor in establishing a positive work environment for nurses. Several studies have demonstrated the benefits of the presence of structural empowerment in the practice setting. These benefits include enhanced perceptions of control over nursing practice, job satisfaction, decreased job tension, and decreased job strain (Laschinger, Finegan, Shamian, & Almost, 2001; Laschinger, Finegan, Shamian, & Wilk, 2001; Laschinger & Havens, 1996; Laschinger, Wong, McMahon & Kaufmann, 1999; Upenieks, 2002). Other research has directly linked structural empowerment to magnet hospital characteristics in nursing work settings (Laschinger, Almost, & Tuer-Hodes, 2003). These findings are consistent with magnet hospital research and provide support for the presence of professional practice structures that enable increased autonomy of practice and input into decision-making.

To demonstrate the applicability of Kanter's theory to professional nursing practice, a content analysis of PPL role descriptions provided by nurse leaders from over 20 institutions across Ontario was conducted. The analysis explored the linkage between the various PPL functions and the elements of Kanter's theory of structural empowerment. In addition to the content analysis of the PPL role descriptions, an

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integrative review of the existing literature describing professional practice leadership roles was also conducted to identify any characteristics or attributes used to described the role.

Kanter's Theory of Organizational Power (Structural Empowerment)

The importance of building from a theoretical foundation cannot be underestimated, as it is this foundation that acts as a guide for determining the purpose, intent, outcomes and degree of success of the intended structure, role or process (Walker & Avant, 2005). Kanter's (1993) theory of organizational power can provide a strong theoretical framework to describe and support the PPL role. Kanter (1993) describes power as the ability to mobilize resources to get things done. Power is achieved through formal and informal sources. Formal power results from job role and functions which are considered extraordinary (i.e. not routine or those that do not require creativity), have a high degree of visibility, are relevant to key organizational processes and goals and are identified with the solutions to organizational problems (Kanter, 1993). Informal power is achieved through peer alliances and the ability to connect with other parts of the system (Kanter, 1979). Kanter describes sponsorship as another source of power. Sponsors can provide a key alliance as they can provide support for the role in key forums and can enable access to information not otherwise available. Sponsors also provide a form of power to others merely through the relationship between the sponsor and role being sponsored. Sponsorship indicates to others inside and outside of the organization, that the role has the backing of someone with power (Kanter, 1993). Individuals with both formal and informal power are viewed as having greater access to opportunities, information, support and resources (Laschinger, 1996). Opportunity refers to conditions that enable advancement and professional development. Information

includes the knowledge (both formal and informal) required to do the work required, whereas support refers to the degree of discretion or exercising of judgment along with feedback. Finally, access to resources (or supplies) means having influence over the environment, such as access to the materials needed to accomplish desired goals. These materials may include time, money and prestige (Kanter, 1979; Laschinger, 1996).

Importance of Empowerment to Professional Practice Environments

The context of professional practice was brought to the forefront in the 1990's, as many hospitals restructured in response to external forces such as changing patient population needs and fiscal restraints. As the largest group of health care providers in any organization, nurses experienced the greatest impact of this restructuring (Blythe, Baumann, & Giovannetti, 2001). Research regarding the impacts of restructuring on nurses revealed feelings of being disempowered, dissatisfied with the degree of input into changes and concerns regarding the ability to provide optimal levels of patient care (Blythe, Baumann, & Giovannetti, 2001; Laschinger, Sabiston, Finegan, & Shamian, 2001).

One example of restructuring was the implementation of program management and the elimination of profession specific departments (i.e. Nursing, Social Work, and Physiotherapy). Health care professionals within program management structures expressed feelings of being disempowered and disenfranchised from their profession (Globerman, White, Mullings, & Davies, 2003). Although implemented widely for more than ten years, there are few empirical studies regarding the impact or benefits of this organizational structure (Byrne, Charns, Parker, Meterko, & Wray, 2004; Young, Charns, & Heeren, 2004). A study conducted by Young, Charns, and Heeren (2004) in 11 hospitals representing 5 states, revealed a negative impact on professionals' job

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satisfaction and professional development as a result of the implementation of program management. The survey population for this study included 1171 employees representing nurses, social workers, and pharmacists, physical, occupational and respiratory therapists, with nurses representing 90% of the population. The study revealed that the program management structure was significantly and negatively associated with both job satisfaction and professional development. Young et al.'s study was the first to provide some empirical evidence regarding the impact of program management on health care professionals. These findings are consistent with the literature describing the experiences of professionals within restructured health care environments, specifically feelings of disempowerment (Blythe, Baumann, & Giovannetti, 2001; Globerman, White, Mullings, & Davies, 2003; Laschinger, Sabiston, Finegan & Shamian, 2001).

To address the concerns of professionals regarding their distinct professional development needs, many health care organizations implemented professional practice structures. Matthews and Lankshear (2003) described the essential elements of a professional practice structure that included access to information, support, resources, and profile for the profession in the organization, and roles to allow for input into decision making. These are similar to the components of structural empowerment as originally described by Kanter (1979). Individuals in roles that have greater access to power structures have a greater ability to achieve organizational goals and empower those around them (Laschinger, 1996). The PPL role is one element of a professional practice structure that can also contribute to maintaining and enhancing the professional practice environment.

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The Professional Practice Leader Role in Ontario

The PPL role has been a part of the healthcare system for the past several years, with literature describing the implementation of the role beginning in the mid 1990's (Adamson, Shackleton, Wong, Prendergast, & Payne, 1999; Bournes & DasGupta, 1997; Comack, Brady, Porter-O'Grady, 1997; Miller, Worth, Barton, & Tonkin, 1999; Ross, MacDonald, McDermott, & Veldhorst, 1996). In most situations, the PPL role was introduced as a result of the implementation of program management (and the elimination of profession-specific departments) and to address concerns from professionals regarding lack of professional identify and development and input into organizational decision making that could impact practice (i.e. professional voice). A significant indicator of the wide spread implementation of this role, is the emergence of the Professional Practice Network of Ontario (PPNO). The PPNO was established in 1999 as a result of an informal conversation between two nursing professional practice leaders who had a desire to connect with colleagues in similar roles. From this modest beginning, the PPNO has grown to include membership of over 60 organizations across Ontario, all of which have some variation of a PPL role in place (PPNO, 2006). The PPNO now provides an interprofessional forum for communication and collaboration among leaders in professional practice. (See www.ppno.ca for more information regarding the Professional Practice Network of Ontario).

Common frustrations expressed by PPNO members are the lack of clarity regarding the role (even as defined among PPLs), the challenges in demonstrating outcomes associated with the role and the varying degree of organizational support provided (i.e. lack of formal authority and time allocation for the role). Although it is recognized that the unique needs and culture of individual organizations will determine

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how any role is operationalized, the significant variation in how the PPL role has been implemented is perhaps a reflection of the lack of a theoretical framework as a guide to implement these existing roles. Some examples of the significant variations that add to this confusion are the placement of the role in the organization (i.e. senior or staff level position), degree of formal authority (i.e. presence or absence of line authority), time allocation for the role and associated functions (i.e. dedicated FTE allocation or "added on" to existing role expectations) and the ascribed functions of the role (i.e. clearly defined role description and outcomes or general statements with no clearly defined expectations or outcomes). With this degree of variability in the operationalization of the role, it is no wonder that such ambiguity and confusion exists regarding the value added contributions of the role – a potentially dangerous position for any role in times of fiscal constraint and outcome focus.

A review of the literature describing the implementation of the PPL role revealed only one article which made specific reference to a theoretical framework as a guide for the role, that being Kanter's theory of structural empowerment. (Ross, MacDonald, McDermott, K., & Veldhorst, 1996). The application of a strong theoretical framework, such as structural empowerment can provide much needed evidence, consistency, and direction and can aid organizational understanding of how best to operationalize the PPL role and determine impacts.

Organizational Power as a Theoretical Foundation for the PPL Role

Despite the variation in how the role is operationalized, if the intent of the PPL role is to promote and maintain the professional standards of their distinct profession and that the definition of power, as described by Kanter (1979) is the ability to get things done in a meaningful way, then the components of structural empowerment provide a

strong theoretical foundation for the PPL role. As the internal representative (and perhaps advocate) for the profession, the PPL role would require a certain degree of formal and informal power in order to adequately provide leadership for their profession. The direct reporting relationship of the PPL can either intentionally (or unintentionally) send a message regarding the importance of the role and associated initiatives. For example, PPLs who report directly to the Chief Nursing Officer (a member of the senior leadership team) are more likely to experience a higher degree of formal and informal power, than PPLs who report to a unit manager (Kanter,1993). Through sponsorship at the senior level, the PPL would most likely have greater access to key information and decision makers within the organization than if sponsorship was at a different level in the organization. The reporting relationship or placement of the PPL role within the overall organizational structure would have an impact on the degree of horizontal and vertical mobility of the PPL role within the organization, hence impacting the ability to develop key alliances both internally and externally. In addition, the responsibilities that are common to PPL roles (i.e. providing consultation regarding professional standards, promoting evidence based practice, promotion of professional development opportunities) would require varying degrees of access to opportunities, information, support and resources in order to facilitate the ongoing maintenance of professional standards and professional development needs of the profession(s) they provide leadership to. The degree to which the PPL role has access to information, resources, support would impact their ability to develop, implement and support professional practice initiatives aimed at enhancing the practice environment.

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Applying Theory to Practice: A Review of PPL Role Descriptions

To determine the application Kanter's theory to the PPL role, a review of PPL role descriptions was conducted. The role descriptions were provided voluntarily by PPNO members in response to a request sent to the entire membership via the PPNO listserv. As a result of the request, 20 organizations responded representing 33% of the PPNO membership. All role descriptions provided were from acute care facilities, with the exception of one role description from a rehabilitation and complex continuing care facility. Template analysis (Loiselle & Profetto-McGrath, 2007) using the components of structural empowerment (i.e. formal and informal power, access to opportunities, information, resources and support) were used to review the role descriptions. Despite the variation in content, the themes present in the role descriptions are consistent with the components of structural empowerment. The degree of formal power is reflected by the titles attached to these roles (i.e. VP, Professional Practice, Professional Practice Coordinator, and Chief of Nursing Practice), the direct reporting relationships, or degree of line authority associated with the role. The degree of formal power could also be inferred from the placement (hence visibility) of the PPL role within the overall organizational structure and the responsibilities associated with the role as they relate to organizational goals and objectives. Informal power was inferred through the identified PPL role functions or responsibilities (i.e. consultation regarding impact of corporate initiatives on profession, establishing and maintaining internal and external relationships, acting as the representative for the profession as required.) requiring the development of key relationships and accessing networks.

Despite the variation in the role descriptions regarding the degree of formal or informal power, each of the reviewed role descriptions contained functions or role

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expectations that logically fall within the areas of access to opportunities, information, resources and support as described by Kanter. The majority of the PPL functions or responsibilities fell within the areas of providing access to information and opportunities for learning and growth. Examples of PPL functions relating to access of information include: acts as a communication link between senior leadership and professional staff regarding professional practice issues, provides internal expertise regarding scope of practice and regulatory requirements and provides consultation regarding professional credentialing and professional competencies. The most significant area of PPL responsibilities identified in the role description related to providing opportunities for professional development, which reflects Kanter's opportunity empowerment structure. Specific examples of this area include: determines profession-specific and interprofessional development needs, provides opportunities for student placements, provides mentorship opportunities, acts as a resource to staff and assists in problem solving regarding professional practice issues. The significance of this area in PPL role descriptions is consistent with the intent of the PPL role as being responsible for the promotion and maintenance of the standards of practice for a distinct profession. As previously noted, these areas were also the areas of greatest concern for professionals within a program management environment – the ability to maintain professional standards and professional development opportunities (Baker, 1993).

Based on our findings from the review of existing PPL roles in Ontario, the use of Kanter's theory can also act as a decision support framework for operationalizing the PPL role, when designing new PPL roles or reviewing existing ones. The components of structural empowerment can assist in determining the scope of the PPL role (i.e. formal and informal power) and the responsibilities and outcomes (access to information,

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resources, support and opportunities for growth). Depending on the desired outcomes of the role (as determined by either the professionals and/or the organization), this may indicate the degree of formal and informal power that will be required for success. For example, how "visible" will the PPL role be in the organization, are the PPL functions clearly linked to the organizational mission and strategic directions, what are the key alliances (internally and externally) that need to be developed, and, what is the information, resources and support that will be necessary in order to achieve the desired outcomes? This same process can be used when reviewing existing PPL roles. The components of structural empowerment can be used to guide a dialogue regarding the barriers or enablers to successfully fulfilling the existing PPL role description. For example, is there a sufficient match between the expectations ascribed to the role and the degree of formal and informal power? Does the current way in which the PPL role is operationalized enable sufficient access to the information, support, opportunities and resources necessary? Application of Kanter's theory of structural empowerment to the PPL role can also provide a foundation for future research regarding the PPL role and the impact the role has on the professional practice environment (i.e. does the presence of the PPL role make a difference and if so, in what way?).

Conclusion

This content analysis of existing PPL role descriptions in Ontario supports the use of Kanter's theory of structural empowerment as an appropriate theoretical foundation for the PPL role. This theory supports the notion that that individuals who have greater access to power structures have a greater ability to achieve organizational goals and empower those around them (Laschinger, 1996), which is reflective of the original intent of the PPL role. The components of structural empowerment can be used by

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organizations and PPLs as a framework to guide the design, implementation, review and evaluation of the PPL role and provide the beginnings for a common language regarding this very diverse and ever evolving role. Management practices, such as the implementation of structures and roles, without a theoretical or evidence-based foundation fails to build on existing nursing administrative science or to create opportunities for the generation of new knowledge. The application of Kanter's theory of structural empowerment provides an opportunity for dialogue within organizations, between professional practice leaders regarding how best to operationalize the role for optimal effectives.

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PAPER THREE

THE PROFESSIONAL PRACTICE LEADER QUESTIONNAIRE: DEVELOPMENT AND PSYCHOMETRIC TESTING

Introduction and Background

For health care facilities, the 1990's were characterized by significant organizational restructuring including widespread implementation of the program management structure This massive change process experienced by hospitals was often accompanied by the elimination of profession specific departments, which prompted many health care organizations across Canada to implement professional practice structures. These structures were introduced to address concerns regarding loss of professional identity and undermining of professional standards (Baker, 1993). A professional practice environment can be described as the system that supports nurses' control over the delivery of nursing care and the environment in which care is delivered and the characteristics of an organization that facilitate or constrain professional nursing practice (Aiken & Patrician 2000; Lake, 2002). When describing the key elements of a professional practice structure, Matthews and Lankshear (2003) noted that the *professional practice leader* (PPL) role was identified as a key element. The PPL is described as being responsible for establishing the systems and processes for supporting the promotion and maintenance of the standards of practice for their distinct profession and/or a variety of health professions (Lankshear, Laschinger, & Kerr, 2006; Miller, Worth, Barton, & Tomkin, 2001). Despite the extensive implementation of this role (e.g. over 60 organizations in Ontario have some variation of a PPL role in place), a scan of the health care literature reveals very few publications focusing on the role (Adamson, Shackleton, Wong, Prendergast, & Payne, 1999; Chan & Heck, 2003; Comack, Brady, &

Porter-O'Grady 1997; Lankshear et al., 2006; Matthews & Lankshear, 2003; Miller et al., 2001), no empirical studies examining the impact or effectiveness of the PPL role and no existing instrument to measure or describe perceptions of PPL role functions.

Professional Practice Leader (PPL)

The PPL role has been a part of the healthcare system for the past two decades, with literature describing the implementation of the role beginning to appear in the mid 90's (Adamson et al., 1999; Bournes & DasGupta, 1997; Comack et al., 1997; Miller et al., 2001; Ross, MacDonald, McDermott, & Veldorst, 1996). The PPL role was introduced primarily as a result of the implementation of program management and the elimination of profession-specific departments that occurred with that change process. It was introduced as a way to address concerns from professionals regarding a perceived loss of professional identify and the lack of development or input into organizational decision making that could impact practice (i.e. professional voice). The PPL is described as being responsible for establishing the systems and processes for supporting the promotion and maintenance of the standards of practice for their distinct profession and/or a variety of health professions (Lankshear et al., 2006; Miller et al., 2001).

Although the literature contains citations which describe professional leader roles (Adamson et al., 1999; Chan & Heck, 2003; Comack et al., 1997; Lankshear et al., 2006; Matthews & Lankshear, 2002; Ross et al., 1996), few empirical studies regarding have examined this role. McCormack and Garbett (2003) employed a concept development approach to determining the characteristics of practice developer roles (PDLs). Practice developers are described as professionals who have formal responsibility for developing practice in their organizations through the following functions: promoting and facilitating change, knowledge translation and, communication, responding to external influences,

education, research into practice and quality. The Nurse Consultant (NC) role implemented in the United Kingdom provides an additional source of information regarding the domains associated with these professional practice roles. First introduced in 1999, the intent of the NC role was to advance practice, research, leadership and education in nursing (Alderman & Lipley, 2001; Higgins, 2003; Woodward, Webb, & Prowse, 2005). The domains of the NC role include: expert practice, professional leadership and competency, education, and practice and service development (Graham & Wallace, 2005; Ryan 2006; Woodward et al., 2005). Common frustrations expressed by current PPLs about their varied roles include the lack of clarity regarding the PPL role (even as defined among members of the Professional Practice Network of Ontario), the challenges in demonstrating outcomes associated with the role and the varying degrees of organizational support provided to PPLs such as lack of formal authority and time allocation for the role (Matthews & Lankshear, 2002). Although it is recognized that the unique needs and culture of individual organizations will determine how any role is operationalized, the significant variation in how the PPL role has been implemented creates challenges when trying to develop a clear definition of the construct which can then be used as the foundation of the creation of a method to measure the construct or phenomenon of interest (Chinn & Kramer, 2004).

Aim

The aim of this study was to develop and test an instrument to measure PPLs' perceptions of role achievement. The aim of the instrument is not to measure individual PPL "productivity", but to enable dialogue regarding the scope of the PPL role and ability to achieve role functions – thus contributing to organizational outcomes. To determine relevant items for inclusion in the questionnaire, the construct of PPL role

functions will be defined as *the formal and informal responsibilities, duties and functions specifically related to addressing issues related to professional standards, education, research and professional development needs of individual and/or multiple professions.*

Methodology

The PPLQ was developed and tested in three distinct phases: item generation, pilot testing and additional psychometric testing. A convenience sample of PPLs with membership in the Professional Practice Network of Ontario (PPNO) was used for each of the three phases. A modified tailored design method (Dillman, 2007) was used for the design and distribution of the materials to the study participants. A paper process was used for Phase 1 (e.g. content validity testing) and a secure, web based electronic survey process was used for Phase 2 (pilot testing) and Phase 3 (additional psychometric testing). As PPLs are known to be high users of electronic communication, it was deemed the most appropriate and user-friendly option for distribution and completion of the questionnaire. Ethics approval was obtained by from the University of Western Ontario Research Ethics Board in February, 2007. All participants were informed of the purpose of the study, the voluntary nature of participation, their ability to withdraw at any time and that confidentiality of responses would be maintained. Participation in the content validity testing and/or pilot testing of the questionnaire was viewed as participate consent to participate in the study. Data analysis for each phase was conducted using SPSS Version16.0.

Phase 1: Item Generation

As the initial step in the process of generating items for inclusion in the PPLQ, the relevant literature was reviewed for descriptions of role functions. The presence of some common themes in the description of the areas of foci or domains of these roles provided

a starting point for item generation (e.g. education, research, professional standards, consultation, and leadership). To ensure that the role functions were consistent with the PPL roles in Ontario, PPNO members were requested to provide a copy of the current PPL role description from all health disciplines. A total of 33 different roles descriptions were provided inclusive of various professions and organizations (e.g. hospitals, community, public health agencies). Content analysis was conducted to determine the most common role functions and areas of accountability described in the various role descriptions provided. The published descriptions of the PPL, PDL, and NC roles described earlier were also used in the initial template for reviewing the content with additional categories added as deemed appropriate (Loiselle & Profetto-McGrath, 2007). This resulted in the identification of five constructs that are deemed to accurately describe the PPL role: consultation, professional development & education, leadership, research and practice. *Consultation* refers to acting in the capacity of the internal expert regarding professional standards and scope of practice issues. *Professional development* and education includes the promotion of ongoing learning opportunities and the development of partnerships with academic programs. *Leadership* involves the active participation in organization-wide committees to represent the perspective of health care professionals as well as providing leadership to profession-specific committees (i.e. Professional Advisory Councils). *Research* involves the active participation in research projects as well as the promotion of staff participation in research. *Practice involves* the development of processes to maximize patient safety and assisting with problem solving regarding professional practice and care delivery issues. The five constructs were represented by a total of 32 items, with the number of items per construct ranging from 11 (Consultation) to three (Research).

To determine the relevance of the items, a content validity exercise was conducted with a convenience sample of 45 PPLs, representing a variety of professions, during a quarterly PPNO meeting. This number of content experts exceeds the recommended number suggested in the literature (Grant & Davis, 1997; Lynn, 1986). Participants were asked to rate the relevancy of the items using a four point Likert scale (e.g. 1 = Not at all relevant to 4 = Very relevant), and to provide written feedback regarding the clarity of the individual items and the comprehensiveness of the items (e.g. where any additional items to be added).

Phase 1: Results

A total of 43 completed surveys were returned. A content validity index (CVI) for the Professional Practice Leader Questionnaire (PPLQ) was determined by calculating the proportion of responses where the rating for the item was scored as either quite relevant or very relevant (e.g. scores 3 or 4 on a 5-point Likert scale), with a resulting CVI of 0.88, higher than the minimum CVI of .080 described in the literature (Davis, 1992; Polit & Beck, 2006). The questionnaire format and item wording were revised based on the feedback provided (i.e. items reflect one idea, wording changes to increase clarity) resulting in 32 items that were deemed to be relevant to and reflective of the PPL role. As the intent of the PPLQ is to obtain information regarding PPLs' perceptions of their ability to achieve role functions, a 5-point Likert scale was applied with response options ranging from Never (1) to Always (5) with higher scores indicating greater frequency of role achievement. The questionnaire instructions directed the PPLs to review each of the items "with your current PPL role in mind, and indicate the degree to which you are able to achieve the role functions listed." See Appendix D: PPLQ 32 items, for examples of items within each construct.

Phase 2: Pilot Testing

Pilot testing of the PPLQ was conducted with members of the PPNO with the invitation to participate in the pilot testing was open to all PPLs within PPNO including Nursing PPLs from Nova Scotia and Newfoundland & Labrador, and PPLs from the various Health Disciplines. Due to the diverse nature of the PPL role, there is no way to determine the exact number of PPLs that are available for inclusion in the study. Based on the assumption of 1 PPL / PPNO member organization, the minimum number of PPLs would be 82. The Ontario-based Nursing PPLs were excluded from pilot testing as they were the target population for a future research study, and would be completing the PPLQ at that time. A modified tailored design method (Dillman, 2007) was used for the design and electronic distribution of the invitation to participate, information materials, link to the questionnaire and reminder notices to the study participants. As an incentive, respondents were offered the opportunity to obtain a certificate of appreciation for participating in the research study. In order to receive the certificate, participants were required to provide their name and email address.

Phase 2: Results

Pilot testing resulted in the return of 121 questionnaires and an item to response ratio of 4:1 which is below the recommended range of 5 – 10 responses per item for conducting factor analysis (Lackey, & Sullivan, 2003; Munro, 2005; Pett, Tabachink, & Fidell, 2001). The pilot test respondents included PPLs from twelve professional designations with various levels of educational preparation, years of experience in the role and time allocation specific to PPL role functions. The distribution of the various professions represented in the survey responses is similar to a "typical" interprofessional

team within a hospital setting, thus strengthening the interprofessional nature of the questionnaire (Table 1).

Table 1

Pilot Study Participants (N = 121)

Professional Designation	Professional experience	Educational background	Time allocated to the Role
Nursing (21%) Occupational therapy (10%) Physiotherapy (9%), Pharmacy (9%) Speech lang. pathology (6%) Dietitian (6%) Social Work (6%) Respiratory therapist (6%) Psychologist (5%) Medical Radiation (4%) Recreation therapy (3%) Medical Lab (2.5%)	5 years/less experience in current PPL role = 78% 5 years or less total experience in PPL roles = 66%	Diploma (14%), Baccalaureate degree (40%) Master degree (40%) Doctoral preparation (5%).	≤ 0.5 Full time equivalent (FTE) allocated to their PPL role = 65%

As the overall incidence of missing data was extremely small (i.e. response rate for survey items ranged from 97% to 100%) and random in nature, mean scores were imputed for missing data in order to retain all available responses (McKnight, McKnight, Sidani, & Figueredo, 2007).

Exploratory factor analysis of the 32 items was conducted using principal component extraction and varimax rotation resulting in five factors generated with an eigenvalue value greater than 1.0 accounting for 54.24% of the variance and a Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy of .849, which is considered by Kaiser as being meritorious or commmendable (as cited in Pett et al., 2003). The five factor solution was also analyzed using principal axis extraction and direct oblimin rotation with similar factor loadings, demonstrating stability of the five factor solution.

After a review of the items the factors were described as: Consultation, Practice and Care Delivery, Professional Development, Leadership and Research. These areas are consistent with the domains described for various roles discussed previously. For items with strong loadings on multiple factors, the item was reviewed and placed within the factor that was conceptually the most appropriate fit. Whereas, items with ambiguous loadings (i.e. low loadings across multiple factors) or loadings less than .40 were deleted from the scale (Pett et al., 2003). This resulted in nine items being deleted from the scale. See Table 2: Factor loadings for exploratory factor analysis of the 32 item PPLQ.

Table 2

Factor Loadings for Exploratory Factor Analysis of the 32 Item PPLQ (Principal Axis Extraction and Direct Oblimin Rotation) N= 121; Scale Reliability = .905

Item #	Item	1	2	3	4	5
Factor # 1: Practice and Care Delivery: 29.72% variance; Cronbach's alpha = .812						
7	Collaborates with key stakeholders regarding care delivery models to enhance client outcomes.	.442				
29	Provides input into the development of service delivery models ensuring they are reflective of professional standards and regulatory requirements (i.e. skill mix and scope of practice)	.691				
30	Acts as a resource regarding the provision of ethical client care	.609				
31	Develops processes for addressing practice issues	.708				
32	Provides consultation regarding maximizing client safety	.692				
Factor # 2: Leadership: 8.0% of variance; Cronbach's alpha = .847						
3	Provides consultation on corporate initiatives, structures and processes that may impact the		.453			

Item #	Item	1	2	3	4	5
	profession					
4	Provides consultation to program/department leadership regarding professional credentialing, and professional competencies		.408			
6	Develops and maintains partnerships with regulatory Colleges, professional associations and other relevant external networks		.578			
11	Provides internal consultation regarding external legislative or regulatory changes (e.g. their impact on the profession within the context of the organization)		.530			
17	Provides leadership to the profession specific committee (e.g. Nursing Council, Nursing Professional Advisory Committee)		.847			
18	Facilitates broad communication within the profession throughout the organization		.452			
20	Participates on organization-wide committees, as content expert regarding professional practice perspectives		.448			
21	Provides leadership in the development of strategic direction for the profession, in alignment with organizational directives.		.477			
Factor # 3: Research : 6.19% of variance; Cronbach's alpha = .739						
23	Provides leadership toward the application of evidence based practices			.464		
24	Actively participates in research projects			.743		
25	Encourages and supports staff participation in research projects			.703		
Factor # 4: Professional Development: 5.41% of variance; Cronbach's alpha = .745						
12	Facilitates professional development and ongoing learning opportunities				.741	
13	Facilitates inter and/or intraprofessional mentorship opportunities for clinical staff				.482	
14	Advocates for resources to support staff participation in educational events (e.g. external conferences and workshops)				.434	
15	Liaises with academic partners to facilitate				.402	

Item #	Item	1	2	3	4	5
	student placements and preceptorships					
16	Provides input into the professional development / learning needs for professionals				.666	
Factor # 5: Consultation: 4.90% of variance; Cronbach's alpha = .805						
1	Provides internal expertise on scope of practice and professional standards.					.807
2	Provides direction on issues relevant to client care and professional practice					.739
Deleted items due to factor loadings < 0.40 or ambiguous loadings across multiple factors						
5	Acts as a communication link between senior leadership and nursing staff regarding professional practice related issue.					
8	Provides consultation into the development of practice support documents (e.g. policy, procedures, directives) that may impact professional practice					
9	Provides opportunities for intra and inter-professional collaboration					
10	Promotes self-regulation of the profession by identifying polices and practice that hinder scope of practice					
19	Enhances the profile of the profession within the organization					
22	Promotes leadership within the profession					
26	Collaborates with relevant program /department leadership regarding professional practice initiatives					
27	Fosters an environment that enables staff input into practice and client care decisions					
28	Acts as a resource to staff and assists in problem solving regarding professional practice situations or conflicts					

Reliability testing

Reliability analysis was conducted for the 23 item scale as well as for each of the five subscales. Inter-item correlations ranged from .056 – .673, subscale correlations ranging from .739 (Research) - .847 (Leadership) and the overall scale reliability was .914. As the desired range of inter-item correlation is between 0.30 – 0.70 (Clark & Watson, 1995; Munro, 2005), the wide range of inter-item correlations presented here verified the opportunity for item deletion.

Although the item to response ratio from the pilot testing sample was low, initial psychometric testing combined with a review of the revised 23 item PPLQ provided initial indication of validity and reliability, as the factors generated by the exploratory factor analysis are consistent with the available literature describing professional practice roles and are consistent with the author's experience with various professional practice structures in Ontario. (See Appendix E: PPLQ 23 item).

Phase 3: Additional Psychometric Testing

To better establish the psychometrics properties of the 23 item questionnaire, further testing was conducted by combining data from the completed PPLQ surveys obtained through a separate research study using the PPLQ (N= 74), and responses from the pilot testing phase (N= 121) resulting in a total of 195 completed questionnaires and therefore increasing the item to response ratio to 8.5, which is within the acceptable range for conducting factor analysis (Munro, 2005; Pett et al., 2003; Tabachink & Fidell, 2001). In this phase, both exploratory and confirmatory factor analysis were conducted. Although exploratory factor analysis is considered to be the appropriate method to use in the early stages of scale development, confirmatory factor analysis can also be used when there is a strong theoretical rationale about the factors and the items (variables) associated with each factor (Hurley et al, 1997; Henson & Roberts, 2006). The theoretical foundation here is drawn from the review of the relevant literature describing the Nurse Consultant role and the core attributes of the role, the content analysis of over 30 PPL role descriptions, conversations with PPLs through the Professional Practice Network of Ontario, and the personal experience of the researcher in a variety of PPL role.

Phase 3: Results

Exploratory factor analysis of the 23 items was conducted using principal component extraction and varimax rotation resulting in five factors generated with an eigenvalue value greater than 1.0 accounting for 61% of the variance and a Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy of .885. The five factor solution was also analyzed using principal axis extraction and direct oblimin rotation with similar factor loadings, demonstrating stability of the five factor solution. After a review of the items within each of the factors, the factors remained primarily unchanged from the previous results with the exception of items deleted due to ambiguous loadings or loadings of < 0.40 (Pett et al., 2003). This resulted in 5 additional items being deleted from the scale. (See Appendix F: PPLQ 18 items). Reliability analysis was conducted for the 18 item scale as well as for each of the five subscales. See Table 3: Factor loadings for exploratory factor analysis of the 23 item PPLQ.

Table 3

Factor Loadings for Exploratory Factor Analysis of the 23 Item PPLQ (Principal Axis Extraction and Direct Oblimin Rotation) N= 195; Scale reliability = .881

Item #	Item	1	2	3	4	5
Factor # 1: Practice and Care Delivery:33.78% variance; Cronbach's alpha = .809						
6	Collaborates with key stakeholders regarding care delivery models to enhance client outcomes.	.446				
20	Provides input into the development of service delivery models ensuring they are reflective of professional standards and regulatory requirements (i.e. skill mix and scope of practice)	.740				
21	Acts as a resource regarding the provision of ethical client care	.598				

Item #	Item	1	2	3	4	5
22	Develops processes for addressing practice issues	.548				
23	Provides consultation regarding maximizing client safety	.692				
Factor # 2: Leadership: 8.9% of variance; Cronbach's alpha = .817						
5	Develops and maintains partnerships with regulatory Colleges, professional associations and other relevant external networks		.558			
7	Provides internal consultation regarding external legislative or regulatory changes (e.g. their impact on the profession within the context of the organization)		.447			
13	Provides leadership to the profession specific committee (e.g. Nursing Council, Nursing Professional Advisory Committee)		.826			
14	Facilitates broad communication within the profession throughout the organization		.542			
15	Participates on organization-wide committees, as content expert regarding professional practice perspectives		.448			
16	Provides leadership in the development of strategic direction for the profession, in alignment with organizational directives.		.485			
Factor # 3: Research: 6.8% of variance; Cronbach's alpha = .813						
18	Actively participates in research projects			.842		
19	Encourages and supports staff participation in research projects			.817		
Factor # 4: Professional Development:6.08% of variance; Cronbach's alpha = .740						
8	Facilitates professional development and ongoing learning opportunities				.749	
9	Facilitates mentorship opportunities for clinical staff				.540	
12	Provides input into the professional development / learning needs for professionals				.693	
Factor # 5: Consultation: 5.43% of variance; Cronbach's alpha = .778						
1	Provides internal expertise on scope of practice and professional standards.					.809
2	Provides direction on issues relevant to client care and professional practice					.743
Deleted items due to factor loadings < 0.40 or ambiguous loadings across multiple factors						
3	Provides consultation on corporate initiatives, structures and processes that may impact practice					
4	Provides consultation to the program/department leadership regarding professional credentialing and professional competencies					

Item #	Item	1	2	3	4	5
10	Advocates for resources to support staff participation in educational events (e.g. external workshops and conferences)					
11	Liaises with academic partners to facilitate student placements and preceptorships.					
17	Provides leadership toward the application of evidence based practices.					

Confirmatory factor analysis.

Factor analysis on the newly derived 18 item scale was conducted by specifying the number of factors to be extracted. The confirmatory factor analysis of the 18 items was conducted using principal component extraction, varimax rotation, resulting in a five factor solution accounting for 66.2% of the total variance and a Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy of .856. The five factor solution was also analyzed using principal axis extraction and direct oblimin rotation with similar factor loadings, demonstrating stability of the five factor solution. After a review of the items within each of the factors, the factors and respective items remained primarily unchanged from the previous results, with all items retained and slight increases in the loadings for each of the items. See Table 4: Factor loadings for exploratory factor analysis of the 18 item PPLQ.

The only noteworthy difference was in the order of the total variance explained for the factors, with Leadership accounting for the majority of total variance (34%), followed by Practice (10.5%), Professional Development (8.1%), Consultation (6.7%) and Research (6.6%). Results from previous exploratory factor analyses indicated Practice as the factor accounting for the majority of variance explained. This increase in

the degree to which Leadership accounts for total variance explained, may be associated with to the deletion of four items from the Leadership factor that occurred as an outcome of the exploratory factor analysis described above.

Table 4

Factor Loadings for Confirmatory Factor Analysis of the 18 Item PPLQ (Principal Axis Extraction and Direct Oblimin Rotation) N= 195; Scale reliability = .881

Item #	Item	1	2	3	4	5
Factor # 1: Leadership: 34.2% of variance; Cronbach's alpha = .817						
5	Develops and maintains partnerships with regulatory Colleges, professional associations and other relevant external networks	.662				
7	Provides internal consultation regarding external legislative or regulatory changes (e.g. their impact on the profession within the context of the organization)	.581				
13	Provides leadership to the profession specific committee (e.g. Nursing Council, Nursing Professional Advisory Committee)	.857				
14	Facilitates broad communication within the profession throughout the organization	.710				
15	Participates on organization-wide committees, as content expert regarding professional practice perspectives	.608				
16	Provides leadership in the development of strategic direction for the profession, in alignment with organizational directives.	.614				
Factor # 2: Practice and Care Delivery: 10.5% variance; Cronbach's alpha = .809						
6	Collaborates with key stakeholders regarding care delivery models to enhance client outcomes.		.529			
20	Provides input into the development of service delivery models ensuring they are reflective of professional standards and regulatory requirements (i.e. skill mix and scope of practice)		.735			
21	Acts as a resource regarding the provision of ethical client care		.718			
22	Develops processes for addressing practice		.672			

Item #	Item	1	2	3	4	5
	issues					
23	Provides consultation regarding maximizing client safety		.773			
Factor # 3: Professional Development: 8.1% of variance; Cronbach's alpha = .740						
8	Facilitates professional development and ongoing learning opportunities				.860	
9	Facilitates mentorship opportunities for clinical staff				.657	
12	Provides input into the professional development / learning needs for professionals				.741	
Factor # 4: Consultation: 6.7% of variance; Cronbach's alpha = .778						
1	Provides internal expertise on scope of practice and professional standards.					.809
2	Provides direction on issues relevant to client care and professional practice					.743
Factor # 5: Research: 6.6% of variance; Cronbach's alpha = .813						
18	Actively participates in research projects			.876		
19	Encourages and supports staff participation in research projects			.882		
Deleted items due to factor loadings < 0.40 or ambiguous loadings across multiple factors						
3	Provides consultation on corporate initiatives, structures and processes that may impact the profession					
4	Provides consultation to program/department leadership regarding professional credentialing, and professional competencies					
10	Advocates for resources to support staff participation in educational events (e.g. external conferences and workshops)					
11	Liaises with academic partners to facilitate student placements and preceptorships					
17	Provides leadership toward the application of evidence based practices					

As a final content validity check, the 18 item PPLQ was again presented to PPLs during the December 2009 meeting of the Professional Practice Network of Ontario where over 30 PPLs reviewed the items and provided verbal feedback that the 18 item PPLQ was reflective of the PPL role and the PPLQ provided a common language and foundation for describing the PPL role. While the factor validity results obtained might provide only moderate support for a claim of adequate psychometric testing results, the overall development and testing of the tool, together with this final endorsement by

content experts who are the ultimate end users of the PPLQ provides evidence that the PPLQ could be as a valid and reliable method for operationally defining PPL role functions.

Conclusions

The preliminary results of psychometric testing of the PPLQ provide initial support for the content validity and internal reliability of the questionnaire. Exploratory and confirmatory factor analysis of the PPLQ resulted in a 5 factor / 18 item questionnaire which provides a parsimonious and relevant description of the roles and accountabilities commonly associated with professional practice leadership roles. See Table 5 for Summary of design and testing phases.

Table 5

Summary of design and testing phases

Phase 1	Phase 2	Phase 3
Item generation • Item generation from literature review and content analysis of PPL role descriptions. • Content expert review using PPNO members • Content validity index = 0.88 • 32 items	Field testing (N=121) • Interprofessional respondents • Exploratory factor analysis • Five factors / 23 items Subscale factor loadings Leadership .447 - .826 Consultation .743 - .809 Practice .446 - .740 Research .817 - .842 Professional Development .540 - .749 Subscale reliability = .739 - .847 Scale reliability = .905	Additional testing (N=195) • Exploratory and Confirmatory factor analysis • Five factors / 18 items Subscale factor loadings Leadership .581 - .857 Consultation .743 - .809 Practice .529 - .773 Research .876 - .882 Professional Development .657 - .860 Subscale reliability = .740 - .817 Scale reliability = .881

Although content validity of the PPLQ has been established, further testing of the PPLQ with more varied sample sizes and settings, as well as in conjunction with other discriminate items (e.g. those that would not be associated with PPL role functions) is required to provide further evidence of criterion validity of the PPLQ and internal reliability of the items and subscales. By further establishing the criterion validity of the PPLQ, construct validity can then be established, thus expanding the use of the PPLQ from being an instrument used to describe a phenomenon, to one that can be used to predict the theoretical relationship between PPL role functions and other variables of interest (DeVellis, 2006).

Implications for Practice

The PPLQ was designed to address a gap in available empirical instruments for obtaining information regarding the ability of professional practice leaders to achieve their role functions. As these roles are implemented in order to address professional practice related issues at the organizational level, it is imperative to be able to understand the degree to which individuals in these roles are able to achieve the desired outcomes. This can be a useful tool for organizations as they strive toward creating and sustaining healthy work environments for all health professions. In addition to being able to empirically measure role functions, the development of the PPLQ subscales provides a common language that can be used to describe the overall foci of the role and key areas of accountability. Based on further discussions with the members of the Professional Practice Network of Ontario, this is viewed as being a key factor in the ability of individual PPLs, and therefore the collective, to clearly and consistently articulate the purpose of the role – regardless of the variation in how the role is operationalized in each organization. Suggested use for the PPLQ have included: as a template for development

and/or review of PPL roles and accountabilities, for identification of core competencies for those in PPL roles, and as a guide for ongoing professional development specific to the needs of this unique and diverse role.

The development and psychometric testing of the PPLQ has generated great dialogue and interest within the PPNO community. Pett et al. (2003) state that for a good instrument to survive, it needs to meet two conditions: it must be operationally well defined and it must be significant in terms of its usefulness to the health care environment. The limited number of PPLs available for inclusion in the sample (e.g. for most organizations there is only one PPL in place for Nursing and perhaps one PPL for other Health Disciplines), provides additional challenges in the design and psychometric testing of new questionnaires specific to this role. Although still in early stages of use, the PPLQ is demonstrating the ability to meet the conditions of validity and usefulness.

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PAPER FOUR

THE PROFESSIONAL PRACTICE LEADER: THE ROLE OF ORGANIZATIONAL POWER AND PERSONAL INFLUENCE IN CREATING A PROFESSIONAL PRACTICE ENVIRONMENT FOR NURSES

Background and Significance

The significant organizational restructuring evident in health care systems in the 1990's was often accompanied by the implementation of program management structures. Program management (also known as service line or product line management) is defined in health care as an administrative system to coordinate and control the work of those who are providing the services, that is structured around specific patient populations or clinical services provided by the organization (Bowers, 1990). A common outcome of the introduction of a program management structure has been the elimination of profession specific departments (e.g. Department of Nursing) and profession specific roles (e.g. Vice-President; Director of Nursing).

Clifford's (1998) investigation of the impact of hospital restructuring on nursing leadership revealed that the absence of a specific nursing department within the organization resulted in a concern over the lack of a central place for addressing client care issues and standards, and the loss of the communication and coordination role that the nursing "department" provided to the rest of the organization. Concerns regarding the loss of professional identity and loss of autonomy were identified in various studies as being key areas of concern for nurses in program management environments (Blythe, Baumann, & Giovannetti, 2001; Lankshear, 1996; Sharp, 2007; Young, Charns & Heeren, 2004).

In relation to perceptions of professional autonomy, the presence of a program management structure was significantly and negatively associated with both job satisfaction and professional development (Young, Charns, & Heeren, 2004). In contrast to these results, a national study of nursing leadership structures in Canada, revealed that senior nurse leaders and middle managers, within a program management environment reported greater organizational support, job security and greater support for professional practice than those in traditional organizational structures (Laschinger et al, (2008). Sharp (2006) also reported positive aspects of program management to include increased involvement of nurses in patient care issues and increased collaboration within the interprofessional team.

To address concerns expressed by health care professionals, the intervention most frequently adopted by program management organizations was the introduction of a professional practice department and/or professional practice leader role (Baker, 1993; Heslop & Francis, 2005). When describing the key elements of a professional practice structure, Matthews and Lankshear (2003) noted that the *professional practice leader* (PPL) role was identified as a key component to success. Despite the extensive implementation in the PPL role (e.g. over 82 organizations in Ontario have some variation of a PPL role in place), a scan of the health care literature reveals very few publications focusing on the role (Adamson, Shacketon, Wong, Prendergast, & Payne, 1999; Chan & Heck, 2003; Comack, Brady & Porter-O'Grady, 1997; Lankshear, Laschinger & Kerr, 2006; Matthews & Lankshear, 2003; Miller, Worth, Barton, & Tonkin, 1999) and no empirical studies examining the impact or effectiveness of the PPL role.

Although the PPL role is commonly described as being accountable for addressing professional practice related issues within the organization such as promotion of professional standards of practice, identification of professional development needs and implementation of evidenced-based practice (Lankshear, Laschinger, & Kerr, 2006; Miller, Worth, Barton, Tonkin, 1999), the role is operationalized very differently from organization to organization. One common element is the lack of any direct line or budget authority pertaining to the health care professionals for whom they provide leadership (e.g. Nursing). Due to the lack of line and budget authority, it is ultimately the manager (or collective management team) who then decides whether any PPL led recommendations will be implemented by allocating budgetary support, establishing performance expectations related to staff participation and/or compliance with the proposed initiatives. As a result, the success of the PPL role relies on the extent of organizational power ascribed to the role and the ability of the PPL to influence key stakeholders (e.g. Unit managers, senior nursing leadership and nursing staff).

A number of factors may influence the ability of the PPL to achieve their role functions, including manager support, the way the role is operationalized within the organization and the ability of the PPL to influence others. The purpose of this study was to determine the role of organizational power and personal influence in enabling the PPLs to fulfill their role functions toward creating a professional practice environment for nurses.

Study Concepts and Measurement

Professional Practice Leader (PPL)

The PPL role has been a part of the healthcare system for the past several years, with literature describing the implementation of the role beginning to appear in the mid

90's (Adamson et al 1999; Bournes & DasGupta, 1997; Comack, Brady, Porter-O'Grady, 1997; Miller, Worth, Barton, Tonkin, 1999; Ross, MacDonald, McDermott, & Veldhorst, 1996). The purpose of the PPL role has been described as being responsible for the promotion and maintenance of standards of practice for their profession (McCormack & Garbett, 2003; Miller et al, 2001). The Nurse Consultant (NC) role, common within the United Kingdom, is perhaps the closest analogy to the PPL role. The main functions of the NC role include expert practice, professional leadership and consultancy, education and training, research and service/program development (Fairley & Closs, 2006; Guest et al., 2004; Humphreys et al., 2007; Redwood, 2007; Woodward, Webb, & Prowse, 2005).

Common frustrations expressed by PPLs about their roles include: (1) the lack of clarity regarding the PPL role, (2) the challenges in demonstrating outcomes associated with the role and (3) the varying degrees of organizational support provided to PPLs such as lack of formal authority and time allocation for the role (Matthews & Lankshear, 2003; Woodward, Webb, & Prowse, 2006). Although it is recognized that the unique needs and culture of individual organizations will determine how any role is operationalized, the significant variation within existing PPL roles has created confusion and significant challenges in determining the impact of the role (Lankshear, Laschinger, & Kerr, 2006). Some of the significant factors that add to this confusion are the placement of the role in the organization (i.e. senior management level or staff level position); the degree of formal authority (i.e. presence or absence of line authority); time allocation for the role (e.g. dedicated FTE allocation or "added on" to existing role expectations); and the ascribed functions of the role (e.g. clearly defined role description and outcomes or general statements with no clearly defined expectations or outcomes).

Organizational Power (Structural Empowerment)

Kanter's theory of organizational power (1979, 1993) provides a useful framework for understanding the relationship between PPL access to organizational and social structures that empower them to accomplish their goals. Kanter argues that when employees have access to information, support, opportunities and resources, they are more likely to achieve their work related goals and employees who are empowered are more likely to then empower others. Formal power results from job roles and functions which are considered extraordinary (i.e. not routine), have a high degree of visibility, are relevant to key organizational processes and goals and are identified with the solutions to organizational problems. Informal power is achieved through peer alliances and the ability to connect with other parts of the system (Kanter, 1979). Sponsorship is another source of power obtained through key alliances, and access to information not otherwise available. The degree of sponsorship indicates to others inside and outside of the organization, that the role has the backing of someone with power (Kanter, 1993).

Individuals with both formal and informal power are viewed as having greater access to opportunities, information, support and resources (Laschinger, 1996). Opportunity refers to conditions that enable advancement and professional development. Information includes the knowledge (both formal and informal) required to do the work, whereas support refers to the degree of discretion or exercising of judgment along with feedback. Finally, access to resources (or supplies) means having influence over the environment, such as access to the materials needed to accomplish desired goals. These materials may include time, money and prestige (Kanter, 1979; Laschinger, 1996).

Personal Influence and Influence Tactics

Yukl (2006) describes influence tactics as types of behaviors that are intentionally used to influence another person's behavior and/or attitudes. Influence tactics include: rational persuasion, apprising, inspirational appeals, consultation, collaboration, ingratiation, personal appeals, exchange, coalition tactics, legitimating tactics and the use of pressure. Various research studies (Yukl & Falbe, 1990; Yukl & Falbe, 1991; Yukl, Guinan, & Sottolano, 1995; Yukl & Tracey, 1992) have demonstrated that, depending on who (i.e. what person or role) you are trying to influence; certain influence tactics are more appropriate and effective than others. For example, rational persuasion and consultation are often used when trying to influence superiors, whereas pressure tactics would not be appropriate or effective and when trying to influence peers, rational persuasion and ingratiation are more effective (Yukl, Falbe, & Youn, 1993).

Research to determine the effectiveness of influence tactics on outcomes revealed that the use of core influence tactics (rational persuasion, inspirational appeals, and consultation) is significantly and positively related to target (i.e. manager) commitment and agent (i.e. PPL) effectiveness (Yukl, Chavez, & Seifert, 2005; Yukl & Tracey, 1992). Due to the lack of line and budget authority assigned to the PPL role, the overall effectiveness of the PPL role requires the ability to effectively utilize these core influence tactics on people in positions of line and budget authority at varying levels of the organization (e.g. front line managers and senior leadership).

Organizational and Personal Power and the PPL Role

If the intent of the PPL role is to promote and maintain the professional standards of a distinct profession and if the definition of power, as described by Kanter (1979) is the ability to get things done in a meaningful way, then the components of organizational

power provide a strong theoretical foundation for the PPL role. As the internal representative (and perhaps advocate) for the profession, the PPL role would require a certain degree of formal and informal power in order to adequately provide leadership for their profession. The direct reporting relationship of the PPL can either intentionally (or unintentionally) send a message regarding the importance of the role and associated initiatives. For example, according to Kanter's theory, PPLs who report directly to the Chief Nursing Officer (a member of the senior leadership team) would be more likely to experience a higher degree of formal and informal power, than PPLs who report to a unit manager (Kanter, 1993). Results of an evaluation of the Nurse Consultant (NC) role, in the United Kingdom conducted by Guest et al (2004) support the importance of senior manager support, wherein NCs who reported high levels of senior management support also reported high level of job control. Woodward, Webb, and Prowse (2006) stated the importance of organizational support in order to maximize the full potential of the NC role. In addition, the responsibilities that are common to PPL roles (i.e. providing consultation regarding professional standards, promoting evidence based practice, promotion of professional development opportunities) would require varying degrees of access to opportunities, information, support and resources in order to successfully implement and support professional practice initiatives aimed at enhancing the practice environment.

The PPLs ability to access empowering structures (e.g. informal power) to create informal power alliances within the organization (e.g. the manager group as a whole) will also contribute to the degree of manager support (Kanter, 1979; Laschinger & Shamian, 1994). Laschinger, Wong, McMahon, and Kauffman (1999), provided further evidence of a strong relationship between staff nurses perception of their workplace empowerment

and work effectiveness and their manager's use of leader empowering behaviors. Guest et al. (2004) reported that Nurse Consultants viewed manager support at essential to enabling their role, but few reported having adequate supports from managers. The PPL must be able to influence the unit manager to support PPL related initiatives in order to garner support when influencing nursing practice.

Professional Practice Environment

Lake (2002) describes the nursing practice environment as the organizational characteristics of the work environment that facilitate or constrain professional nursing practice. Within nursing, the link between organizational attributes, practice environments and nursing practice has been well established. Kramer and Schamlenberg (1988) first described the elements of nursing environment that resulted in enhanced recruitment and retention in hospitals described as "Magnet hospitals". Aiken et al. (1999) took this research further to demonstrate the impact of the nurse's practice environment on patient mortality and demonstrated that the magnet characteristics of autonomy, control over practice and positive nurse-physician relationships contribute not only to positive nurse outcomes (i.e. increased job satisfaction), but also to positive patient outcomes such as decreased mortality. The connection between magnet hospital characteristics, empowerment and patient safety was described as nurses who perceived their environments to be empowering and therefore enabling professional practice, are more likely to perceive their environment as supporting a culture of patient safety (Armstrong & Laschinger, 2006; Armstrong, Laschinger, & Wong, 2009). The relationship between organizational characteristics, nursing leadership and nursing job satisfaction was also described by Upenieks (2003), in that nurses within magnet

hospitals reported greater perceptions of empowerment and experienced greater job satisfaction than nurses in non-magnet hospitals.

In addition to the variables described above, control variables will also be incorporated in the analysis. Nursing specific control variables will include professional designation (e.g. Registered Nurse, Registered Practical Nurse), and education background (e.g. Diploma, Baccalaureate, graduate degrees) to determine if these have an impact on their perceptions of their professional practice environment. PPL specific control variables will include reporting structure (e.g. reporting to Chief Nursing Executive versus Manager), years of experience in PPL role and educational background to determine whether these impact PPL role functioning.

Hypothesized Study Model

The purpose of this study was to determine the role of organizational power and personal influence in enabling the PPLs to fulfill their role functions toward creating a professional practice environment for nurses. Specifically, it is hypothesized that the degree of organizational power of the PPL and personal influence tactics used by the PPL will directly impact the degree to which the PPLs achieve their role functions and that the personal influence tactics used by the PPL will partly mediate the effect of organizational power. It is also hypothesized that the relationship between PPL influence tactics and role achievement is moderated by PPL perceptions of manager support, thus ultimately impacting the way in to which nurses perceive their practice environment as being supportive of their professional practice. See Figure 4: Theoretical Model and Relationships of Main Study Variables.

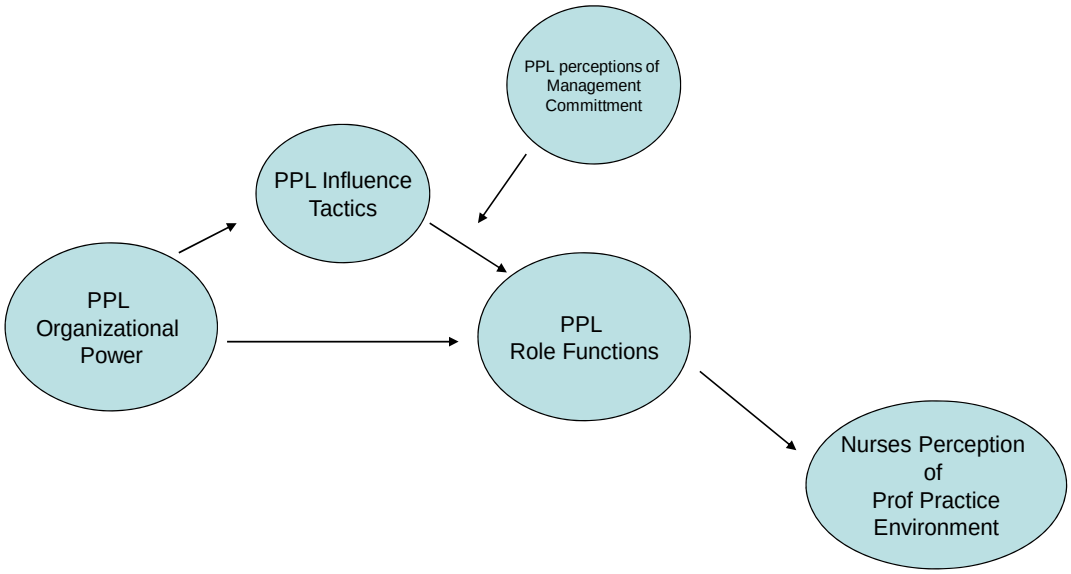

Figure 3. Theoretical Model and Relationships of Main Study Variables

Methods

Design

A non-experimental, descriptive correlational research design was used to investigate the relationship the PPL perceptions of their role functions, degree of organizational power and personal influence tactics, and degree of manager support combined with nurses' perceptions of their professional practice environment.

Sample

In this study, the setting included all Ontario hospitals with Nursing PPL roles in place. The initial list of hospitals was drawn from the membership list of the Professional

Practice Network of Ontario (PPNO), a networking group comprised of individuals in PPL roles, as well as non PPNO member hospitals where Nursing PPL positions were known to be in place.

Based on the rules of thumb described by Muthen (2002) and Houser (2007) and the known limited PPL population, a sample size of 60 PPL "units" and 2850 nurses was deemed sufficient for this study. Due to sampling restrictions, the random sample of nurses provided by the College of Nurses (CNO) database could not be limited to the specific PPNO hospitals and, therefore, included nurses from all hospitals within the selected Local Health Integrated Networks (LHINs). This resulted in the need for an expanded sample of 5700 nurses to optimize the targeted 2850 completed nurse surveys, while accounting for non-response rates and the inability to filter out nurses from non-PPNO hospitals.

Data collection for both targeted samples followed the Tailored Design Method as described by Dillman (2007). All contact with PPLs was done electronically, with a link to a secure and confidential website provided to the PPLs to complete the questionnaires. All contact with nursing participants was through their home addresses provided by the CNO using paper format. In order to match PPL and nurse responses according to specific organizations, an item was included within the demographic section of both the PPL survey package and Nurse survey package, asking the respondent to indicate the name of the hospital(s) in which they are currently employed. This matching of PPLs and nurses at the organizational level, enabled the analysis regarding the impact of control variables such as PPL role, full time equivalent (FTE) allocation and reporting structure on PPL perceptions of role function as well as to determine the relationship between PPL role function and nurses' perceptions of their professional practice

environment. Ethics approval for the study was obtained from University of Western Ontario (UWO) Research Ethics Board, as well as approval from PPNO to use the membership list for the purposes of this study.

Measurement

Two study specific surveys were compiled for the study: 1) a survey specific for PPLs, containing items designed to measure PPL perceptions of organizational power, personal influence and PPL role functions and 2) a nurse specific survey containing items designed to measure nurses' perceptions of their professional practice environment. Descriptive demographic items were also included in both surveys.

Organizational Power

PPL perceptions regarding the degree of organizational power, was obtained through the use of the Conditions for Work Effectiveness (CWEQ-II). The CWEQ-II was developed by Laschinger, Finegan, Shamian, and Wilk in 2000 and is a modification of the original 35 item CWEQ which was derived from Kanter's ethnographic study of work empowerment. The CWEQ-II consists of 19 items designed to measure each of the elements of structural empowerment: access to opportunity, information, support, resources, and perceptions of informal and formal power. Also included in the CWEQ-II are 2 items to assess global empowerment, with these two questions also functioning as a construct validity check. Participants are asked to respond to each item using a 5-point Likert (1 = none, 5= a lot). A Total Empowerment score, as the total of all subscale scores, will be used to represent PPL Organzitional Power in testing of the hypothesized model.

Initial testing of the CWEQ-II demonstrated acceptable internal reliability for each subscale ranging from 0.79 – 0.82 with an overall reliability of 0.82. The CWEQ-II

has been used in numerous studies, consistently demonstrating acceptable internal consistency for each subscale. Internal reliability testing with this study also demonstrated acceptable Cronbach alpha scores for the subscales ranging from 0.79 – 0.84 and overall scale reliability of 0.85.

Influence Tactics

The Influence Behavior Questionnaire (IBQ) was completed by the PPLs to assess self-reported influence tactics they use most often. Developed by Yukl, Lepsinger and Lucia in 1992, the IBQ was intended to measure the influence tactics used by agents (influencers) on those they wish to influence (targets). While not specific to nursing or health care environments, the IBQ consists of 44 items that represent the 11 influence tactics described by Yukl: Rational persuasion, apprising, inspirational appeals, consultation, collaboration, ingratiation, personal appeals, exchange, coalition tactics, legitimating tactics, and pressure. Scores are based on the types of influence tactics used most often with higher scores on scale of 1 – 5, indicating more frequent use of the particular influence tactic.

As the focus of this research is to determine the relationship between the influence tactics used and PPL role function, only six of the eleven influence tactics and 24 of 44 items, were included in the data collection. A Total Influence score is obtained by summing the scores of the six subscales utilized in this study. The existing research regarding the use of influence tactics has revealed that the use of core influence tactics such as rational persuasion (e.g. use of evidence, logic) inspirational appeal (e.g. appealing to values), consultation (e.g. encourage input), and collaboration (e.g. offers of resources in exchange for support) are strongly associated with an increased ability to positively influence others and thus obtain increased commitment (Yukl, Chavez, &

Seifert, 2005; Yukl and Tracey, 1992). In addition to the four influence tactics mentioned above, the influence tactics of coalition (e.g. enlisting the help of others) and legitimating (e.g. verifying the authority of the request) were also included due to the nature of the PPL role. For example, due to the lack of formal budget and line authority, the PPL may gain support through a coalition of individual managers or through their "sponsor" and may legitimize support through their role as the content expert in a particular area (e.g. professional standards and regulations).

The initial testing of the IBQ by Yukl and Falbe (1991) demonstrated alpha reliabilities for the influence tactics ranging from 0.63 – 0.92. A more recent assessment of construct validity was conducted by Yukl, Chavez, and Seifert (2005) demonstrated acceptable internal reliability for all scales ranging from 0.70 – 0.86. The scoring for the IBQ is based on the mean score for each of the individual influence tactics (subscales). Reliability analysis for this study demonstrated subscale alpha scores ranging from 0.63 – 0.86.

Professional Practice Leader Role Function

Due to the lack of existing instrument specific to the PPL role, the Professional Practice Leader Questionnaire (PPLQ) was developed to support this study. Developed with data obtained from 195 PPLs representing 12 health professions, the PPLQ consists of 23 items within five subscales: Leadership, practice & care delivery, consultation, research and professional development. Using a five option response scale (e.g. 1 = Never, 5 = Always), participants are asked to describe the degree to which they are able to achieve the role functions included in the questionnaire. PPL Total Influence Score will be calculated by summing the five subscale scores. Initial psychometrics of the 23 item PPLQ provide indication of validity and reliability with overall scale reliability of

.905 and subscale reliability ranging from .739 to .847. The PPLQ was completed by the PPLs to assess self-reported ability to achieve PPL role functions. [See Paper # 3: Professional Practice Leader Questionnaire – Development and psychometric testing, for details on instrument design and results of psychometric testing.]

Nurses' Professional Practice Environment

The Practice Environment Scale (PES) was completed by the nursing staff participants to measure their perceptions of the practice environment. Developed by Lake in 2002, the PES provides a profile of the professional practice elements evident within an organization. Originally derived from the Nursing Work Index (NWI-R), the PES consists of 31 items across 5 subscales: Nurse participation in hospital affairs, nursing foundations for quality of care, nurse manager ability, leadership and support of nurses, staffing and resource adequacy and collegial nurse-physician relationships. For each item, nurses are asked to indicate the degree to which the item is present in their current work environment and rate each item on a 4-point Likert scale, with higher scores indicating greater agreement. The PES scores are depicted as a mean composite score and mean subscale scores. The PES demonstrated an overall Cronbach alpha of 0.80, with the subscales also demonstrating adequate internal consistency (range = 0.71-0.84). Additional research studies have provided further evidence of the psychometric properties of the PES with subscale alpha reliabilities ranging from 0.81 – 0.87 (Thomas-Hawkins et al 2004) and 0.65 – 0.84 (Leiter & Laschinger, 2006). Subscale reliability scores pertaining to this study ranged from 0.81 – 0.85.

Statistical Analysis

The Statistical Package for Social Sciences (SPSS) Version 16.0 was used to conduct descriptive and inferential analysis. To test the multi-level nature of the

conceptual model, Multi-level structural equation modeling was attempted using Mplus Version 5.2, and despite various approaches (e.g. Complex and Two-level type used, and exclusion of control variables) all attempts resulted in "model non-identification". Due to the limitations of the final matched sample size (e.g. less than 100 units) and degree of the model complexity, structural equation modeling was deemed to be not feasible (Kline, 2005), therefore path analysis was chosen as the most appropriate method to test the model.

Descriptive Results

Participants Demographics

A total of 2873 (51%) Nurse surveys were returned, inclusive of a total of 127 hospitals (81% of all Ontario Hospitals), with the number of nurse surveys per organization ranging from 1 – 179 surveys. In terms of professional designation, 82% of respondents are Registered Nurses (RN), with 18% being Registered Practical Nurses (RPNs).Consistent with the provincial profile of Registered Nurses (CNO, 2008), the majority of Registered Nurses were educationally prepared at the Diploma level (73%). Although 85% of RPN respondents indicated educational preparation at the Diploma level, the option of Certificate preparation for RPNs was mistakenly omitted as a response option on the survey. Therefore, the degree of the certificate level of educational preparation for RPNs cannot be definitively described. The employment characteristic is also reflective of provincial statistics, with the majority in both nursing categories (65.8%) working full time.

An item included in the demographic section asked respondents if there was a professional practice leader role in their organization with the response options of yes, no or not sure. Fifty-one percent of nurses indicated they were aware of the presence of a Nursing PPL position within their hospital, with approximately 32% not sure of a PPL

role in their organization. Due to the nature of the PPL role (e.g. only one role for the entire hospital and involvement in initiatives often strategic in nature), and characteristics of Nursing staff (e.g. large numbers, across multiple units/ sites, and variety of shift work), the PPL role is often described as being "under the radar screen" and, therefore, the role or associated activities may not be apparent to all nursing staff within the hospital. This lack of visibility and role ambiguity is often cited as a source of frustration by PPLs (Lankshear, Laschinger & Kerr, 2007, Redwood, 2007). With this in mind, and to optimize inclusion of all possible hospitals with PPLs in place, the nurse responses for the variable "do you have a professional practice leader role in your organization" were reviewed by the researcher and re-coded based on the known presence of a Nursing PPL role within that hospital. The recoding of the variable resulted in a significant change in the distribution of responses with the percentage of "Yes" responses changing from 51% to 85% of nurses from organizations with PPL positions in place. As a result, the re-coded variable was then used to identify the organizations and, therefore, the nurse and PPL surveys for inclusion in the final data set for analysis.

A total of 74 PPLs surveys, representing 47 different hospitals were completed. Due to the diverse nature of how the PPL role is described within each organization (e.g. titles, and role descriptions), there is no current mechanism for determining the exact number of PPLs that would constitute the total PPL population and therefore the denominator for research purposes is unknown. Sixty percent (n=44) of PPLs in this study had five or less total years of experience in PPL roles and 80% (n=59) indicated they had five or less years of experience in their current PPL role. Seventy percent (n= 52) reported their role as being "full time" (e.g. 1.0 FTE) and only three percent (n=2) of respondents indicated having no time directly allocated to the role. Fifty-seven percent (n=42) of PPLs reported to senior level positions such as Chief Nursing Executive or

Vice- President of Programs, with 31% (n= 23) reporting to individuals at the Director level. In comparison to Nurse respondents, the vast majority of PPLs were educated at either the Baccalaureate (34%; n= 25) or Masters (59%; n=44) levels. When asked to describe their organizational structure, 46% (n=34) indicated they functioned within a program management structure, 41% (n= 30) in a matrix structure (combination of program management and traditional departmental structures), with the remaining 12% (n=9) in traditional departmental structures.

Of the 47 PPL organizations represented, 39 (83%) were represented by a single PPL survey response, and for the remaining eight organizations, there were multiple PPL survey responses, ranging from two to four completed surveys. This is consistent with what is known regarding Professional Practice Leader role structures in Ontario (e.g. vast majority with a single Nursing PPL role for the entire organization).

Final Matched Sample

As one of the purposes of the study was to determine the impact of PPL role functions on nurses' perceptions of their professional practice environment, the criteria for inclusion in the final sample for data analysis consisted of only those hospitals with both Nurse and PPL survey response (with a minimum of two Nurse surveys). Based on these criteria, the final sample consisted 62 (84%) PPL surveys and 2128 (74%) of Nurse surveys from a total of 45 hospitals. Of the 45 hospitals included, eight hospitals included responses from multiple PPLs, ranging from 2- 4 PPL responses. In these instances, a single PPL score was derived from the mean scores of the combined PPL surveys from the individual hospital. See Figure 4: Final Matched Data Set.

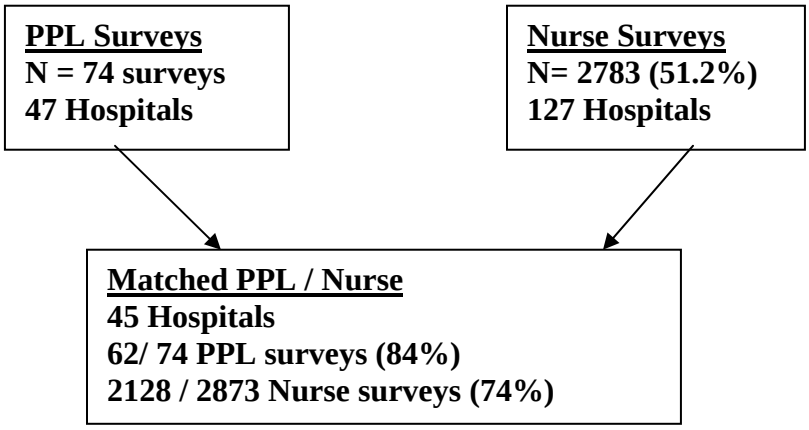

Figure 4. Final Matched Data Set

Descriptive Statistics

Nurses who participated in this study described their practice environment as being moderately supportive (M = 2.5, SD =.30). Mean scores for the subscales ranged from 2.32 (Foundations for Quality of Care) to 2.61 (Participation in Hospital Affairs). These results are consistent with nurses' perceptions of practice environments as reported in previous studies (Aiken et al, 2008; Armstrong & Laschinger, 2006; Lake & Friese, 2006; Leiter & Laschinger, 2006).

Overall, Professional Practice Leaders reported a moderate degree of organizational power (M = 21.83, SD = 3.9), with total empowerment scores ranging from 12.25 to 29.00. Subscale mean scores indicate that PPLs perceive having less access to resources (M = 2.58, SD = .76) when compared to their access to information (M = 3.98, SD = .94), support (M= 3.98, SD = .94) and opportunities (M = 4.1, SD = .82) and Informal power (M = 3.5, SD = .90) was rated as being higher than formal power (M = 3.61, SD = .75). This is consistent with the typical structure of the PPL role, in that the role often does not have formal line or budget authority, therefore no direct access to

resources required to support initiatives. These findings are also consistent with PPL empowerment scores reported by Laschinger and Wong (2007).

Influence tactics most frequently used were consultation ($M = 4.4$, $SD = .71$) and rational persuasion ($M = 4.3$, $SD = .67$), followed by moderate use of inspirational appeal ($M = 3.8$, $SD = .89$), legitimizing ($M = 3.8$, $SD = .82$) and collaboration ($M = 3.9$, $SD = .72$), while coalition ($M = 3.0$, $SD = .80$) was described as being used occasionally with the manager group. These results are reflective of the existing research regarding influence tactics. For example, rational persuasion and consultation are often used when trying to influence superiors, whereas pressure tactics would not be appropriate or effective (Yukl, Falbe, & Youn, 1993).

Regarding their ability to fulfill their role functions, PPLs reported that they are frequently able to achieve role functions ($M = 19.03$, $SD = 2.7$), with the area of consultation where they are the most effective ($M = 4.16$, $SD = .60$), followed by professional development ($M = 3.89$, $SD = .64$), leadership ($M = 3.85$, $SD = .70$), practice and care delivery ($M = 3.78$, $SD = .71$), and least effective in the area of research ($M = 3.33$, $SD = .85$). These results are consistent with the findings of evaluation studies of the Nursing Consultant role where the leadership function is deemed as being highly important (McIntosh & Tolson, 2008, Guest et al., 2004) and the research function being the area of least activity (Redwood, 2007).

Correlation Coefficients

Total empowerment was moderately related to PPL Role Function ($r = .399$, $p < .01$), Manager Support ($r = .378$, $p < .01$) and Manager Commitment ($r = .378$, $p < .01$), with a weak relationship to PPL Influence Tactics ($r = .197$, $p < .01$). This suggests the importance of structural supports such as organizational power and manager support to

PPL role functions and effectiveness. In addition to organizational supports, PPL role function was also moderately related to both Manager Support ($r = .564$, $p < .01$) and Manager Commitment ($r = .676$, $p < .01$) as well as Total Influence ($r = .421$, $p < .01$). Manager Support (3 three item variable) was strongly related ($r = .878$, $p < .01$) to Manager Commitment (single item), indicating the presence of multicollinearity. As a result, the single item variable Manager Commitment was retained for model testing due to the clarity of the single item and existing support in the literature linking influence tactics and manager commitment (Yukl & Falbe, 1991). Despite the moderately strong relationships between the PPL related variables, only a weak, but statistically significant relationship was observed between PPL role and Practice Environment Scale (PES) Composite score ($r = .057$, $p < .01$). See Table 6

Table 6

Means, Standard Deviations And Correlation Matrix For Main Study Variables

Study Variables	Mean	SD	(1)	(2)	(3)	(4)	(5)	(6)
(1) PES Composite	2.5	.30	1.00					
(2) PPL Total Organizational Power	21.83	3.9	.015	1.00				
(3) PPL Total Influence Tactic	23.34	3.4	.024	.197**	1.00			
(4) PPL Total Role Function	19.03	2.7	.057**	.399**	.431**	1.00		
(5) Mgr Support (3 items)	3.47	1.03	.034	.499**	.249**	.564**	1.00	
(6) Mgr Commitment (single item)			.068**	.378**	.487**	.676**	.674**	1.00

For those variables with moderately strong relationships, correlation matrices were also generated for the variable subscales to further identify possible underlying relationships contributing to the results observed between the main study variables. For example, all PPLQ subscales, as descriptors of overall PPL role functions, were moderately strongly associated with the Organizational Relationship Subscale (e.g. informal power) which includes items such as collaborating with clinicians and being sought out by managers and peers. In particular, Consultation was strongly correlated with ORS (r = .547, p < .01), followed by Practice *(*r =.505, p < .01), Professional Development (r =.470, p <.01), Leadership (r =.427, p <.01) and Research (r =.410, p <.01). This is consistent with the experiences as expressed by PPLs (PPNO members, personal communication, June, 4, 2010) and items frequently included as role accountabilities within PPL job descriptions. PPL role functions of Practice (r = .462, p < .01) and Leadership (r = .429, p < .01) were also more positively associated with Total Empowerment scores. This is consistent with Redwood's (2007) view that due to the strategic nature of the consultant (e.g. PPL) role, those in the role must be able to cross professions and traditional departmental structures.

When considering the influence tactics that are most positively associated with PPL role functioning, legitimizing had moderately strong correlations with all PPLQ subscales such as Leadership (r =.651, p <.01), Practice (r =.562, p <.01), Research (r =.523, p <.01), Consultation (r =.472, p <.01) and Professional Development (r =.465, p <.01). Inspirational appeal was the second influence tactic with moderate correlations to Research (r =.452, p <.01), Practice (r =.396, p <.01) and Leadership (.352, p <.01). See Table 7

Table 7

Correlation Matrix for Professional Practice Leader Role, Organizational Power and Influence Tactics Subscales

	Practice	Professional Development	Leadership	Research	Consultation
Information	.349**	.180**	.401**	.161**	.093**
Support	.349**	.180**	.401**	.161**	.093**
Resources	.165**	-.055**	.001	.216**	-.038**
Opportunity	.556**	.328**	.526**	.285**	.391**
Formal power	.233**	-.007**	.216**	.078**	.018
Informal power	.505**	.470**	.427**	.410**	.547**
Total empowerment	.462**	.235**	.429**	.274**	.234**
Inspirational appeal	.396**	.235**	.352**	.452**	.159**
Rational persuasion	.060**	.079**	.174**	.096**	-.102**
Consultation	.094**	-.095**	.152**	-.074**	-.080**
Collaboration	.221**	.168**	.263**	.194**	.201**
Coalition	.353**	.024**	.362**	.189**	.169**
Legitimizing	.562**	.465**	.651**	.523**	.472**

** $p = < .01$

The relationships between nurse related control variables (e.g. professional designation, employment status and educational preparation) and nurses' perception of their practice environment were for the most part, very weak and nonsignificant. As anticipated, there was a moderate, negative relationship between PPL reporting structure and total empowerment scores ($r = -.510$; $p < .01$) indicating that PPLs who reported to managers, as opposed to Chief Nursing Officer, reported lower empowerment scores. The relationship between all PPL control variables (e.g. educational preparation, time allocation to role, years of experience and organizational structure) and PPL role function, although statistically significant, were weak with correlations ranging from 0.99 to 0.30.

Testing of the Study Model

All path estimates were in the expected (e.g. hypothesized) direction, although not all paths estimates were statistically significant. Goodness-of-Fit Indices for the hypothesized model indicated a good fit of the proposed path model to the data [Chi-square = 39.20, *df* (24), p < 0.02, Comparative Fit Index = .905; Root-Mean-Square Error of Approximation= 0.017]. As proposed, organizational power had a direct and positive effect on PPL role functions ($\beta = 0.43$; $p < .007$) and PPL influence ($\beta = 0.17$; $p = .24$), but the latter was not significant, failing to provide support for the mediation hypothesis. Although PPL influence had a direct and positive impact on PPL role function ($\beta = 0.50$; $p < .001$), the proposed mediating effect of organizational power on PPL role function was not supported ($\beta = .084$; $p = .212$); nor was the hypothesized moderated effect of Manager Commitment on PPL role function ($\beta = .121$; $p = .449$). Finally, there was a small but statistically significant, relationship between PPL role function and nurses' perceptions of their practice environments ($\beta = .052$ $p < .05$) (See Table 8: Standardized path estimates and model fit indices and Figure 5: Path analysis of Model Testing).

Discussion of Results according to Research Questions

Although not all paths in the hypothesized full model were supported, the results of this study provide insight into the factors that contribute to the ability of Professional Practice Leaders (PPLs) to achieve their role function. The results depict the direct, positive relationship between organizational power and PPL role functioning highlighting the importance of aligning organizational power with the assigned roles, accountabilities, and deliverables assigned to the PPL. Informal power, as a subcomponent of organizational power, had the greatest impact on PPL role function across all five PPL subscale areas, highlighting the ability to collaborate with members of the health care,

being sought out by managers and peers to assist in problem solving as a key component of the PPL role and reinforces the importance of informal power in the absence of formal line and budget authority or power.

Table 8

Standardized Path Estimates and Model Fit Indices

Dependent Variable	Independent Variables	R2	β	SE	*p*
PPL Role		.420			.000
	Org. Power (direct)		.428	.158	.007
	PPL Influence (direct)		.496	.155	.001
	Org Power to PPL Influence (indirect)		.084	.067	.212
	Mgr support (moderator/ interaction effect of PPL influence X Mgr commitment)		.121	.160	.449
	Org. power (total effects)		.512	.175	.003
PPL Influence		.432			.000
	Org. Power (direct)		.170	.145	.242
Nurses Perception of practice environment		.016			.002
	PPL role function		.052	.025	.034
Goodness-of-Fit Indices	Chi square / *df* / p	CFI	RMSEA		
	39.20, df(24), $p < 0.02$	.905	.017		

Note. *p<.05, **p<.01, ***p<.001

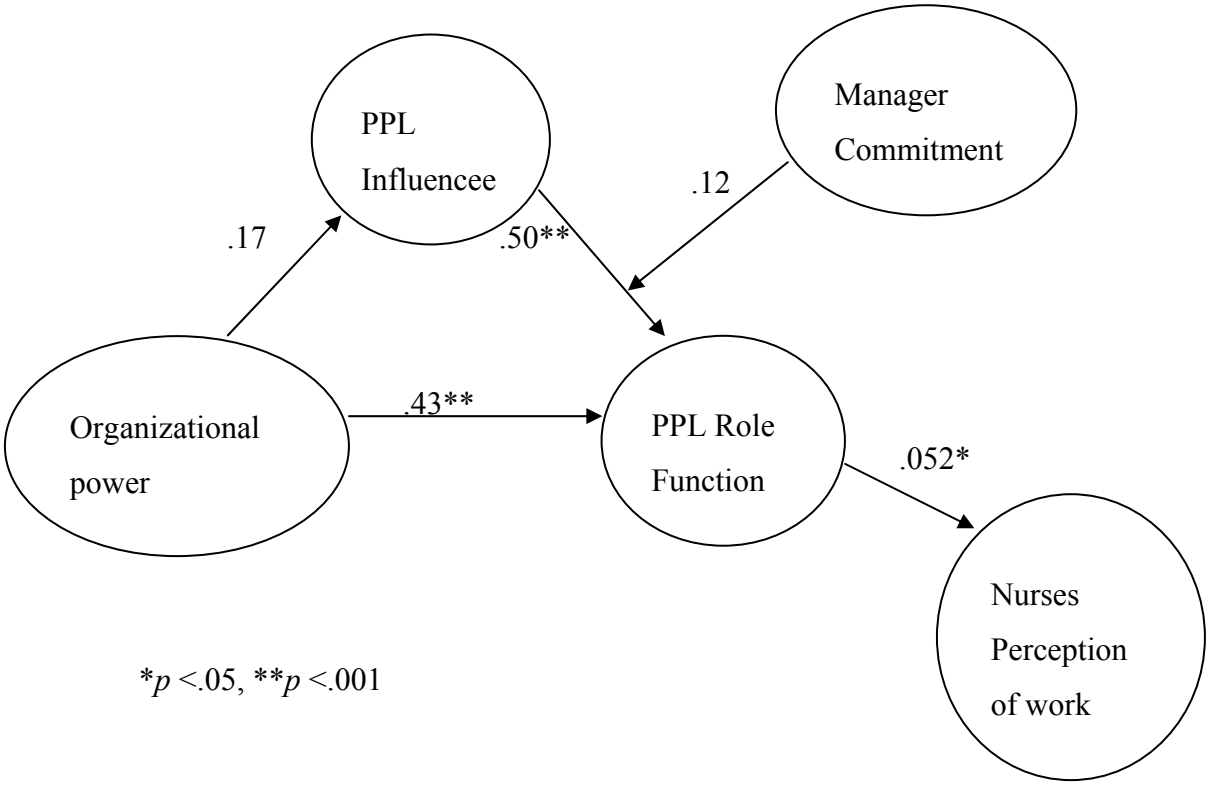

Figure 5. Path Analysis Results of Model Testing

The relationship between legitimizing influence tactics used and PPL role functions is not surprising. As the "legitimate" content experts for professional practice issues, whether profession specific or interprofessional, the PPLs can exert influence for areas that might typically exceed their authority associated with their position within the organization (e.g. PPL position at staff level providing recommendations/ direction to management). By linking to the purpose of the PPL role, they can legitimize requests by showing that the request is in alignment with internal policies, external legislative requirements and professional standards of practice. This is supported by strong, positive correlation between legitimizing and perceptions of manager commitment (r = .67; p <.01). It is of interest to note that legitimizing was the influence tactic most strongly

correlated with PPL role functions; while the core influence tactics (e.g. collaboration, rational persuasion, and inspirational appeal) were used most frequently yet demonstrated weaker correlations to PPL role function. This reinforces the importance of the PPLs to tap into their role as the legitimate source of knowledge regarding professional practice.

Despite the strong correlations between PPL role functioning and the degree of manager commitment, the moderating role of manager commitment on PPL role functioning proposed in the model was not supported. This may be due to the direct relationship between personal influence tactics used by the PPL to influence key stakeholders and achievement of PPL role function. The frequent use of legitimizing and inspirational appeal as influence tactics may act in combination with organizational power to achieve the degree of manager commitment required to support professional practice initiatives. As the PPLs are viewed as the content expert in terms of professional practice, and therefore the "legitimate" resource for professional practice in the organization, this in combination with the use of inspirational appeals (e.g. linking initiatives to organizational goals and patient outcomes) that may directly impact PPL role rather than through a moderating effect of manager commitment. The results here will be of interest to PPLs as a way of advocating for how the role is structured and positioned in the organization, and highlighting the need for PPLs to leverage their legitimate source of power and leadership role in strategic practice initiatives to influence those with formal authority (e.g. budget and line).

Although statistically significant, the proposed relationship between PPL role function and nurses perception of their practice environment was not strong. There are a variety of possible explanations for this result. First, in 86% of the organizations included in this study, there was a single Nursing PPL role for the entire organization;

therefore it may be unrealistic to assume that the initiatives led by one person would directly impact the practice environment of several hundred or perhaps several thousand nurses. Second, the lack of visibility of the PPL role was evident in the responses on the nurse surveys regarding the "presence of a professional practice leader role in your organization", with original responses indicating that only 31% of respondents indicating there was a PPL role in place, although 85% of respondents were from organizations with a PPL role in place. Third, the strategic nature of the majority of PPL functions are related to the implementation of professional practice initiatives at the organizational level (e.g. implementation of best practices, determining implications of regulatory changes, professional standards, and care delivery models), Therefore, the connection between PPL and organizational practice initiatives may not be clear to nurses at the point of care. Fourth, due to the complexity of the current health care environment and individual practice settings, there are a wide variety of other factors that would impact nurses' perceptions of their practice environment (e.g. staffing, workload) and these factors may be unrelated to PPL related initiative or functions. Descriptive analysis of PES results indicated that nurses were most dissatisfied with was resources and staffing, two operational issues over which PPLs have no input or control.

Limitations

Several study limitations should be noted. The research findings are based on surveys of nurses and PPLs who participated in the research study. Although the overall response rate from nurses (e.g. 51%; N=2873) and PPLs (N= 75) was adequate, the final number of matched units (N=45) was small resulting in low statistical power (Kline, 2005), creating challenges when testing the hypothesized model. Further studies with larger samples (e.g. 200 "units" or more) would provide a more solid foundation for

analysis and enable model testing using multi-level structural equation modeling, including a more detailed measurement model approach allowing for sub-scale level examinations of effects.

The source of data from the Professional Practice Leaders (PPLs) was derived from the Professional Practice Leader Questionnaire, a newly developed instrument. Although the preliminary results of psychometric testing of the PPLQ provide initial support for the content validity and internal reliability of the questionnaire, further testing of the PPLQ with larger samples, is warranted.

Lastly, the use of total scores for each of the key study constructs in testing of the model may have limited the ability to identify potential unique effects of contribution of the various subscales by diluting the subscale effects within the total score.

Implication for Practice and Future Research

As the accountability agreements for health care organizations increasingly refer to the requirement for evidence- based practices and quality monitoring of patient outcomes, the emphasis on professional practice is increasing across all sectors, resulting in a shifting of primary customer of the PPL role from the individual professional group (e.g. nursing), to a that of all health care professionals and their individual and collective role in organizational outcomes. Professional practice portfolios, the majority of which still have a specific Nursing PPL role, are viewed as a "support service" providing leadership to organizational initiatives that may impact practice (e.g. changes to patient populations, programs, service delivery models) and determining the impacts of external regulatory and professional standards that will impact the organization (e.g. Provincial health legislation such as Bill 179: An Act to amend various Acts related to regulated health professions and certain other Acts and Bill 46: The Excellent Care for All Act).

The evidence generated from this study highlights the importance of organizational supports (e.g. access to opportunities, and internal collaboration / consultations) to the leadership and practice components of the PPL role, therefore providing guidance to organizations regarding the factors that can optimize the ability of the PPL role to support organizational initiative and desired outcomes.

As the returned nurse surveys consist of nurses from organizations with and without PPLs in place (i.e. 74% and 26% respectively), there exists the opportunity to conduct a secondary analysis of this data to determine if nurses' perceptions are different and the potential contributing factors.

Finally, based on the available empirical evidence and the evolving role of the PPL role a potential future model for researching the impact of the PPL role would shift to a focus on the direct impact of *professional practice portfolios*, as a collective unit, on staff and organizational outcomes, and the potential indirect effect on patient outcomes. The current experience in Ontario reveals that the vast majority of professional practice portfolios have the responsibility for leading organizational initiatives that are aimed at improving patient care (e.g. implementation of best practice guidelines, care delivery models, and patient safety initiatives) as well as creating a healthy work environment (e.g. professional development programs, recruitment and retention strategies). These organizational impacts are described by Guest et al (2004), where Nurse Consultants reported organizational impacts such as enhanced patient focused care, improvements to systems, challenging status quo and influencing the behaviours of clinicians through the use of evidence. It is through these strategic, organizational initiatives where PPLs,

through the collective efforts of the entire portfolio, can have an impact on patient outcomes and the practice environment (See Figure 6: Potential Future Research Model).

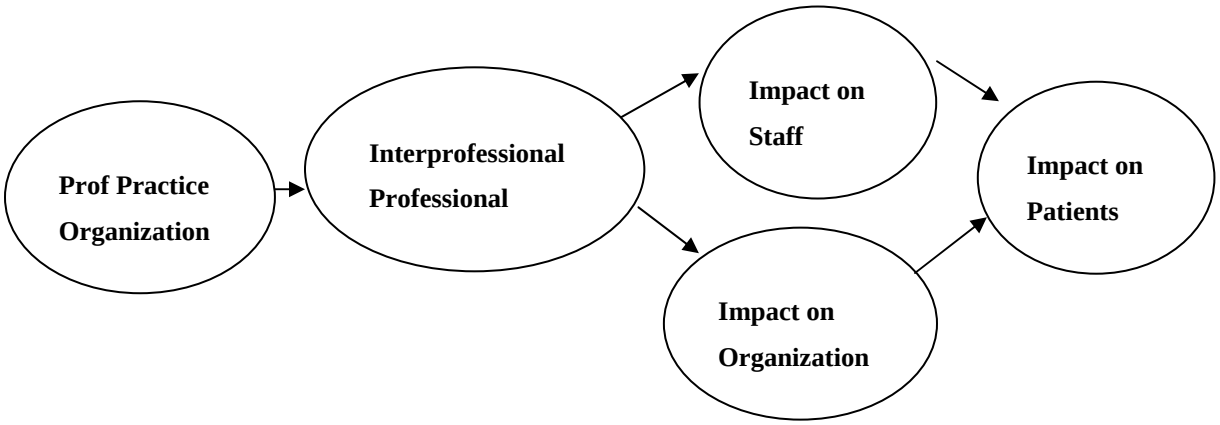

Figure 6. Potential Future Research Model

Conclusions

As this was the first known research study specific to the PPL role, the proposed model served as the initial model for investigating the factors which may contribute to the PPL role functioning as well as nurses' perceptions of their practice environment. The evidence generated from this study can be used to inform current practices regarding the design, implementation and evaluation of the PPL role as well as future research regarding the impact of professional practice roles and/or portfolios on staff, organizational and perhaps more importantly, patient outcomes.

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CONCLUSION CHAPTER: THE PROFESSIONAL PRACTICE LEADER: THE ROLE OF ORGANIZATIONAL POWER AND PERSONAL INFLUENCE IN CREATING A PROFESSIONAL PRACTICE ENVIRONMENT FOR NURSES

Conclusions

The papers comprising this dissertation reflect the evolution of the activities and research conducted to further our understanding of the Professional Practice Leader (PPL) role, the factors that enable or hinder the achievement of PPL role functions, and the impact of the PPL on the professional practice environment of nurses. The synthesis of the findings included within these manuscripts provides new insights into the vast area of professional practice, professional practice leadership roles and the factors which impact outcomes related to them.

The four papers contained in this dissertation described key learning in the following areas: 1) a review of the literature describing professional practice; 2) the application of a theoretical framework to describe the PPL role; 3) the development of an instrument to enable measurement of the PPL role and 4) the empirical testing of a theoretical model depicting factors related to the PPL role and its impact on nurses practice environments. These papers reflect the progression of knowledge accessed, gained and generated to further our understanding of the PPL role.

An important contribution of this study is the development of a *common language* which can be used when describing the concept of professional practice, as it relates to professions, professional organizations, and professional practice roles. The review of empirical and theoretical literature described in Paper # 1 resulted in the identification of five attributes of professional practice which can be used to form the basis of a common understanding of the areas that are included when discussing professional practice. As

demonstrated through the review of the literature, these five attributes (e.g. self-regulation, knowledge based, autonomy and control over practice, commitment to service, and collaborative practice) can be applied when describing professional practice as it related to individuals (e.g. performance expectations), structures (e.g. what is within scope for professional practice portfolios) and roles (e.g. areas of accountability). As a result, the following definition of professional practice in health care was developed: *"the utilization of specialized knowledge combined with the ability to exercise legitimate control over practice in order to provide collaborative, ethical, client centered care"* (Lankshear, 2011). As there is often confusion or ambiguity regarding practice versus operational functions and accountabilities, these five attributes and the associated definition can be used to help clarify the areas that fall within the legitimate domain of professional practice portfolios (e.g. standards of practice, credentialing, professional development) versus operations (e.g. fiscal planning, performance management), and the areas where there are implications for both practice and operations (care delivery models, skill mix, recruitment and retention). Although professional practice can be described as a "support service" within the organization, the legitimate role as internal content expert regarding professional practice related areas needs to be acknowledged in order to fully realize the advantages of effective collaboration between management (e.g. operations) and practice when making decisions that have implications for client care, professional standards, and fiscal accountability (See Figure 7: Attributes of Professional Practice).

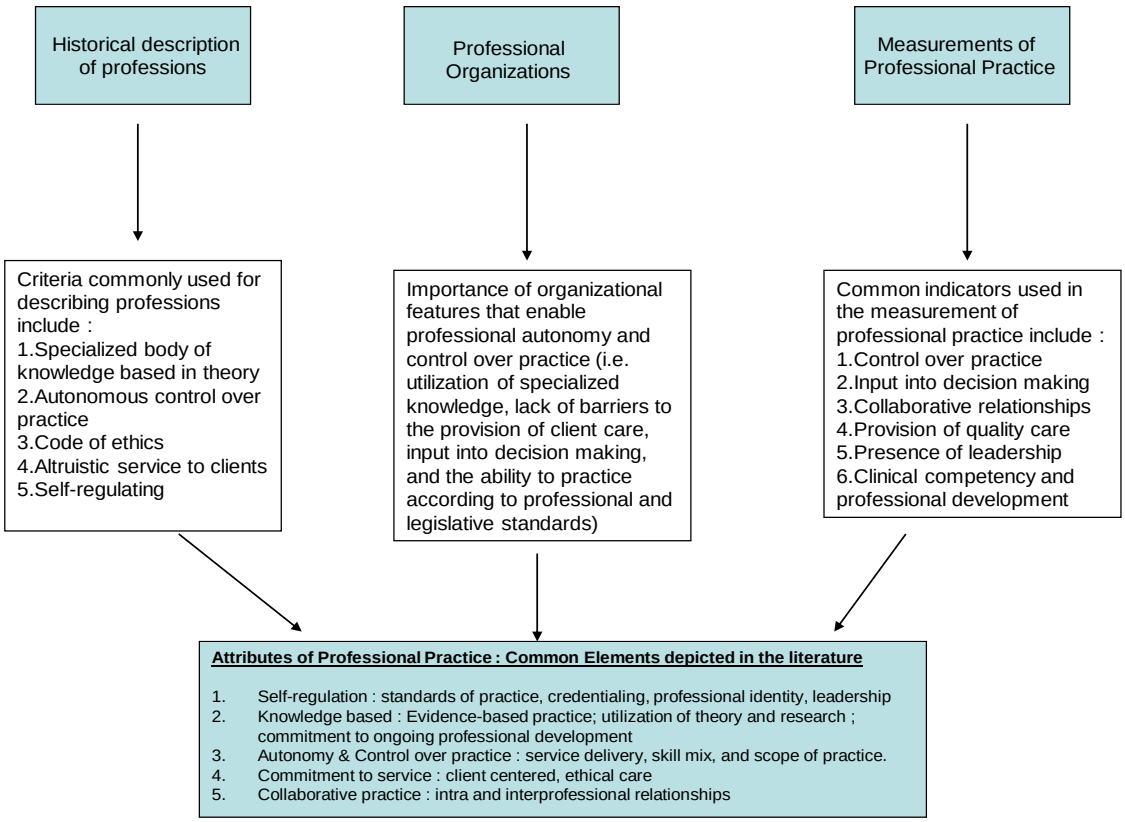

Figure 7. Attributes of Professional Practice

The relevance and application of these five attributes and the areas that are included within them were also evident in the content analysis of the Professional Practice Lead roles which contributed to the development of the Professional Practice Leader Role Questionnaire (PPLQ) described in Paper # 3. Examples of these five attributes of professional practice that were commonly included within PPL role descriptions include: provides internal expertise on scope of practice and professional standards, provides leadership toward the application of evidence based practices, collaborates with key stakeholders regarding care delivery models to enhance client outcomes, and acts as a resource regarding the provision of ethical client care. As with the review of the literature described above, the five subscales (e.g. leadership,

consultation, professional development, practice & care delivery and research) included in the instrument, provide a common language for describing and measuring the PPL role despite the variety of ways the role is operationalized in the various organizations or practice settings.

The PPLQ can be a useful tool for organizations to provide a common language that can be used to describe the overall foci of the role and key areas of accountability. Suggested use for the PPLQ may include use as a template for development and/or review of PPL roles and accountabilities, for identification of core competencies for those in PPL roles, and as a guide for ongoing professional development specific to the needs of this unique and diverse role, thus addressing a gap in available empirical instruments for obtaining information regarding the ability of professional practice leaders to achieve their role functions.

In addition, to the contributions described above, the application of Kanter's Theory of Organizational Power (1993), as described in Paper # 2, also provided a common language and framework for describing the PPL role. The importance of building from a theoretical foundation cannot be underestimated, as it is this foundation that acts as a guide for determining the purpose, intent, outcomes and degree of success of the intended structure, role or process. (Walker & Avant, 2005). The utilization of Kanter's theory enables the application of an established theoretical framework to provide guidance and direction when considering the design, implementation and evaluation of this very diverse and ever evolving role. Management practices, such as the implementation of structures and roles, without a theoretical or evidence-based foundation fails to build on existing nursing administrative science or to create

opportunities for the generation of new knowledge (Huber, Maas, McCloskey, Scherb, Goode, & Watson, 2000).

As no previously published study has investigated the impact of the PPL role, the outcomes of this study are significant, in that they provide initial evidence regarding the factors that contribute to PPL role achievement and the resulting impact on nurses' perception of their professional practice environment. In particular, the results of the model tested for this study, described in Paper # 4, highlight the direct and significant contribution of organizational power to achievement of PPL role functions. As the saying goes *form follows function and function follows form*, and this axiom highlights the importance of providing the appropriate degree of organizational power as the foundation (e.g. form) for what can realistically be achieved by the roles within those structures (e.g. function). As the professional practice role acts as the link between the professions and the professional organizations, it is vital to ensure that they have an appropriate level of access to the resources, information, supports and opportunities required to effectively carry out their role functions. Without the realization of the relationship between organizational power and ability to achieve outcomes, there can be an overestimation of what can realistically be accomplished by PPLs, leading to increased frustration not only by PPLs, but by the administrative leadership within the organization.

Over the past few years, the role of the PPL has evolved beyond profession-specific foci (e.g. professional standards, professional development) to also include areas such as patient safety, risk management, and quality of care. These higher lever, strategic areas require certain a degree of formal power (e.g. degree of visibility, linkage to

organizational priorities) and informal power (e.g. internal and external networking) as described by Kanter (1993) in order for the PPL to be effective.

Perhaps the most interesting finding from the model testing was the significant role of legitimizing and inspirational appeal as the influence tactics most strongly associated with PPLs' perceptions of role achievement. Although the core influence tactics of consultation, rationale persuasion and inspirational appeal were the tactics the PPLs reported using most frequently, consultation and rational persuasion demonstrated weak correlations with PPL role function and the degree of manager support. This is inconsistent with the published research regarding use of influence tactics with peers or managers (Yukl, Falbe, & Youn, 1993; Yukl & Tracey, 1992; Yukl, & Tracey, 1992;) which indicates that the use of these core influence tactics is associated with higher degree of support (e.g. from managers) and therefore the ability to achieve desired outcomes. The impact of the legitimizing influence tactic on manager support and PPL role function, reinforces the important role of the PPL as the internal content expert regarding professional practice, and therefore the *legitimate* source of knowledge and direction regarding professional practice related issues and initiatives. The use of inspirational appeal was also highly correlated with PPL role functions, indicating the importance of being able to link professional practice initiatives to organizational strategic goals. It may be assumed that the ability to effectively do so would be related to the degree of organizational formal power (e.g. visibility, and link to organizational goals) as described by Kanter (1993), in that PPLs must be viewed as being associated with organizational strategic goals and therefore able to clearly articulate the link between professional practice initiatives (e.g. achievement of PPL role functions) and organizational goals. Although these relationships may appear to be theoretically

supported, the results of this study did not support this as the correlations between inspirational appeal and the subscales within organizational power, although statistically significant were weak, ranging from $r = 0.15$ (Access to Information and Support) to $r =$ .32 (Access to Resources).

A potential benefit of the strong association between legitimizing tactic and achievement of PPL role function is that the legitimizing denotes more of an internal locus of control in terms of influencing others, whereas tactics such as consultation and collaboration focuses the locus of control on others' participation and engagement. If the PPL is confident in viewing him/herself as the "legitimate" source of knowledge and expertise regarding professional practice issues, then the source of power is internal to the role versus relying on the need to consult or collaborate with others – inferring that outcomes can only be achieved through others. By viewing themselves as the legitimate source of knowledge and expertise, this can potentially enhance collaborations with managers as PPLs may then view themselves in a peer relationship with the managers. Although the moderating effect of manager support was not supported in this model, the positive and strong relationship between manager support and PPL role function, suggests that the degree of manager support is associated with PPL role function. A possible explanation for this may be due to the PPLs preconceptions about traditional power and leadership roles. If the PPLs do not view themselves as that legitimate source of expertise, or as having sufficient organizational power, the locus of control shifts from internal (e.g. PPL driven) to viewing the managers' as the main external source of power and control over their outcomes. This possible explanation is supported in the outcomes presented here associated with the use of influence tactics whereas although PPLs reported the tactics used most frequently were consultation and rationale persuasion, the

most effective influence tactic associated with achievement of PPL role functions was legitimizing.

When considering the typical profile of the PPL role (e.g. one Nursing PPL role per organization), it is not surprising that there was a weak, although statistically significant relationship between PPL role functions and nurses' perceptions of their professional practice environment. This suggests that even with the limitations associated with the role (e.g. lack of visibility of the role in the organization and often a single role for the entire organization) there is a positive relationship between the ability of PPLs to achieve role functions and the organizational characteristics that directly impact nurses.

Implications for Education

The five attributes of professional practice described in Paper # 1 : self-regulation, knowledge based, autonomy and control over practice, commitment to service and collaborative practice, can provide a useful framework in the development of curriculum to describe professional practice and the areas of professional accountability and autonomy. As self-regulated professions, who practice within organizations, it is important to be able to clearly articulate what is meant by the term professional practice (e.g. a common definition), the areas that are contained within the construct of professional practice (e.g. self-regulation, utilization of knowledge, control over practice, client centered care and collaborative practice) and the interconnectedness between practice and operational aspects of health care delivery. This framework can also be used as the foundation to support reflective practice for current health care providers as a way to reconnect with professional accountabilities inherent to their role as a regulated health

care professional, and beyond those that are described in the organization specific job descriptions.

Implications for Practice

The results of this study can be used to further our understanding for the desired skills and competencies associated with the PPL role. Due to the lack of published research regarding the PPL role, there are few supports for organizations to draw from to determine the necessary skills required. The development of the Professional Practice Leader Questionnaire (PPLQ) provides a framework for describing the essential components associated with the role including leadership, consultation, research, professional development and practice. These five components and the 18 items included in the PPLQ provide a common foundation for describing the necessary competencies and skills required to successfully achieve PPL role functions. In addition to the core components described in the PPLQ, those in professional practice leadership positions need to have or develop a degree of leadership competency in order to fully access and utilize the degree of organizational power available to them. The combination of Kanter's theoretical framework along with the description of the scope and areas of responsibility associated with the PPL role, as described in the PPLQ, can provide a useful framework for the description of the PPL role, competencies required to fulfill the role, and professional development programs specific to these unique leadership roles.

Additionally, the strong and significant contribution of legitimizing and inspirational appeal influence tactics can be used by PPLs to refocus the locus of control over outcomes from external sources (e.g. managers) to more of an internal locus of control. This will require PPLs to possess a high degree of role clarity, specialized knowledge (e.g. relevant legislation and professional regulations) and skills (project

management, development and monitoring of indicators) as well as personal and professional confidence in their ability to articulate the purpose of the PPL role and connection to organizational strategic priorities.

Implications for Nursing Policy

There are two main policy implications identified from the study results. The first implication concerns the application of theoretical frameworks to the design and implementation of organizational structures and roles. The significant variation in the scope of current PPL roles, reporting structures and accountabilities provides support for a strong theoretical foundation from which to build the structure or role. This will enable the ability to articulate the rationale for the "why" the role is structured the way it is (e.g. position within the organization, time allocation, resources), the "what" the role is expected to achieve (e.g. scope and deliverables) and the "how" (e.g. mechanisms or supports to achieve associated deliverables). Without a strong evidence-based foundation, it becomes very difficult to advocate for the desired role characteristics or components. The second policy implication is directly related to the significant evolving nature or the PPL role, in that organizations need to review current PPL role descriptions and reporting structure to ensure that the degree of organizational power is reflective of the scope of the PPL role and the expectations or deliverables associated with the role. If the intent of the PPL role is to function as the champion for organizational strategic priorities such as implementation of best practices and patient safety initiatives, then it is vital that role is highly visible in the organization, and clearly linked to the achievement of organizational strategic priorities and initiatives, with the PPL role viewed as being the legitimate source of information and direction regarding these initiatives. The results of this study provide further support for the contribution of organizational power to

achievement of desired outcomes. With the introduction of Bill 46: Excellent Care for All Act (ECFAA), there is an increased focus on a focused quality agenda for all health care organizations. The quality dimensions that all health care organizations must annually report on, through the submission of a quality improvement plan (QIP) are: safety (e.g. falls, pressure ulcers, nosocomial infections), effectiveness (e.g. length of stay, readmission rates), access (e.g. wait times) and patient centered care (e.g. patient satisfaction). Quality improvement and monitoring strategies for these areas now commonly fall with the domain of professional practice portfolios as these indicators are directly impacted by the care provided by the various health care professionals at the point of care.

The results of this study may have implications for other professional practice leadership roles such as Medical Chief of Staff, Department Chiefs (e.g. Chief of Surgery, Chief of Pathology), Chief Nursing Officer (those without line or budget authority), and roles associated with Infection Control and Quality / Risk Management. These roles are often accountable for monitoring the quality of the practice of others (e.g. physicians, health care providers, support staff), ensuring adherence to standards (e.g. professional standards, legislation, organizational policies), and implementation of best practices or strategic priorities, yet have no direct line authority for the staff positions they are to provide direction and leadership to. These roles have similar accountabilities to that of the PPL role, experience the same frustrations (e.g. broad accountabilities and few dedicated resources), and are viewed as providing leadership to their professional colleagues (e.g. peers) and the link between organizational performance and professional practice. The findings here can be used to advocate for the organizational supports (e.g. sponsorship, access to resource, information, support and identification as the legitimate

resource) required to enable individuals in these roles to achieve the outcomes associated with the roles.

Implications for Research

As this was the first known study of the PPL role in Canada, the findings generated here provide indications of other research studies that can be conducted to further our understanding of the various professional practice leadership roles and their impact on the practice environment. Due to the evolving PPL role and expansion of Professional Practice Portfolios, the replication of this study to include all professional practice leadership roles, such as Chief of Staff roles, PPLs for the other health care professions (e.g. Physiotherapy, Occupational Therapy, Social Work, and Respiratory Therapy) and those hybrid PPLs roles that have organizational accountabilities for areas such as patient safety, quality and risk would enable the investigation of the collective contributes to the professional practice environment and organizational outcomes.

Although the moderating role of manager support was not supported in this study, due to the perceived significant importance of manager support as either an enabler or barrier to success, further investigation of the relationship of management support to those in professional practice leadership roles is warranted. Lastly, the expansion of this study to provinces outside Ontario where PPL roles are in place (e.g. Alberta, Nova Scotia, and Newfoundland) would enable a comparison of PPL structures across the country as well as provide access to a larger sample of PPL/Organizational dyads to enhance model testing using multi-level structural equation modeling including a more detailed measurement model approach allowing for sub-scale level examinations of those factors hypothesized to impact the professional practice environment.

Despite the lack of evidence regarding the impact of the PPL role on the nurse practice environment, the fact that organizations continue to invest in PPL roles and have expanded the role beyond a focus on profession specific issues (e.g. Nursing) to interprofessional issues that impact health care professionals functioning within complex organizations and their contribution to quality patient outcomes, provides some anecdotal "evidence" of the contributions of the PPL role. There is an increased awareness within health care organizations of the direct link between the ability to achieve quality patient outcomes and the need for systems and structures to support those directly involved in care delivery, with professional practice portfolios and PPL role proving the link between operations and practice. The components comprising this dissertation will help to address the current void in theoretically grounded resources to support the conceptual (e.g. common language) and the empirical description of the value and contributions of the professional practice leadership roles.

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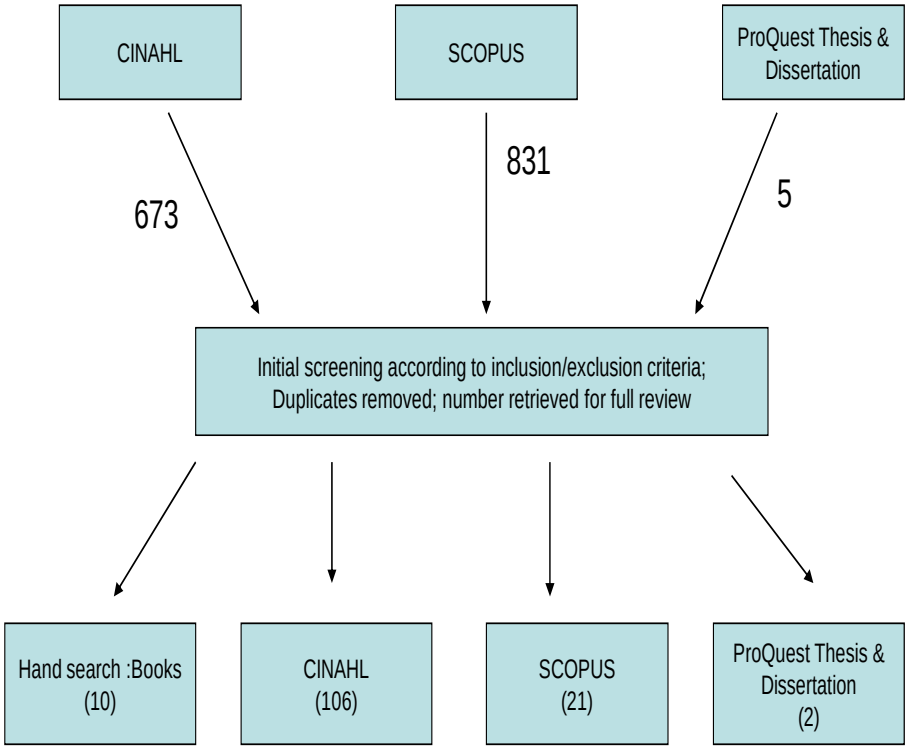
Appendix A: Search and Retrieval Process



The inclusion criteria for the theoretical literature included titles that described the processes and issues related to the identification of professions, the evolution of professions and professional status; the professionalization of groups and the professionalization of the practice setting.
The inclusion criteria for empirical studies required that the research design identified a component of professional practice as either the independent or dependent variable. Exclusion criteria for research studies and citations were those where the focus was a clinical treatment or intervention.

Appendix B: Included Studies

The studies described below are grouped according to the following areas of focus: professional organizations, professional practice environments, professional practice models, professional practice behaviors and professional practice roles. Studies were chosen for inclusion based on the presence of a professional practice being identified as either the independent or dependent variable.

Professional Organizations / Bureaucracies

Study	Purpose	Method	Sample/Setting	Variables	Tools	Outcomes	Summary
Aiken, Sloane, Lake, Sochalski, & Weber (1999)	To compare difference unit / magnet characteristics on AIDS patient 30-day mortality (dedicated specialty units and non dedicated units)	Mixed method design using qualitative and quantitative approaches	Sample of 40 units across 20 hospitals in 11 US cities; 1205 AIDS patients admitted between Sept 1990 – December 1991; 820 nurses employed on 40 units	Hospital characteristics (Magnet) Unit characteristics (dedicated specialty unit) Patient satisfaction 30–day mortality	Patient interviews Nurse surveys 30-day mortality rate	Patients on dedicated AIDS unit in magnet hospitals had better outcomes (.e. less mortality, increased continuity of care, patient perception of quality care, higher patient satisfaction) than patients on non-dedicated units.	Demonstrates the importance of contextual characteristics on patient outcomes. Organizational systems (i.e. resources and policies) that govern the delivery of care are important features to consider.
Blythe, Baumann & Giovannetti (2001)	To describe the effects of restructuring on nurses in Ontario	Qualitative study using focus groups and taped interviews	59 nurses from med-surgical units in three hospitals in Ontario	Restructuring Effects of redeployment Relations between nurses and management	Transcribed audiotapes from interviews/ focus groups	Three themes emerged : 1. Fragmentation of relations 2. increased uncertainty 3. disempower-ment	Impacts of organizational restructuring described at the individual, team and professional level.

Study	Purpose	Method	Sample/Setting	Variables	Tools	Outcomes	Summary
Hall (1968)	To determine the relationship between professionalization and bureaucratize-tion	Descriptive comparative study of occupations that are considered professions and some that are aspiring to become professions	Purposive sample of occupations drawn from 27 organizations representing 11 occupations	Autonomy : including structural attributes & attitudinal attributes	Professionalism scale (Attitudinal attributes) Bureauc-racy scale (Structural attributes of occupation)	Wide degree of bureaucratization among the occupations ; Higher degrees of autonomy were associated with lower bureaucratization and higher professionalism	Inverse relationship between professionalism and the degree of bureaucratization
Laschinger & Havens (1996)	To examine the relationship between nurses perceptions of work empowerment and control over practice.	Descriptive correlational study; mail survey	127 randomly selected nurses from 2 US teaching hospitals	Structural empowerment Control over nursing practice	Conditions of Work Effective-ness Control over Nursing Practice Multi-factor Leader-ship Question-naire	Work empowerment was strongly correlated to perceptions of control over nursing practice; informal power demonstrated the highest degree of correlation with control over nursing practice; also high correlation between empowerment and work satisfaction.	Results indicate the impact of structural design on perceptions of control over nursing practice and work satisfaction. Informal power viewed as being highly significant highlighting the importance of collaborative relationships.
Young, Charns, & Heeren (2004)	To determine the effects of organizational structure (product line management and functional structure) in two general hospitals on performance and human resource outcomes.	Multi-method design including survey, onsite observation and interviews	Convenience sample of 11 hospitals; involving over 1100 professionals (90% nurses); 55% response rate	Organizational structure Job satisfaction Professional development Quality and innovation of professional services	Survey Site visit including interviews with senior team, middle managers and staff.	Product line structure was significantly and negatively associated with job satisfaction and professional development; Neither structure had a positive impact on service quality or innovation	Results indicate that product-line management does not offer clear advantages for service and potential disadvantages regarding human resource outcomes; further research warranted

Professional Practice Environment

Study	Purpose	Method	Sample/Setting	Variables	Measures	Outcomes	Summary
Aiken & Patrician (2000)	To report on the development and utility of the Revised Nursing Work Index (NWI-R) in measuring the characteristic of professional nursing practice environments	Utilization of the NWI-R in sample of 40 units across 20 hospitals	Nurses employed on 40 units across 20 hospitals; response rate ranged from 73 - 86%	Subscales : 1.Autonomy 2.Control over the work environment 3.Relationships with physicians 4.Organizational supports	Revised Nursing Work Index (NWI-R)	Instrument modified from 66 to 57 items; reliability and validity demonstrated ; Scale = 0.96; Subscale ranges = 0.84 – 0.91	NWI-R provides potential for evaluating nursing practice environments
Laschinger, Almost, Tuer-Hodes (2003)	To test a theoretical model linking nurses' perceptions of workplace empowerment, magnet hospital characteristics and job satisfaction	Secondary analysis of data from three previous studies of nurses and nurse practitioners in Ontario	Study 1 = 233 randomly selected nurses in urban tertiary hospital Study 2 = 263 randomly selected nurses in 8 rural community hospitals Study 3 = 55 ACNP in urban tertiary hospital	Structural empowerment Job satisfaction Magnet hospital characteristics	Revised Nursing Work Index (NWI-R) Conditions for Work Effectiveness Questionnaire (CWEQ-II) Global Job Satisfaction	Empowerment scores were highly correlated with scores on NWI-R. Structural empowerment and magnet characteristics were strong predictors for job satisfaction.	Support for linking structural empowerment and magnet hospital characteristics therefore creating an enhanced professional practice environment for nurses.

Study	Purpose	Method	Sample/Setting	Variables	Measures	Outcomes	Summary
Laschinger, Shamian, & Thomson (2001)	To test a model linking nurses' workplace conditions to organizational trust, burnout, satisfaction and nurse assessed quality of care.	Subset of larger sample; stratified random sample of nurses in Med-Surgical units	Larger sample consisted of 3016 nurses drawn from 135 hospitals including urban, community and rural hospitals	Organizational attributes Job satisfaction Nurse assessed quality of care Burnout Trust	Nursing Work Index (NWI) Interpersonal Trust at Work Scale Human Services Survey Quality of Care (Quality care / Quality Unit)	Nursing work environments affected job satisfaction indirectly through emotional exhaustion and trust in management. Higher levels of autonomy was associated with higher levels of trust – resulting in higher levels of satisfaction and perceptions of quality of care.	Model supported that features of nurses work environment (i.e. magnet characteristics) have an impact on trust, satisfaction and nurses perceptions of the quality of care provided.
Upenieks (2003)	To conduct a comparison between magnet and nonmagnet hospitals regarding levels of nurses' job satisfaction and empower-ment	Mixed method design incorporating qualitative and quantitative methods	Convenience sample of nurses from two magnet hospitals (44% response rate) and 16 nurse leaders from magnet and nonmagnet hospitals	Job satisfaction Retention	Conditions for Work Effective-ness Question-naire Revised Nursing Work Index Individual interviews with nurse leaders using semi-structured interview format	Nurses employed at magnet hospitals experiences higher levels of job satisfaction and empowerment when compared to nurses in non-magnet hospitals ; Nurse leaders who experiences greater degrees of empowerment reported greater leadership success	Results support theories of empowerment and magnet characteristics as being indicative of structures that support nurses job satisfaction and perceptions of empowerment

Study	Purpose	Method	Sample/Setting	Variables	Measures	Outcomes	Summary
Lake & Friese (2006)	To describe the nursing practice environments	Cross sectional analysis of nurse and administrative data from 1999	3 sources of data : (1) 156 Hospitals in Pennsylvania (2) 16 original magnet hospitals (3) 7 hospitals who had achieved ANCC Magnet status	See Appendix for listing of Factors included in instrument	Practice Environment Scale : 31 items within 6 factors	Hospital environments with higher (above 2.5) scores on PES were classified as being favorable as where those with Magnet status	Results indicate that it may be incorrect to assume that hospital characteristics can be used as proxies for the attributes of the practice environment
Kramer & Schmalenberg (2003)	To determine the meaning of "control over practice" for nurses and attempt to quantify this concept through the categorization of nurses descriptions.	Serial case study design : incorporating interviews and survey	20 nurses from 14 Magnet Hospitals; 279 participants	Control over practice Job satisfaction Quality of care	Individual interviews using structured guide; Comple-tion of Essentials of Magnetism list (37 items synthe-sized from NWI)	Definition of control over practice versus professional autonomy revealed; Identification of "5 dimensions of control of nursing practice" scale developed which describes control over practice as 1. Highly effective control structure 2. Control with reservations 3. Input but no control 4. Refer to authority source 5. Minimal or no control over practice	Differentiation of individual autonomy and group control over practice of relevance t design of org supports; Identification of dimensions of control over practice can be useful in determining org. effectives for nursing.

Study	Purpose	Method	Sample/Setting	Variables	Measures	Outcomes	Summary
Armstrong & Laschinger (2006)	To test a theoretical model linking quality of the nurses' practice environments to patient safety	Exploratory study using predictive, non-experimental design: part of quality improvement initiative; Mail survey	Small community hospital in Ontario; 51% response rate	Structural empowerment Patient safety Magnet characteristics	Conditions for Work Effective-ness Question-naire Practice Environme nt Scale Safety Climate Survey	Empowerment was significantly and positively correlated with magnet hospital characteristics; Empowerment and Magnet hospital characteristics were both and significantly positively correlated to perceptions of patient safety culture	Empowerment is identified as a key factor in creating professional practice environments; which in turn predicts nurses perceptions of patient safety culture.
Aiken, Clarke, & Sloan (2008)	To determine the effects of nurse practice environments on nurse and patient outcomes.	Cross sectional analysis of hospital, nurse and patient data from 1999	Data from 1999 study utilized consisting of 168 hospitals, 40,000 nurses, and 232,342 patients aged 20-85.	Hospital structural characteristics Nurses Staffing Nurse Education Patient Care Environment Patient outcomes	Practice Environ-ment Scale Maslach Burnout Inventory 30 day mortality	Nurses concerns regarding quality of care were between 42 – 69% lower in hospitals with better environments; Mortality rates were 60% higher in poorly staffed, poor environments.	Results suggest that improved nurse staffing, increased education, and improved practice environment have a direct impact of nurse and patient outcomes.

Professional Practice Roles

Study	Purpose	Method	Sample/Setting	Variables	Tools	Outcomes	Summary
Fairley & Closs (2006)	To describe the activities undertaken by a critical care nurse consultant and to determine possible patient outcomes associated with the role.	Mixed method design Qualitative study design using self-reports through diary entries by the nurse consultant over 4 months Entries were then coded, categorized and analyzed using SPSS	Large teaching hospital; Eight bed critical care unit in UK.	NA	Consultant diary entries	Qualitative data revealed two themes of Clinical reasoning (i.e. problem solving) and clinical instruction (minimizing risk through teaching)	Lack of evidence to directly link activities of the nurse consultant to patient outcomes. Identifies areas of overlap with other nursing roles and importance of support and teaching role of nurse consultant.
Woodward, Webb & Prowse (2006)	To identify the characteristics and achievements of nurse consultants	Qualitative design using in-depth , unstructured interviews	Convenience sample of 10 nurse consultants from one region	NA	Interview question included : "Tell me about your role" ; followed by probes	Four themes emerged – although only two reported in this article : Characteristics of the nurse (attributes and motivation) and role achievements (role development and concerns)	Nurse consultant that were coping well in the role had higher degrees of education, more years of practice, high degree of self-confidence and the ability to work collaboratively. Results provide insight into recruitment strategies and supports required.

Study	Purpose	Method	Sample/Setting	Variables	Tools	Outcomes	Summary
Woodward, Webb & Prowse (2005)	To determine the organizational influence on the nurse consultant role.	Qualitative design using in-depth , unstructured interviews over a period of 18 months	Convenience sample of 10 nurse consultants from four NHS trusts	NA	Details not provided	Two themes emerged: Support systems were generally positive (networks and support from colleagues) and NHS influences were mixed in degrees of (policy, power bases, research focus).	Achievement of the role of highly affected by a variety of influences outside the control of the individual Highlights the importance of organizational support for the role to be successful.
Guest et al (2004)	The aim of the study is to evaluate the impact of nurse consultant role on service delivery and patient care and to explore their leadership role and to determine factors associated with role effectiveness.	Multi-method longitudinal approach incorporating: Interviews, focus groups, questionnaires surveys and longitudinal panel phone interviews	Sample of 162 consultants Survey response rates ranged from 95% (Phase 1) to 79.4 % (Phase 3) Longitudinal interviews = 32 consultants Leadership interviews = 11 consultants All representative of various regions and specialties	Leadership Impact on patient outcomes Role Satisfaction	Question-naire / survey Semi-structured interviews	Outcomes reported regarding nurse consultant role impacts on patient care, leadership, role development and socialization.	Areas of impact for the consultant role were identified; greatest challenges identified related to lack of support, resources and authority.

Appendix C: Professional Practice Environment Measurement Instruments

Instrument	Nursing Work Index (NWI) Kramer and Schamlenberg	Nursing Work Index –Revised (NWI-R) Aiken and Patrician	Practice Environment Scale (PES) Lake	Professional Practice Environment Scale (PPE) Ives Erickson et al	Essentials of Magnetism (EOM) Kramer and Schamlenberg
Date	1989	2000	2002	2004	2004
Subscales	1. Management style 2. Quality of leadership 3. Organizational structure 4. Professional practice 5. Professional development	1. Autonomy 2. Control over the work environment 3. Relationships with physicians 4. Organizational supports	2. Nurse participation in hospital affairs 3. Nursing foundations for quality of care 4. Nurse manager ability, leadership and support of nurses 5. Staffing and resource adequacy 6. Collegial nurse-physician relations	1. Handling disagreement and conflict 2. Internal work motivation 3. Control over practice 4. Leadership and autonomy in clinical practice 5. Staff relations with physicians 6. Teamwork 7. Cultural sensitivity 8. Communication about patients	1. Cultural Values 2. Control of nursing practice 3. Supportive nurse manager : leadership behaviors and managerial behaviors 4. Autonomy 5. RN-MD Relationships 6. Clinically competent nurse 7. Support for education 8. Adequate staffing
Cronbach's alpha	Scale overall = 0.96; Subscale ranges = 0.84 – 0.95	Scale overall = 0.96; Subscale ranges = 0.84 – 0.91	Scale overall = 0.80 Subscale ranges = 0.71 – 0.84	Scale overall = 0.93 Subscale ranges = 0.78 – 0.88	Scale overall = 0.85 Subscale ranges = 0.81 – 0.90

Appendix D: PPLQ 32 Items

Professional Practice Leader Role Functions Questionnaire (PPL / RFQ)

Questionnaire Items and Demographic Sheet

Professional Practice Leader

The PPL role is described as the position responsible for the promotion and maintenance of the professional standards of practice, research, education and professional development for their distinct profession. (Miller, Worth, Barton, Tonkin, 1999).

When considering your ***current*** PPL role, describe the degree to which you are able to achieve the following role functions.	1 = Never 2 = Seldom 3 = Sometimes 4 = Often 5 = Always				
Consultation					
1. Provides internal expertise on scope of practice and professional standards.	1	2	3	4	5
2. Identifies and provides direction on issues relevant to client care and professional practice	1	2	3	4	5
3. Provides consultation on corporate initiatives, structures and processes that may impact the profession	1	2	3	4	5
4. Provides consultation to program/department leadership regarding professional credentialing, and professional competencies	1	2	3	4	5
5. Acts as a communication link between senior leadership and nursing staff regarding professional practice related issue	1	2	3	4	5
6. Develops partnerships with regulatory Colleges, professional associations and other relevant external networks	1	2	3	4	5
7. Collaborates with key stakeholders regarding care delivery models to enhance client outcomes.	1	2	3	4	5
8. Provides consultation into the development of policy and procedures that may impact professional practice	1	2	3	4	5

When considering your ***current*** PPL role, describe the degree to which you are able to achieve the following role functions.	1 = Never 2 = Seldom 3 = Sometimes 4 = Often 5 = Always				
9. Provides opportunities for intra and inter-professional collaboration	1	2	3	4	5
10. Promotes self-regulation of the profession by identifying polices that hinder scope of practice	1	2	3	4	5
11. Provides internal consultation regarding external legislative or regulatory changes and their impact on the profession within the organization.	1	2	3	4	5
Professional Development / Education					
12. Promotes and facilitates professional development and ongoing learning opportunities	1	2	3	4	5
13. Facilitates inter and/or intraprofessional mentorship opportunities for clinical staff	1	2	3	4	5
14. Advocates for resources to support staff participation in educational events (e.g. external conferences and workshops)	1	2	3	4	5
15. Liaises with academic partners to facilitate student placements and preceptorships	1	2	3	4	5
16. Provides input into the professional development / learning needs for professionals	1	2	3	4	5
Leadership					
17. Provides leadership to the profession specific committee (e.g. Nursing Council, Nursing Professional Advisory Committee)	1	2	3	4	5
18. Facilitates broad communication within the profession throughout the organization	1	2	3	4	5
19. Enhances the profile of the profession within the organization	1	2	3	4	5
20. Participates in organization-wide committees to represent professional practice perspectives	1	2	3	4	5
21. Provides leadership in the development of strategic direction for the profession, in alignment with organizational directives.	1	2	3	4	5

When considering your ***current*** PPL role, describe the degree to which you are able to achieve the following role functions.	1 = Never 2 = Seldom 3 = Sometimes 4 = Often 5 = Always				
22. Promotes leadership within the profession	1	2	3	4	5
Research					
23. Provides leadership toward the application of evidence based practices	1	2	3	4	5
24. Actively participates in research projects	1	2	3	4	5
25. Encourages staff participation in research projects	1	2	3	4	5
Practice					
26. Collaborates with relevant program /department leadership regarding professional practice initiatives	1	2	3	4	5
27. Fosters an environment that enables input into practice and client care	1	2	3	4	5
28. Acts as a resource to staff and assists in problem solving regarding professional practice situations or conflicts	1	2	3	4	5
29. Provides input into the development of service delivery models ensuring they are reflective of professional standards and regulatory requirements (i.e. skill mix and scope of practice)	1	2	3	4	5
30. Provides leadership and consultation regarding the provision of ethical client care	1	2	3	4	5
31. Develops and maintains processes for addressing practice issues	1	2	3	4	5
32. Provides consultation regarding maximizing client safety	1	2	3	4	5

PPL Demographic Information

Please answer the following items in the spaces provided.

How many years have you been in a Professional Practice Leader role in *total*?	
How many years have you been in your *current* Professional Practice Leader position?	
What is the amount of Full Time Equivalent (FTE) dedicated to your current PPL role?	
What is your age in years?	
What is your current job title?	
Where is the PPL role positioned in the organizational structure?	Staff position Manager Director Vice-President Other
What is the title of role that you directly report (insert Title only, no names)	
Describe the Organizational structure	Program structure Departmental structure Matrix (Combination of Programs and Departments)

Appendix E: PPLQ 23 items

Professional Practice Leader Role Functions Questionnaire (PPLQ)

Professional Practice Leader : the position responsible for the promotion and maintenance of the professional standards of practice, research, education and professional development for their distinct profession. (Miller, Worth, Barton, Tonkin, 1999).

With your current Professional Practice Leadership role in mind, use the scale below to describe the degree to which you are able to achieve the role functions listed below.

1= Never 2= Not at all 3=Occasionally 4= Frequently 5= All of the time

1.	Provides internal expertise on scope of practice and professional standards.	1	2	3	4	5
2.	Identifies and provides direction on issues relevant to client care and professional practice	1	2	3	4	5
3.	Provides consultation on corporate initiatives, structures and processes that may impact the profession	1	2	3	4	5
4.	Provides consultation to program/department leadership regarding professional credentialing, and professional competencies	1	2	3	4	5
5.	Develops and maintains partnerships with regulatory Colleges, professional associations and other relevant external networks	1	2	3	4	5
6.	Collaborates with key stakeholders regarding care delivery models to enhance client outcomes.	1	2	3	4	5
7.	Provides internal consultation regarding external legislative or regulatory changes (e.g. their impact on the profession within the context of the organization)	1	2	3	4	5
8.	Promotes and facilitates professional development and ongoing learning opportunities	1	2	3	4	5
9.	Facilitates mentorship opportunities for clinical staff	1	2	3	4	5

10. Advocates for resources to support staff participation in educational events (e.g. external conferences and workshops)	1	2	3	4	5
11. Liaises with academic partners to facilitate student placements and preceptorships	1	2	3	4	5
12. Provides input into the professional development needs for professionals	1	2	3	4	5
13. Provides leadership to the profession specific committee (e.g. Profession-specific Council, Interprofessional Professional Advisory Committee)	1	2	3	4	5
14. Facilitates broad communication within the profession throughout the organization	1	2	3	4	5
15. Participates on organization-wide committees, as content expert regarding professional practice perspectives	1	2	3	4	5
16. Provides leadership in the development of strategic direction for the profession, in alignment with organizational directives.	1	2	3	4	5
17. Provides leadership toward the application of evidence based practices	1	2	3	4	5
18. Actively participates in research projects	1	2	3	4	5
19. Encourages and supports staff participation in research projects	1	2	3	4	5
20. Provides input into the development of service delivery models ensuring they are reflective of professional standards and regulatory requirements (i.e. skill mix and scope of practice)	1	2	3	4	5
21. Provides leadership and consultation regarding the provision of ethical client care	1	2	3	4	5
22. Develops and maintains processes for addressing practice issues	1	2	3	4	5
23. Provides consultation regarding maximizing client safety	1	2	3	4	5

Appendix F: PPLQ 18 items

Professional Practice Leader Questionnaire ® (PPLQ)

Instructions: With your current Professional Practice Leadership role in mind, use the scale below to describe the degree to which you are able to achieve the role functions listed below.

	Never	Not at all	Occasionally	Frequently	All of the time
1. Provides internal expertise on scope of practice and professional standards.	1	2	3	4	5
2. Identifies and provides direction on issues relevant to client care and professional practice	1	2	3	4	5
3. Develops and maintains partnerships with regulatory Colleges, professional associations and other relevant external networks	1	2	3	4	5
4. Collaborates with key stakeholders regarding care delivery models to enhance client outcomes.	1	2	3	4	5
5. Provides internal consultation regarding external legislative or regulatory changes (e.g. their impact on the profession within the context of the organization)	1	2	3	4	5
6. Promotes and facilitates professional development and ongoing learning opportunities	1	2	3	4	5
7. Facilitates mentorship opportunities for clinical staff	1	2	3	4	5
8. Provides input into the professional development needs for professionals	1	2	3	4	5
9. Provides leadership to the profession specific committee (e.g. Profession-specific Council, Interprofessional Professional Advisory Committee)	1	2	3	4	5
10. Facilitates broad communication within the profession throughout the organization	1	2	3	4	5
11. Participates on organization-wide committees, as content expert regarding professional practice perspectives	1	2	3	4	5
12. Provides leadership in the development of strategic direction for the profession, in alignment with organizational directives.	1	2	3	4	5

	Never	Not at all	Occasionally	Frequently	All of the time
13. Actively participates in research projects	1	2	3	4	5
14. Encourages and supports staff participation in research projects	1	2	3	4	5
15. Provides input into the development of service delivery models ensuring they are reflective of professional standards and regulatory requirements (i.e. skill mix and scope of practice)	1	2	3	4	5
16. Provides leadership and consultation regarding the provision of ethical client care	1	2	3	4	5
17. Develops and maintains processes for addressing practice issues	1	2	3	4	5
18. Provides consultation regarding maximizing client safety	1	2	3	4	5

S. Lankshear 2009

Appendix G: Ethics Approval and Letters of Consent

Ethics Approval

Office of Research Ethics
The University of Western Ontario
Room 00045 Dental Sciences Building, London, ON, Canada N6A 5C1
Telephone: (519) 661-3036 Fax: (519) 850-2466 Email: ethics@uwo.ca
Website: www.uwo.ca/research/ethics

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. M.S. Kerr
Review Number: **15262E** **Review Level:** Expedited
Review Date: June 26, 2008
Protocol Title: The Professional Practice: The role of organisational power and personal influence in creating an professional practice environment for nurses
Department and Institution: Nursing, University of Western Ontario
Sponsor:
Ethics Approval Date: July 16, 2008 **Expiry Date:** June 30, 2009
Documents Reviewed and Approved: UWO Protocol, Letters (2) of Information and Consent (PPL, Nurses), Advance Notice Postcard, Repeat mail out letters, Email Advance Notice, Email Reminder Notice
Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced study on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the HSREB:

a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) all adverse and unexpected experiences or events that are both serious and unexpected;
c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

PPL Email: Information and Consent

Dear Colleague,

You are being invited to participate in a research study designed to determine the impact of the Professional Practice Leader (PPL) role in creating a professional practice environment for nurses. As you are aware, there is great variability in how the PPL role is operationalized across the various organizations. This may contribute to role confusion and ambiguity about the PPL role and functions. The purpose of this study is to determine the role of organizational power and personal influence in creating a high quality professional practice environment for nurses. Specifically, it will be proposed that the degree of organizational power (how the role is structured in the organization) of the Professional Practice Leader (PPL) and personal influence tactics used by the PPL will directly and indirectly impact the degree to which the PPLs are able achieve their role functions, thus ultimately impacting the way in which nurses perceive their practice environment. The degree of manager support, as perceived by the PPL will also be investigated as an indication of the personal influence tactics used by the PPL. This research study is the main component of requirements for doctoral research pertaining to the PPL role.

How were you chosen?

You are being invited to participate because of your experience and expertise regarding the PPL role. Your name provided through the Professional Practice Network of Ontario (PPNO) membership list. As an incentive to enhance your participation in the study, you will be provided with a certificate of appreciation for your participation in this research study. This certificate can be used as evidence of meeting your Reflective Practice requirement for the College of Nurses of Ontario annual review.

What is required?

If you agree to participate in this study, you will be asked to complete a total of four questionnaires: Professional Practice Leader Role Questionnaire, Conditions for Work Effectiveness, Influence Behaviour Questionnaire and a short demographics questionnaire. Based on previous pilot testing, the time required to complete all of the items is approximately 45 minutes.

To maintain confidentiality of responses, the questionnaires are available to you on a secure independent web site. You will not be required to provide any personal identification information. Instructions for gaining access to the web-based questionnaires can be found at the end of this letter.

Is this voluntary?

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time. Reminder notices will be emailed to you approximately every three weeks. Should you wish not to participate in the study, please "reply" to this email message, indicating you wish not to participate in the study. This will ensure you do not receive any further reminder notices pertaining to the study.

What happens to the information?

All information collected will be kept confidential and at no point will personal identifiers be collected or used. You will be asked to indicate your current place of employment in order to successfully match responses between PPL and nurse participants. As one of the often cited rationales for the establishment of the PPL role is to enhance the practice environment, this linkage will provide the foundation to establish possible relationships between PPL role effectiveness and nurses' perceptions of their professional practice environments. If the results of this exercise are published, no

information that discloses personal identity will be released. Participants will be informed of the research findings through future meetings of the Professional Practice Network of Ontario.

Risks and benefits to participating?

There are no known risks to your participation in this study. There are no known risks to your participation in this study with any effect on your employment status or status with the College of Nurses of Ontario. As an incentive to enhance your participation in the study, you will be provided with a certificate of appreciation for your participation in this research study. This certificate can be used as evidence of meeting your Reflective Practice requirement for the College of Nurses of Ontario annual review. In addition to receiving the certificate, your responses will contribute to the empirical evidence regarding the impact of the PPL on nursing professional practice environments. Completion of the questionnaires will be considered an indication that you have reviewed this letter, that the nature of the study has been adequately explained to you, any questions have been answered to your satisfaction and that you freely consent to participate in the research.

Questions about the study?

If you have any questions about the conduct of the study, you may contact the Office of Research Ethics by phone (519) 661 – 3036 or email ethics@uwo.ca

Thank you for your time and input. Thank you for considering participation in this study.

To access the Professional Practice Leader Role Research questionnaire, please click on the link below or copy/paste the link directly into your web browser:

http://www.surveymonkey.com/s.aspx?sm=AKyAZitmqtTYjq11ymvmiw_3d_3d

Please keep this message for your future reference and use.

Should you have any questions about the conduct of this study you may contact either:

Dr. Michael Kerr
Assistant Professor,
University of Western Ontario
London, Ontario

Sara Lankshear
PhD Candidate
University of Western Ontario
London, Ontario

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Mickey Kerr PhD (Supervisor)

University of Western Ontario

Sara Lankshear PhD Candidate

University of Western Ontario

Nurse Letter of Information and Consent

Dear Nursing Colleague,

I am writing to invite you to participate in a research study designed to describe the organizational characteristics that are important to the professional practice of nurses in Ontario. The practice environment for nurses plays an important role in your ability to provide excellent patient care and achieve job satisfaction as a nurse. The purpose of this study is to gain a better understanding of the essential elements of a professional practice environment for nurses. This research study is a component of requirements for doctoral research designed to describe professional practice environments for nurses. Your participation in the research study will greatly contribute to knowledge regarding the features of a professional practice environment that are most important to nurses.

How where you chosen?

Your name was randomly selected from the College of Nurses of Ontario membership database. The participants for this study include approximately 6000 Registered Nurses and Registered Practice Nurses who are employed in a full-time or part-time position in an Ontario hospital.

What is required?

If you agree to participate in this study, you will be asked to complete a short questionnaire consisting of 32 items and some information about your professional experience and background. Based upon prior studies, the time required to complete the questionnaire is approximately 20 minutes. Upon completion of the questionnaire, please place it in the attached self-addressed stamped envelope and mail to the researcher listed on the envelope.

Is it voluntary?

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time. Reminder notices will be mailed to you approximately every three weeks. Should you wish not to participate in the study, please return the blank survey in the attached self-addressed stamped envelope. This will ensure you do not receive any further reminder notices pertaining to the study.

What happens to the information?

All information collected will be kept confidential by the researcher and at no point will personal identifiers be collected or used in the presentation of the research finding. Participants are matched to surveys through the use of a unique identification number found on each survey. If the results of this exercise are published, no information that discloses personal identity will be released.

Risk or benefits to participating?

There are no known risks to your participation in this study with any effect on your employment status or status with the College of Nurses of Ontario. As an incentive to enhance your participation in the study, you will be provided with a certificate of appreciation for your participation in this research study. This certificate can be used as evidence of meeting your Reflective Practice requirement for the College of Nurses of Ontario annual review. In order to receive the certificate of appreciation, you must be willing to complete the questionnaire and return the survey to the researcher in the self-addressed, stamped envelope provided. Your name will be matched to the survey identification number on the returned survey in order to provide the certificate. Completion of the questionnaire will be considered an indication that you have reviewed this letter, that the nature of the study has been adequately explained to you, and that you freely consent to participate in the research.

Questions about the study?

If you have any questions about the conduct of the study, you may contact the Office of Research Ethics by phone (519) 661 – 3036 or email ethics@uwo.ca

Thank you for your time and input. Thank you for considering participation in this study.

Please keep this letter for your future reference and use.

Should you have any questions about the conduct of this study you may contact either:

Dr. Michael Kerr

Assistant Professor,
University of Western Ontario
London, Ontario

Sara Lankshear

PhD Candidate
University of Western Ontario
London, Ontario

CURRICULUM VITAE
Sara Lankshear, RN, PhD

Education

University of Western Ontario — London, Ontario
Doctoral program, Nursing Administration
(September 2004 – present; estimated completion May 2011)

Brock University — St. Catherine's, Ontario
Master of Education, 1996

Niagara University — Niagara Falls, New York
Baccalaureate, Nursing 1982

Research & Program Evaluation Studies

The Professional Practice Leader: The role of organizational power and personal influence in creating a professional practice environment for nurses. (Doctoral dissertation research, in progress).

Design and psychometric testing of a scale to measure Professional Practice Leader role functions.

Changing clinician practice: An evaluation of knowledge transfer strategies to enhance physician documentation of cancer stage. (Cancer Care Ontario).

2008 Nursing Plan Reports for Hospital and Long Term Care Sectors. Principle investigator; Funded by Nursing Secretariat, Ministry of Health & Long Term Care. (RFP # FFS-1997.01)

Nursing Plan Phase 3: Implementation of Nursing Plans for Hospital, Long Term Care, Community, Public Health sectors (2007). Principle investigator; Funded by Nursing Secretariat, Ministry of Health & Long Term Care; Grant # 06204B

Nursing Plan Phase 2: Implementation of Nursing Plans for Long Term Care, Community, Public Health sectors and implementation of the revised Hospital sector nursing plan (2006). Principle investigator; Funded by Nursing Secretariat, Ministry of Health & Long Term Care; Grant # 06204A

Review of the Hospital Sector Nursing Plan Template (2004). Principle investigator; Funded by Nursing Secretariat, Ministry of Health & Long Term Care; Grant # 06204

Nursing Longevity: The characteristics and qualities of nurses who choose to remain actively involved in the bedside for 20 years or more. (2001). Co-investigator
Funded by Nursing Professional Advisory Committee, Toronto Rehabilitation Institute.

Nurses reporting to non-nurse managers: Issues of professional identity and accountability (1996). Thesis, Master of Education degree

Publications and Reports

Gilbert, J., Green, E., Lankshear, S., Hughes, E., Burkoski, V. & Sawka, C. (2011) Nurses as Patient Navigators in Cancer Diagnosis: Review, Consultation, and Model Design. European Journal of Cancer Care, 20, 228-236.

Lankshear, S. & Rush, J. (2010). 2008 Hospital Sector Nursing Plan Report. Ontario Ministry of Health & Long Term Care, Toronto, Ontario (RFP # FFS-1997.01)

Lankshear, S. & Rush, J. (2010). 2008 Long Term Care Sector Nursing Plan Report. Ontario Ministry of Health & Long Term Care, Toronto, Ontario (RFP # FFS-1997.01)

Lankshear, S., Lefebre, N., Huckstep, S., Leiterman, J., & Simon D. (2010). The A.L.I.V.E. Program (Actively Leading in Virtual Environments): Development of a web-based professional development program for Nursing Leaders in the Home Healthcare Sector. Canadian Journal of Nursing Leadership. Vol. 23s; 61-74.

Lankshear, S., Brierley, J., Imrie, K. & Yurcan, M. (2010). Changing clinician practice: An evaluation of knowledge transfer strategies to enhance physician documentation of cancer stage. Healthcare Quarterly; 13(1), 84-92.

Lankshear, S. & Rush, J. (2008). 2007 Hospital Sector Nursing Plan Report. Ontario Ministry of Health & Long Term Care, Toronto, Ontario (Grant # 06204B).

Lankshear, S. & Rush, J. (2008). 2007 Long Term Care Sector Nursing Plan Report. Ontario Ministry of Health & Long Term Care, Toronto, Ontario (Grant # 06204B).

Lankshear, S. & Rush, J. (2008). 2007 Community Sector Nursing Plan Report. Ontario Ministry of Health & Long Term Care, Toronto, Ontario (Grant # 06204B).

Lankshear, S. & Rush, J. (2008). 2007 Public Health Sector Nursing Plan Report. Ontario Ministry of Health & Long Term Care, Toronto, Ontario (Grant # 06204B).

Lankshear, S., Laschinger, H., Kerr, M. (2007). Exploring a theoretical foundation for the Professional Practice Leader role. Canadian Journal of Nursing Leadership; 20(1), 62-71.

Matthews, S., Lankshear, S. (2003). Describing the essential elements of a professional practice structure. Canadian Journal of Nursing Leadership Vol. 16 (2), 63-71.

Lankshear, S. , Thompson, G. , Lomaszewycz, Sandy. , Yurcan, M. , Norton, Linda. (2001). Stewarding the resources of patients and residents: The funding support assistant role at West Park Healthcare Centre. Hospital Quarterly, Vol. 4 (3), 64 – 67.

Awards/ Grants

Nursing Leadership Network of Ontario Research Award	2009
Nursing Health Sciences Research Unit; University of Toronto Site; Co-Investigator Small Grants Competition Award 2008/09	2008
Niagara University Nursing Alumni Award For Nursing Leadership	2007
University of Western Ontario, Graduate Student Research Award	2006

Professional Experience

Relevé Consulting Services September 1999 – present

Independent nursing consultant specializing in the areas of professional practice, scope of practice, role clarity, care delivery and professional practice structures and roles.

For an updated list of project work and client list, see information included on website: www.releveconsulting.ca

Examples of project work to date include:
• Design, implementation and evaluation of knowledge transfer strategies to support organizational change initiatives.
• Design, implementation and evaluation of Nursing Plan template within Hospital, Community, Public Health and Long Term Care Sectors (Project funded by the Nursing Secretariat, Ministry of Health & Long Term Care).
• Design, implementation and evaluation of professional practice structures and roles (profession specific and interprofessional)
• Organization restructuring (job analysis and work/role redesign) within a rehabilitation and complex continuing care facility.
• Operational reviews: Quality and utilization processes within a large acute care community hospital; programs and services for a large multi-site organization; including care delivery models, skill mix and staffing patterns.
• Facilitation of organizational strategic direction and planning
• Board self-assessment : customization of a self-assessment tool, evaluation of results
• Focus group facilitation : Walker Panel : SARS debriefing (Ministry of Health & Long Term Care)
• Management development program : measuring the impact of manager development at the point of care
• Design, implementation and evaluation of a Leadership development program
• Review and synthesis of literature regarding evidenced based practice in nursing; generation of discussion paper (unpublished).

Ryerson University — September 2004 - present
Toronto, Ontario
G. Raymond Chang School of Continuing Education
Faculty, School of Nursing
Courses taught
Organizational context of practice
Leadership
Research and Statistical methods
Evolution of theoretical knowledge
Current trends and issues

Lawrence S. Bloomberg Faculty of Nursing — September 2006 - present
Sessional contracts
University of Toronto
Toronto, Ontario
Courses taught (Master level)
Organizational Behavior in Healthcare
Program Planning and Evaluation
Patient Information/Workload Measurement Systems

Sheridan College Institute of Technology and Advanced Learning — September 1990 - 2009
Oakville, Ontario
Part-time Faculty, Educational Assistant program
School of Community and Liberal Studies

Toronto Rehabilitation Institute — January 2000 – March 2003

Corporate Professional Leader, Nursing

Accountable for the advancement of the nursing profession in the field of rehabilitation through innovation and discovery in practice, education and research.
Leadership role in the following initiatives:

• Creation and management of the Patricia Lyon Fellowship Award. This award provides full tuition assistance for nursing employees enrolled in graduate studies in Nursing, University of Toronto)
• Development the Toronto Rehabilitation Nursing Fellowship. Provide direct support and supervision to nursing staff seconded to participate in a research project with support from relevant internal and external nursing leaders. .
• Development of Nursing Professional Affairs Committee structure that includes corporate and program specific components. The purpose of the committee is to promote academic and reflective practice for nursing professionals.

• Development of annual Academic Plan for Nursing in consultation with University of Toronto, Faculty of Nursing academic partner and Nursing Professional Affairs Committee membership.
• Leadership role in the implementation of a computerized Workload Measurement system for all health professionals.

Humber River Regional Hospital July 1996 – September 1998

Director, Organizational Development

Accountable for addressing the organizational development and learning needs within a newly merged multi-site organization. Internal customers range from frontline staff to senior management.
Leadership role in the following initiatives:

• Member, Organizational Design Steering Committee, which was accountable for determining the initial organizational structure and senior roles for the newly merged organization.
• Leadership role in the formal evaluation of the program management structure with development of an action plan to address gaps within structure and systems.
• Team building, role clarity, and process redesign initiatives : post merger and program consolidation
• Design implementation, and quality monitoring of a computerized clinical documentation system utilized by all health care professionals across three sites.
• Design and implementation a profession specific and interprofessional professional practice structure for a multi-site organization.
• Accreditation preparation; member of Steering Committee responsible for overall planning for Accreditation survey as the first hospital surveyed after initial GTA mergers.

York Finch General Hospital January, 1996 – July 1997

Coordinator, Clinical Practice and Professional Development.

Accountable for the development of systems and processes to address the professional development needs of health care professionals within the organization.
Leadership role in the following initiatives:

• Design and implementation of a computerized clinical documentation system utilized by all health care professionals.
• Member, Organizational Design Steering Committee, which was accountable for determining the initial organizational structure and senior roles for the newly merged organization.
• Design and implementation of a professional practice structure, professional practice leader role and orientation program for professional practice leaders

West Park Hospital September 1991 - 1995
Toronto, Ontario

Organizational and Personal Development Consultant.

Accountable for the ongoing assessment of learning needs within the organization and for determining the most appropriate approach to address identified needs.
Leadership role in the following initiatives:

• Design, implementation and evaluation of a professional practice structure for nursing.
• Design and implementation of an internal consulting model, which dramatically changed the way educational services were delivered.
• Design and evaluation of a self-directed learning approach for clinical staff. Evaluation of the program demonstrated a significant decrease in the costs associated with training and an increase in customer satisfaction with the learning process.
• Development a model for determining staffing skill mix for patient care areas that incorporated professional standards of practice, operational considerations, and patient outcomes.

Mohawk College of Applied Arts and Sciences September 1989 – 1990
Hamilton, Ontario
Faculty, Nursing Program, sessional contract

Victorian Order of Nurses 1987 – 1991
Burlington, Ontario
Registered Nurse
Roswell Park Memorial Institute 1982 – 1987
Buffalo, New York
Registered Nurse: Bone Marrow Transplant Unit, Surgical Oncology Unit, Intensive Care Unit

Presentations (Refereed)

Srigley, J., Lankshear, S.; Yurcan, M.; McGowan, T.; Divaris, D.; Rossi, r.; Ross, J.; Brierley, J.; and Sawka, C. (2011). Standardized synoptic cancer pathology reports: So what and Who cares? A population based survey of 970 pathologists, surgeons and oncologists. Paper presentation, United States and Canadian Association of Pathology Annual conference; San Antonio, Texas.

Lankshear, S., Kerr, M., Laschinger, H., & Wong, C. (2010). The role of power, influence and manager support in creating a professional practice environment for nurses. Nursing Leadership Network of Ontario Annual Conference; Toronto, Ontario.

Gilbert, J., Green, E., Hughes, E., Lankshear, S. & Burkoski, V. (March 2010). The Role of Patient Navigation in Cancer Diagnosis: What, Why and Who? Paper presented 16th International Conference on Cancer Nursing; Atlanta, Georgia.

Lankshear, S., Kerr, M., Laschinger, H., Wong, C., & Berdahl, J. (2009). The Professional Practice Leader Questionnaire (PPLQ): Design and psychometric testing of a scale to measure Professional Practice Leader role functions. International Nursing Administration Research Conference; Maryland School of Nursing.

Lankshear, S., Kerr, M., Laschinger, H., Wong, C., & Berdahl, J. (2009). The role of organizational power and personal influence in creating a professional practice environment for nurses. International Nursing Administration Research Conference; Maryland School of Nursing.

Lankshear, S., Kerr, M., Laschinger, H., Wong, C. & Berdahl. J. (2009). The Professional Practice Leader Questionnaire (PPLQ): Design and psychometric testing of a scale to measure Professional Practice Leader role functions. Paper presentation; Daphne Cockwell School of Nursing 2nd Annual Research Day; Toronto, Ontario

Lankshear, S., Kerr, M., Laschinger, H., Wong, C. & Berdahl. J. (2009). The role of organizational power and personal influence in creating a professional practice environment for nurses. Paper presentation; 21st Annual Research Conference; London, Ontario

Lankshear, S. (2009). The impact of nursing culture on the development and utilization of nursing knowledge. Paper presentation Nursing Leadership Network of Ontario Annual conference; Toronto, Ontario.

Lankshear, S. & Kerr, M. (2007). An integrative review exploring the theoretical and empirical literature describing professional practice. Paper presentation; 20th Annual Research Conference: Celebrating Research and Innovation in Achieving Nursing Excellence'; London, Ontario

Lankshear, S., Laschinger, H., & Kerr, M. (2007). Exploring a theoretical foundation for the Professional Practice Leader role. Paper presentation; 20th Annual Research Conference: Celebrating Research and Innovation in Achieving Nursing Excellence'; London, Ontario

Lankshear, S., Laschinger, H., & Kerr, M. (2007). The role of organizational and personal power in creating a professional practice environment for nurses. Poster presentation International Nursing Administration Research Conference (INARC) conference; Indianapolis, Indiana.

Lankshear, S. & Lesmond, J. (2007). Influence : An essential leadership skill. Paper presentation; Nursing Leadership Network of Ontario Annual conference; Toronto, Ontario

Lankshear, S. (November 2006). Professional Practice within and across the LHINs. Panel presentation, Ontario Hospital Association annual conference, Toronto, Ontario.

Lankshear, S. (November, 2006). The impact of nursing culture on the development and utilization of nursing knowledge. Paper presentation, RNAO Health Workplaces in Action conference, Toronto, Ontario.

Lankshear, S. (November 2005). Professional Practice Leader role: Value added or just added? Paper presentation, RNAO Health Workplaces in Action conference, Toronto, Ontario.

Cooper, M., Lankshear, S. (March 2005). Building leadership capacity : An innovative entrepreneurial model. Paper presentation, Nursing Leadership Network of Ontario, Toronto, Ontario.

Lankshear,S. , Melton, D. , Myshkevich, L. , Fedunkiw, L. (March 2004). The ripple effect : The impact of manager development at the point of care. Paper presentation, Nursing Leadership Network of Ontario, Toronto, Ontario.

Lankshear, S., Andrew, J. , Chan A. , Clifford, P. , Cook, K. , Jones, & B. Manzer, I. (May 2004). It started with one call: The creation of a interprofessional practice network. Poster presentation, Nursing Leadership Network of Ontario, Toronto, Ontario.

Lankshear, S., Keirsnowski, W. (May, 2003). Why they stay: The characteristics and qualities of nurses to choose to remain actively involved at the bedside for 20 years or more. Paper presentation, National Rehabilitation Nurses conference, Ottawa, Ontario.

Lankshear, S. (April, 2003). Nursing Longevity: The characteristics and qualities of nurses to choose to remain actively involved at the bedside for 20 years or more. Abstract accepted for paper presentation, University of Toronto, Faculty of Nursing Research Day, Toronto, Ontario; conference canceled (SARS).

Lankshear, S. , Boutcher, F. (April, 2003). Bringing research to the bedside: The vision at Toronto Rehabilitation Institute. Abstract accepted for poster presentation, University of Toronto, Faculty of Nursing Research Day, Toronto, Ontario; conference canceled (SARS).

Seidman-Carlson, R. , Keirsnowski, W. , Lankshear, S. , Campbell, H. (November 2002). Nursing Longevity: The characteristics and qualities of nurses to choose to remain actively involved at the bedside for 20 years or more. Paper presentation, Registered Nurses Association of Ontario, Healthy Workplaces in Action, Toronto, Ontario.

Lankshear, S. , Lutes, P. (November 2002). The Nursing Fellowship: Tapping into the expertise of the experienced nurse. Paper presentation, Registered Practical Nurses Association conference, Beyond the basics: Practical Nursing in Specialty Areas, Toronto, Ontario.

Lankshear, S. (October 2002). Transformative and emancipatory learning: Fostering reflection in the adult learner. Paper presentation, Registered Nurses Association of Ontario Embracing the future: Educating tomorrow's nurses, Toronto, Ontario.

Lankshear, S. , Thachen-cary, M. (November 2001). Sponsoring excellence: Creating a unique leadership opportunity for the experienced nurse. Paper presentation, Registered Nurses Association of Ontario, Healthy Workplaces in Action International Conference, Toronto, Ontario.

Lankshear, S. , Campbell, H., Seidman-Carlson, R. (November 2001). Shifting from clinical to academic practice in rehabilitation nursing. Poster presentation, Ontario Association of Rehabilitation Nurses, Toronto, Ontario.

Lankshear , S. (March 2001). Emancipatory learning : A vital skill for all leaders. Paper presentation for Nursing Leadership Network of Ontario annual conference, Toronto, Ontario.

Campbell, H. , Lankshear, S. , (February 2001). Creating a center of professional excellence: Implementing Strategies at the organizational, professional, and frontline levels. Poster presentation 2001 Nursing Leadership Conference, Ottawa, Ontario.

Cournyea, N. , Krull-Naraj, K., Lankshear, S. (March 1997). The consolidation and transfer of programs and services within a newly merged organization: Lessons learned. Paper presentation, Annual Conference for Health Care Managers and Administrators, Toronto, Ontario

Lankshear, S. (March, 1997). Nurses Reporting to Non-nurse Managers: Issues of Professional Identity and Accountability. Paper presentation, Provincial Nurse Administrators Interest Group Annual Conference, Toronto, Ontario.

Lankshear, S. (November, 1996). Creating Empowered Learners. Paper presentation, Ontario Society for Training and Development annual conference, Toronto, Ontario.

Lankshear, S. (May, 1995). Internal Consultant : New Role for the Nurse Educator. Paper presentation at Innovations in Nursing Education Conference, Toronto, Ontario.

Lankshear, S. (May, 1995). Transformative Learning: Practical Applications for the Nurse Educator. Paper presentation at Innovations in Nursing Education Conference, Toronto, Ontario.

Bell, J. , Lankshear, S. , Larman, M. (March, 1994). Shared Governance and Program Management: Putting Theory into Practice. Paper presentation at Provincial Nurse Administrators Interest Group Conference, Toronto, Ontario.

Lankshear, S. (November, 1993). Evaluating the Effectiveness of Education in the Workplace. Paper presentation at Innovations in Nursing Education Conference, Toronto, Ontario.

Hesch, P. , Lankshear, S. (November, 1993). Program Management: What we have learned through experience and formal evaluation. Paper presentation at Fourth Annual National Rehabilitation Nursing Conference, London, Ontario.

Presentations (Invited)

Lankshear, S. (November, 2006). An end to angels : Nursing as a knowledge based profession. Ontario Perianesthsia Nurses Association of Ontario Annual Conference, Toronto, Ontario.

Lankshear, S. (June, 2006). Professional Practice: A few less shades of grey? Professional Practice Network of Ontario Annual General Meeting, Orilla, Ontario.

Lankshear, S. (November 2005). Patient safety and professional practice: Linking research and practice. 5th Annual Professional Practice Conference, Newmarket, Ontario.

Lankshear, S. (May 2005). Nurses celebrating Nursing. Providence Healthcare, Toronto, Ontario.

Lankshear, S. (May 2005). An end to angels : Nursing as a knowledge based profession. RNAO Simcoe Chapter, Barrie, Ontario.

Lankshear, S. (September 2003). Enhancing leadership in nursing. Ontario Hospital Association, Enhancing Nursing Leadership conference, Toronto, Ontario.

Campbell, H. , Lankshear, S. (February, 2003). Why we choose to stay at the bedside for 20 years and longer: Nurses describe their commitment to care. Nursing academic seminars, School of Nursing, McMaster University.

Lankshear, S. (January, 2003). Are we having the right discussions? What is driving our scope of practice decisions? Ontario Hospital Association, Scope of Practice Summit, Toronto, Ontario.

Lankshear, S. (November 2002). The Interprofessional team : Understanding the various roles. Presentation to Therapeutic Recreation students, Brock University, St. Catherine's, Ontario.

Lankshear, S. , Cook, K. (October 2002). Identifying the essential elements of a professional practice structure. Paper presentation, Tribalism to collaborative practice: Creating a professional practice environment. Toronto, Ontario.

Lankshear, S. , Campbell, H. (October 2002). Competition for excellence: Craving out a role for Rehabilitation nursing. Paper presentation, Ontario Hospital Association, Rehabilitation Nursing: Champions of the processes of care conference, Toronto, Ontario.

Campbell, H. , Lankshear, S. (October 2000). Competing for excellence: Craving out a role for nursing in an interprofessional team. Keynote address for Ontario Association of Rehabilitation Nurses annual conference, Toronto, Ontario.

Lankshear, S. (October, 1997). Fostering Reflective Practice in the Workplace. Paper presented at International Foundation for Action Learning annual conference, Toronto, Ontario.

Lankshear, S. (May, 1996). Nursing Staffs' Perceptions of a Generic Service Manager Position. Paper presented at Quality Mandate: Measuring outcomes of nursing in health care redesign conference, Buffalo, New York.

Professional Activities

Reviewer: Canadian Journal of Nursing Leadership
Reviewer: Journal of Research in Interprofessional Education and Practice
Reviewer: Academy of Management Annual conference: submission of manuscripts
Co-Chair; Mid-Career Working Group; Nursing Secretariat, Ministry of Health & Long Term Care (present)
Steering Committee member: Nursing Workload Advisory Group, Nursing Secretariat, Ministry of Health & Long Term Care (2009)
Registered Nurses Association of Ontario (2009), Board member (Region 5 representative).
Development Panel member, Registered Nurses Association of Ontario (2006). Collaborative Practice among Nursing Teams. Toronto, Canada: Registered Nurses Association of Ontario
Development Panel member, Registered Nurses Association of Ontario (2005). Educator's resource: Integration of best practice guidelines. Toronto, Canada: Registered Nurses Association of Ontario
Professional Practice Network of Ontario (President-elect 2009)
Association of Nurse Executives of Greater Toronto Area (Chair, 2003-2009)
Ontario Hospital Association, Nursing Expert Advisory Group (2003-2004)
Registered Nurses Foundation of Ontario (Board member; Fund Development and Gala Committees)
Assistive Devices Program Ministry of Health & Long Term Care, Sensory Standing Committee (Chair, 2003 – 2007)

Professional Affiliations

Registered Nurses Association of Ontario
Sigma Theta Tau, Lamba Pi at-Large Chapter

Nursing Leadership Network of Ontario
Academy of Management
Ontario Society for Training and Development (Advanced Standing)
College of Nurses of Ontario (Registered in Ontario, 1985)

Volunteer Activities

Board Member, Registered Nurses Association of Ontario; Region 5 Representative
Chair, Board Geogian Bay Cancer Support Centre
Nursing Leadership Network of Ontario, Conference Planning Committee
Thunder Beach Association (2004 – present)
Registered Nurses Foundation of Ontario; Gala Committee
St. Gabriel School Council: Chair and Parent representative (1999 – 2002)