

Advanced nursing practice: a futures model derived from narrative analysis of nurses' stories

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ABSTRACT

Objective

To present a model of advanced nursing practice based on a narrative analysis of advanced practice stories provided by nurses.

Design

Using narratives depicting their clinical practice, nurses were asked to provide illustrations of advanced practice. Analysis of fifty nine narratives enabled exploration of aspects of advanced practice.

Setting

Stories depicted contexts of advanced nursing practice including mental health, child and family health, acute and aged care.

Results

Findings revealed six themes: *Knowticing*; *Getting a doctor*; *Trans-action*; *Taleoring care*; *Experiencing vulnerability* and *Transporting: facilitating comfort and control*. Three narrative aspects representing advanced practice were described: *Rescue*; *Recognition* and *Responsibility*; and *Respect*. The stories were of complex care situations relating to diverse areas of work highlighting critical incidents. Some incidents gave nurses great satisfaction whilst others were challenging.

Conclusions

The findings are presented as a model of advanced practice. Both the *world of advanced practice* a diagrammatic representation of the findings, and the futures model of advanced nursing practice incorporate the themes that emerged from the study. They highlight the central, often invisible place of the nurse in patient care. Advanced practice nurses assume responsibility for optimising care. They believe they make a difference and they call for recognition. The models reflect the multi-dimensional nature of advanced practice, its inherent complexity, dynamism and the potential for amplification of practice roles and functions.

INTRODUCTION

The research reported in this paper is based on a secondary analysis of data from a study that was commissioned by the Australian Nursing Federation (ANF) (in McMillan et al 1997). The overall purpose of this study was to determine the essential elements underpinning competencies for nurses practising at an advanced level. The method for the study, (hereafter referred to as the Advanced Nursing (AN) Project) used storytelling by nurses. The 142 stories were elicited from nurses in workshops, and by mail, through advertising in nursing publications (McMillan et al 1997). Nurses were asked “to provide a story from your practice which illustrates an aspect of what you see as advanced practice” (McMillan et al 1997). Whilst the practice stories were commissioned some time ago, the essential elements of advanced practice are consistent with contemporary practice.

The main aim of the discussion that follows in this paper is to present a representation of the *World of advanced practice* and the *futures model of advanced nursing practice*, which were developed as a result of analysing the stories of the nurses who participated in the AN project.

The stories provided by the nurses were of complex care situations. Their content related to diverse areas of work and highlighted critical practice incidents. Some incidents gave nurses great satisfaction whilst others were disturbing. In the first phase of the AN project, behaviours relating to advanced practice were identified and coded to the ANCI competencies (ANCI 1994) but the meaning of many of the incidents remained unexplored from an advanced practice perspective. For the secondary analysis of this data set the researchers asked, “What else were the nurses saying?” (Kucera 2007)

Literature review

According to the Victorian Nurse Practitioner Project Taskforce, the advanced practice nurse is:

an umbrella term given to a registered nurse who has met advanced clinical practice and educational requirements (ANA¹ 1997). These nurses demonstrate a high level of professional autonomy, conduct comprehensive health assessments, and

have expert skills in the diagnosis and treatment of complex responses of individuals, families and communities to actual or potential health problems. Working in collaboration with other health care professionals, the advanced practice nurse formulates clinical decisions to manage acute and chronic illness and to promote health. The advanced practice nurse integrates advanced clinical practice with education, research, management, leadership, and consultation. (ANA 1991) (in Victorian nurse practitioner project: Final report of the taskforce 2000 p. 102).

There is much debate about the roles and functions of advanced practice nurses (Bryant-Lukosius et al 2004) which largely emphasise inconsistency. Read et al (as cited in Furlong and Smith 2005) argue that the “ANP² has broader knowledge and skills, while the CNS³ uses narrower knowledge and practices within a specialist area” (p.1062). Chiarella (2006) and Bryant-Lukosius et al (2004) argue there is overlap and confusion between the various titles and the roles that are used around the world. Bryant-Lukosius et al, (2004 p 520) argue that whilst variability amongst roles is to be expected and desired, there needs to be consistency with regards to the core characteristics. In Australia, the terms used for advanced practice roles include clinical nurse specialist (CNS), nurse practitioner (NP), clinical nurse consultant (CNC) and advanced practice (AP) (Refer to ANMC 2007a). The National Nursing and Nursing Education Taskforce (2006) provide a comprehensive overview of definitions, including specialist practice and advanced practice (Heartfield 2006)⁴.

Irrespective of, and despite the difficulty with labels and definitions, examination and investigation into the nature of advanced practice continues. For example, there is lack of understanding of the role of nurse practitioners within the nursing profession as well as amongst other health care providers (Lathlean

¹ American Nurses' Association

² Advanced nurse practitioner

³ Clinical nurse specialist

⁴ Because all were considered as potentially belonging to 'advanced practice' as an initial premise of the literature review the differences between countries regarding terminology was not an issue and not pursued further. This allowed all categories to be considered for their potential to add to meaning and for later comparison with the findings. Where required, distinctions between titles are noted.

2007; Murphy 2007; Chang et al 2006). The need for clarification and understanding of advanced practice roles is indisputable as is the need for the identification of the core characteristics. Research designed to compare the roles of clinical nurse specialists and nurse practitioners (both viewed as advanced nursing practice) were often limited to surveys and comparisons of curricula (Fenton and Brykczynski 1993). More recently Higuchi et al (2006) examined the success of advanced practice nursing. Whilst interviews with nurses were conducted the focus was on the more concrete outcomes of the project, thus limiting understanding of how nurses viewed the meaning of their work. From their research, Furlong and Smith (2005) suggested the “core concepts for the advanced nursing practice role are: autonomy in clinical practice, pioneering professional and clinical leadership, expert practitioner and researcher” (p. 1059). The findings of the narrative analysis presented in this paper elucidate these concepts.

Rationale

At the time of the original work, in response to pressures from changes in the health care environment (Cooke 1993; McGee 1993; Hockenberry-Eaton 1991; Keane 1994;) nurses from all areas of practice were encouraged to explore and to clarify their roles. In addition there was limited literature that defined advanced practice. Terms such as *advanced*, *expert*, *specialist* and *independent practitioner* were often used interchangeably. Because of such confusion, and given the uniqueness of Australian society and nursing, the stories collected in the AN project, provided a rare and valuable opportunity to explore what advanced practice means to these nurses.

Later a document that discussed the implications for contemporary nursing education and practice on the scope of nursing practice provided support for this when “the need to differentiate more effectively and consistently between roles functions and expectations of levels of nurses” and “the need for transferable principles due to the diversity of practice contexts” are recognised (McMillan et al 2001, p. 8). Contemporary practice needed to meet many new expectations. Increasing consumer demand had forced roles to change. Hospital based practice had

changed. Many community based programs had been developed. Practice nurses were increasingly gaining more independence. This expansion in responsibility alerted the authors to the importance of thinking about and acting on opportunities for the future.

This situation is still relevant today. With nurse practitioners, clinical nurse consultants and other advanced level clinicians practising in contexts that demand advanced and extended functions within their roles, there is an increasing need to appreciate the elements of the suite of abilities that inform education and practice and enable nurses to provide optimal patient care. The latter centres on preventive as well as acute care and have particular relevance for the encouragement of patient managed care. More importantly, there is a critical need for nurses to engage in thinking about the future and their relevance to quality patient care. Linton (2005) believes the challenge is to shape the future of nursing in a positive way (p. 3) “The future is not something that just happens to us. The future is something we do” (Hiemstra 2005).

To date, there are no known studies on advanced practice that use multi-staged narrative analysis for the development of a futures based practice model.

Aim and Objectives

While the primary aim of the study was to uncover the meanings and experiences within the stories provided by nurses, based on a narrative analysis, other study objectives were to:

- explore activities and roles and identify how nurses see themselves;
- explore and link some of the social, historical and cultural forces that shape or influence how nurses think and act; and
- develop a model of advanced nursing practice.

Research Questions

The key research questions were:

- What are the meanings nurses have of their practice, as expressed through their stories of advanced practice?
- What does nursing practice at an advanced level mean to and for nurses?

Methodology

Narrative analysis was used in this study. The purpose of narrative analysis is “to see how respondents impose order on the flow of experience to make sense of events and actions in their lives... It tells not only about past actions, but how individuals understand those actions, that is, meaning” (Reissman 1993, p. 2).

The methodological approach examines the story and analyses how it is put together, including the linguistic and cultural resources it draws on. Analyses of narrative studies do not simply focus on the content to which language refers, but asks why the story was told that way? (Polkinghorne 1988, p. 1).

Data Collection

Originally nurses were invited “to provide a story from your practice which illustrates an aspect of what you see as advanced practice”. The stories were returned by mail, or collected at workshops as part of the AN project. Workshop participants completed a consent form that allowed use of the stories for further research. Consent was granted from the ANF to access the stories for the secondary data analysis reported here. The anonymity of all participants was ensured: personal details were not accessed by the researcher. Any identifying information was coded. Ethics clearance was granted from the University of Newcastle.

In total one hundred and forty two stories were obtained from voluntary participants. Ninety one stories were obtained for use in the study reported here, based on their eligibility from the consent given. A total of 59 stories were selected for analysis. Stories that focused on research, administration, management and infection control were excluded. Incomplete stories or stories that had major or numerous transcription errors were excluded. Stories that were written in the third person were also excluded. Adherence to methodology was a major determinant in the final selection of stories. The accounts had to be suitable for narrative analysis. To be compatible with the chosen method, two critical conditions had to be met (Polanyi 1985):

1. the response had to be defined as a story; and
2. the research question required that the stories were the nurses' own.

Data Analysis

Analysis was based on the writings of Polanyi (1985), and further guided by the work of Hall et al (1992), Meleis et al (1994) and Stevens (1994). Stevens (1995) called this method a ‘multi-staged narrative analysis’. Chart 1 summarises the process of data analysis.

Chart 1: procedure for data analysis: ‘multi-staged narrative analysis’* (Kucera 2007, p 63)

- 1. Selection and reading of stories:** Accounts were classified as stories during selection process. Stories were then reread identifying and recording the events. Each story was read to obtain overall understanding.
- 2. Construction of adequate paraphrase:** an adequate paraphrase of each story was constructed to identify the points being made, based on evaluation
- 3. Theme identification:** Once the paraphrases were written, the most important heavily evaluated aspects were identified, listed, considered and explored. Questions were asked: Why this story? How is it organised? Patterns or responses were grouped together and common meanings and patterns of shared experience were identified. This enabled the identification of the themes and meanings expressed by the story tellers, i.e. the common points of the stories. Points were identified and grouped, then collapsed into themes. The less common points were acknowledged These were discussed where appropriate.
- 4. Recheck and confirm:** the process and results of the identification of themes from paraphrases until satisfied that all key points, meanings, common characteristics and patterns were identified
- 5. Identification of narrative aspects:** It was asked: what else is the story about? What world is evoked? Identification and formulation of the narrative aspects was achieved by ‘decomposing’ the paraphrases, identifying propositions that were common and categorising the aspects. Considering the ‘moves’ (see Method, Kucera 2007) and comparing them between stories was attended. Confirming and formalising interpretation of the aspects in terms of what advanced practice meant to these nurses was completed.
- 6. Recheck and confirm the resultant themes and aspects:** A final look at both the paraphrases and stories to ensure the most important points, meanings and messages portrayed by teller were identified. Links between themes and aspects were noted.
- 7. Identity:** Revisit the paraphrases and stories. Identify and list the qualities laid claim to by the nurse. Interpretation allowed the development of a picture shaped by the common qualities, skills and approaches discovered by the analysis.

Each stage involved interpretation

Examples were chosen and presented in the research report.

Reissman (1993) notes that ensuring quality in narrative analysis is difficult; the researcher must take responsibility for the view of the subject's experience. Bailey (1996) argues that validity, as a measure of quality, is a process of confirmation, whereby there is a reconstruction of meaning, not truth, that the researcher wishes to understand and reinterpret theoretically (p. 187). Presentation of the original data and a clear outline of each step undertaken in the analysis give the reader the opportunity to validate the researcher's interpretations or draw alternate conclusions. Based on this commentary, care was taken to document the methodology, making obvious and reinforcing the interpretative nature of the process.

FINDINGS

The identification of the themes and aspects in the stories informed the research on how nurses conceptualised nursing at an advanced level. The people, events and processes that are important to the nurses were identified as well as the qualities, abilities and skills that are valued⁵. A list of components and competencies is not what defined practice for these nurses. Critically, the nurses 'told' the authors that advanced practice is represented by much more than the event.

Analysis led to the formation of six themes: *Knowticing*; *Getting a doctor*; *Trans-action*; *Experiencing vulnerability*; *Taleoring care*; and *Transporting: facilitating comfort and control*. These themes are representative of what practicing at an advanced level means to the nurse. The themes are the point of the stories. Using these themes, the model depicting 'the world of advanced practice' was derived.

Knowticing is represented by knowing and noticing. It is complex, described in varying ways and defined by four criteria (Kucera 2007). The nurse notices or notes *something* about the patient or situation.

Getting a doctor depicts the nurses' attempts to get the patient's situation attended to by a medical officer. The timely action of the nurse in *getting*

a doctor is a key factor in classifying advanced practice. The struggle to get a doctor emphasises the difficulties and importance of nurse/doctor relationships. The success of developing favourable *working relationships* was found to be greatly dependent upon conviction, communication and credibility. While conflict between doctors and nurses was acknowledged, interestingly it was rarely pursued in these stories. As with many of the studies that accessed nurses' views, the focus was directed towards the patient's need and the nurse's resolve.

Trans-action is knowing what to do and doing it. It involves the ability, knowledge, skill and competence to practice. The translation of thought to action is fundamental and encompasses all levels of skills as well as cognitive processes, and involves technical, physical and emotional responses.

Experiencing vulnerability, deals with nurses dealing with vulnerability including their own. *Taleoring care* constitutes the relationship between the nurse and the patient.

By *taleoring care* the nurse is specific to and focused on and with the individual. The nurses described care as being achieved through three essential components: *discussion, negotiation and direction*. Care is tailor made. Equally relevant is the way nurses nurse. An open, unassuming, non-judgemental dialogue and contact is established with the patient, allowing the patient to tell their story is a priority. This is what sets advanced practice apart from usual practice. In a way care is compartmentalised in that it is often only one instant in time we see through these stories, but we sense that it is dynamic and ongoing. It relies on a workable relationship and while the encounter is ended it is clear that the relationship is not. Care is planned, facilitated and given. *Taleored care* is person-centred relying on the nurse's confidence but not arrogance.

Transporting: facilitating comfort and control. By using a variety of mechanisms to provide comfort and control, the nurses *transport* the patient through the disruption or difficult period. Comfort and control take on new meaning, they are vehicles.

⁵ The main qualities laid claim to by the tellers were identified and interpreted to create a composite of an advanced practice nurse: an identity but are not addressed in this paper

Transporting is represented by decreasing distress, anxiety, pain and discomfort. There is a transition from helplessness to control. It includes maintaining dignity and promoting a feeling of command over the situation, thus fostering coping.

Narrative aspects were also identified (Polyani 1985). Narrative aspects represent underlying and embedded messages inherent in the stories. The narrative aspects encompass the themes and link the stories. They demand and direct attention not only to the work, but to the world of advanced practice. In answer to the question 'what else is the story about?' three narrative aspects represented this facet of analysis and depict the 'world evoked by stories' (Polyani 1985). These were: *Rescue*; *Recognition and Responsibility*; and *Respect*.

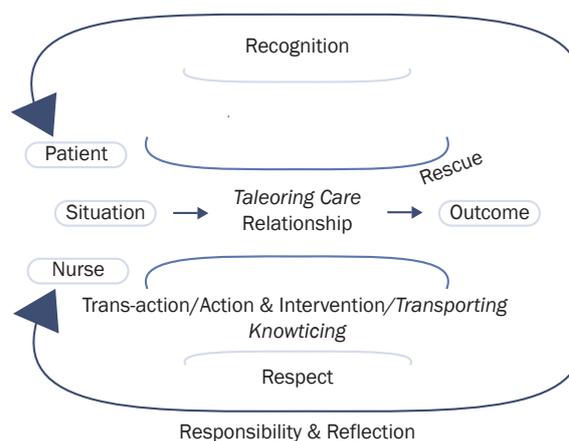
The findings collectively represent advanced practice as highly developed, requiring a capacity to deal with dynamic and complex situations, many in need of improvement. Advanced practice nurses have foresight and consider consequences to all involved. Practice is based on genuine respect. The nurse guides, supports and travels with the patient through the encounter. Thought and action are connected; knowledge and experience are the foundations for advanced practice. Competence, capability and maturity are prominent qualities of the advanced practice nurse. Being able to deal with their own vulnerability add to the advanced nature of practice. Advanced practice nurses often achieve improvement (rescue) and make a difference. At all times the nurse's practice is in the interest of the people for whom they care.

The World of Advanced Nursing Practice

The themes and aspects are inextricably linked and are brought together diagrammatically in figure 1, The World of Advanced Practice. This world derives directly from the findings and reflects the situation and interactions between the patient and nurse. Two arcs outline the encounter and *taleoring care* is located between them. Some themes and features of advanced practice are located below, signifying the support and guidance within the relationship. Nurses' activity is carried out alongside and with the patient

(*transporting*), not in isolation. The overlapping of activity is apparent. This relationship is strategically embraced and surrounded by the aspects that extend and blur any boundaries.

Figure 1: The World of Advanced Practice



Recognising advanced practice – the messages, the meanings

In the stories the nurses called for recognition. Important concepts have been identified that constituted advanced practice. The relationships between several of these concepts represented in the models are described more specifically in the following discussion.

Knowticing

Advanced practice means, to many nurses, *knowticing*. Feelings are heeded, actions often affording protection to the patient. The stories suggested that *intuition* belongs to the advanced practitioner. Varied attempts exist to identify, define and explain *intuition* (McCutcheon and Pincombe 2001; Cioffi 1997; Carper 1978). However, no nurse wrote the word *intuition* in their stories. Instead, nurses explained actions based on the ability to recognise worrying situations, as *knowing* when to ask questions, and *knowing* from past experience. In offering explanations nurses said they had refined applying knowledge, experience, perception, awareness and thinking.

From the stories, *knowticing* is rational and logical. Benner and Tanner (1987) use the term *intuitive judgement* (p. 23) to explain the phenomena of

knowing. Lumby (1996) uses Kennedy's term 'practice knowledge' (as cited in Lumby 1996) or practical knowledge, practical know-how, personal knowledge and intuition distinguishing it from book knowledge (p. 327). Brokensha (2002) also argues that intuition is related directly to knowledge and experience. McCutcheon and Pincombe's (2001) study demonstrates the interaction of a number of factors: experience, expertise and knowledge, personality, environment, acceptance of intuition as valid, and the presence or absence of a relationship with the patient. Herbig et al (2001) argue that tacit knowledge is acquired during experiences in a special domain or 'experience-guided' working. Interestingly, Ruth-Sahd and Hendy (2005) note nurses have difficulty explaining intuition to colleagues "whom nurses believe support more logical and analytical clinical diagnostics to guide decision on patient care." (para. 2). Paley (2006) asserts that the non-scientific 'ways of knowing' are not evidence" (p. 39).

While it is not questioned that knowing the patient facilitates care, the stories do not tell us that this is a requirement for *knowticing* (recognising, interrogating, worrying about, questioning). Searching for tangible evidence not only justifies the initial concerns but is required when attempting to *convince the doctor to respond*.

Respons-ability

The translation of thought to action is fundamental. The ability to respond and act has been described as *trans-action* (knowing what to do and doing it. It involves the ability, knowledge, skill and competence to practise.). In their stories, nurses referred to what needed to be done and that they did it. It was not determined by the complexity of the act or task.

Respons-ability assumes *recognition* of the need to be ready and be capable of acting. Knowing what to do and knowing how to do it is linked to experience. They have the ability to understand, prioritise, organise and respond manually, technically and emotionally.

Responding to dynamic situations and environments requires *managing vulnerability*, theirs and others' concentration and management of work progress.

The ability to *knowtice*, prioritise and respond effectively relies on a sense of responsibility and intent. The latter entails constant awareness, attending, conscious receptiveness and readiness. The nurse is ready to respond. Benner et al (1996) talk of "collective" or "pooled" "attentiveness and responsiveness" (p. 207). This study elevates these qualities of surveillance to 'states of being', a critical element of identity.

RESPONSIBILITY

Nurses devoted enormous attention to *recognition and responsibility* within their stories. This illustrated the centrality of the nurse; they made the difference. The stories show that the advanced practice nurses places themselves physically and mentally at the centre of the situation. They bring themselves to the situation, their knowledge and experience. There is *responsibility* for improving the patient situation, controlling the situation and facilitating comfort. These actions are emphasised because others fail to do it.

Nurses demand attention and claim this area of *responsibility* because nurses' actions are often invisible. In practice, many actions, interchanges and feelings are not reported. Maintaining a presence, protecting, guarding and monitoring are abstract. One cannot see the states of attentiveness, receptiveness, readiness or responsiveness. The subjective aspects of practice, the *responsibility* for other patients and the routine that goes on in the background lead to the invisibility of much of the nurses' work. Similarly the nurse's involvement and effort in *getting a doctor* goes unnoticed. Reassurance is invisible.

Development of the Model: the Advanced Practice Story

The world of advanced practice (figure 1) formed the beginning of a story. Particular patterns became evident from the analysis and interpretation and informed on the nature of practice, the dimensions of time and the evolving future. Analysis highlighted the inextricable link between the nurses' thoughts and actions and the meaning of action in context. Because the nurses tell the authors how they do what

they do, because they tell us why – so through the stories the authors gain insight into their behaviour, motivations and intent, the author realise the genuine person centred stance underlying practice. The concept of authenticity thus expressed led to the following inference:

the essence of the meaning of advanced practice centres on the authentic relationship between the nurse's thought about his/her practice and his/her actual practice, that is in all instances, person/patient centred.

Overwhelmingly the analysis suggested the nurses were carving out a place that had not as yet been recognised. The nurses were calling for recognition. Advanced practice nurses are not rule or routine bound. Though they are rule conscious and respectful, they are role making, making nursing and oriented to the future. Degeling et al (2000, p.133) said an accounting of how 'nurses make nursing' within specific contexts will aid in understanding the identity of nursing. If, nurses make nursing, then advanced practice nurses make advanced practice.

Futures thinking and studies provides tools, theories, methods and processes to look at the future in an attempt to better understand, decide strategy, and even create the future. This seemed an appropriate way to explore the nursing situations presented in this study.

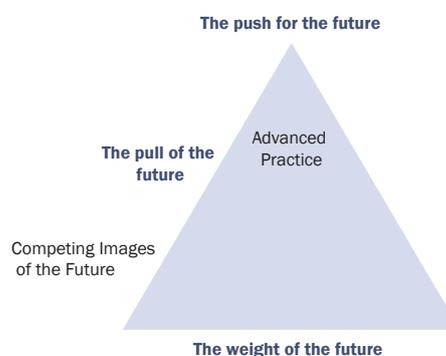
According to futures thinking, there are three dimensions that shape the future: the pulls, the pushes and the weights (Inayatullah 2004a). The futures triangle allows us to map these influences (Inayatullah 2004b Mapping the future section, para. 2).

Using this framework it was possible to reflect on and consider how nurses engage in role making or 'making' nursing.

Figure 2 presents a futures triangle for advanced practice nursing. Advanced practice emerges and develops in response to pushes and pulls, often despite the perceived weights. Competing images belong to the pulls.

Specific to nursing, factors such as improved technology, demographic shifts, acuity and chronicity within the clientele accessing health services, enabling legislation and models of health care belong to the pushes, while limited resources, interdisciplinary tensions and fiscal constraint can be identified as weights (McMillan et al 2004). However importantly, it is how these competing tensions are perceived by the individual nurse that will determine their influence on and effect in practice, both present and future.

Figure 2: Futures Triangle



Advanced practice nurses demonstrate high level practices that align with patient needs in contemporary health care. They are not caught in tradition and they have learned how to move beyond the weights and obstacles to 'make' advanced practice nursing.

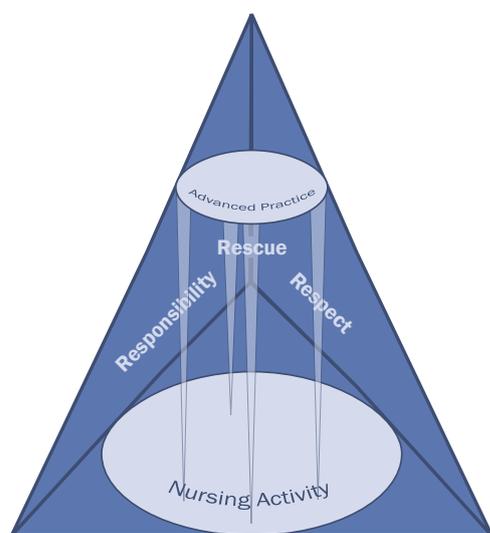
The futures triangle thus provided the framework for a model of advanced practice based on the findings from the stories (the stories commented on many things that enhance or limit advanced practice).

A Futures Model of Advanced Practice Nursing

The nature of practice, the subjective reality, where nurses place themselves within the world of practice and how they portray themselves culminates in a story, the advanced practice story.

Figure 3 presents a model of advanced nursing practice that emerges from and is supported by the interpretation and examination of nurses' stories. This diagrammatic representation illustrates the links: what practising at an advanced level means to the nurse.

Figure 3: A Futures Model of Advanced Nursing Practice



'The world of advanced practice' is represented in figure 1. When the futures triangle (figure 2) is superimposed over the world of advanced practice, a futures model of advanced practice emerges. Situated near the base of the futures triangle, Nursing Activity represents the foundations of practice, viewed here as *usual* practice.

In this model nursing activity is represented by Andersen's Nursing Activity Model (1991). This model is applicable today despite changing contexts, technology and increased acuity. It was derived from observation of actual practice and represents "an activity called into being in response to a change in a person's situation" (Andersen 1991, p.105). The goal of action taking in this model is situation improvement or "the process of enquiry as it applies to and shapes nursing intervention" (Andersen 1991, p. 105). The concept of situation improvement, along with other concepts such as initiating, guiding and responsible care, are consistent with the findings of this study. Based on these associations Andersen's model was used to depict the minimum requirements of contemporary nursing practice.

Advanced practice is distinguishable from usual practice because of its placement higher up in the Futures Model of Advanced Nursing Practice (figure 3). While the parallels in the findings to Andersen's model are evident (Andersen 1991, p. 106), the

extension of this model in particular areas allows the additional dimensions identified within the stories to be envisaged. The amplification of selected activities, practice states, skills and abilities define advanced practice. While anchored, they arise and expand from the elements within Andersen's Nursing Activity Model (1991). Components of experience, knowledge, achieving and functioning at a higher level, and using a full repertoire of skills are all represented by this elevation of practice. Because it is higher up the diameter is smaller representing the refinement and honing of skills.

However as with Andersen's (1991) model, "the activity is more than the sum of its parts or elements" (p. 105). The relationship between thinking, judgement and action-taking that is represented in Andersen's (1991) model, crucial to advanced practice, is amplified. The stories qualify thinking as intelligent and knowledgeable. Action is accurate, appropriate and purposeful. Behaviour and attitudes are critical. The person centred care is better represented. The relationship between the nurse and the patient and its importance is depicted more strongly for advanced practice. Nurses' activity is carried out alongside and with the patient (*transporting*), not in isolation.

The nature of advanced practice emanates primarily and prominently because of the nurse's focus. The focus for the advanced practice nurse is the patient. The progressive nature of interaction is seen as well as the overlapping of activity, rather than a stepwise process as in usual practice (refer figure 1 for details). These are the things that make the difference - that set practice apart as advanced.

At the same time, the futures triangle frames the world of advanced practice describing the competing dimensions of the future and illustrating the dimension of time. The world of advanced practice is further away from the weights; closer to the pushes and less stretched by the pulls (smaller circumference), illustrating that the nurses are role-making for 'their future'. Dealing with difficulties and troublesome issues (weights) are acknowledged in this model, issues not obvious and not mastered

in usual practice. Advanced practice nurses are not weighed down, they have responded to the pulls. They have the capacity to deal with contemporary demands. They are utilising a range of futuristic functions. They are forever updating. Making nursing practice is an approach to respond to and meet demands, a complex integration of thought and activity, a dynamic process. This model allows us to see the influences and responses as well as where advanced practice nurses are situated in time, and in practice. We see where advanced practice fits. Colour attempts to emphasise the complexity and dynamic nature of practice and shows the fluidity of practice and room for expansion. The pillars show how the level of practice is raised and amplified. The pyramid represents the enveloping of the aspects: how they surround, support, form and shape advanced practice. The multidimensional form signifies the nature of advanced practice.

CONCLUSION

In Australia nursing activities were described in the ANMC statement on the roles of the registered nurse and enrolled nurse (ANCI 1995; ANMC 2007b). Although nurses have input into the policies and regulations that define the scope of nursing practice, including all fields and specialities, by necessity the result is limited to the formulation of general goals and basic core competencies. There is recognition that “clinical decision making needs to be consistent with elements of National Competency Standards, Codes of Ethics and Professional Conduct” (Bellchambers and McMillan 2006 p. 24). Despite the usefulness and necessity of professional guidelines, since it is often unclear how decisions are finally made, any understanding of what influenced the decisions to include a particular activity, or of how nurses view their practice, is impossible to decipher from this literature.

Many studies that describe nursing roles and the boundaries of practice are limited in that they place little relevance on the nurse’s view. The focus of many studies, the nature of the questions, and the methodologies employed, has limited the

contribution to an understanding of practice from the nurses’ perspective. In general, studies that focus on competencies or activities of nursing provide little insight as to how nurses perceive their work.

When processes are included, much more understanding is gained. From the AN project the researchers compiled a set of guidelines regarding advanced practice. Much detail and explanation was included which when explored and examined using the modified narrative analysis methods, allowed a more complete picture to surface.

The development of the Futures Model of Advanced Nursing Practice presented here assists in clarifying and understanding the complete narrative that emerged from the nurses’ stories about their experiences.

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