THE LIVED EXPERIENCE OF NURSE PRACTITIONERS PRACTICING WITHIN A PROFESSIONAL PRACTICE MODEL: A PHENOMENOLOGICAL STUDY

A DISSERTATION

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DEDICATION

To Doug, my loving husband, for his unconditional love and support. Without his encouragement I would not be where I am today. The journey has been long, but the travel is sweet with a partner that is my best friend and the love of my life.

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I would like to thank all the people who have contributed to the success of this dissertation. I am sure that I will miss someone in this acknowledgement, but my gratefulness extends to everyone that offered support in my journey.

First, I would like to thank the members of my committee. I would like to thank Dr. Anne Young, my dissertation chair, for offering her leadership and gentle guidance in keeping me on track and providing support along the way. I would like to thank Dr. Lene Symes for her visionary support and expertise in qualitative research. I would like to thank Dr. Nina Fredland for reviewing my manuscript and offering her expertise as a nurse practitioner. I would also like to thank Dr. Marlene Walden, who is my best friend and mentor, for her diligent support of my educational endeavors. She has been my champion and has offered insights into my own abilities to be successful.

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Thank you to Texas Children's Hospital, who encourages research and developing new knowledge not only in clinical arenas, but also in leadership and professional development of all staff. Their support in allowing time to complete the necessary scholarly work has made this academic success possible.

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ABSTRACT

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THE LIVED EXPERIENCE OF NURSE PRACTITIONERS PRACTICING WITHIN A PROFESSIONAL PRACTICE MODEL: A PHENOMENOLOGICAL STUDY

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Professional Practice Models (PPMs) are the gold standard for nursing practice in organizations committed to nursing excellence and quality patient outcomes. The framework for guiding nurses in their practice consists of a system of structure and processes supporting the environment of care. PPMs originated in 1983 and are a required element for all Magnet designated hospitals. This study describes the lived experiences of nurse practitioners (NP) practicing within the Transformational Advanced Professional Practice (TAPP) Model.

While Magnet designated hospitals require PPMs that are reflective of all levels of nursing, a gap exists in supporting nurse practitioners (NP) within a specifically designed registered nurse (RN) PPM. NP professional practice is different in education and training and also different in required competencies. In addition to nursing care, NPs also deliver medical aspects of care guided by their state boards of nursing regulatory requirements. PPMs should reflect the level of professional practice accomplished by NPs. The TAPP Model is an evidence based specific NP PPM that supports a patient care domain and professional development domains of practice.

This phenomenological study describes the lived experience of NPs practicing within the TAPP Model. Interviews were conducted with concurrent data analysis utilized Colaizzi's Methodology and a Mind Mapping Technique resulting in three major themes: 1) transforming professional practice; 2) cultivating the inner self; and, 3) mentoring professional transitions. Transforming professional practice reflected NPs' concept of expanded practice and support needed to effectively interface with the healthcare team. Cultivating the inner self revealed how NPs grew into role expectations and the embodiment of professional practice roles within their human experience. Mentoring professional transitions spoke to how PPMs were useful devices to guide new NPs in their role development.

Findings identified that elements of the TAPP Model are inextricably interwoven with NP professional practice and development. Implications for NP practice include informing hospital organizations, leaders, and NPs about the importance of transitioning RN roles to NP roles through the development and implementation of specific NP PPMs. Research implications include additional studies measuring the impact of NP-specific PPMs on role and job satisfaction, retention, and patient outcomes.

TABLE OF CONTENTS

LIST OF TABLES

Table Page

LIST OF FIGURES

CHAPTER I

INTRODUCTION: PROFESSIONAL PRACTICE MODELS

Focus of Inquiry

Control over professional practice and the environment in which nursing care is delivered requires a system of support that can be defined by a professional practice model (PPM). Hoffart and Woods (1996) defined a PPM as a system of structure, process, and values supporting the delivery of nursing care in the environment in which care is delivered. Chamberlain et al. (2013) states the attributes of autonomy, accountability, professional development, and attention to quality care are best supported in an environment with an established PPM. Organizations that subscribe to PPMs will see positive patient care outcomes and improved job satisfaction (Chamberlain et al., 2013).

As early as 1983, the American Academy of Nursing (ANA) began its focus on hospital environments that supported professional nursing. Retaining talented nurses that deliver quality patient care was gaining the attention of organizations across the county. In 1994, the American Nurses Credentialing Center (ANCC) recognized the first Magnet®-designated hospital (ANCC, 2014). Today, there are 418 Magnet®-designated hospitals recognized both nationally and internationally. Magnet®-designated organizations believe that the pathway to nursing excellence is nursing innovation in professional nursing practice and quality patient outcomes. Magnet®- designated

hospitals define the characteristics of exemplary nursing practice and are responsible for the development and implementation of PPMs (ANCC, 2014). Understanding what constitutes a PPM requires a good foundation of what a PPM does and knowledge of what constitutes professional nursing practice (Berger, Conway, & Beaton, 2012). The defining attributes that PPMs share in Magnet® designated organizations include autonomy, empowerment, and cost-effective quality care. PPMs provide theoretical frameworks that guide how nurses will exert control of their professional practice, assist in defining variation in patient care, and predict patient outcomes (Anthony, Brennan, O'Brien, & Suwannaroop, 2004; Luzinski, 2011).

Of the 2.8 million practicing nurses in the United States, over 205,000 are nurse practitioners (NPs) (ANCC, 2014; HRSA, 2013). Nurse practitioners are registered nurses with advanced education and training and are often included in conversations for nursing in general. However, professional practice is different, competencies are different, and there is a difference in the standard of professional development that cannot be inclusive of the basic RN role. While Magnet® designation reflects the practice of nursing and the support of a PPM inclusive of NPs, there remains a gap in the literature between the practice of nursing and the advanced practice nurse as part of the organizational PPM.

The impetus for this study followed the development and implementation of a NP PPM in a large pediatric and women's hospital in Houston Texas. With the rapid growth of NPs over a period of two years the organizational and professional leaders of NPs desired a framework that would guide professional practice and professional

development. The Transformational Advanced Professional Practice (TAPP) Model was developed, implemented and has been in place for the past three years at Texas Children's Hospital (TCH). The model was adapted from an acute care advanced practice registered nurse (APRN) model created at Strong Memorial Hospital in 1996. The TAPP Model is based on Benner's novice to expert for clinical practice and professional development (Ackerman, Norse, Martin, Wiedrich, & Kitzman, 1996); Benner, 1984). The direct comprehensive family-centered care domain of the TAPP Model forms the essence of APRN practice. Professional domains of the model include organizational priorities, quality and safety, evidence-based practice and research, education, transformational professional practice, and credentialing and regulatory practice. A thorough review of the model is needed to assess outcomes related to professional development that will continue to support NP practice. Such a review will also provide guidance for other institutions as they implement PPMs for NP practice.

Statement of Purpose

This study provided an evaluation of the application of the TAPP Model as it relates to the professional development of NPs. Discovery of how NPs experience the TAPP Model in their daily clinical practice will inform professional development and add to the body of knowledge of nursing. The purpose of this study will answer the research question, "What are the lived experiences of nurse practitioners practicing within the Transformational Advanced Professional Practice Model?"

Rationale for the Study

Developing and implementing a PPM that sets expectations of the role and competencies basic to the practice of a NP demands validation. As with evidence-based clinical practice, PPMs impact patient care outcomes, organizational strategies, and provide a framework for scholarly advancement of NPs (Chamberlain et al. 2013; Stallings-Welden & Shirey, 2015). Chamberlain et al. (2013) states that when a nurse can articulate the impact of a PPM, decision-making is improved and nurses develop their own professional identity. Although quality-outcomes data are not available to measure the specific impact NPs attribute to practicing within a PPM, nursing excellence literature supports that significant positive patient outcomes are associated with a PPM that supports the environment of care and alignment within the organizational context (Stallings-Welden & Shirey, 2015). The elements of the PPM are integrated into a system that should function efficiently and effectively, making the whole greater than the sum of its parts (Chamberlain et al., 2013). PPMs are meant to be dynamic, assuring that changes to the model will occur when practice expectations occur and competencies change as NPs move from novice to expert.

The need for PPMs is supported in the literature and the authors of the pioneering models have met the obligation to represent the responsibility of organizations, educational institutions, and personal responsibility for professional develeopment (Ackerman et al. 1996; Brown, 1998; Calkin, 1984; Elliott & Walden, 2015; Erickson & Ditomassi, 2011; Hamric, 2009; Hitchings, Capuano, & Bokovoy, 2010; Oberle & Allen, 2001; Shuler & Davis, 2007). The literature does not address the NPs perspective of how

the application of a PPM supports professional practice and professional development. Nurse practitioner perspectives of how PPMs are applied to practice are part of the evidence needed to measure the outcomes of professional practice and professional development.

Study Assumptions

This study was based on the following assumptions:

1. NPs working within the TAPP Model will have evidence of transformational professional practice through dissemination of knowledge beyond the NPs' practice setting.
2. NPs are able to describe their experiences of practicing within the TAPP Model.
3. The interview process will elicit data to inform the research question.
4. Purposeful sampling will allow the researcher to recuit NPs who are actively participaing in the TAPP Model with evidence of professional development since the inception of the model.
5. The direct exploration, analysis, and description of the lived experience of NPs practicing within the TAPP Model will assist in understanding the application of the TAPP Model and opportunties needed for NPs to be successful within a PPM.

The researcher has been a RN for more than 26 years and has been a NP in the neonatal intensive care (NICU) for 19 of those years. The researcher currently is the director of advanced practice providers for a large healthcare system.

Philosophical Underpinnings

Turning from a reflective awareness to understand the lived experience requires phenomenological reduction, bringing all the subtle elements into clarity. Understanding the essences (eidos) of the experience is necessary and invariant. It is necessary because the essence illuminates the essential characteristics of the phenomenon and invariant because the lived experiences will reveal a pattern that is constant. A second reduction is required to understand the essence of the experience (eidetic reduction) (Husserl, 1980). Husserl's descriptive (eidetic) phenomenology serves as the philosophical underpinning for this study.

Husserl believed that people intentionally go about the daily business of living without giving critical thought to their experiences and their perceived experiences as having scientific value (Husserl, 1970). He believed that these acts of intentionality are a phenomenological property of mental states or experiences that inform states of conscious awareness. Only through retrospective examination of an experience that is already lived through can one really "reflect" on the lived experience. A person cannot truly reflect on the lived experience while being in the moment. Nursing as a profession has long been involved in accessing the lived experiences of their patients through thoughtful inquiry. The *ideal of rigorous science* is the systematic investigation of the essence of everything considered empirical, thereby giving absolute clarity to the distinct

differences between levels of inquiry (Husserl, 1970). Phenomenological research provides insight into the life-world, the world of the lived experience, that is not readily accessible in what Husserl calls the "natural attitude." This attitude is taken for granted and is thought to be so common that failure to see what surrounds us demands a phenomenological study to uncover the fundamental structures of our life-world. Within the *natural attitude*, according to Husserl (1980), we already know about characteristics of the phenomenon, the framework, and the meanings associated with the phenomenon. But without a phenomenological attitude, we are unable to ask what makes the PPM a PPM; what constitutes *it* as a PPM. By intuiting, we can state what characteristics *it* must maintain to stay a PPM. The PPM's essential meaning, its 'essence', cannot be discovered without raising and answering these questions within a phenomenological attitude in such a way as not to take the meaning for granted.

Grounding the Husserlian approach in phenomenology supports the wisdom that the science of origins is recognized as the "mother of all cognition"; "everything leads back" to the "maternal-ground of all philosophical methods" (Husserl, 1980, p. 51). His belief that human experiences contain meaningful structures in relation to being (ontology) and that nature and ground represents knowledge (epistemology) are wholly present in his *philosophic radicalism.* Husserl believed fundamentally you bear responsibility for yourself and for your culture, an *ethos of radical autonomy* (Cohen & Omery, 1994).

There are essential structures that make up the lived experiences that are concrete, contextually bound, and occur within discrete circumstances (O'Brien, Martin,

Heyworth, & Meyer, 2009; van Manen, 1990). By using eidetic reduction, these structures are discovered and understood through *imaginative variation* to discover the essential characteristics representing the *respect for wonders*, exemplified by being aware of self and aware of others (Chan, Fung, & Chien, 2013). Phenomenology aims to gain a deeper understanding of the meaning of everyday experiences and guides understanding of what is experienced by the individual. The *intentionality of consciousness* is an act that gives direction toward an object and the experience reveals the object as it is, a way to define perception as reality (Cohen & Omery, 1994; Smith, 2003). Husserl's influence in this study will provide directed awareness supporting impartiality, preconcieved notions, and any researcher bias through the technique of bracketing.

Summary

Professional practice models provide a guide for nursing practice that supports autonomy, empowerment, and cost-effective quality care. While PPMs are used by both registered and advanced practice nurses, the differences in the levels of education and training of RNs and NPs, influence how PPMs are used in practice. The TAPP model is a PPM specifically designed for NPs. Discovering how NPs apply specifically designed PPMs not only defines practice roles, it contributes to the overall professional development needed to support continuous learning and mastery of competencies. This phenomenological study described the experiences that underpinned the application of the TAPP Model of NPs practicing within the model.

CHAPTER II

REVIEW OF LITERATURE

This chapter is an article published in *Journal of the American Association of Nurse Practitioners.*

Elliott, E. C., & Walden, M. (2015). Development of a transformational advanced professional practice model. *Journal of the American Association of Nurse Practitioners, 27*(9), 479-487. http://dx.doi.org/10.1002/2327-6924.12171

Development of the Transformational Advanced Professional Practice Model

Abstract:

Purpose: The purpose of this article is to describe the development of a professional practice model (PPM) for advanced practice registered nurses (APRNs).

Data sources: A literature review was conducted on PPMs. Simultaneous review of authoritative resources, including The National Organization of Nurse Practitioner Faculties (NONPF) and the Licensure, Accreditation, Certification and Education (LACE) Consensus Model, was performed. An expert panel was established to validate the transformational advanced professional practice (TAPP) model.

Conclusion: APRNs are relied upon by organizations to provide leadership in the delivery of high-quality, cost-effective healthcare while improving access and eliminating preventable morbidities. Existing models fail to fully capture the professional scope of practice for APRNs. The TAPP model serves as a framework to guide professional

development and mentorship of APRNs in seven domains of professional practice (DOPP).

Implications for practice: To meet the Institute of Medicine's recommendations for the future of nursing, APRNs should practice to the fullest extent of their education and training. Providing clarification regarding the DOPP of the APRN role is needed to standardized professional practice. The TAPP model is an inspiring blueprint that allows APRNs to model the way by delivering comprehensive health care in seven DOPP.

Key words:

Advanced practice nurse (APN); nurse practitioners; practice models; professionalism.

Introduction

Advanced practice registered nurses (APRNs), numbering over 266,000 are at the epicenter of excellence in nursing and quality patient outcomes (Okrent, 2012). APRNs are relied upon by organizations to provide leadership in the delivery of high-quality, cost-effective health care while improving access and eliminating preventable morbidities. APRNs are the highest level of nursing at the bedside and are expected to advance nursing through direct care, research, education, leadership, and various other scholarly activities (Ackerman, Norsen, Martin, Wiedrich, & Kitzman, 1996). In order for the APRN role to flourish, the domains of professional practice (DOPP) must be distinct, recognizable, and describable. Existing models for APRN practice fail to fully capture the professional scope of practice, leaving APRNs and healthcare organizations uncertain regarding APRN practice. This article describes a model that outlines the DOPP of the APRN.

Background

In the 21st century, healthcare reform is changing the face of the nation. By virtue of their numbers, scientific knowledge, and adaptive capacity, APRNs are poised to assist healthcare organizations to transform the health- care system to meet the demands for safe, quality, and affordable care (The Future of Nursing: Leading Change, Advancing Health—Institute of Medicine, 2010). Results of a systematic review indicate that APRNs have similar or better outcomes than care provided by physicians in areas such as patient satisfaction, health and functional status, cost of care, length of stay, complication rates, and mortality (Newhouse et al., 2011). In order to meet the goals of high-quality

health care, APRNs should be allowed to practice to the full extent of their education and training (AANP—IOM Future of Nursing, 2011). This will allow APRNs to supplement the healthcare system to improve access to care and support reform efforts (Newhouse et al., 2011).

Quality, cost, and access to health care are high priorities for global healthcare systems. However, the optimal model of care delivery and the role of the APRN within the model remains elusive and under debate (Dunphy & Winland-Brown, 1998; Gardner, Chang, Duffield, & Doubrobsky, 2013; Newhouse et al., 2011; Pearson, 2011). A clear vision and reduction of role ambiguity is an imperative for the discipline. Defining professional practice within an organization is necessary in order for APRNs' professional practice to be more visible and effect meaningful change for patients, families, communities, and our current healthcare system (Gardner et al., 2013; Lowe, Plummer, O'Brien, & Boyd, 2012; Storey, Linden, & Fisher, 2008). Professional practice models (PPMs) should be used as systems of care to support the APRNs' control over professional practice and the environment in which care is delivered. The American Nurses Credentialing Center states that a PPM is a "schematic description of a theory, phenomenon, or system that depicts how nurses practice, collaborate, communicate, and develop professionally to provide the highest quality care for those served by the organization (e.g., patients, families, community)" (Luzinski, 2011). A stable, robust PPM for APRN practice will depend on the extent to which the APRNs practice is fully incorporated into systems of care, including structure, process, and outcomes (Spross &

Lawson, 2009). This will require a strong centralized leadership approach to ensure success (Bahouth et al., 2013).

Description of the model

Strong Memorial Hospital was the first to publish an advanced practice model for the acute care APRN, which has been validated by several other researchers (Chang, Garnder, Duffield, & Ramis, 2010; Doerksen, 2010). The Strong model places the family at the core and consists of five domains of practice—direct comprehensive care, support of systems, education, research, and publication and professional leadership. The domains of practice are linked through unifying strands that include empowerment, scholarship, and collaboration (Ackerman et al., 1996). Benner's model of novice to expert forms the clinical expertise continuum of the Strong model and pro- vides guidance for professional development within the domains of practice (Benner, 1984).

The Texas Children's Hospital's transformational advanced professional practice (TAPP) model for APRNs was adapted from the Strong model of advanced practice. The elements of the Strong model were expanded based on the current conceptualization of the APRN role. Two additional DOPPs were added to include quality and safety and credentialing and regulatory practice. Professional ethics was also added as a unifying strand. Several of the domains in the Strong model of advanced practice were renamed in the TAPP model to provide additional clarity to the model.

As with other APRN models, advanced practice is built upon the basic foundation of the art and science of nursing practice. At Texas Children's Hospital (TCH) the PPM for registered nurses (RNs) provides the root system for the TAPP model and consists of

the elements of professional values, professional advancement, collaborative relationships, and leadership and governance. The core values contained within the RN PPM provides a solid foundation on which to build APRN practice that ultimately results in quality and safe patient outcomes.

Certain core criteria or qualifications are required before a nurse is eligible to be recognized as an APRN. The APRN consensus workgroup and the National Council of State Boards of Nursing Committee have drafted a new model for future APRN regulation that incorporates clear expectations for licensure, accreditation, certification, and education for all APRNs with a targeted timeline for full implementation of the model by 2015 (Stanley, 2009). These baseline criteria are also necessary core elements for entry into the TAPP model. First, the APRN must have earned a graduate degree with a concentration in an advanced practice nursing role and specialty. The second criterion requires the APRN to hold national certification in the given specialty. These criteria must be met before the APRN can gain recognition at the state level.

In the TAPP model there are four major elements. The elements include domains of practice, unifying strands, continuums of practice, and core competencies (Figure 1).

Domains of professional practice (DOPP)

The TAPP model consists of one patient care domain and six professional development domains. The direct comprehensive family-centered care domain forms the essence of the APRN role and informs and shapes the execution of the six professional development domains: (a) organizational priorities, (b) quality and safety, (c) evidence-based practice and research, (d) education, (e) transformational professional practice, and

(f) credentialing and regulatory practice. While the percent effort in the domain of direct comprehensive family-centered care is weighted the highest, the extent to which individual APRNs choose to lead in each of the professional development domains are flexible. The time each APRN devotes to practice within each domain may vary depending on organizational requirements, needs of the population served, and the individual APRNs interests and strengths.

Figure 1 Transformational advanced practice provider model.

Direct comprehensive family-centered care. According to the TAPP model, direct comprehensive family-centered care consists of patient focused activities, such as assessments, diagnostic and therapeutic procedures, interpretation of data, patient

management, and patient/family counseling. While APRNs are empowered to make independent assessments and decisions within their scope of practice, scholarly inquiry and collaboration with the multidisciplinary team in the delivery of care is critical for optimal patient outcomes.

Organizational priorities. Organizational priorities describe activities that promote operational effectiveness. APRNs utilize systems acumen to engage major stakeholders in evaluation of care practices and problem resolution that ultimately leads to organizational efficiencies and improved outcomes related to quality, patient satisfaction, and access to care. APRNs influence and advocate for best practices by leading clinical teams, chairing committees, and directing other initiatives aimed at improving patient care and/or the clinical practice of nurses and other professionals.

Quality and safety. This domain focuses on the degree to which healthcare delivery is safe, effective, timely, efficient, equitable, and patient/family centered. APRNs must be able to effectively participate in and lead interdisciplinary teams toward data based conclusions and process improvements. It is critical that APRNs become proficient in the use of tools and information systems that support quality improvement and safe patient outcomes.

Evidence-based practice and research. The APRN is a pivotal factor in promoting evidence-based practice and research in any clinical setting. The APRN is expected to engage in scholarly activities that seek to generate and apply best evidence to support patient- and family-centered care or the advanced practice role. This domain

supports a culture of clinical inquiry through the generation of knowledge and the translation of research findings that leads to quality patient outcomes.

Education. The education domain is central to APRN professional practice. The APRN assesses learning needs and uses educational strategies to promote knowledge development of students, peers, nursing staff, and inter-disciplinary colleagues. The APRN uses professional expertise to develop educational programs and resources that address specific patient- and family-learning needs. APRNs also educate the public on pertinent health-care issues related to specialty care practice and the APRN role.

Transformational professional practice. This domain involves professional activities that transform professional practice through promotion and dissemination of healthcare knowledge beyond the APRN's practice setting. Selected activities in this domain include professional organizational membership and involvement, presentations, publications, and legislative and policy making activities that influence health services and the APRN role.

Credentialing and regulatory practice. The domain of credentialing and regulatory practice incorporates activities related to licensure, credentialing, certification, billing and coding, reimbursement, and other regulatory requirements. It is vital that the APRN take accountability for their professional practice by adhering to professional and regulatory standards that affect the APRN's practice. This domain also emphasizes the importance of being involved in professional activities such as educating lawmakers on APRN issues or seeking appointments on advisory committees and task forces and other regulatory and credentialing bodies.

Continuums of professional practice

In the TAPP model, three superimposed continuums describe the professional practice and development of the APRN: the clinical expertise continuum, the health continuum, and the role continuum (Figure 2). On the clinical expertise continuum, there is a progression of the APRN from novice to expert in the provision of care in all seven DOPPs (Benner, 1984). The level of clinical expertise may vary for each individual APRN depending on years of APRN experience, differing roles, and specialty experiences. On the health continuum, APRNs advance in their clinical and role expertise from being able to successfully provide care for patients who are healthy or have common, stable, or chronic health conditions to caring for patients with more complex, acute, critical, or rare conditions. On the role continuum, the APRN is initially dependent on colleagues and mentors for consultation and supervision in the provision of direct patient care and varied role responsibilities. With clinical and role experience, the APRN moves from a dependent role to assume a more independent role in each of the patient care and professional development domains of practice. In the Direct Comprehensive Patient and Family Centered Care Domain, the practice of the APRN progresses along the three continuums. However, in the six professional development domains, only the clinical expertise continuum and the role continuum are active.

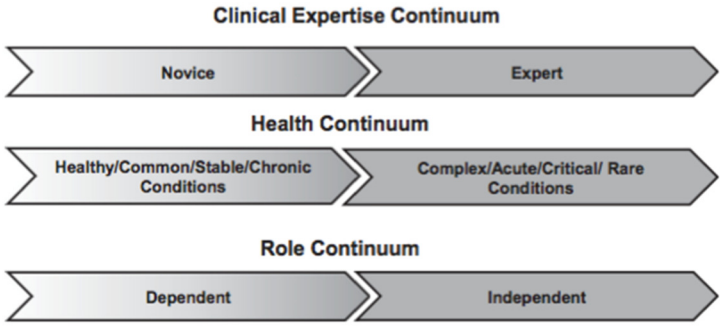

Figure 2 Continuums of professional practice.

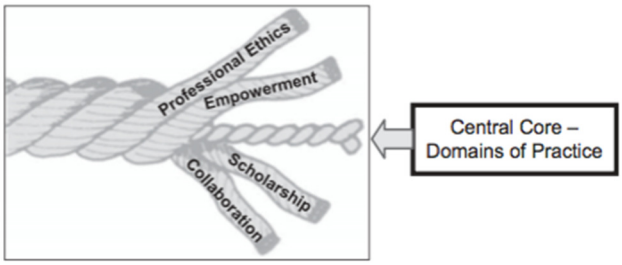

Figure 3 Four strands of advanced professional practice.

Conceptual Strands

Four unifying conceptual strands describe the attributes of professional practice, approach to care, and professional attitudes that define APRN practice within the TAPP model. The strands are professional ethics, empowerment, scholarship, and collaboration and are woven throughout the DOPPs.

Professional ethics. Professional ethics is the personal and organizational standards of behavior expected of the APRN. This moral philosophy guides the APRN in identifying, organizing, analyzing, and justifying choices by applying the principles of ethics needed to determine the right thing to do in a given situation.

Empowerment. Empowerment bestows the APRN with both the authority and accountability to identify and analyze relevant problems and to develop, implement, and evaluate a plan of action within their scope of practice. Empowerment is central to the

APRN role and requires the APRN to actively participate in decision-making within the boundaries of the APRN's specialty knowledge and expertise.

Scholarship. Scholarship signifies the constant inquiry that underlies every action and decision of the APRN and incorporates professional activities that systematically advance the teaching, research, and practice of health care. Without scholarly inquiry, APRN practice does not exist.

Collaboration. Collaboration represents the belief that the unique skills and abilities of various care providers, in combination, contribute to the goal of excellence in patient- and family-centered care. Collaboration represents a synergistic alliance that maximizes each team member's commitment and contribution to quality patient care.

Figure 3 depicts the relationship between the unifying strands and the DOPPs that are at the core of APRN practice. The purpose of the core is to guide practice and professional development. The unifying strands are positioned helically around the core domains and serve to influence and provide strength to the APRN's practice.

Core competencies

Four levels of core competencies represent a continuum of learning and career progression as the APRN progresses from dependent to independent, novice to expert in their practice. In the TAPP model, beginning APRN competencies are derived from shared core competencies for entry into practice from the National Organization of Nurse Practitioner Faculties (NONPF; Thomas et al., 2011). As APRNs develop clinical and professional expertise over time, core competencies are expanded to guide continued professional development. For example, in the domain of evidence-based practice and

research, an entry-level competency may be to identify potential areas of research related to clinical practice or specialty role. As the APRN progresses from novice to expert, the APRN would participate in progressively more advanced activities, such as data collection for a clinical study, collaborating with others to write and implement a clinical research study, and writing a grant to obtain funding for a proposed research study. These competencies within the DOPPs are not intended to be either mutually exclusive categories or an exhaustive list of exemplar core competencies (Table 1).

Implementing the TAPP model

Implementing an APRN PPM is a highly complex organizational change that requires strategic planning and expert leadership in order to be successful. Incorporating a PPM meets the challenges of clarification of the domains of practice of the APRN role and forms the basis for standardizing the process for hiring, orientation, performance appraisals, and professional development. In addition to an APRN PPM, a strong centralized leadership model is needed to reduce role ambiguity and meet the professional needs of APRNs in complex hospital environments (Bahouth et al., 2013; Gardner et al., 2013). The leadership team must work in collaboration with Human Resources to design a targeted recruitment plan that takes into account the alignment of the candidate's qualifications with the collective talents of the current workforce. Advertisements, behavioral interviews, and job descriptions should drive recruitment strategies to ensure the candidates fit within the organization.

Within the TAPP model, a performance cycle of planning, performing, and evaluating phases is used to guide professional development of the APRN. The planning

phase includes activities such as a structured orientation and outlining a professional development plan that matches the APRN's interests with appropriate mentors. Alignment of core competencies and reaching agreement on the development plan are critical elements in the planning phase. The performing phase includes documenting performance, feedback, coaching, and interim reviews. The evaluating phase includes annual performance review for continued progress and development. Recognition of exemplary practice and dissemination of achievements through annual reports should highlight the collective talents of the APRNs within the organization (Figure 4).

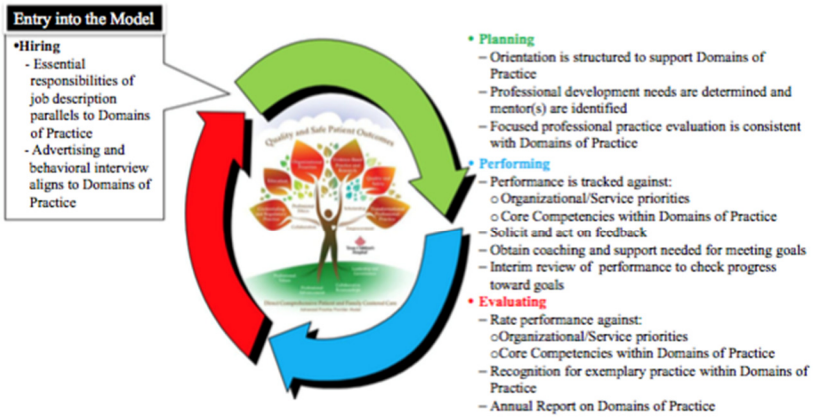

Figure 4 Organizational approach to application of the TAPP model.

Case study

Melody is a graduate nurse and is new to the organization. She has recently completed her bachelor's degree in Nursing and was hired as an RN in the neonatal intensive care unit (NICU). As a new hire, Melody was assigned a preceptor, according to standard organizational practice. At TCH, nursing leadership uses a PPM to guide training and development of all nursing employees. Melody is mentored in her RN

practice by senior nurses and leadership in the areas of professional values, professional advancement, collaborative relationships, and leadership and governance to provide quality care for neonatal patients and their families. After 5 years of nursing experience, Melody returns to school and obtains her master's degree in Nursing as a Neonatal Nurse Practitioner (NNP). Following graduation, she accepts a position as an NNP in the NICU.

Table 2 summarizes Melody's professional development according to the DOPPs identified within the TAPP model. The TAPP model assisted Melody and her leaders in developing a robust plan for professional development within the organization. Over time, the TAPP model continued to guide Melody in transformational professional practice through publications, presentations, and professional organizational involvement. The TAPP model also provided the opportunity for partnerships with patients, families, communities, and the healthcare system in the delivery of high-quality, cost-effective health care.

Future directions

The TAPP model can be used to lay the foundation for advanced practice providers at all levels within the organization. The model can be easily adapted to guide the professional practice of Clinical Nurse Specialists, Certified Nurse Midwives, Certified Registered Nurse Anesthetists, and Physician Assistants. While the DOPPs continuums of professional practice and unifying strands remain the same, the entry-level core competencies and the emphasis on the percent of effort within the DOPPs may vary based on national standards, organizational requirements, the needs of the population served, and the individual advanced practice providers interests and strengths. The TAPP

model may be used as a framework in an incentive program for advanced practice providers and should serve as the basis for performance evaluations. Future research is needed to establish the validity of the model to guide advanced practice providers professional practice and their contributions to quality outcomes.

Conclusions

The TAPP model serves as a conceptual framework to guide professional development and mentorship of APRNs. When successfully implemented, the TAPP model will benefit the patient/family, the APRN, the organization, and the profession of nursing. However, disregarding the importance of one's professional practice can hinder professional growth, longevity, career advancement, and impair organizational effectiveness. The TAPP model will be useful to other organizations as a blueprint for establishing the structures and processes to support exemplary advanced practice.

Table 1 Exemplar core competencies within domains of practice

Direct Comprehensive Family-Centered Care
- Improved knowledge of pathophysiology, evidence-based practice standards of care, and practice guidelines in planning and implementing care
- Advanced critical thinking and diagnostic reasoning skills in clinical decision making
- Providing the full spectrum of healthcare services between inpatient and outpatient setting
- Lead or participate in palliative and end-of-life care
- Advancing skills necessary to recognize and respond to clinical emergencies
- Increasing knowledge and skills in partnering with patients/families from diverse cultures and ethnic backgrounds in the delivery of health care
- Increasing knowledge and skills to resolve complex ethical issues
- Increasing skills in collaboration and conflict resolution to improve patient care management
- Serve as a consultant in improving patient care in area of specialization

Support of Organizational Priorities
- Lead or participate in the development, implementation, and evaluation of policies, procedures, or practice guidelines
- Lead or participate on a committee or task force responsible for review and update of evidence-based clinical protocols for practice
- Lead or participate in use of technology, such as clinical information systems, to promote safe, quality, and cost-effective care
- Lead or participate in an organizational or medical staff committee or council

Quality and Safety
- Lead or participate in quality and safety initiatives
- Lead or participate in analyzing and recommending products, processes, or system changes that would result in costs savings for the department and/or organization
- Lead or participate in benchmarking best practices or developing a business plan to support departmental or organizational quality or safety initiatives
- Attend and complete a quality project for Lean Six Sigma course or an Advanced Quality Improvement Program

Evidence-Based Practice and Research
- Lead or participate in development of evidence-based guidelines and order sets related to an area of clinical practice
- Serve as a primary investigator or collaborate with others to write and implement a clinical research study
- Write a grant to obtain funding for a clinical research study and/or program development
- Serve as a research mentor for research design, implementation, obtaining Institutional Review Board (IRB) approvals, grant writing, and dissemination of findings

Education
- Develop and use innovative educational strategies to more effectively engage adult learners
- Lead or participate in a journal club or an educational offering within department or organization
- Lead or participate in problem-based learning/medical simulation to improve initial or ongoing core knowledge and skill competencies
- Serve as a mentor for students, staff, peers, or interdisciplinary colleagues
- Partner with academic institutions to provide lectures or skills laboratory for advanced practice providers
- Lead or participate in development of educational programs/resources to support patient/family learning needs
- Lead or participate in community-based initiatives

Transformational Professional Practice
- Lead or participate in a committee/taskforce of a professional organization at the local, regional/state, or national/international level
- Serve on a Board of Directors for a professional organization at the local, regional/state, or national/international level
- Present at a local, regional/state, or national/international professional conference
- Author/coauthor/editor of a journal manuscript, book chapter, online course, or healthcare textbook
- Serve on an editorial board or as a reviewer of a professional peer-reviewed journal
- Lead or participate in legislative and policy-making activities that influence roles and healthcare reform

Table 2 Case study of APRN professional development by DOPP

Core Criteria: Entry into the APRN Role
Education
■ MSN → PhD
National Specialty Certification
■ Certified as an NNP
Licensure
■ APRN state recognition
Direct Comprehensive Family-Centered Care
■ Graduate NNP in NICU → 30 years of NNP experience
■ Leader in palliative and end-of-life care
■ Leader in interfacility transport program
■ Chief NNP in community partner hospital
Organizational Priorities
■ Member of Pain Committee charged with development of evidence-based guidelines on assessment and management of pain in the NICU[a]
■ Chair of Research Council[a]
Quality and Safety
■ Leader in department and hospital-wide quality pain initiative
■ Participant in organizational quality and safety priorities (pressure ulcers, blood stream infections, etc.)
■ Participant in Advanced Quality Initiative Program
Evidence-Based Practice and Research
■ Member of Pain Committee charged with development of evidence-based guidelines on assessment and management of pain in the NICU[a]
■ Chair of Research Council[a]
■ Nurse scientist and grant writer—NIH grant to study pain in preterm neonates
■ Staff consultation: research and evidence-based practice[a]
■ Lead faculty, Research Scholars Program[a]
Education
■ Academic appointment in School of Nursing's NNP Program
■ Author, children's book to prepare siblings of NICU infants
■ Faculty, community in neonatal education initiatives
■ Lead Faculty, Research Scholars Program[a]
Transformational Professional Practice
■ Planning Committee member, regional and national neonatal and perinatal professional conferences
■ Editorial board, neonatal journals
■ Board of Directors, National Association of Neonatal Nurses (NANN)
■ Distinguished Service Award, NANN
■ Author, NANN Pain Guidelines
■ Invited keynote presenter on pain in neonates at regional and national conferences
■ Editor, Core Curriculum for NICU
■ Consultant on pain assessment and management in other regional/national NICUs
Credentialing and Regulatory Practice
■ Peer review, nurse practitioner practice
■ Member of Medical Staff Committee

[a]Activity that crosses several domains of practice.

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CHAPTER III

METHODS

Procedure for Collection and Treatment of Data

This study used Husserl's descriptive (eidetic) phenomenology as a direct exploration, analysis, and description of the lived experience of NPs practicing within the Transformational Advanced Professional Practice (TAPP) Model and sought to examine more fully the essences of thoughts and feelings in order to ensure understanding is achieved (Sandelowski, 2000; Streubert & Carpenter, 2011). Husserl's descriptive phenomenology was used to reveal subjective information in seeking to understand NPs' motivation and actions that are influenced by what they perceive as real (Flood, 2010; Reiners, 2012). Husserl's approach includes four main steps: bracketing, intuiting, analyzing, and describing. Central to the phenomenological approach is the ability to enter into the investigation of the study with an a priori knowledge of the phenomenon (Natanson, 1973). The researcher had knowledge and experience with the development and implementation of the TAPP Model. Empirical subjectivity was suspended through the process of bracketing. Imaginative variation through Mind Mapping was used to bracket the essence of the researcher's personal thoughts and feelings surrounding the experiences of NPs practicing within the TAPP Model. This chapter presents material regarding the study setting, participants, protection of human subjects, data collection, analysis, and study rigor.

Setting

This study took place at Texas Children's Hospital (TCH) located in Houston Texas; one of the largest medical centers in the world. TCH is a not-for-profit organization and is one of the top-ranked pediatric hospitals in 10 specialties. The U. S. News and World Report ranks TCH number four among all hospitals nationwide. The host facility is a quaternary academic pediatric and women's hospital and ambulatory care center. The host facility has a capacity of 650 beds and over 3.3 million completed patient-encounters annually.

Participants

The sample of participants met the following criteria:

Table 3.1

Participant Criteria

Inclusion Criteria
• Recognized as NP through the Texas State Board of Nursing; • Employed at the host hospital main campus and credentialed as an affiliate medical staff member; • Employed full-time or part-time; • Participated in the TAPP Model for years 2014 and 2015; • Received an Exceptional or Consistently Exceptional on the annual performance evaluation in years 2014 and 2015.

The population is made up of 270 NPs practicing in both inpatient and outpatient areas caring for pediatric patients. To qualify for inclusion into the study, NPs must have participated in the TAPP Model for the past two years, and received a performance evaluation rating of exceptional or consistently exceptional. Purposive sampling was used to identify participants who were representative of the broader group of NPs successfully practicing within the TAPP Model. Maximum variation in sampling was accomplished by selecting NPs with diverse practice experiences from both in-patient and out-patient settings and who practiced within both medical and surgical delivery care models (Polit & Beck, 2012). A direct leader provided the researcher a list of actively engaged NPs in professional practice who met the eligibility criteria for participation in the study.

The researcher sent a recruitment email explaining the purpose of the study, eligibility criteria, time commitment, data collection methods, and requested their participation in the study. The researcher answered all questions from the participants regarding the study purpose. After the participant agreed to be part of the study, a meeting time, and a mutually agreed upon private location for the interview was identified. The researcher sent an email reminder to the participant 24-48 hours prior to the scheduled interivew.

Sample size and composition was determined when no new themes or patterns unfolded and data saturation was achieved (Sandelowski, Davis, & Harris, 1989). The sample size was determined by the nature of the data that was collected as a whole and provided redundancy of information for new information that emerged as a critical

variation (Lincoln & Guba, 1985). The sample size was estimated to be no more than 20 participants related to the availability of adequate representation of NPs practicing in the in-patient and out-patient groups, composition of participants from medical or surgical practices, and saturation of themes as they unfolded.

Protection of Human Subjects

Institutional Review Board (IRB) approval from Texas Woman's University through a request to Initiate Institutional Authorization Agreement (IAA) (Appendix A) with Baylor College of Medicine IRB (Appendix B) was signed and executed for this study. In addition, the TCH Chief Nursing Officer and Research Council provided letters of approval to conduct the research. Each participant was given two copies of the consent form for his or her signature; one copy for the participant and one copy for the researcher. Time was allowed for the participant to review and discuss the background information, purpose of the study, eligibility criteria, the time commitment, potential risks, data collection methods, and details about the informed consent and the demographic questionnaire.

The list of participants and their assigned subject identification numbers was stored in a locked filing cabinet in the office of the researcher or in a locked filing cabinet within the researcher's home. All electronic files were stored on a password-protected computer on a secured network drive. When the researcher was not transcribing the interview, the recorder, the consent, and the demographic questionnaire remained within the researcher's possession in a locked filing cabinet in a locked office or locked in a filing cabinet within the researchers home. All unique identifiers were removed during

the transcription and the researcher reviewed interview transcripts while listening to the recording and confirmed the accuracy of the transcription. Each participant was afforded the opportunity to withdraw from the study at any time without penalty. Each participant received a depiction of the TAPP Model and the definitions of the domains of practice before the start of the interview.

After study completion, the signed consent forms and demographic data forms will be shredded. A commercial software application designed to remove all data from storage devices will be utilized to destroy audiotape recordings. All recordings and all identifiable information will be destroyed after publication of the study findings.

Data Collection

After participants sign the consent form and complete the demographic questionnaire, the signed consent form and demographic questionnaire was assigned a subject identification number to be used on all study documents. The questionnaire focuses on demographic information such as NP specialty recognition; department of service (medical or surgical); patient population (in-patient or out-patient); number of hours spent weekly in direct patient care; professional development time given in the role, and annual performance evaluation level (Appendix C).

The researcher conducted all interviews and interview times ranged between 40 and 55 minutes. Data were generated using an interview guide (Appendix D) that consisted of one main question to start the interview: “How would you describe your professional practice prior to practicing with the TAPP Model?” Further probe questions were used throughout the interview.

In the event of ambiguous or inaudible comments from the transcription process, the researcher followed up with the participant for clarification. Participant body language, facial expressions, and contemplative silence were captured in a reflective diary during the interview and immediately post-interview and reviewed during each transcription. At the conclusion of the interview process the participants received a $5.00 gift certificate as a courtesy for participating in this research study.

Data Analysis

Demographic data were analyzed using SAS version 9.4 (SAS Institute Inc., Cary, North Carolina) to compute frequencies and percentages to summarize participant characteristics. Data analysis was concurrent with data collection and allowed for inquiry making, compositing, confirming and evaluating themes as they emerged, to reveal a deeper understanding of the lived experiences of the NPs practicing within the TAPP Model (Snowden & Martin, 2010). To insure rigor, the researcher participated in Mind Mapping before data collection for bracketing (Buzan & Buzan, 1993). To support the philosophical orientation of phenomenology, data was audited according to the seven steps of Colaizzi's Method in the practice of descriptive research (Colaizzi, 1978). Colaizzi's method of data analysis called for an interrogative approach to presuppositions leading to uncovering beliefs and attitudes about the phenomenon. Colaizzi's method calls for phenomenological reduction; however, Colaizzi does not call for researchers to "bracket" their presuppositions. As an adjunct to Colaizzi's method, the Mind Mapping technique was used to address eidetic reduction through bracketing.

A mind map has four essential characteristics: 1) a central image that represents

the subject; 2) themes that radiate from the central idea; 3) branches off the main theme; and, 4) a connected structure (Spencer, Anderson, & Ellis, 2013). Mind mapping was used as a tool to *"bracket"* presuppositions, personal biases, and assumptions about the phenomenon (Buzan & Buzan, 1993). This methodology supported eidetic reduction as a process of abstraction; leaving all that is perceived as a mental object and leaving what is necessary to reveal what the object is. Mind mapping represented free imaginative variation and awakened possibilities of discovering the object without changing the identifiable phenomenon (Buzan & Buzan, 1993). The process included starting with a central assumption about the phenomenon and captured how the researcher would feel if the participant expressed negative experiences working within the TAPP Model. From this central node, free imaginative variation occurred, denoting possible subsets in the imaginative consciousness of the researcher. From the central node, branches were added allowing for related insights and paradigms reflecting internal structure and processes (Burgess-Allen & Owen-Smith, 2010). The result of the Mind Map served as an external mirror of personal thinking surrounding the phenomenon.

The seven steps of Colaizzi's Methodology and Mind Mapping Methodology are described below in Table 3.2

Table 3.2.

Colaizzi's Steps and Mind Mapping Steps

Colaizzi's Method	**Mind Mapping**
1. Read and re-read each transcript to obtain a general sense about the whole content.	1. Identify central belief, attitudes and relationship to central node.
2. Extract significant statements that pertain to the phenomenon under study and highlight these statements noting the page number and line numbers on the transcripts.	2. Brainstorm around central idea to predict personal experiences that would radiate negative reaction to the model and place idea on a primary branch.
3. Meanings will be formulated from the significant statements and transcribed in an Excel data file.	3. Review meaning of words or sentences on the branch and radiate new meanings through basic ordering of ideas to create key concepts.
4. Meanings will be sorted into categories, clusters of themes, and themes.	4. Continue to create secondary branches that are an extension of central key concepts and include more concrete illustrative information.
5. Meanings and findings will be integrated into an exhaustive description of the phenomenon under study.	5. During interview transcribing, review responses and compare to central key concepts to assure bracketing occurs.
6. The fundamental structure of the phenomenon will be described.	6. Take key themes and add branches to key bracketing concepts to show bracketing effective for ideas, beliefs, values and attitudes.
7. Validation of the findings will be sought from the participants to compare the researchers descriptive results with their own experiences.	7. Review results with participants creating a mind map with key concepts.

Scientific Rigor

The goal of scientific rigor in qualitative research is to accurately represent the study participants' experiences. The trustworthiness (or truth value) of the experiences can be found in confirmability (or auditability), credibility, and fittingness (or transferability) (Lincoln & Guba, 1985). Confirmability was observed in the documentation or paper trail of the researcher's thinking, decisions made regarding categories and themes, and methods related to the study. The researcher's decision-making was evident in the field notes, memos, transcripts, and the researcher's reflective diary.

Credibility in the truth value or the believability of the study's findings is demonstrated through strategies associated with debriefing with faculty advisors regarding the research process and findings, and member checking to ensure the participant's experiences were reflected in the researcher's interpretation. The researcher's response in the interview process was monitored through bracketing reflected in the mind mapping process. Reflexivity of the researcher was recognized with the familarity of the subject matter that could lead to an obstacle in accurately intrepreting and then describing the essences discovered. This could contribute to credibility as the reader will be aware of possible influences of the researcher on the study.

Fittingness (or transferability) of NPs experiences of practicing within a professional practice model (PPM) has meaning to other NP groups, organizations

seeking Magnet® recognition, and can be applied to other APRNs and physician assistants. Accurate, rich, thick descriptions of the research findings demonstrated fittingness by providing data analysis that answered the research question.

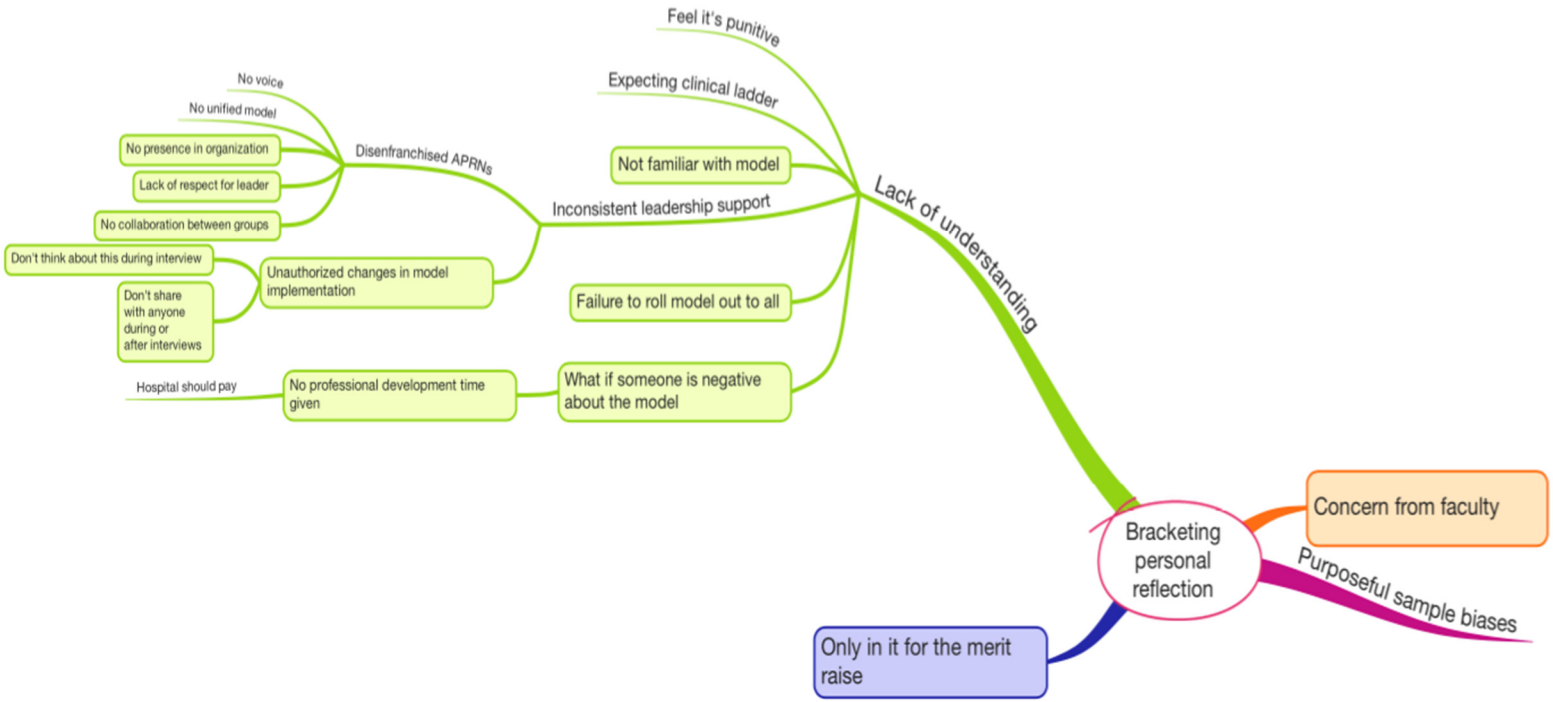

Figure 3.1. Bracketing using mind mapping

CHAPTER IV

RESULTS

This chapter contains a manuscript of an article that has been submitted for publication in *The Journal of the American Association of Nurse Practitioners*. This article provides a complete description of the research study design, describes the methodology and analysis employed and presents the findings with a discussion of results and implications and recommendations for future research

The Lived Experiences of Nurse Practitioners Practicing within the Transformational Advanced Professional Practice Model: A Phenomenological Study

Elizabeth Elliott, Anne Young, Marlene Walden, Lene Symes, and Nina Fredland

Abstract

Objective: The purpose of this study was to describe the lived experiences of nurse practitioners (NPs) practicing within the Transformational Advanced Professional Practice (TAPP) Model, a professional practice model (PPM).

Methods: A descriptive phenomenological analysis using semi-structured interviews of eleven NPs across multiple inpatient and outpatient clinical areas at Texas Children's Hospital. Member checking and theming data occurred using the mind mapping technique.

Results: Main themes included: (1) transforming professional practice; (2) cultivating the inner self; and, (3) mentoring professional transitions.

Conclusions: The findings of this study provide qualitative evidence that the TAPP Model influences role transition and professional development. Transforming NP practice within organizations and within the nursing profession itself will take mindfulness with an intentional approach to design PPMs specifically for NPs.

Keywords: phenomenology, professional practice models; PPM; Husserl; Colaizzi; nurse practitioners; Transformational Advanced Professional Practice Model; TAPP Model; Mind Mapping

Introduction

Nursing professional practice models provide a system of support enabling "control over professional practice and the environment in which health care is delivered" (Hoffart & Woods, 1996, p. 354). Chamberlain et al. (2013) describes the attributes of a PPM as reflecting values that exemplify the organizational culture. This study describes the lived experiences of NPs practicing within a PPM known as the Transformational Advanced Professional Practice (TAPP) Model (Elliott & Walden, 2015).

Background

The TAPP Model, developed and implemented in 2009, is an evidence based PPM that supports the professional development of advanced practice providers at Texas Children's Hospital (TCH) (Elliott & Walden, 2015). There are seven non mutually exclusive domains of practice, three continuims of practice, and four unifying strands (Figure 4.1). For a full description of the TAPP Model refer to the work of Elliott and

Walden (2015). TCH is a Magnet® designated organization and is required to provide an ongoing evaluation of its organizational PPM for nurses (ANCC, 2014). While the literature does not distinguish differences between general nursing and advanced practice PPMs, the National Organization for Nurse Practitioner Faculties emphasizes that education and competencies are different than those required for general nursing (NONPF, 2012). Most health care organizations struggle to distinguish the differences between Registered Nurse (RN) competencies, NP competecies and the role of the NP. The TAPP Model is one of the few PPMs for NPs reported in the literature that makes the distinction between the professional practice and competencies of NPs and RNs.

Philosophical Underpinnings

Husserl's descriptive (eidetic) phenomenology served as the philosophical underpinning for this study. Husserl believed that people go about the daily business of living without giving critical thought to their experiences and their perceived experiences as having scientific value (Husserl, 1970). Only through retrospective examination of an experience that is already lived through can one really "reflect" on the lived experience. Phenomenological research provides insight into the life-world, the world of the lived experience, that is not readily accessible in what Husserl calls the *natural attitude* (Husserl, 1980). This attitude, taken for granted, is so common that failure to see what surrounds us demands a phenomenological study to uncover the fundamental structures of our life-world. Within the *natural attitude*, we already know about characteristics of the phenomenon, the framework, and the meanings associated with the phenomenon. Without a phenomenological attitude, we are unable to inquire as to what makes the

phenomenon what *it* is. Without raising and answering questions within a phenomenological attitude, the essential meanings and essences of practicing within the TAPP Model will be undiscovered.

Methods

Husserl's descriptive (eidetic) phenomenology permitted a direct exploration, analysis, and description of the lived experience of NPs practicing within the TAPP Model. Husserl's approach includes four main steps: bracketing, intuiting, analyzing, and describing the lived experience. Central to the phenomenological approach is the ability to enter into the investigation of the study with an *a priori* knowledge of the phenomenon (Natanson, 1973). Empirical subjectivity is bracketed to assist the investigator to discover the "pure" phenomena from the NPs point of view. Imaginative variation through Mind Mapping (Buzan & Buzan, 1993) allowed for discovering essences of the experiences of NPs practicing within the TAPP Model. The investigator also developed mind maps during each interview and elicited feedback from each participant before ending the interview to assist in the validation of emerging themes.

The hospital's Nursing Research Council and affiliated Universities Institutional Review Boards approved this study. Each participant took part in face-to-face semi-structured interviews that elicited their lived experiences of practicing within the TAPP Model.

Sample and Setting

This study occurred at TCH, a quaternary academic pediatric hospital, and ambulatory care center in the Texas Medical Center in Houston, Texas. Eleven NPs were

purposefully selected based on employment status, performance evaluation rating, and years of participation in the TAPP model (see Table 4.1). Sixty-four percent of the participants were employed full-time and 73% of the participants were rated consistently exceptional in the organization's performance evaluation process (see Table 4.2).

Researcher Characteristics and Reflexivity

The researcher is the senior leader of NPs at the research site. The researcher has over 26 years of nursing experience with 16 years as a formal leader of NPs. Familarity with the subject matter may bias the researchers ability to describe the essences to be discovered. To avoid the appearance of coercion or undue influence when recruiting participants, direct solicitation of NPs was not part of the researcher's recruitment strategy. Mind mapping allowed bracketing of presuppositions, personal biases, and assumptions about the phenomenon. The process of Mind Map bracketing supports eidetic reduction as a process of abstraction; leaving what is necessary to reveal what the object is. The process started with a central assumption about the evaluation of the TAPP Model and the feelings of the researcher if participants expressed negative experiences while working within the TAPP Model. The result of Mind Map bracketing served as an external mirror of the researcher's personal thinking surrounding the evaluation of the TAPP Model throughout the study process (Figure 4.2).

Data Collection and Analysis

Colaizzi's analysis process for descriptive phenomenology allowed for compositing, confirming, and evaluating themes as they emerged (Colaizzi, 1978). In addition to Colaizzi's methodology, Mind Mapping (Buzan & Buzan, 1993) captured

themes during the interview process. The resulting individual mind maps were reviewed concurrently with Colaizzi's steps to create a data audit trail and facilitate member checking. The researcher transcribed all recordings verbatim and verified the transcriptions with repeated listening to the tapes for continued immersion into the data. The researcher placed emerging themes in an Excel data file in order to cluster into subthemes, resulting in a meaningful and exhaustive representation of the data. Data were also themed using the Mind Mapping method and compared to the coding of themes from the transcripts (Figure 4.3). Demographic data were analyzed using SAS version 9.4 (SAS Institute Inc., Cary, North Carolina) to compute frequencies and percentages to summarize participant characteristics.

Findings

NPs described their professional practice and the TAPP Model elements as inextricably interwoven. NPs actively used components of the model to guide care delivery and professional activities. Three major themes emerged from analysis: (1) transforming professional practice; (2) cultivating the inner self; and, (3) mentoring professional transitions.

Transforming Professional Practice

Before implementation of the TAPP Model, participants practiced under a general nursing model that lacked role clarity, was disjointed, and seemed task focused. It was hard for NPs to find structure around their practice and they sought the support of others outside of their organization to provide professional mentorship. Outside support gave the NPs a sense of cohesiveness to their new role as an NP. After implementation the TAPP

Model provided a specific interconnected framework for day-to-day professional practice based on the clinical role and professional competencies. A new NP reflected on the differences in her practice related to having a tool to help guide her NP role.

> I think it [TAPP Model] helps us … maintain[s] our focus on how we're going to actually direct ourselves in providing care. It's one thing to ask someone to do it [participate in the model] and it's another thing to give the people [NPs] the **tools** to do it … I'm given the proper tools in order to be able to implement the model correctly.

A more experienced participant shared her practice transformation since the TAPP Model's implementation

> … the TAPP Model has become such a part of practice that it's not necessarily something I think about every day. And, I don't necessarily think about how things fit into the TAPP Model because it's just, that just how we work now. … It's just the culture, the environment and it's the way we practice. It's become second nature.

Professional practice transformed into a richer and fuller endeavor as described by an experienced NP:

> I would say that my practice is … transformed. ... is definitely a well- rounded, much more rich practice in that there are key elements beyond just the clinical aspect of my profession that are important. …it will give you the framework to develop your practice. You can start identifying key elements that maybe you're passionate about.

While initially perceived as abstract, the experiences of working in the model made it become more concrete and influenced NPs' ability to make choices around the competencies that needed more attention in their practice. For example, some participants recognized the need to have the proficiency in monitoring credentialing and regulatory practice that is an expectation in the model. However, participants have a choice to either pay attention or ignore this competency and then deal with the resulting consequences. Participants stated that the domain of practice around this competency was abstract, until they suffered the consequence of not paying attention. This participant shared:

> … I'm a person who likes concrete things that can help things that are pretty abstract, such as our practice, professional practice, into something more concrete. I think this is what that does for me [points to the regulatory domain].

Another participant shared her thoughts around scope of practice:

> I think it helps to know what the priorities are and to know that I'm very visual and concrete. … so I think the model helps me in order to stay within [the framework by asking] am I functioning appropriately within my role and I am doing the best that I can to take care of the needs of the patient.

Participants expressed that the model gave them greater role clarity, increasing their sense of administrative support for the advanced practice role. Evidence based practice and research took on a new importance following model implementation. Competency based practice became a routine expectation for practice and having a model that helped to organize the approach to professional practice was experienced as invaluable.

Participants viewed their professional development differently, setting developmental goals that included research participation, internal and external presentations, and publications. An appreciation for organizational priorities, standards of care, and policy and procedure development were examples of how NPs felt they had made a professional contribution. One NP reported that her practice changed to include developing policies and procedures to optimize care within her specific population, developing an evidence based practice guideline promoting safety in preoperative sedation. NPs viewed themselves as more credible and as partners on the health care team when they actively engaged in helping to set policy and implement guidelines to support regulatory standards resulting in safe, quality patient care. One participant shared that improving relationships with the care team led to her being recognized as a "resource and not just a workhorse".

> We are definitely seen and treated more as a partner in the care. … it has improved the collaborative relationships we have within the nursing staff as well as our medical staff. …the fact that we have self-governance gives us a lot of credibility in shaping our practice …

Because of the model, participants expressed that they were able to be more assertive with medical staff. NPs experienced a sense of empowerment because the TAPP Model is an evidence based practice model and evidence is power. NPs began advocating for their patients using an evidence-based approach, thus improving relationships with residents, fellows, and other nurses. One NP shared that the model

guidelines helped her to approach her medical chief and explain that she was required to participate in a quality and safety project for her department.

Not all participants agreed with the addition of professional development domains that the TAPP Model included. Although the TAPP Model's primary domain of practice is around direct patient care, two participants felt that administrative leadership viewed their direct care practice as less important than the professional development domains. Although these participants expressed and experience of improved consistent care of the patient with the implementation of the Model, they also felt that less attention was given to the value they brought to the patient and consistent clinical care was not recognized and rewarded

> I like it [TAPP Model], … I wish there were a section just for clinical practice because sometimes I see the evidence based practice and research and then I see organizational priorities . . . I feel it [TAPP Model] doesn't capture the clinical side as much."

Performance evaluations are a reflection of the TAPP Model, and this participant expressed that direct patient care was insufficiently weighted and less rewarded:

> The only big thing … was the patient care, because I don't think it [TAPP Model] takes [or], weights it high enough. … but the skill and effectiveness of the clinical practice sometimes is hard to see. . is not recognized.

However, most other NPs recognized that the patient care domain was the predominant domain and drives professional development. This NP shares:

> …not just clinically driven. You have these other factors that define your profession that your organization supports, then it's easy to grow and mature and go from that novice clinician to the more experienced provider.

Cultivating the Inner Self

NPs were internally motivated to do a good job of providing family centered care and viewed their practice as being *"part of what we do, of who we are."* This internalized self that drives the passion for work as a NP and motivation for practice excellence is not necessarily at the forefront of consciousness. The journey of cultivating the inner self had a dual focus with one participant. She experienced her inner self as being part of an extended family with her co-workers, and "it's not just about patient care, it's about your extended family." There is personal satisfaction in the role of NP when thinking of "yourself as part of a team, part of a family" and that "you have a responsibility to each other". Support at the organizational level supports the "innate" passion to serve each other. When describing the nature of their work, NP's needed a moment to reflect and become aware of this internal element that was so innate to their practice. Participants were notably uncomfortable talking about their own sense of accomplishments as a NP. When asked to reflect on the deeper question of "why" one participant stated, "OK. I feel like I'm selling myself here" and was truly uncomfortable with this line of questioning. Another participant explained that her motivation is around having children of her own and stepping into the place of a parent with a sick child motivates her to deliver excellent care. While most participants experienced the TAPP Model as empowering their professional practice, they also recognized that without their

personal awareness, they are unable to cultivate their inner self. One participant spoke of becoming more "aware" as she shared what motivates her daily:

> I really enjoy helping someone [that is] in a disadvantaged position and improve their outcomes and improve their ability to cope with stress [in] a devastating event that has happened in their life.

The essential nature of being a NP represents the true self:

> I'm a Christian. …being someone that serves others has always been something that I was raised to be and have always thoroughly enjoyed, even as a child. … [It is] gratifying for me. … [to] listen to that inner voice where my strengths and talents can be fostered and grown, so that I can be fostered to grow to be the best version of myself. And then [ask] how does that best version of myself *serve others?*

The TAPP Model and the experiences of professional practice were described as being "inextricably interwoven". This experienced practitioner shares:

> I mean even from what I said in the very beginning I think I was doing a lot of this [points to model] but didn't know how to show it or how to explain it. So, I do think that NPs by nature tend to have an internal motivation to do these things. … But I think the model helps us better communicate what we do; which is important. Not everyone outside our profession understands what we do.

One participant shared that her journey of discovering her inner self has not always been the way she experiences her practice now. She gives credit to the model for inspiring and reigniting her passion. She speaks about the TAPP Model as being

something you "put on and wear and you don't really think about it, you just do it." She attributed her discovery as being invested in her practice and in herself as a professional:

> I haven't always loved it [practicing as an NP], and there were times I wanted to go to work at a [local home improvement store] but since we've really [been] encouraged with the [TAPP] Model, it reignites your passion, [you once again find] you love it, you love the families and you believe that this love of families and what you want to do is the best of yourself to offer.

Mentoring Professional Transitions

The transition from RN to NP is usually stressful and challenging. Shifting from expert RN to a novice NP role is one of the most significant adjustments made in one's professional career. While there was some concern that the model might initially appear complicated for new NPs, experienced NPs saw potential for using the TAPP Model as a guide during this transition. A suggested strategy to facilitate model utilization with new NPs was to begin with a focus on clinical care delivery. One veteran NP would advise

> So, just know that you're not going to be exceptional in everything, especially in the beginning. … but looking at the model, it will give you the framework to develop your practice. You can start identifying key elements that maybe you're passionate about. . . But the model serves as your framework or guide to your professional practice. So in the beginning it may seem overwhelming, but just to [stop and] think that you don't have to be an expert in every domain [points to every domain of practice on the tree].

Organizational support was important to the transition of RN to NP. This participant advises to "pay attention" to the TAPP Model when starting your career. She states:

> I tell them in the midst of trying to figure out how to be a provider, and how to work within these walls [organization] to look at the TAPP Model, to start paying attention to it because over time it's going to become increasingly important to them. One to two year[s] down the road it's going to be a very useful tool … as a roadmap for their future …

And one participant sums mentoring professional transitions as:

> *I would tell them that this model does give them many ways to achieve success. It provides structure and a guidance to practice.*

Discussion

In summary, the lived experiences of NPs practicing within the TAPP Model is described as being transformative, having a sense of self, and recognizing the importance of transitioning roles through mentoring. Participants frequently referred to their prior experiences within a PPM as less than satisfying both personally and professionally. Transformational professional practice requires an adoption of change in personal behaviors. Ruddy, Thomas-Hernak, and Meade (2016) describe transformation as being a "deep alteration of our frames of reference" (p. 624) in such a way as to change the way we think and then adjust our actions. Authentic practice through professional development is necessary if we are to change the health care systems and better meet the needs of patients (Ruddy, Thomas-Hernak, & Meade, 2016). The transformation

experiences varied depending on the area of interest for the participant. If the interest was, for example, in the area of quality and safety, there was a sense of "driving your own practice" and moving toward an internal "inclination" to do "what's right for the patient." The participants described their experiences as being personal as they move from an abstract PPM to a concrete experience resulting in a much more directive, vivid and clear practice. Participants felt the TAPP Model domains were relevant to their practice and provided options based on what their professional interest were. They found that the general nursing models that they had previously practiced under were no longer relevant as a framework and guide for their NP practice, thus supporting the need for an advanced practice PPM.

The passion identified as cultivating the inner self was seen through motivation and was determined to be integral to the "why" NPs practice the way they do. This intrinsic or "internal" feeling propelled them forward in their service to others. Collectively their voices described their professional *"being"* as who they are and what they do. The NP role allowed them an avenue to fulfill their personal and perhaps spiritual needs to serve others. That inner drive can lead to a passion for one's professional career and commitment to deliver evidence-based patient care that leads to improved outcomes.

The participants' passion for service resulted from internal motivation that is part of their personal identity as a NP. This intrinsic passion produces a motivational force that aids the NP in engaging in the activity of service willingly (Vallerand, Paquet, Phillipe, & Charest, 2010).

Participants stated that the TAPP Model provided opportunities to guide the newer generation of NPs in the transition from RN to NP. They expressed how the model supported their professional competencies and aided their transition from RN to NP. By reinventing the professional identity of the RN, the NP redefined "self" which is critical for transforming professional practice (Barnes, 2015). What was clear in the interview process was that mentorship served both mentor and mentee. Mentors freely and generously share nursing specialty expertise, knowledge, and experience (Mamaril, 2016). Just as the TAPP Model and the experiences of NPs are inextricably interwoven, the act of professional development and mentorship are inextricably interwoven. Professional generosity, or mentorship, is an opportunity to "pay it forward" or to give back to the profession of advanced practice nursing thereby leaving a legacy that will not be lost or forgotten (Mamaril, 2016).

Implications for Practice

The Institute of Medicine recommends that organizations prepare NPs by offering a residency program to ensure that NPs make a successful transition into practice. Residency programs or other onboarding programs assist novice nurses to transition to practice and demonstrate clinical readiness (IOM, 2010). Programs that are rich in exposure to specialy care rotations, and that have a strong evaluation component to the program are highly desirable by new employees (Brown, Poppe, Kaminetzky, Wipf, & Woods, 2015). Consistent implementation of onboarding, orientation, and performance evalaution is needed to support NP practice across inpatient and outpatient clincal areas. Participants shared the importance of focusing on the TAPP Model during orientation and

onboarding as an important professional tool in the transition to practice process.

Consistency in leadership support for the TAPP Model was found to be lacking and the experience revealed that some leaders in the organization "do not have a clear understanding" how to support the NP within the TAPP Model. Re-education of NP leadership on the TAPP Model will be important to overcoming some of the organizational barriers expressed by the participants and will be crucial to sustaining the professional gains expressed by participants practicing within the TAPP model.

PPMs that are specific for NP competencies and professional development have implications for practice. Knowledge of role transition, differences in RN to NP autonomous practice, and facilitation of a positive role transition are important PPM outcomes that may result in increased NP satisfaction and retention (Sargent & Olmedo, 2013; Weiland, 2015). With the continued success of development, implementation, and evaluation of PPMs, health care organizations have an opportunity to support advanced practice nursing through the development of specific PPMs for NPs. MacLellan, Levett-Jones and Higgins, (2015) found that members of the health care team and the NP require change and adaptation and failure to do so undermines the delivery of health care. These authors confirm that health care environments that nurture NPs and promote improved inter-professional collaboration present the most effective strategy of ensuring role transition.

NP leaders are called upon to recognize that the voice of NPs is best heard when the practice reflects the culture and practice of nursing within the organization. Strategies to identify and understand how to better transition the RN to the NP role with consistent

leadership is one strategy that will eliminate barriers to practice while meeting the professional needs of the NPs (Bahouth, et al., 2013). NPs represent the highest level of nursing at the bedside and when the voice of the NP is heard NPs, patients, families, and the health care team all benefit.

Implications for Research

The findings in this study provide evidence that the TAPP Model supports the role transition and professional development of NPs. A mindful and intentional approach to creating specific NP PPMs is needed if NP practice is to be transformed within organizations and nursing itself. Research is necessary to develop, implement and then evaluate NP PPMs and the impact they have on quality nursing practice, patient outcomes, and professional development.

Figure 4.1. Transformational advanced professional practice model. Copyrighted 2014 by Texas Children's Hospital. Reprinted with permission.

Table 4.1.

Inclusion/Exclusion Criteria

Inclusion criteria	Exclusion Criteria
Recognition by Texas Board of Nursing as APRN	Employed per-diem or agency
Employed at TCH and credentialed as affiliate medical staff	Direct report to primary investigator
Employed full-time or part-time	Employed with Academic Medical Partner
Practice location Main Campus	
Participation in TAPP Model for two year consecutive years between 2012 and 2015	
Received "Exceptional" or "Consistently Exceptional" on annual performance evaluation between 2012 and 2015	

Table 4.2.

Subject Characteristics

Characteristic	**Frequency (%)**
Gender (n=11)	
Female	11 (100%)
Age, years (n=8)	
25-34	1 (13%)
35-44	3 (38%)
45-54	3 (38%)
55-64	1 (13%)
Ethnicity (n=11)	
Asian or Pacific Islander	1 (9%)
Hispanic or Latino	1 (9%)
White / Caucasian	9 (82%)
APRN specialty recognition (n=11)	
PNP-PC	6 (55%)
PNP-AC	1 (9%)
FNP	3 (27%)
NNP	1 (9%)

(continued)

Years practiced as an APRN (n=11)	
<5	4 (36%)
10-15	4 (36%)
>15	3 (27%)
Years practiced as RN before becoming an APRN (n=8)	
<5	4 (50%)
5-10	3 (38%)
>15	1 (25%)
Department (n=11)	
Medicine	10 (91%)
Surgery	1 (9%)
Hours of patient care per week (n=11)	
10-15	1 (9%)
20	1 (9%)
24	2 (18%)
40	7 (64%)
Given professional development time (n=11)	
Yes	9 (82%)
No	2 (18%)
Performance evaluation level last 2 years (n=11)	
Exceptional	3 (27%)
Consistently Exceptional	8 (73%)

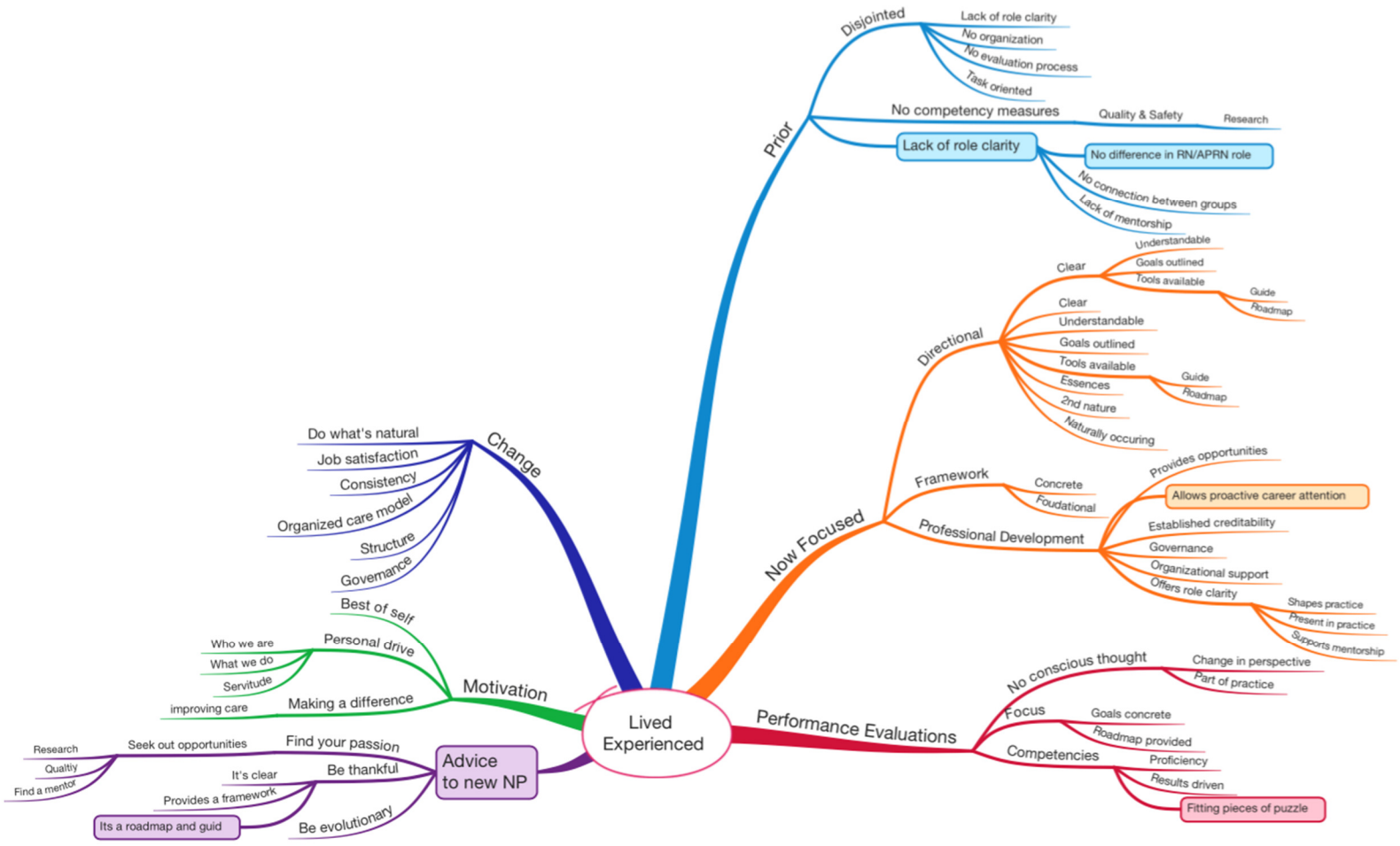

Figure 4.1. *Thematic coding from participant member checking using Mind Mapping*

CHAPTER V

SUMMARY OF THE STUDY

The purpose of this descriptive phenomenological study was to describe the lived experiences of nurse practitioners (NPs) practicing within the Transformational Advanced Professional Practice (TAPP) Model. This chapter presents a summary of the study conclusions, implications for practice, and recommendations for further research.

Summary

Husserl's phenomenological philosophy underpinned the study, guiding exploration of the lived experiences of NPs practicing within the TAPP Model. A purposive sample of 11 NPs who were either full-time or part-time clinicians were interviewed. Data collection progressed and three emerging themes revealed what was important to the success of NPs practicing within the TAPP Model. The TAPP Model represented the foundation needed to engage NPs in transforming professional practice through cultivating the inner self and mentoring professional transitions.

Transforming professional practice offered structural value to the NPs whose previous practice was lacking role clarity and was task oriented. The lack of support from the organization led NPs to seek external support in defining their roles and professional practice boundaries. In the beginning, the NPs found the model to be abstract, and found pieces of the professional development competencies less than desirable. NPs discovered that over a period of time they found concrete experiences offered within the TAPP Model led to a richer and more fulfilling practice. Participation

in quality initiatives changed the way that NPs delivered patient care and care was "more consistent."

Cultivating the inner self was a difficult journey for NPs and resulted in a hesitancy to talk about their professional self-achievements. Through the process of telling their stories, it became evident that the essential nature of the true self. The TAPP Model and the inner self was described as being interwoven. Professional mindfulness, through the act of mentoring professional transitions, reflected an act of professional accountability. Although there was evidence that the model offered a guide to successful role transitions, the participants felt that the model could also be overwhelming to the novice NP.

Discussion

A PPM represents a theoretical framework for professional practice that supports a relationship between the theory of nursing and nursing practice (Slatyer, Coverntry, Twigg, & Davis, 2016). NPs require their own specific PPM that supports professional practice and advanced practice clinical competencies. Participants in this study described their experiences as being transformative, for themselves and for new NPs. They also described the journey in self-reflection that revealed their innermost passion to care for others.

NPs are often expected to particiate in a PPM that is appropriate for the registered nurse (RN) role. Practicing within these PPMs comes with the risk of remaining in the RN role and the inability to transition into the NP role (Barnes, 2015). The need to reinvent the RN to NP role was described as critical to transforming their professional

practice (Barnes, 2015). NPs also described the impact that organizational leaders had on the success of the role transition. The need for health care organizations to promote the role of the NP was found to be a direct positive correlation to the implementation of the TAPP Model. Motivation for self development and excellence in practice is linked to the inner self and the individual NPs need to make a difference in the lives of the patients they are caring for. Although not specifically mentioned, the NPs eluded to having a strong moral compass for delivering safe responsible care to their patients. The terms that the participants used during their interivews were consistent with "connection to children and families," "excelling in performance to make a difference," and "receiving positive feedback" from patients and their families represents the fabric that was interwoven with professional excellence. Of primary importance and the strongest motivational theme was the drive "to be the best that I can be." They experienced feelings of thankfulness, passion, and caring that ultimately resulted in excellent patient care. NPs stated that the TAPP Model enouraged them to "tap into what they already knew as a nurse" and to "maximize their personal and professtional potential." Sharing knowledge was critical to their professional growth and taking every opportunity to educate others impacted how they felt about their professional practice. Professionalism results in excellence of patient care and is the prime directive for cultivating the inner self (Madara, 2016).

Conclusions

Conclusions derived from this study include:

1. NPs actively utilize PPMs to guide their professional practice
2. Organizational and leadership support is required for the success of the NP.
3. PPMs have the capacity to guide the transition from the RN role to the NP role.
4. Mentoring is required to guide transitions to practice and this is not only for new NPs, but also for the professional development of experienced NPs.
5. Cultivating the inner self drives passion to care for others.

Implications for Practice

Based on the findings of this study, the following recommendations for NP practice for organizations included:

1. Development and implementation of specific competency-based PPMs is required to assist in guiding NP practice and professional development.
2. Consistent leadership is required to nurture and support NPs clinical and professional practice.
3. Knowledge of role transition and differences in RN and NP competencies is required for successful practice.

4. Consistent orientation and onboarding is required to support transition to NP practice.

Implications for Research

Based on the findings of this study, recommendations for further research include:

1. A mindful and intentional approach to creating specific competency based PPMs for NPs.
2. Evaluating the impact of PPMs that support NP professional development and specific clinical competencies on patient outcomes.
3. Quantitative studies that measure the impact of PPMs on role and job satisfaction, retention, and job performance.
4. Organizational commitment to mentoring NPs and exploring the impact on workplace settings.
5. Explore how NPs across the performance spectrum embrace a PPM.
6. Explore how a new NP utilizes a role specific PPM.

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APPENDIX A

Institutional Authorization Agreement

and

Memorandum of Understanding

Memorandum of Understanding
Between
Texas Woman's University
And
Baylor College of Medicine
Concerning
Reliance by Texas Woman's University on Baylor College of Medicine's Institutional Review Boards for Review and Approval of Certain Research

This Memorandum of Understanding ("MOU") is entered by Texas Woman's University ("the Relying Institution") and Baylor College of Medicine ("BCM") and sets forth the terms and conditions in accordance with which the Relying Institution may rely upon BCM for review and approval of human subjects research (the "Research").

Applicable Research

1. The Officials signing below agree that the Relying Institution may rely on BCM Institutional Review Boards or a BCM-designated IRB (referred to collectively as "BCM IRB") for review and continuing oversight of the following Research only:

Project: The Lived Experiences of Nurse Practitioners Practicing within A Professional Practice Model: A Phenomenological Study
BCM Investigator: Elizabeth Charlene Elliott, MSN RN NNP-BC

Compliance and Accreditation Activities

2. The review performed by the BCM IRB will meet the human subject protection requirements of Baylor College of Medicine's OHRP-approved FWA.

3. This research will be reviewed by the BCM IRB as the IRB of record. The review and approval will be done in accordance with federal and BCM requirements, including but not limited to:

   - 45 C.F.R. Part 45 (The "HHS Common Rule");
   - 21 C.F.R. Parts 50 and 56 (where applicable);
   - The BCM FWA; and
   - BCM IRB policies and procedures
   - Federal and state laws

4. The BCM IRB will report to the IRB at the Relying Institution within five working days any investigation or inquiry into this research involving:

   a) Issues of human subjects protection
   b) Unanticipated problems involving risks to subjects or others, or
   c) Regulatory compliance issues

5. BCM and the Relying Institution shall cooperate in the event of investigations and inquiries by providing all pertinent documentation pertaining to specific protocols, including minutes of the BCM IRB and any relevant BCM IRB review committee(s), to the other party's Human Protections Administrator. This shall be effective for investigations and inquiries relating to:
   - Specific issues of human subjects protection; and
   - Unanticipated problems involving risks to subjects; and
   - Regulatory compliance issues; and

- Review of processes to assure accreditation standards are met.

This documentation will be exchanged at a time and place agreeable to both parties.

6. The Relying Institution will ensure the necessary expertise and qualifications of the Relying Institution's investigators regarding conducting human subject research, including, but not limited to, human subject research training as deemed acceptable by BCM. Proof of this training will be kept on file by BCM Principal Investigators.

7. The Relying Institution shall remain responsible for ensuring compliance with the designated IRB's determinations and the terms of its own Institution's FWA.

8. The BCM IRB will be responsible for the following:

   a) Reviewing the protocol and study-related materials submitted for review
   b) Reviewing adverse events as submitted according to required reporting
   c) Conducting continuing review of approved Research
   d) Reporting to the IRB at the Relying Institution in the event a Relying Institution protocol is suspended or terminated
   e) Reporting to the IRB at the Relying Institution any noncompliance with human research subject regulations
   f) Auditing, as necessary, selected investigators from the Relying Institution for compliance and reporting the results to the Relying Institution
   g) Informing sponsors of the BCM IRB's decision to terminate or suspend approval of the Research
   h) Reviewing data safety monitoring board reports and taking appropriate actions in response;
   i) informing BCM of any communication with the U.S. Food and Drug Administration ("FDA"), OHRP or other regulatory agency relating to Research approved by the BCM IRB;
   j) Reporting conflicts of interest disclosed by Principal Investigator and/or key personnel to the conflicts of interest committee at the Relying Institution;
   k) Maintaining a duly constitution institutional review board registered with the U.S. Department of Health and Human Services Office for Human Research Protections that is experienced in reviewing human subject research

9. The Relying Institution will be responsible for the following:

   a) Monitoring, evaluating and continually improving the protection of human research participants; dedicating resources sufficient to do so; exercising oversight of human research protection; educating Principal Investigators and other personnel about their ethical responsibility to protect human research participants; and, when appropriate, providing a mechanism to intervene in human subject research and to respond directly to concerns of research participants;
   b) Informing the BCM IRB of the termination, suspension or modification of privileges of, or any disciplinary measure taken by the Relying Institution against, Principal Investigators or any other personnel participating in Research approved by the BCM IRB;
   c) Designating a conflict of interest liaison for consultations with the BCM IRB;
   d) Reviewing reported conflicts of interest and advising the BCM IRB of outcomes, including conflict of interest management plans;
   e) Reporting to the designated IRB any contact by the FDA, OHRP, HHS or other persons or entities regarding any Research approved by the BCM IRB;

The Documentation

10. The BCM Office of Research ("OOR") will maintain all BCM IRB documents pertaining to the research as required by BCM IRB policies and procedures and in accordance with applicable laws.

11. BCM IRB files for closed protocols will be maintained for 3 years after the date of closure.

12. OOR will provide access to the Relying Institution Human Protections Administrator (HPA) named in the institutional FWA (and/or his or her designee) for all the Relying Institution protocols. This access shall include:

    - Access to BRAIN and applicable reporting;
    - IRB status of all protocols which involve BCM research personnel (submitted, assigned to committee, pending approval, approved, or closed);
    - Access to submitted and approved protocols; and
    - Correspondence regarding modifications required for IRB approval;
    - IRB approved consent forms;
    - Adverse event reports; and
    - Protocol amendments;
    - Relevant minutes of the BCM IRB, as reasonably requested by the Relying Institution;

Additional Terms

13. The parties hereto enter into this MOU as independent contractors, and nothing in this MOU shall be deemed to authorize either party to represent, enter into contracts for, or conduct operations on behalf of the other party; and this agreement shall not be deemed to constitute an employer/employee relationship, partnership, or joint venture.

14. The effective date of this MOU shall be the date of the last signature to this MOU and shall remain in effect until such time as authorized agents of BCM and the Relying Institution mutually agree to terminate or modify this MOU. Either party may terminate this MOU by giving the other party at least sixty (60) days prior written notice of such party's intent to terminate this MOU.

15. This document must be kept on file by both parties and provided to OHRP upon request.

Signature of Signatory Official (Texas Woman's University):

R. Neely Date: 8/19/15

Print Full Name: Robert K. Neely, PhD Institutional Title: Provost

Signature of Signatory Official (Baylor College of Medicine):

Stacey Berg Date: 9/2/15

Print Full Name: Stacey Berg, M.D. Institutional Title: Institutional Official

APPENDIX B

Institutional Review Board

August 04, 2015

Baylor College of Medicine
Office of Research
One Baylor Plaza, 600D
Houston, Texas 77030
Phone: (713) 798-6970
Fax: (713) 798-6990
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ELIZABETH CHARLENE ELLIOTT
BAYLOR COLLEGE OF MEDICINE
PEDIATRICS: NEWBORN

H-36691 - THE LIVED EXPERIENCES OF NURSE PRACTITIONERS PRACTICING WITHIN A PROFESSIONAL PRACTICE MODEL: A PHENOMENOLOGICAL STUDY

APPROVAL VALID FROM 8/4/2015 TO 7/21/2016

Dear Dr. ELLIOTT

The Institutional Review Board for Human Subject Research for Baylor College of Medicine and Affiliated Hospitals (BCM IRB) is pleased to inform you that the research protocol and consent form(s) named above were approved.

The study may not continue after the approval period without additional IRB review and approval for continuation. You will receive an email renewal reminder notice prior to study expiration; however, it is your responsibility to assure that this study is not conducted beyond the expiration date.

Please be aware that only IRB-approved informed consent forms may be used when written informed consent is required.

Any changes in study or informed consent procedure must receive review and approval prior to implementation unless the change is necessary for the safety of subjects. In addition, you must inform the IRB of adverse events encountered during the study or of any new and significant information that may impact a research participants' safety or willingness to continue in your study.

The BCM IRB is organized, operates, and is registered with the United States Office for Human Research Protections according to the regulations codified in the United States Code of Federal Regulations at 45 CFR 46 and 21 CFR 56. The BCM IRB operates under the BCM Federal Wide Assurance No. 00000286, as well as those of hospitals and institutions affiliated with the College.

Sincerely yours,

JULIE PAMELA KATKIN, M.D.
Institutional Review Board for Baylor College of Medicine and Affiliated Hospitals

APPENDIX C

Demographic Data Collection Form

Demographic Questionnaire:

What are the lived experiences of NPs practicing within the TAPP Model?

1. What is your gender?
    - □ Female
    - □ Male

2. What is your age in years?
    - □ Years
3. What is your ethnicity?
    - □ American Indian or Alaskan Native
    - □ Asian or Pacific Islander
    - □ Black or African American
    - □ Hispanic or Latino
    - □ White / Caucasian
    - □ Prefer not to answer
4. What is your APRN Specialty recognition?
    - □ PNP-PC
    - □ PNP-AC
    - □ FNP–C
    - □ NNP-BC
5. How long have you practiced as an APRN (in years)?
    - □ Years
6. How long have you practiced as a registered nurse prior to becoming an APRN?
    - □ Years
7. What department do you practice for?
    - □ Department of Medicine
    - □ Department of Surgery
8. Where do you practice?
    - □ Inpatient area

□ Outpatient area

□ Both

9. In a typical week, how many hours do you spend in direct patient care?

_____Hours

10. Are you given professional development time in your role?

□ Yes

□ No

11. In the last two years, what was your performance evaluation level?

2014	**2015**
□ Exceptional	□ Exceptional
□ Consistently Exceptional	□ Consistently Exceptional

APPENDIX D

Semi-Structured Interview Guide

Semi-Structured Interview Guide:

I. Opening:

a. (Establish rapport) [Shake hands] and welcome to the interview.
b. (Purpose). I would like to ask you some questions about how the TAPP Model has worked or not worked for you.
c. (Motivation) I hope to use this information to validate and improve the TAPP Model for NPs
d. (Timeline) This interview should take approximately 45 minutes to 1 hour
e. (Process) I will be using a recorder to capture an accurate record of our conversations. I will also be taking notes during the interview. I will be transcribing the interview and will contact you if there are any questions.

(Transition: Let's discuss the consent form process and I will answer any questions you may have about the study, the process, data collection procedures, and how the results will be used.)

II. Body

a. (Topic) General demographic information
    i. Questions asked are on the informational biographical sheet

III. (Transition to the interview questions)

1. How would you describe your professional practice prior to practicing within the TAPP Model?
2. How would you describe your professional practice now since practicing within the TAPP Model?
    a. Give me an example of when you applied the TAPP Model in your practice.
3. What has changed over time in your practice since practicing in the TAPP Model?
4. How would you describe your motivation for "doing-what-you-do" in your professional practice?
5. How has the performance evaluation process supported the TAPP Model and your professional development?
6. What advice would you give to a new NP using this model?

IV. Closing

a. (Summarize). I appreciate the time you took for participating in this interview. Is there anything else you think would be helpful for me to know about your experiences of practicing within the TAPP Model?
b. (Action to be taken). I should have all the information I need. As a final validating step, I would like to ask you if my descriptive results compare with your experiences (review the Mind Map methodology)

c. Would it be all right to call you to validate my descriptive results or if I have any more questions?

d. Thanks again. I look forward to sharing the results with you.