USING PROFESSIONAL PRACTICE MODELS

USING PROFESSIONAL PRACTICE MODELS:

A PHENOMENOGRAPHIC STUDY OF PROFESSIONAL PRACTICE EXPERTS' CONCEPTIONS

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Abstract

The centrality of health care practice environments to the safety and quality of care that patients receive is well established. Hospitals often develop and implement a professional practice model (PPM) as one strategy to improve practice environments. In the United States, the incentive of magnet hospital designation is a driving force in PPM implementation. In Ontario, Canada, despite the lack of magnet hospital designation potential, many hospitals have also implemented PPMs. However, there appear to be differences in how PPMs are implemented in Ontario. There is a need to evaluate the utility of PPMs in assisting Ontario hospitals toward quality practice environments.

This phenomenographic study examined professional practice experts' conceptions of PPM implementation and use in Ontario acute care hospitals. It offers unique insight into the complexity of these phenomena. The findings indicate that PPM implementation is a dynamic and emergent phenomenon that occurs in cyclical phases of growth or renewal followed by periods of reduced activity or "lulls".

Seven categories of PPM use are described (a) creating alignment/consistency, (b) supporting evidence-based practice, (c) enabling interprofessional practice, (d) enhancing professional accountability, (e) enabling patient-centred care, (f) creating/ strengthening linkages, and (g) strategic positioning professional practice. Variations and different levels of use were evident within each category. As well, categories exhibited hierarchical relationships to one another, with more foundational uses providing support for higher level uses.

Three structural themes were identified (a) model design and structure, (b) professional practice leadership, and (c) organizational support. These themes work individually and synergistically, within and across the categories to influence the utilization and potential impact of the PPM. Progressively fuller and more complex use of the PPM appears to occur under increasingly intense influence of the structural themes.

The phenomenographic analysis provides new information about the relationships within and among the categories of PPM use and enables a more powerful understanding of the phenomenon than has been previously described. This provides insight as to how organizations might maximize return on investment with PPM implementation. Seven key recommendations arising from the study were identified:

1. Ensure an intentional PPM design aligned with articulated implementation goals.
2. Design PPMs to ensure that all elements work together.
3. Ensure PPM elements and implementation goals align with hospital strategic plan.
4. Commit to adequately resourcing all PPM elements to function optimally.
5. Design the PPM such that professional practice leader roles are appropriately positioned within the organization to achieve implementation goals.
6. Set clear expectations related to participation in the PPM and ensure accountability is demonstrated.
7. Anticipate that PPM implementation is longitudinal and create space for and celebrate PPM growth, emergence.

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Dedication

This thesis is dedicated with love to:

My mother, Joyce Margaret (Lloyd) Jones, who has always believed so strongly in me that I had to believe in myself and from whom I've learned what motherly pride means. Thank you Mum, for always, always being there with love.

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List of Abbreviations and Symbols

American Association of Colleges of Nursing (AACN)

American Nurses Credentialing Center (ANCC)

Best Practice Spotlight Organization (BPSO)

Emergency Room (ER)

Hospital Quality Alliance Composite Score (HQACS)

Nursing Assistant (NA)

Nursing Worklife Model (NWI)

Ontario Nurses' Association (ONA)

Per Patient Day (ppd)

Principle Investigator (PI)

Professional Practice Environment(s) (PPE) (PPEs)

Professional Practice Leader(s) (PPL) (PPLs)

Professional Practice Model(s) (PPM) (PPMs)

Professional Practice Network of Ontario (PPNO)

Registered Nurse(s) (RN) (RNs)

Registered Nurses' Association of Ontario (RNAO)

Registered Practical Nurse(s) (RPN) (RPNs)

United States (US)

University of Pittsburgh Medical Center (UPMC)

Chapter 1

Introduction

The centrality of health care practice environments to the safety and quality of care that patients receive is well established (Kramer & Schmalenberg, 2008; Spence Laschinger, 2008). Stemming from the American Academy of Nursing magnet hospital research (Cook, Hiroz, & Mildon, 2006), an enduring focus on practice environments over the past two decades has given rise to the implementation of PPMs, as replacement of more traditional nursing practice models (Arford & Zone-Smith, 2005; Zelauskas & Howes, 1992). Indeed, "professional models of care" are one of the forces of magnetism in the ANCC Magnet Recognition Program® (ANCC, 2008; Arford & Zone-Smith, 2005).

The implementation of a PPM within a health care organization is a major change initiative and requires an extensive investment of human resources. While there is a fairly large body of literature related PPMs, there has been little attempt to evaluate model utility. As well, most references that describe the actual utility of PPMs in moving organizations toward their quality practice environment goals are from the US, where the incentive of magnet hospital designation is a driving force. Because magnet hospital designation is exclusively a nursing system designation, the largest body of literature discussing PPMs has a nursing focus and a significant emphasis on PPM utilization at the patient care unit level (Cone, Conner McGovern, Barnard, & Reigel, 1995; Hastings, 1995; Rose & Reynolds, 1995; Rusch, 2004; Walker, 2001; Zelauskas & Howes, 1992).

In Ontario, Canada, despite the lack of magnet hospital designation potential, many hospitals have implemented PPMs (Mathews, & Lankshear, 2003). However, there appear to be differences in how these models are implemented in the Ontario context. Mathews and Lankshear (2003) reported sixteen "essential elements" of ideal PPMs, as generated by members of the PPNO during a PPNO quarterly meeting.

Perhaps as a response to the introduction of the Regulated Health Professions Act (1993), PPMs in Ontario tend to focus on interprofessional processes and structures, rather than a distinct focus on nursing. This is evidenced by the following elements reported by Mathews and Lankshear (2003) (a) interprofessional nature, (b) multidisciplinary roles (beyond nursing), and (c) collaborative practice principles. In addition, identified elements supporting a view that PPMs in Ontario tended toward corporate implementation versus a focus on unit based implementation were (a) purpose with a corporate/strategic view, (b) senior administrative support and linkages, (c) non-silo, cross program approach; (d) clear linkage to organizational mission and vision, (e) well-established linkages within the organization, and (f) corporate and unit based council structures. This is likely in part, a response to the advent of program management administrative structures in Canadian hospitals (Davis, Heath, & Reddick, 2002; Lankshear, 2007; Mathews & Lankshear, 2003).

There is a paucity of literature addressing PPM use in Ontario hospitals. Mathews and Lankshear (2003) noted that "although most organizations espouse a professional practice culture, there is great variability in the degree of operational supports in place to achieve that culture" (p. 71). They further commented that professional practice leaders

(PPLs) were hampered by ambiguity and a lack of empirical evidence as to which are the key elements needed for successful implementation of PPMs. In addition, legislation governing Ontario's public hospitals was seen as a barrier to full implementation of PPMs because it limited scope of practice of some professional groups and afforded different status to credentialed versus non-credentialed practitioners, particularly physicians.

Matthews and Lankshear (2003) further reported that the existence of a PPL was thought by PPNO members to be an essential element of a PPM. Lankshear (2007) noted that more than 60 health care organizations in Ontario had PPLs. In summary, although the use of PPMs in the Ontario hospital practice context is a relatively common phenomenon, there has been no systematic study of exactly why (what goals they are hoping to achieve) and how (how are the models chosen/designed and used) hospitals are implementing PPMs. The elemental design and utility of these models is not well understood or documented and the scant documentation that exists in the literature is largely US in origin. Given the differences described above between the US and Ontario contexts and given that PPM implementation is a complex and resource intensive endeavor (Storey, Linden, & Fisher, 2008) that may or may not be supporting hospitals to strengthen their professional practice environments (PPEs), further examination of the use of PPMs in Ontario is warranted.

The primary purpose of this study was to begin to fill the gap in knowledge identified above and describe how professional practice experts in Ontario acute care hospitals implement and use PPMs to improve the practice environment (PPE) of their

hospitals. In addition, descriptions of elements of the models in use in Ontario acute care hospitals were elicited.

Chapter 2

Review of Literature

Multiple electronic databases (Canadian Health Network, CINAHL, Cochrane, ERIC, HealthSTAR, MEDLINE, SAGE Nursing & Health Sciences, SAGE Management & Organization, Pubmed, Scholar's Portal, Social Sciences citation index, Web of Science) were searched using a variety of terms. Terms included professional practice elements/essential elements, PPMs/frameworks/structures, nursing practice models/frameworks/structures, practice models/frameworks/structures, use of, utilization of, clinical governance, shared governance and combinations of these. The searches were not restricted based on year, given that research and publication around this topic crossed several decades. Manual searches of references generated by these searches and from known seminal sources yielded additional references.

Magnet Hospitals & Professional Practice Environments

In the early 1980's, a severe nursing shortage prompted the American Academy of Nursing to commission a policy study, the purpose of which was to identify those organizational characteristics that both attracted and retained nurses. These outlier hospitals were called "magnets" (ANCC, 2008b). Fourteen "forces of magnetism" were identified in the study, including quality of nursing leadership, organizational structure, staffing, PPMs, quality of care, autonomy, interdisciplinary relationships and professional development (ANCC, 2008b). These forces or characteristics were felt to be distinguishing features of magnet hospitals.

Kramer and Schmalenberg (1988a & 1988b) continued to research magnet hospitals in a study that mapped eight characteristics of well-run corporate companies onto a sample of magnet hospitals. Their findings indicated there was a strong correlation between the characteristics of magnet hospitals and those of successful corporations. The study lent support for the primacy of nursing in the achievement of the corporate goal of quality patient care and as a central study focus.

> Patient care is the product that is produced. In the magnet hospitals, it was recognized that the main department in this product line is nursing…The central theme of all the excellent companies is that everything, all other departments, must support the product line (Kramer & Schmalenberg, 1988b, p.17).

This research set the tone for another decade of research related to the magnet hospital characteristics and nursing professional practice systems.

In a review of this research, Scott, Sochalski, and Aiken (1999) concluded that there were common perceptions, across a broad range of study samples, sites and methods, about the central attributes of a quality nursing PPE. These attributes included the centrality of the nurse-patient relationship, professional autonomy (the ability to control one's own practice, including participation in clinical decision making), professional recognition and status, and interprofessional (particularly nurse-physician) collaboration. Additionally, the importance of visionary and transformational nursing leadership was consistently identified as a central attribute.

These attributes correspond with those characteristics deemed by the AACN to be the "hallmarks" of a professional nursing practice environment. Additionally, the AACN

(2002) identified professional accountability, executive level nursing leadership, professional development support, including clinical advancement programs, and the use of clinical practice technology support as hallmarks.

A valid critique of this body of research is that there is an inherent selection bias in studying only magnet hospitals. In response to this, Lacey et al. (2007) conducted a cross-sectional comparative study of magnet, magnet-aspiring and non-magnet hospitals, using the Individual Workload Perception Scale to measure 3, 337 staff nurses' views on organizational support, workload, satisfaction and intent to stay. The findings support statistically significant differences between the three types of hospitals with relatively stronger PPEs evident in magnet and then magnet-aspiring hospitals compared with non-magnet hospitals. Another cross-sectional comparative study, conducted by Patrician, Shang and Lake (2010) compared RNs' responses across twenty-three Army Medical Department hospitals based in the US, utilizing the Practice Environment Scale of the Nursing Worklife Index. They found that across all hospitals, practice environment scores were consistently the strongest predictor of negative work outcomes, including job dissatisfaction, emotional exhaustion and intent to leave. In this study, lower practice environment scores were also the strongest predictor of fair to poor care quality ratings.

Professional Practice Models & PPM Utility

Several references in the PPM literature reviewed attempted to offer a definition of PPM (Arford & Zone-Smith, 2005; Cava, 2008; Hoffart & Woods, 1996; Massaro et al., 1996; O'Rourke, 2006; Zelauskas & Howes, 1992). All of these definitions or explanations included discussions of values, structures and processes that supported

professionals' autonomous practice through their involvement in shared clinical decision-making and control over the practice environment. The terms "model", "structure" and "framework" are used synonymously in the literature and will be represented by the term PPM in this report.

There is evidence in the literature of relationships among the articulated goals, essential elements and identified utility of PPMs. Several commonly articulated goals related to PPM implementation include improving and standardizing quality of care, improving both patient and staff satisfaction, and enhancing work effectiveness and fiscal efficiency (Davis, Heath, & Reddick, 2002; Lake, Keeling, Weber, & Olade, 1999; Massaro et al., 1996; Wolf, Hayden & Bradle, 2004). As well, there is a strong theme related to enhancement of the professional role in terms of clarity, accountability and empowerment as a goal of PPM implementation (Arford & Zone-Smith, 2005; Cava, 2008; Davis, Heath, & Reddick, 2002; Girard, Linton, & Besner, 2005; Hoffart & Woods, 1996; Latta & Davis-Kirsch, 2011; O'Rourke, 2003 & 2006; Wolf, Hayden, & Bradle, 2004). These goals echo the characteristics of magnet hospitals outlined earlier. Additionally, and again echoing the magnet hospital research, there was acknowledgment in the literature about the utility of PPMs in forwarding hospital goals of professional recruitment and retention.

The inclusion of specific elements in the PPM design is related to articulated goals of PPM implementation. How the PPM is used to achieve the identified goals, or in other words, the model utility is intrinsically connected to the elements included in the model and the design of their interaction within the model and within the organization. It

follows that in order to achieve the goals of PPM implementation, whatever they may be, an intentional model design process needs to occur and must include model utility planning (Rose & Reynolds, 1995). In essence, the planning process needs to answer the questions, what do we need to include and how do we use what we put in place to get to where we want to be from where we are now? In several instances, the identification of design elements for PPMs represented in the literature was facilitated by some process of empirical inquiry with staff, in the form of focus groups, surveys and/or interviews, with these efforts supported by literature review (Cava, 2008; Davis, Heath, & Reddick, 2002; Girard, Linton, & Besner, 2005; Ingersoll, Witzel, & Smith, 2005; Lake, Keeling, Weber, & Olade, 1999; Mathews & Lankshear, 2003; Wolf, Boland, & Aukerman, 1994). Other authors referred only to the literature or spoke theoretically about the essential PPM elements (Arford & Zone-Smith, 2005; Hoffart & Woods, 1996; O'Rourke, 2003 & 2006). Latta and Davis-Kirsch (2011) maintained that "the development of a theory-derived, organizationally compatible PPM comes alive in practice only when it is pragmatically developed and clearly articulated" (p. 581).

Of all sources, the one most often cited in the PPM literature is Hoffart and Woods (1996). These authors outlined five subsystems/elements of PPMs (a) governance model/management approach, (b) care delivery model, (c) professional values, (d) professional relationships, and (e) compensation/rewards. They conducted an analysis of existing literature, comparing five existing PPMs that were documented in the literature, in order to identify the ways in which these elements were operationalized in each PPM. A five-strand rope depicted the Hoffart and Woods representation of PPM elements, with

each strand representing an identified PPM subsystem. Professional Values is the central strand around which the others revolve. The Hoffart and Woods representation is meant to be generic and adaptable in many practice settings. Although it is not a prototype model, it represents the most typical elements of many models represented in the literature. In addition, there is some empirical evidence to support the use of Hoffart and Woods representation as a framework for "defining and quantifying professional nursing practice" (Fasoli, 2008, p. 61). Figure 1 is an adaptation of the Hoffart Woods model that has been adopted for use by the University of Maryland Medical Center. The five strand rope described by Hoffart and Woods has been modified slightly in that the patient and family, rather than professional values are identified as the central strand around which the five model elements revolve. The wording of the five elements is slightly different, but the central meaning of each is retained.

Figure 1. University of Maryland Medical Center Professional Practice Model, based on Hoffart and Woods 1996; http://www.umm.edu/nursing/nppm.htm

Professional values. Hoffart and Woods (1996) posited the central position of Professional Values in any PPM, maintaining that without clearly articulated values, the other elements lack focus and intentionality. These authors viewed values as foundational to the attitudes, characteristics and action orientation of the organizational/professional culture. Commonly articulated professional values in the PPM literature include care continuity and patient focus, professional autonomy and accountability, collaborative interprofessionality, critical thinking, innovation, stewardship of resources, care excellence/quality, commitment to professional development and professional respect and recognition. PPMs support the enactment of professional values and so, these values must be articulated in the design and evident in the utility or implementation of the model.

Several authors specifically indicated the utility of the PPM in maintaining an organizational focus on the essential components of professional practice in the face of competing resources and health care environments characterized by fiscal constraint (Davis, Heath, & Reddick, 2002; Wolf, Boland & Aukerman, 1994; Wolf, Hayden, & Bradle, 2004). PPMs can be used to help preserve the value of patient care in increasingly business focused health care environments.

Governance model. The most commonly articulated goal of PPMs is enhancement of autonomous professional role enactment and professional accountability. This is most often achieved through the use of a decentralized or shared governance structure, designed to bring practice decision-making closer to the point of care and consequently place the ownership and accountability for practice values, standards, and

processes into the hands of care practitioners. PPM design dictates the levels at which this goal is achieved and/or desired within the organization from the corporate level to the program or unit level and to the level of the nurse-patient interaction (Hoffart & Woods, 1996).

Mathews and Lankshear (2003) reported that the existence of professional practice council structures at strategic levels within health care organizations as one of the essential elements of a PPM whereas O'Rourke (2003 & 2006) argues strongly for the development of the professional role with accompanying accountability in each individual professional. Correspondingly, the O'Rourke PPM includes two main components, the Model of the Professional Role plus, the Stability of Patient Condition and Professional Practice Decision-Making Process Model (O'Rourke, 2006, p. 31). The focus of the O'Rourke PPM design and utility is set at the level of the nurse-patient encounter, whereas the other PPMs include a focus on unit, program and/or corporate decision-making processes (Cava, 2008; Davis, Heath, & Reddick, 2002; Hoffart & Woods, 1996; Mathews & Lankshear, 2003; Rose & Reynolds, 1995; Zelauskas & Howes, 1992).

Care delivery model. The care delivery model or patient care delivery system is the element in a PPM that defines the "structure and process by which responsibilities [and accountabilities] for patient care are assigned and work is coordinated among the members of the [health care team]" (Hoffart & Woods, 1996, p. 355). Depending on the design, the care delivery system element in a PPM can be utilized to achieve goals related

to staff and patient satisfaction, practitioner autonomy and accountability, consistency of care, collaboration, interprofessionality and fiscal efficiency.

Each of the five PPMs reviewed by Hoffart and Woods (1996) articulated primary nursing as the nursing care delivery model. Since the time of the review however, at least one of those models has shifted to a collaborative interprofessional model of care (Wolf, Hayden, & Bradle, 2004). Lake, Keeling, Weber, and Olade (1999) and McGlynn, Quinn Griffin, Donahue, and Fitzpatrick (2012) also describe a Collaborative Care model, but the focus is clearly on nursing care delivery. Although Mathews and Lankshear (2003) did not specifically identify a single model of care, their findings indicated a strong group preference towards care delivery systems that were interprofessional, collaborative and client-centred in nature. Davis, Heath, and Reddick (2002) outlined a PPM, in use in eastern Canada that follows this preference and allows for the delivery of client-centred care by an interprofessional team using a variety of unit-specific care delivery models. These authors specified that the PPM they described was designed for use in a program management operational structure, again supporting the findings of Mathews and Lankshear (2003). Poochikian-Sarkissian and colleagues (2008) and Cote, Lauzon, and Kyd-Strickland (2008) each described the development of interprofessional models of care in large Ontario tertiary care hospitals. Miles and Vallish (2010) articulated a "patient centered" model of care delivery.

Professional relationships. Whether having a nursing focus or an interprofessional focus, there was strong support in the literature that PPMs should assist in the cultivation and support of collaborative interprofessional relationships.

Relationships characterized by mutual respect and mature professional role enactment were seen to enable shared governance, effective scope of practice utilization, more flexible models of care delivery, and more efficient care delivery (Hoffart & Woods, 1996; Wolf, Boland, & Aukerman, 1994). The Transformational Model, for example outlines the following concepts within the collaborative practice element of the model: professional communication, organizational and unit norms governing professional interactions, professional shared governance, and interdisciplinary role enactment (Wolf, Boland, & Aukerman, 1994). These authors further outlined a model process component that emphasized critical thinking and negotiated care planning. Some degree of role differentiation within articulated care delivery processes was common to all models reviewed by Hoffart and Woods (1996).

Compensation & rewards. In their review of the US literature, Hoffart and Woods (1996) illustrated that four of the five PPMs reviewed contained some compensation and reward structure, including salaried nursing positions versus hourly rates, monetary bonuses for productivity and clinical outcomes, higher salaries for RNs in blended models of care, advancement and recognition programs, and even gain sharing. Although Hoffart and Woods (1996) noted that the Transformational Model did not include mention of compensation and rewards, Wolf reported that the nursing pay structure at the University of Pittsburgh Medical Centre was based on the performance levels articulated in the Transformational Model (personal communication, February 20, 2007). Massaro et al. (1996) articulated salaried compensation for nurse as one of two key components in the PPM implemented in their organization and reported a 0%

turnover rate within one year of PPM implementation. Ingersoll, Witzel, and Smith (2005) described a performance level evaluation model arising from the PPM and based on organizational mission, vision and values.

Discussion of compensation and rewards in relation to PPMs was entirely absent from the Canadian literature reviewed (Cava, 2008; Davis, Heath, & Reddick, 2002; Girard, Linton, & Besner, 2008; Mathews & Lankshear, 2003). None of the sixteen "essential elements" identified by PPNO members contained any mention of compensation or even status recognition (Mathews & Lankshear, 2003). Certainly within Ontario's unionized healthcare environment, career laddering or differential incentive compensation strategies may be difficult to discuss, let alone implement. As a result, Ontario PPM implementation does not articulate goals related to compensation and rewards. In fact, Leiter and Spence Laschinger (2006), in their study of Canadian hospital nurses' PPEs and burnout eliminated the career ladder questions from the Nursing Work Index survey tool. Canadian literature, like the US literature base commonly noted goals related to professional status and autonomy.

Practice Environment Outcomes

There are few actual implementation studies involving PPMs and measured outcomes. Several implementation studies reported on the implementation of only portions of a PPM, most often a shared governance structure and/or a model of care and these are discussed below. Upenieks (2000) reviewed six studies of nursing unit-based shared governance implementation. The studies reviewed were described as pre and post-test or quasi-experiment designs comparing PPM implementation on various nursing

units. Upenieks reported that despite wide variation in the actual intervention, implementation of a shared governance structure consistently resulted in increases in job satisfaction, personal power and accountability scores and improvements in unit culture, although the latter were often reported anecdotally rather than statistically.

Barden, Quinn Griffin, Donahue, and Fitzpatrick (2011) used a descriptive correlational study design, to examine the relationship between nurses' perceptions of governance and empowerment. An interprofessional shared governance model had been implemented within the hospital and nurses working on a variety of units across the hospital were surveyed at least six to twelve months post implementation. The index of Professional Nursing Governance and the Conditions of Work Effectiveness II Questionnaire were used. Findings indicated a statistically significant relationship between shared governance and nurse empowerment. The relationship, a linear correlation indicated that "as shared governance increased, so did empowerment" (p. 215).

Similarly, Hastings (1995) reviewed two longitudinal studies of nursing unit-based PPM implementation and reported consistent nursing workforce findings such as increased staff satisfaction and decreased turnover, agency nurse use and sick time. She also however, reported no significant differences between nursing units that implemented the Professional Practice Partnership Model in a large Maryland academic medical center. However, Hastings noted that these results might have been secondary to inconsistent implementation across the units. In a secondary analysis comparing across units, Hastings noted that critical care nurses report more favorable outcome results

compared with nurses from a general medical unit and posited that work group effects played a vital role in PPM implementation and findings. She concluded that successful PPM implementation varied with the particular practice setting and the one size and style of PPM may not fit all units.

In a quasi-experimental design comparing outcomes between a 26 bed unit implementing a unit-based PPM and a matched control unit, Zelaukas and Howes (1992) reported statistically significantly higher job satisfaction, professional growth, perception of patient care quality and professional decision-making as well as decreased sick time and turnover on the implementation unit. As well, the PPM unit after the introduction of a salaried compensation model as part of the PPM implementation reported significant reduction in the cost per patient day (ppd) as compared with the control unit. This difference stabilized over a four-year period, related to an increase in RN salaries. However, even after four years, the cost ppd was lower on the all RN implementation unit than it was on the mixed skill control unit. In another quasi-experimental study, Hayes (1992) reported no statistically significant difference in patient satisfaction scores between the implementation and control units in a study that evaluated the implementation of a nursing model of care. The implementation model positioned RNs in a managerial role with respect to nursing assistants on the unit. There were significant changes in the RNs' leadership function scores compared with the control unit over the study period.

McGlynn, Griffin, Donahue, and Firtzpatrick (2012) found a statistically significant negative relationship between overall job satisfaction and satisfaction with the

PPE among RNs working in units post PPM implementation. This descriptive, cross-sectional study utilized Lake's (2002) Practice Environment Scale of the Nursing Work Index to evaluate practice environment satisfaction. The authors commented that the PPM was implemented in the study hospital only ten months prior to data collection and postulated that "implementation of a PPM may heighten awareness of the missing components within a practice environment and lead to decreased overall satisfaction" (McGlynn et al., 2012, p. 260).

This was not supported in another descriptive cross-sectional study by Newcomb, Smith, and Webb (2009). This study was designed specifically to study the impact of PPM implementation on nurse job satisfaction. Using the Index of Work Satisfaction, the authors measured satisfaction at three points across PPM implementation, prior to, during and one year after and predicted that satisfaction would drop during implementation. They found that there were minimal changes in satisfaction across the three data collection points, although scores dipped on several items during implementation. However these were temporary and not evident in the post implementation survey.

The Transformational Model for Professional Practice (Wolf, Boland, & Aukerman, 1994; Wolf, Hayden, & Bradle, 2004) was implemented during a massive merger within the UPMC, with the articulated goals of achieving efficient, quality care; standardizing essential care across sites; developing proactive staff; and maintaining the unique culture of each site. In one of the only studies that directly examined PPM implementation and patient care outcomes, Wolf, Hayden, and Bradle (2004) conducted a retrospective analysis between UPMC sites using and not using the model. They reported

statistically significant improvements in patient care outcomes (reduction of medication errors and central line infections) and wait times (ER to admission and ER to discharge) at implementation sites. As well, in implementation sites there were statistically significant reductions in staffing costs in both medical/surgical units and intensive care units with equal or better patient outcomes being achieved compared with the non-implementation sites. The authors noted that these differences cannot be causally attributed to the PPM implementation but maintained that "even if only 30% of these differences could be credited to the Transformational Model, the demonstrated cost and quality outcomes were operationally significant" (Wolf, Hayden, & Bradle, 2004, p. 182). The model was subsequently adopted across the UPMC.

In contrast in a longitudinal study, Mark, Salyer, and Wan (2003), using multi-level structural equation modeling, found that the strength of the PPE at the nursing unit level had no statistically significant relationship to the incidence of medication errors when analyzed at either the unit or the hospital level. This study did not evaluate PPM implementation per se, but rather measured strength of professional nursing practice defined by level of active participation in decision-making, practice autonomy and nurse-physician collaboration. Nurses (n=1682) and patients (n=1326) in 124 medical/surgical units across 64 US hospitals were surveyed in this study. The survey tools are not named but are described, often as researcher-designed, multi-item likert scale tools. Based on demonstrated strength of relationships in the theoretical model used in the study, the authors conclude that professional nursing practice had little impact on any patient outcomes at the nursing unit level and that contextual factors such as the availability of

support services and the size of the nursing unit were more relevant to these outcomes. The findings did indicate statistically significant relationships between nurse satisfaction and PPE strength at both the unit and hospital levels of analysis.

In similar fashion, several studies (Leiter & Spence Laschinger, 2006; Siu, Spence Laschinger, & Finegan, 2008; Spence Laschinger, 2008), all using predictive, non-experimental designs testing the same structural model have examined relationships between PPE strength and various other concepts. PPE, as evaluated by the Nursing Work Index Professional Environment subscale has been found to be positively predictive of conflict management and unit effectiveness (Siu, Spence Laschinger, & Finegan, 2008). In particular, nurse involvement in decision-making, the presence of a nursing model of care, leadership support of nursing and a collaborative relationship between nurses and physicians were found to be related to PPE strength.

Leiter and Spence Laschinger (2006) found that the existence of a nursing practice model that effectively articulated shared practice values positively predicted nurses' perceptions of personal accomplishment. They also found that staffing adequacy was predictive of nurses' emotional exhaustion. However, "regardless of their level of exhaustion or depersonalization, nurses who recognized elements of a nursing model of care operating within their hospital were able to derive a deeper sense of accomplishment from their work" (p. 144). Spence Laschinger (2008), in a study of 234 Ontario hospital nurses found that structural empowerment was foundational to the creation of positive PPEs and to nurses' perceptions of quality of care. These same nurses evaluated their PPE as only somewhat supportive of professional nursing practice.

Finally, Fasoli (2008) studied the effect of professional nursing practice on global hospital performance using an observational cross-sectional survey design. Using Hoffart and Woods PPM (1995) and the Revised Nursing Workload Index to measure strength of nursing PPE and the HQACS as a measure of global hospital performance, Fasoli surveyed 1815 nurses and 28 Senior Nurse Executives in 28 US hospitals. Although the findings did support the use of the Hoffart and Woods' PPM as an appropriate framework for studying professional nursing practice, the strength of nursing PPE was not a predictor of higher HQACS scores.

Summary

The literature reviewed has identified scholarly activity occurring over several decades identifying which elements or characteristics of health care organizations set them apart from other organizations in their ability to attract and retain professional staff. There is a body of literature that addresses the use of professional practice structures, models and frameworks as one of these key organizational elements or characteristics, particularly as related to nursing practice. The literature supported the idea that PPM implementation goals, model design and model utility are interrelated. It follows that there is a need for PPMs to be designed intentionally, with consideration of goals and utility. However, there is virtually no discussion in the literature of this process, linking model design to planned utility and goal achievement. This gives rise to questions about the relative merits of one PPM design versus another and their relative use in attaining PPE enhancements.

There is some empirical evidence in the literature that PPMs and particularly shared governance structures within PPMs have an impact on the strength of PPEs in the areas of shared values and decision-making and practice autonomy. Several studies (Barden, Quinn Griffin, Donahue, & Fitzpatrick, 2011; Fasoli, 2008; McGlynn, Griffin, Donahue, & Fitzpatrick, 2012; Newcomb, Smith, & Webb, 2009)) utilized observational or descriptive cross-sectional survey designs which yield relatively weaker evidence for causality than other designs (Huley, Cummings, Browner, Grady, & Newman, 2007). Several others (Leiter & Spence Laschinger, 2006; Mark, Salyer, & Wan, 2003; Siu, Spence Laschinger, & Finegan, 2008; Spence Laschinger, 2008) utilized predictive, non-experimental designs to test theoretical structural models that included PPE as one of the model structural elements. However, these studies did not specifically study the impact of PPM implementation on PPEs. Another group of studies (Hayes, 1992; Upenieks, 2000; Zelaukas & Howes, 1992) utilized pre/post-test or quasi-experimental designs to assess the impact of PPM implementation on a variety of outcome variables. Results of these studies showed variable results with some supporting improved outcomes with PPM implementation and others yielding equivocal or negative results.

There was significant diversity within the literature reviewed, in terms of study instrument psychometrics. Some of the instruments used in the studies had known reliability and validity (PPE scale, Nursing Work Index, Revised Nursing Work Index). However, others were likert scale measures developed by investigators for the specific study without known reliability or validity.

Despite the existence of PPMs in Ontario hospitals, there is some evidence that the strength of PPEs in Ontario are relatively low (Spence Laschinger, 2008; Tourangeau, Coghlan, Shamian, & Evans, 2005). This study, using a descriptive, cross-sectional survey design reported on results from 5,065 nurses in 75 Ontario acute care hospitals. "Serious issues persist within hospital nursing practice environments. Medical and surgical nurses evaluated their PPEs with failing grades" (Tourangeau, Coghlan, Shamian, & Evans, 2005, p. 66). Notably, this study did not examine the direct contributions or even the existence of PPMs in the hospitals studied.

Differences between the US and Ontario, Canada, professional practice contexts are evident in the review of the literature (Table 1). While it is unclear what the significance of these differences might be, at very least, in view of these differences, caution is warranted when applying results of US PPM studies to the Ontario context.

Table 1

Differences between US and Ontario, Canada Professional Practice Model Implementation

United States	Ontario, Canada
Nursing/nursing system focus	Interprofessional focus
Unit-based implementation	Corporate implementation
Remuneration as means of professional status recognition is a core PPM element	Remuneration as means of professional status recognition is absent from articulated PPM elements

Chapter 3

Methods

Statement of the Problem

The presence of a strong PPE has been identified as one of the distinguishing features or characteristics of a US magnet hospital (Latta & Davis-Kirsch, 2011). There is an underlying assumption that the implementation and use of a PPM will strengthen the PPE in a hospital. However, there is little direction to be gleaned from the literature as to which elements of PPMs are most helpful in achieving a stronger PPE. This finding echoes that of Mathews and Lankshear (2003) and points to a need for more systematic evaluation of PPM design and utility. Evaluation within the context of Ontario hospitals is supported in view of the evidence presented in the literature of differences between the US and Ontario professional practice contexts.

Primary Research Question

This study addressed the primary question "how do professional practice experts from Ontario acute care hospitals describe their experiences implementing and utilizing PPMs"?

Secondary Research Question

Secondarily, this study addressed the question "how do professional practice experts from Ontario acute care hospitals describe the PPMs in use in their hospitals"?

Phenomenography

Phenomenography is a qualitative research approach of relatively recent origin. Rather than philosophically based, phenomenography is more an empirically based

research tradition. Originating in Sweden in the mid-1970s, it was first used to examine questions related to education and ways of learning (Akerlind, 2005a; Marton, 1981). More broadly applied however, the object of phenomenographic research is the variation in human understanding or conception of the experience of a particular phenomenon or phenomena. The aim of phenomenographic research is the description of conceptions related to the phenomenon of study (Svensson, 1997). Phenomenographic research views knowledge as a subjective process of creating meaning in understanding objects or phenomena that are grounded in a real world external to the individual (Svensson, 1997).

Phenomenography is a research method adapted for mapping the qualitatively different ways in which people experience, conceptualize, perceive, and understand various aspects of and phenomena in, the world around them (Marton, 1986 as cited in Bowden, 2000, p. 2). Conceptions are seen by phenomenographers to be dependent upon both human activity and the reality external to the individual. Knowledge is relational and is "created through thinking about external reality" (Svensson, 1997, p 165). Therefore, phenomenography is neither traditionally positivistic nor purely interpretive in its approach. Conceptions are seen to hold relationship to the external object or phenomenon through the human activity of perceiving and thinking about that object or phenomenon (Akerlind, 2005b). As Svensson (1992) notes, in phenomenography "the emphasis on reality as part of the relation that knowledge is, is combined with the assumption that what is entering the relation has to be a part of reality…Conceptions are not entirely naturally given entities neither are they totally subjectively constructed entities" (p. 166).

Because phenomenographic research aims to describe the ways in which groups of people relate to a particular phenomenon (Bowden, 2000), it was well suited to support the aim of this study, which was to describe professional practice experts' experiences implementing and using PPMs in their hospitals. The methodological emphasis on describing the variation of ways of understanding or conceptualizing the experience of PPM use allowed for the development of a more complete and deeper understanding of this phenomenon.

Sampling

This study used a convenience sample of professional practice experts recruited through the PPNO. The PPNO is a network of more than 75 member organizations from across Ontario and outside the province. The network members consist of acute care hospitals, other hospitals, regulatory colleges, community agencies and private consultants (for more information about PPNO, please see the website at www.ppno.ca). The membership contact list consists of one primary and in some instances, one secondary contact person per organization. The majority of these contact members are PPLs in their organizations. If the organization has a PPM, these contact members likely hold primary accountability for the implementation of the model.

The study sample (n=7) was drawn from PPNO members working in acute care hospitals in Ontario. The majority of available literature pertaining to the use of PPMs represents this sector of health care organizations. This study limited data collection to acute care hospitals, in order to capture the variability of experience of the phenomenon

of PPM use and to increase the adequacy of the data collected (Morse, 1991). Additional criteria for inclusion in the study were:

1. The participant was a PPL with primary accountability for the implementation of the hospital's PPM. This ensured the appropriate expertise in the sample and eliminated those hospitals that did not have an articulated PPM.
2. The participant must have been in this role for a minimum of one year prior to participation in the study. The target sample size was 6-10, an appropriate size for a focus group (DiCenso, Guyatt, & Ciliska, 2005; Freeman, 2006).

A letter of introduction to the study (Appendix B) was sent via email from the PI to acute hospital member PPNO contact people. Members interested in participating in the study responded, indicating consent to receive further information about the study from the PI. The investigator contacted each respondent to ensure that the inclusion criteria were met and to explain the data collection process. Once agreement to continue in the study had been expressed, an information letter and consent form (Appendix C) and Demographic Data Sheet (Appendix D) were emailed to the participant. The participant was then asked to complete and submit the forms.

All 7 participants submitted signed consent forms. Participants received two reminder emails to complete and submit the demographic data collection form.

Ethical Considerations

Ethics approval for the study was received from the Research Ethics Board of McMaster University. This was a non-invasive study utilizing capable adult professionals as the study participants. The topic of study was not of a personal or

distressing nature. Informed consent was obtained from each participant prior to data collection and included consent to audiotape interviews and consent for possible use of the data for secondary analysis at a later date. Participants were informed during the consent process and during the data collection process that they had the right to withdraw from the study at any time without consequence.

Participants were assigned identifying codes and therefore were anonymous, except to the PI in all reports and presentations. All study materials will be kept in a secure location for ten years following study completion and then will be disposed of in a manner that ensures participant privacy. Risk to participants of the study was minimal and basically consisted of risk of identification and breach of privacy. Measures taken as described above minimize this risk for participants. Findings are presented in an aggregate form that does not identify individuals or their organizations. Participants each received a gift card as a small token of appreciation for participation.

Data Collection

Basic demographic data about the study participants was collected at the outset of the study using the Demographic Data Sheet. However, several participants failed to submit this form, despite repeated reminders and so no demographic analysis was conducted. The remaining study data was collected by two methods. Firstly, participants attended a 60-90 minute focus group via teleconference call. A minimally guided interview tool (Appendix E) was used to guide the focus group, consistent with the study methodology. "The phenomenographic interview is non-directive with one exception: this occurs when the interviewer 'leads' the interviewee to focus on some predetermined

content in a particular context" (Walsh, 2000, p. 19). Three focus groups of 2-3 participants each were conducted between March and April, 2010.

Secondly, participants were asked to complete and submit a single page Supplemental Data Sheet (Appendix F) after the focus group. Only one of the participants chose to do so and this information was included in the analysis. As well, one additional participant chose to share the document outlining the PPM in use at that hospital and this information was included in the aggregated data regarding PPM structure.

Data Analysis

Phenomenographic research examines the key aspects of the aggregate of data collected, rather than the rich detail of individual accounts (Akerlind, Bowden, & Green, 2005). Marton and Pong (2005) summarize the phenomenographic data analysis process as follows: "These 'different ways of understanding', or conceptions, are typically represented in the form of categories of description, which are further analyzed with regard to their logical relations in forming an outcome space" (p. 335). The final outcome space is generally represented by a narrative and/or graphic picture containing the categories of description and the structural relationships between and among these categories. Hierarchical depictions of structural relationships are common in phenomenographic research and depict categories that are inclusive of other categories, not categories that are more or less important or significant than others (Akerlind, 2005a; Akerlind, Bowden, & Green, 2005).

Digital recordings of the focus group were transcribed immediately following the interviews. Transcripts from the three focus groups were then aggregated into a single data source for analysis, along with the Supplemental Data sheet and PPM model information submitted by two participants. This is consistent with a phenomenographic approach (Akerlind, personal communication, August 11, 2008; Akerlind, Bowden, & Green, 2005).

Data analysis was an iterative process that took place intermittently over a period of 18 months, with isolated periods of more intense focus in between periods of analytic hiatus. Initial analysis was assisted by the use of qualitative analysis software and was grouped according to the phenomena outlined in the primary and secondary research questions; experience of model use, experience of model implementation and model description. This first iteration of analysis was difficult to work with and presented a rather fragmented, choppy story of the phenomena. For example, with model use ten parent categories emerged in initial analysis and of these, three had sub or child categories associated with them, including one that had twelve such sub-categories. There was no evidence of structural relationship between the categories. After review and discussion with the supervising committee, the analysis was felt to be too detailed to be useful in terms of categories of description.

After an analytic hiatus of 6 months, the initial analysis was set aside and the data re-engaged in a different way. The aggregated transcript was read as a whole several times without coding in order to get an overall sense of the engagement of the participants with the phenomena of interest and any similarities and differences between

the participants' stories. The understanding that emerged from this process was that the interaction between the phenomena and the participants was intimate and dynamic and that there seemed to be different "levels" of PPM model use being described by the participants. The transcript was then manually coded with respect to categories of use, experience of implementation and model elements, with each iteration of coding refining the categories and also including notations about the interaction between participants and the phenomena. These notations represented emerging structural elements between the categories and so the categorical and structural elements of the outcome space were co-constituted as the analytic process unfolded.

Separately, each thesis committee member reviewed one transcript and brought analytic impressions resulting from the review into the discussion of the emerging outcome space. This helped to finalize the descriptive categories by creating consensus as to which categories were qualitatively distinctive as opposed to variations on an existing category. It also helped to define the structural relationship between the categories as investigator impressions were validated or challenged by the independent reviews of the committee members. This iterative approach is characteristic of phenomenographic research. As Akerlind (2005b) notes, "exploring the data from a series of different perspectives enables one to help illuminate various aspects of the categories of description in turn, each aspect leading to further clarification of the whole" (p. 67).

As the categories emerged from the data, analysis began to include consideration of the logical structure between the categories. Akerlind (2005b) summarizes the goals

of phenomenographic data analysis as follows:

> Phenomenographers are explicit about not attempting to represent the full richness of variation in experience of a phenomenon, but just those aspects that seem critical in distinguishing qualitatively different ways of experiencing. This focus on critical aspects allows structural relationships to be highlighted in a way that would not be possible if the analysis focused on every nuance of meaning…The aim is to describe variation in experience in a way that is useful and meaningful, providing insight into what would be required for individuals to move from less powerful to more powerful ways of understanding a phenomenon (p. 72).

Validity in phenomenographic research is achieved in part by extensive re-engagement with the data and analysis in an iterative fashion (Akerlind, Bowden, & Green, 2005). Closure of the analysis phase of the study occurred when the supervising committee members and the investigator agreed that repeated iterations yielded no qualitatively distinct insights.

Chapter 4

Findings

The findings of the study will be described in three sections: (a) model implementation, (b) model use descriptive categories, and (c) model use structural analysis.

Model Implementation

Study participants (n=7) described the implementation of a PPM as a dynamic and emergent phenomenon that occurs in somewhat cyclical phases. The first phase is characterized by the presentation of a driver for implementation to begin. Several of the participants described that the initial implementation driver was the amalgamation or merger of two or more health care organizations or sites, usually hospitals, as is illustrated by the following participant comment:

> We were, you know, in the process of amalgamating, and we're on many sites, and the cultures of the different sites were, you know, being formed into one culture. So there was a lot of work around building interprofessional teams and building communication processes.

Others discussed a strategic planning process or an articulated goal orientated driver to implement or improve interprofessional or patient centered care. One participant described that "we're in the midst of doing a re-vamping of the organization, and re-looking at our mission, vision and values, and going from there to develop a model of care of which professional practice was imbedded as part of a model".

Once the driver was identified and a decision made to implement a PPM, participants described that the first element of the model structure, the PPL role, then had accountability to lead the next phases of model creation/identification and model implementation. This PPL could be positioned at any level in the organization including the senior leadership team. However, more often participants described this position at the director, middle manager or even coordinator level. In this way, the PPL was intimately linked to the model, not only as an essential structural element of the model, but also as its primary guide. This is well illustrated by this participant's comment. "Some of the service that we amalgamated…integrated into our hospital came from a program management model. It's not the model we use here, and it was the [professional] practice leader's job to kind of figure out how this was all going to fit into our organizational chart".

Various processes were described as having been undertaken by study participants and their organizations in the model creation/identification phase. Only one participant described a process of identification of an existing model in the literature and adoption of that model for implementation. The remainder of participants described processes that included a literature review and/or external consultation process followed by some form of internal consultation/creation process in which the model elements and design were established. Even the one organization that adopted an existing PPM also included an additional internal consultation process that resulted in modification and customization of the model described in the literature. Establishing internal engagement and "ownership"

of the model was identified as a key characteristic of this phase as is illustrated in the following participant comments:

> I came in and my work was to, you know, do a literature review and see if there was something that I could find that would be something that would work in our organization and I, you know, selected a model, and then I started communicating through the hospital in whatever different forums there were about what this model would be, and then got representatives from all of those different forums together in order to make that model our own.

> What we've been doing over seven months is meeting with different groups and talking about what for them is professional practice, what for them are the attributes of professional practice, the competencies, and how they fit together…what it means to people to develop a pictorial vision of it, and then to make the parts of it be real from the pictorial vision…it was the only way we could think of in order to get people to really feel that this was their PPM, and not something else that hung on a wall.

Participants' descriptions of the model implementation phase illustrated intricate interrelationships between model design and structure and model use. The most commonly cited characteristic of early model implementation was establishing elemental roles and structures of the model design. For example, one participant commented "the process of engagement was number one, and then number two was getting the systems and structures in place…both here a X [hospital] and at W [hospital] was getting the structures of councils". Another participant noted that "the first thing we did [after the

model was created] was we created a professional practice systems team, which has a representative from all the regulated health professions, and we also have a representative from pastoral care…they would have some, if not all responsibility for practice issues in their department".

Once some of these elemental model roles and structures were established, participants started to describe how the model was initially used in their hospitals. Model use will be fully described below. Participants also described that at some point after the initial implementation, their hospitals experienced a period of decreased activity or growth related to the PPM. Sometimes this reduced activity period was described as being related to change in professional practice leadership, or a shifting of organizational priorities. The following comments are illustrative of the descriptions of this phenomenon:

> There was then a lull for a period of time that followed that where we were really in a bit of a maintenance phase and there wasn't sort of a lot of growth.

> We've had a PPM at the hospital here that predates me, and we have a pretty strong professional practice infrastructure, but a few years ago we…under the leadership of a VP who is no longer with us so, I mean, I think that's part of the problem because, you know, she retired and there was a gap there…so it's been stagnant somewhat.

Following this period of reduced PPM activity, participants described how a new driver presented and precipitated a revision, renewal or some other type of accelerated

growth of the model. The new drivers described included organizational restructuring with the arrival of new roles or people, a new strategic priority, such as becoming an academic teaching hospital, or a regional push to embrace interprofessional care and even a new merger or joint venture with an external partner. The following participant comments are illustrative descriptors of this phenomenon of renewal in response to a new driver:

> We built our model prior to the attention being put on interprofessional care and education, and we're going through some pilot projects right now with money supported through Health Force Ontario…so as we are moving through those projects, I think we're building our model to become more of what it needs to be in order to integrate and consolidate those concepts.
>
> We needed to articulate why we were doing those pieces, and we needed to better support the various pieces in a comprehensive way, and tied those really more to the organizational sort of strategic plan, particularly around becoming a teaching and research centre.

The process of PPM implementation is a dynamic one, with a cyclical pattern of emergence as is illustrated below in Figure 2. "The model has to be dynamic, so it needs to continue to evolve with new information, new literature, new research coming out…We're going to continue to learn, and one of the things that I think is really dangerous is when a model is developed and then it stays static". The PPL is intimately involved with the implementation process. This will be discussed in more detail in the discussion of structural analysis.

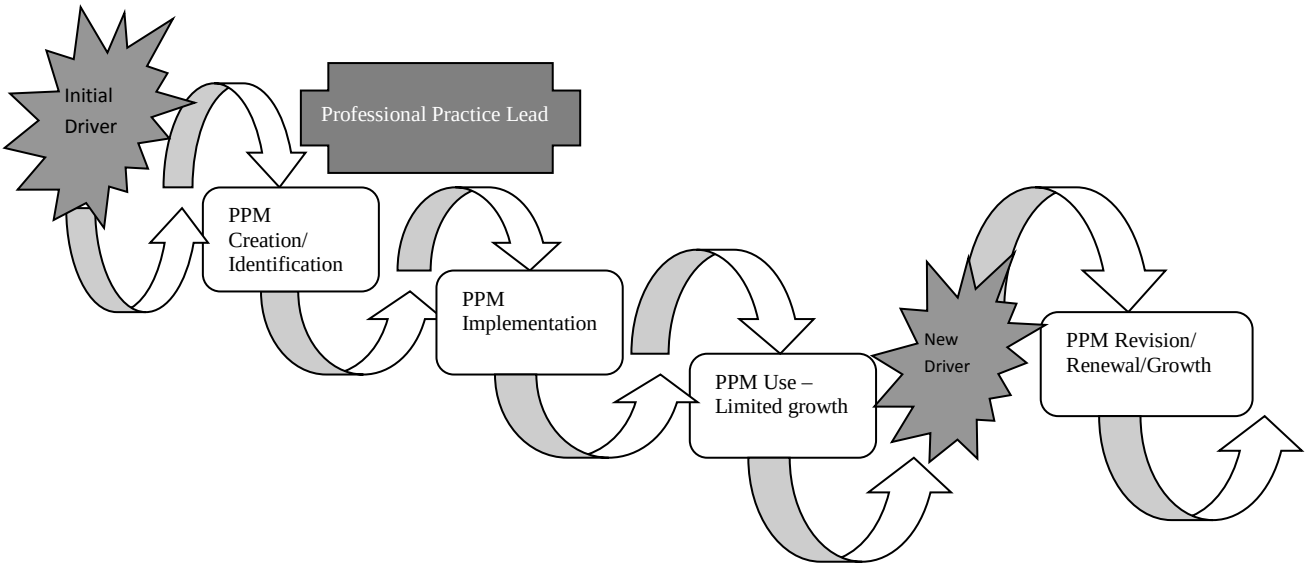

Figure 2. Cyclical Process of PPM Implementation

Model Use Descriptive Categories

Analysis of study participants' discussions of PPM use yielded seven distinct descriptive categories as follows(a) creating alignment/consistency, (b) supporting evidence-based practice, (c) enabling interprofessional practice, (d) enhancing professional accountability, (e) enabling patient centred care, (f) creating/strengthening linkages, and (g) strategic positioning professional practice. There is considerable variation within each descriptive category. The discussion that follows will identify the overall category description and outline the intra-category variation, with illustrative participant comment exemplars.

Create alignment/consistency. The need to create alignment and/or consistency whether with the organizational strategic plan, between hospital sites or across professions was described by several participants as the driver that initiated PPM

implementation. As well as being described as one of the primary drivers toward implementation of a PPM, this was also identified as one of the most fundamental and concrete ways in which hospitals use their model once it is in place. PPMs provide structures, processes and values/principles that enable a shared understanding of goals and consistent ways in which to achieve these goals across differences, such as geographic site and professional "silos". Participants described that their PPM serves as a communication vehicle and a touch point, especially in times of change or uncertainty and that the model is used, particularly by PPLs to provide a consistent focus and messaging. The following participant comment exemplifies in summary the meaning of this category of use:

> And at many points in that process we pulled out the model of inter-professional care and professional practice, and we made sure that we were aligning with the principles in there when discussions began to get a little heated or off track. It's that model then we would turn back to and say, "Okay, you know, what are we committed to here, what kind of practice, what kind of collaboration? So the model really became our guide through some, you know, rather turbulent waters.

PPM structures such as governance councils bring professionals together in a forum that enables collaborative decision-making. As previously discussed, the establishment of these foundational structures enables the creation of alignment/ consistency and enables other uses of PPMs in a fundamental way. Participants identified a variety of ways in which PPM structures are utilized within this descriptive category, including ensuring alignment of practice policy and procedure documents

across hospital sites, consistency of practice standards and scope of practice enactment across professional groups and/or hospital areas, collaborative education, and shared learning. One participant, commenting on the creation of a professional practice systems team, summarized this well as follows:

> One of the biggest challenges we had when we first started was that there were a lot of things going on in these little professional silos across the organization, and there wasn't any real consistency to the way that practice issues were being dealt with, and there was almost no education going on that was related to practice-specific issues…changes in the regulatory legislation, changes in scope of practice. Nobody was addressing those things…what we've dedicated ourselves to is any policy and procedure changes that are going to have an impact on any of the regulated professional has to be screened by us so we know what the hell is going on.

PPMs generally articulate a core set of principles and/or values regarding practice delivery and are used to ensure practice delivery changes reflect and are aligned and consistent with these core commitments. For example, one participant discussed how the PPM was used to guide a major scope of practice/model of care; introducing RPNs across the hospital. "What do we need to do to support the integration of our RPNs into these units in a way that is going to continue to build our commitment to professional practice, not to undermine it; and how are we going to do it in such a way that it's going to enhance our patient-centred care rather than erode it, and the model helps us to do that".

Enable evidence-based practice. Participants identified that PPMs in their hospitals are also used to enable practice that is supported by evidence or that is identified in some way as "best practice". Although it is similar in some respects to creating alignment/consistency, the focus of this use is not merely ensuring consistency of practice but is specifically focused on enabling the translation of research or evidence supported knowledge into practice. A common vehicle for enabling both consistency and evidence-based practice is the development and implementation of practice support documents such as policies, procedures, guidelines, directives and standards of care. This process is supported through both the PPM governance structures and the PPL roles. One participant noted that this is a fundamental use of the PPM in that hospital commenting that "for me it [PPM] gets used really the most around policy and procedure development, looking at the evidence-based model of care…and making sure that that part is captured".

Two participants, whose hospitals are involved in the RNAO BPSO program (http://rnao.ca/bpg/bpso), noted that the leadership for that evidence-based practice initiative sits within the professional practice structure. One commented that "care delivery is provided on a macro level is certainly something that falls within the purview of professional practice" while the other stated that "there's a very strong connection between our PPM and our commitment as a RNAO best practice spotlight candidate".

As well as enabling the availability of evidence-based practice support documents, PPMs are also used to reinforce sustainability of evidence-based practice at both corporate and local levels within hospitals. Participants described how PPM

structures and roles function to disseminate practice guidelines to the point of care delivery and also to support practitioners to be accountable for consistent implementation. In fact, one participant noted that the PPM had recently changed in that hospital, in part to facilitate this use as is illustrated in the following comment:

> We're not ready to do that yet [participate in the BPSO program], but we have tried to put in the structure to help support it, so I've just hired [two new managers]…even though we have lots of clinical resources, and even though we have those committees…within this department [Professional Practice] we needed to have some capacity to be in the clinical areas…and focus in on clinicians around using evidence in the every day.

Enabling evidence-based practice then, requires PPM use at both the corporate level and the local practice level and involves accessing and brokering evidence supported practice knowledge, and supporting its application at the point of care delivery.

Enable interprofessional practice. Discussion and description of how PPMs support the development and sustainability of interprofessional practice was reported consistently throughout the interview process and across all participants. It is another fundamental way in which Ontario hospitals utilize PPMs. All PPMs in use in the participant hospitals include a practice governance structure composed of representatives from the various professional disciplines and as has already been illustrated, these structures are used in a variety of ways to create alignment and consistency and to enable an evidence-based practice approach to care delivery. However, this category of use speaks to more than just having a group of different professional representatives engaged

in decision-making together. It describes a specific and intentional focus on developing a practice culture in which deeply knowledgeable, respectful and collaborative working relationships across professions and in service of patient outcomes are characteristic. The meaning of this descriptive category is summarized by a participant:

> We wanted to make sure that we were going truly interprofessional in our documentation, which required change in practice, right, because if you're going to have one interprofessional assessment online that is completed by multiple stakeholders, then you have to have some pretty solid discussions around who assesses what, how do I trust that the history that you've taken is credible, you know, so it's relationship building. It's understanding scope of practice. It's understanding opportunities to support one another.

PPMs are used in a variety of ways to enable interprofessional care and examples of these have been provided. PPMs in use in the participants' hospitals identified some core values and/or principles supporting interprofessional collaboration, care and education. As well, simply providing a structure and process for meaningful dialogue across and among professional groups and setting an expectation for collaborative decision-making is a basic enabler. Interprofessional practice support documents and standards, education/rounds as well as models of care that maximize scopes of practice are additional ways participants described that PPMs are used to enable interprofessional practice. One participant when describing the mandate of the interprofessional practice council noted "what they're starting to do first is looking at core competencies across all professions". Sharing of knowledge and experience across professions while doing work

within the mandate of the PPM also enables interprofessional practice, helping to cultivate deep knowledge and respect as this participant articulates well; "our pharmacy group is very sophisticated, very clear about using knowledge and evidence, very open to challenging each other. Well, they're serving as role models to help other PPLs take some tentative steps in trying that in their own profession, then bringing it back to the larger group for a discussion".

Several participants identified that their hospital was seeking teaching hospital status in affiliation with an academic partner and that there were clear expectations from the partner(s) that the hospital would provide interprofessional educational experiences for health profession learners. Participants directly linked this work to the PPM.

> You can't have interprofessional education opportunities without having strong models of interprofessional care in your organization…you can't have strong interprofessional care without a real commitment to the principles that we've developed around professional practice, so it all links together and so once again we're pulling the model out and referring to it as we try to develop our interprofessional education framework.

The relationship can be somewhat reciprocal however in that while the PPM can influence and inform how interprofessional education is manifest in the hospital, so can the external requirements and expectations of a partner serve as a new driver to review and review the PPM. This concept was illustrated previously in the analysis of model implementation.

Enhance professional accountability. Almost as a consequence of the PPM uses described above, professional accountability is also enhanced. For example, achieving consistency and alignment around practice support documents set clear expectations for practice to which professionals are accountable. One participant described the opposite situation graphically saying, "the accountability doesn't work…if they're looking for a policy and they find thirteen ones on restraint, which one should they be following that you're holding them accountable to. So we're destroying that and rebuilding it, so that's another example to me of the PPM at work". However, participants specifically mentioned that the use of PPMs serves this distinct purpose; to enhance professional accountability. Interprofessional dialogue, education and shared learning enhance professional accountability by clarifying scope of practice, clinical roles and collaborative standards of care.

Professional governance councils are given a mandate and accountability for practice in a way that doesn't exist without these structures such as for example when an operational department leader has accountability for the department. Some participants noted that their practice councils are structured to have accountability to the senior administrative team. One participant described that the PPM is structured to position the Medical Advisory Committee on par with the interprofessional practice council, with cross representation from each group at the senior executive level; "I'm going with him [Chief of Medical Staff] to MAC and he's coming with me to [interprofessional practice council], and our vision is to make them equal accountability". Another participant identified how the PPM in that hospital structures vertical alignment of practice

accountability from the unit council level up through the program level structures to the corporate level practice council. That participant makes this comment about influencing and directing that intentional use of the PPM. "Certainly, I pushed hard to have them [unit councils] anchored into our [interprofessional practice council] process, and to build in accountability structures". This conception also illustrates the very intimate relationship that exists between the model structure, the PPL and model use.

In summary, PPMs raise the profile and give voice to the professional within a budget-driven, operations environment. The following participant comment provides clear summary of this PPM use category.

> We have a higher awareness of professional accountability…people feel more comfortable in saying, you know what, because of policies I have in my department, I'm afraid it's going to compromise my ability to give safe or competent care, and if they can't…if that message won't be heard by their manager, they can bring it to the professional practice forum…I think that's one of the most positive things that has come out of the existence of a PPL or model that we have here.

Enable patient centred care. Patient centred care was identified by participants as one of the core values or principles of their PPM and so enabling patient centred care is very much related to creating consistency and alignment around this core value as is illustrated in the following participant comment; "this model has really become a way of centering ourselves again, and because it points to the patient at the centre…regardless if we're talking about accessibility or sustainability of service or maintenance of high

quality of services, we're always putting the patient at the centre…the model helps us to do that".

Participants describe using the PPM focus on patient to balance the focus on interprofessional care; "the model really helps people to be able to say, it's not provider focused, it's patient focused". They use this to centre discussions regarding practice change, scope of practice and models of care around the best interests of the patient as opposed to interests of various professional groups. "How do we coordinate care better for the patient by knowing what our scopes of practice are and how we're working together". In other words, the PPM directs having the right care provider, providing the best care to the patient at the right time.

Participants also spoke of this concept at a more strategic level and about how they use the PPM to influence organization strategy and operations. One participant described that the hospital had mandated the operations managers to take the internal patient centred care course that was being offered to clinicians. This intentional decision was made in order to ensure that managers would be able to understand and support the service delivery change that resulted as direct service providers changed their approach to be more patient centred. One participant summarized the high level impact that this PPM use can have at a hospital as follows:

> Patient centred care is part of our model, and it speaks to everything we do. At every senior team discussion, we talk about the impact on the patient…We actually are considering a measurement of our own abilities at the senior team in which we measure the percentage of our time that's spent discussing patients…It

> is the philosophy we ascribe to, and the model is really how we put that into place.

Creating and strengthening linkages. As with the other categories, this one, creating and strengthening linkages, also exhibits variations and different levels of use within the category. At the most fundamental level of PPM use, structures such as practice governance councils create linkages within and between professional groups where none or few existed prior to the PPM implementation. As one participant described, "when there are significant changes that are happening, we should be identifying that at nursing council and, you know, making sure those linkages are happening because our nursing council didn't exist before I got into this [PPL] role". Another participant noted that a wide variety of professional resource roles are now working together in the organization toward common goals rather than working disparately.

> We had clinical resources – educators, nurse clinicians, advanced practice nurses, advanced practice physios, CNSs and NPs…PPLs…close to sixty, I repeat six zero of those resources within our organization! And they never met together, and they were all going off and doing their own thing so, it actually took me three months to find out who all they were, and …once a month we now get together. We formed a Terms of Reference of what we want to do and they're learning together and they're starting to interact together.

Yet another participant described how horizontal linkages were being created among the interprofessional practice council and other corporate resource areas, such as infection

control and hand hygiene since the organization's quality data started being reviewed at the council. As well, vertical linkages were being made with the unit level on the initiative of the corporate level practice council related to the quality issues being identified.

Participants described a different level of linkages created and strengthened by the PPM between the professional practice roles and structures and the operational roles and structures. Role definition and clarification are an important component of these linkages as is described in this participant comment; "the people in management roles…as well as the people in professional practice leadership positions…spend a fair bit of time in discussion around okay, so who are you; what are you doing; and how are we going to work together?…What's the role of the manager and the PPL and how do those interface?".

In a similar fashion but again at a different level, participants describe using the PPM to strengthen linkages between other corporate support services such as Human Resources.

> I know at [hospital] W we had…and similarly here at [hospital] X, we're looking at the partnership between human resources and the professional practice vision…the whole HR structure started to focus on the dimensions of patient centred care, which could then be turned in the dimensions…of person centred management…a patient centred PPM…then became the HR model as well. So I think that, you know, one of the key steps is in the partnership with Human Resources.

The linkages created and strengthened by the PPM can vary in scope and formality within a hospital. The following participant describes a very extensive network of linkages being formally created across roles at various levels within the hospital.

> We're formalizing in writing the expectations, responsibilities, competencies…the partnerships – the partnerships between the clinical director and the medical director, the partnership between the operational directors and myself because all of our educators have a dual reporting structure between [operations] program and professional practice…formalizing the partnership between the patient care manager…and the educational resource…actually formalizing it, and between the RNs and the RPNs and then interprofessionally, so we're doing it at different levels over a three year chart…All of this is around professional practice…so [we'll have] very clear individual parameters, but also the partnership parameters.

A number of factors seem to play an important role in how extensively the PPM is used in this and other ways and these will be discussed in the structural analysis section to follow. However, in the first iteration of data analysis, assisted by analytic software, creating and strengthening linkages was the most densely coded use category. Participants spoke most frequently about and provided more examples of this use than any other. They also seemed to be more intimately involved with this use and with the next category of use, strategic positioning of professional practice.

Strategic positioning of professional practice. The final category of PPM use also exhibits variety and levels within. It is markedly different in character from the

other categories being more intra-professional practice focused and more for the exclusive use of the roles that live within the PPM than for the use of the hospital community at large. In this sense, it provides a perspective of the internal world of the PPM. It was within this category that the elements of the structural analysis emerged most prominently and this will be discussed in the next section.

At the most fundamental level of this category of use, participants describe that PPLs use the PPM to prioritize and communicate their work both within the "department" of professional practice and to the rest of the organization. In doing this, participants described that they also define and protect their sphere of responsibility and action within the hospital. This serves a number of strategic purposes including defining the value of professional practice as an organizational entity and ensuring that the relatively scarce resources of the PPM are being directed toward those activities most likely to achieve the strategic goals of the PPM. One participant spoke eloquently and at some length in illustration of this particular variation of use and the following quotation is composed from excerpts of discussion that occurred at several points across the interview.

> I think those of us who are involved in the work of professional practice use it [PPM] to guide our work plans as we go forward on an annual basis. We use it to protect what little area we have, so for instance one of the things that people want us to get involved with is recruitment and retention, and so, we're able to pull the model out and talk about what's the role of professional practice. Certainly there are some elements of retention that are important but, you know recruitment is not

> part of what our model includes, and so I think what we use it for, really is to guide the projects that we will be the leaders for…there's tons of work that needs to get done…so, just using the model in order to strategize, to prioritize…because there are limited resources in order to be able to meet the professional practice mandate of the hospital, and of the professionals in the hospital so you use the model to help you make decisions on a, I would say, a very frequent basis.

At a different level, participants described how they use the roles and model elements to strengthen the profile and influence of the PPM within the hospital. One participant described a process of working to adjust the role structure within the PPM to be more aligned with the operations role structure in order to equalize the power of the professional practice voice at a more strategic level of leadership within the hospital.

> I've been trying…fighting to get recognition as a director because sometimes when it comes toe to toe and you have somebody who's entrenched in what I call old think – you know, who's not willing to look at making a change that might benefit our ability to deliver care and may benefit the professionals in a department…I could flex some muscle by saying I'd rather deal with you on this level or we have to bump it up to senior management…recognition of practice at a director-level position in this organization would go a long way to making some people understand we're collaborating as peers, and this is not a pecking order situation.

Finally, participants described how they use and position the PPM to have direct alignment with and influence on the strategic direction of the hospital. Professional

practice experts in this study identified the centrality of the PPM to the overall strategic mission of the hospital. The mix of study participants represents PPLs at a variety of administrative levels in their hospitals from the coordinator and manager level through the director level to the senior administrator level. Each one of them discussed and described the ways in which they function to broker that knowledge and understanding at different levels of the hospital, a "flow of information bottom up and top down that's coherent, effective and makes a difference". One commented on this role saying, "it's really kind of bringing it all together. I look at our strategic goals…and I see that very much echoed in our PPM…I haven't seen it as articulated clearly – how it all fits together- and I think that's a piece that's missing". The image participants collectively created in their discussions about this was one of a tireless weaving of threads back and forth between the organizational strategic plan and the PPM. One participant noted that "the strategic plan was born out of the whole PPM", while another commented that "it's the goals and guiding principles of the organization through the mission, vision and values that are helping to inform the development of the PPM…it's hand in hand, helping the organization meet its goals".

In addition to this knowledge-brokering role, participants also described strategic positioning of professional practice to directly influence the organizational strategic plan. In particular, one participant stated, "I think the PPM gives you a focus, and I tie it into our strategic planning…I made a point of getting on the central strategic planning team for the hospital…so that I could make sure that practice was part of the strategic planning

related to the transition, the teaching hospital, the nature of the work we were going to be doing".

Summary

The collective narratives of study participants describing their experiences in using PPMs yielded seven different categories of description (a) create alignment and consistency, (b) enable evidence-based practice, (c) enable interprofessional practice, (d) enhance professional accountability, (e) enable patient centred care, (f) create and strengthen linkages, and (g) strategic positioning of professional practice. The discussion of findings has illustrated that within each of these seven categories there are variations of use and also that there are different levels of use. These levels range from foundational and concrete to complex and sophisticated and, as presented appear to have some relation to one another with more foundational uses providing support for higher level uses. As well, between the categories there appears to be a similarly hierarchical relationship from foundational to strategic, the nature of which will be outlined in the structural analysis. Figure 3 below depicts the descriptive categories and their proposed order of relationship to one another and represents the PPM use outcome space at this juncture.

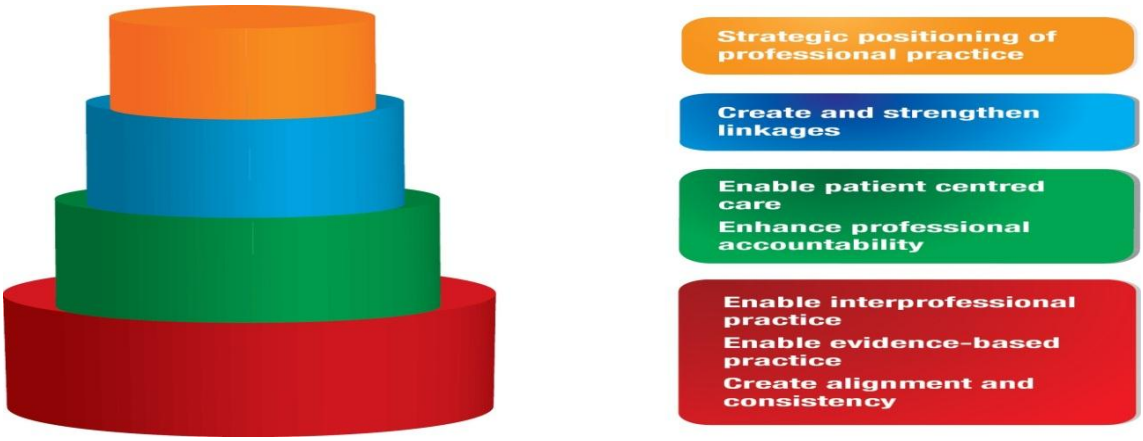

Figure 3. Categories of PPM Use

Structural Analysis of Model Use

Akerlind (2005b) notes that the structural relationships between categories of description in phenomenographic analysis "are commonly expected to form a structural hierarchy of inclusiveness, with some ways of experiencing being more complex than others, but including aspects of awareness constituted in less complex ways of experiencing" (p. 72). The phenomenon of experience under investigation in this study is the use of PPMs as conceptualized and described by professional practice experts and therefore, the structural analysis reflects the relationships across the descriptive categories of PPM use. As noted previously, it appears that initial categories describe more concrete, less complex uses of the PPM and that these give rise to progressively more complex and sophisticated uses. However, a progressive complexity of use is demonstrated within each of the categories as well as across the categories. Analysis of the influences or structural elements that cross categories and deepen the understanding of the phenomenon of PPM use yielded three themes or streams of influence that

modulated the descriptive categories, both within and across in the same fashion; giving rise to increased complexity and sophistication of use. These three structural influences are (a) model structure and design, (b) professional practice leadership, and (c) organizational support. The three themes work individually and in combination across the categories of use to enable increasingly complex and fuller experience of use of PPMs.

Model structure and design. The experience of PPM use is influenced by the structure and design of the PPM. The PPMs at the participant hospitals all had in common several design elements that enabled the specific PPM uses described. As discussed in model implementation, the PPL role presented in this study as a common PPM design element and one that was important to the implementation of the model, particularly the more complex and sophisticated uses of the PPM. As well, practice governance structures, both intra and inter professional were commonly identified as foundational model elements. Finally, a framework of guiding principles and/or values was identified as a core design element.

These design elements combined easily to enable the first three categories of PPM use, create consistency/alignment, support evidence-based practice and enable interprofessional practice, as was evident in the discussion of each of these categories. The establishment of structures and processes that bring professionals together around a common frame of reference for professional practice creates the foundation for the use of the PPM. Participants described that the initial work of those structures often related to the development of practice support standards and policy and procedure documents.

These documents and standards served as fundamental supports to bringing evidence into practice.

Although several participants described that it was the PPL that pulled together the governance structure and led its work, others described that this structure was put into place initially and the appointment/hiring of a designated PPL followed. One participant noted, "It doesn't have to be someone who is, you know, in a professional practice leadership role who is chairing that committee". So, although the inclusiveness of a practice governance council in the PPM design/structure appears to be essential to the less complex PPM uses of creating alignment, supporting evidence based practice and enabling interprofessional practice, the presence of a PPL is not necessarily essential to accomplishing these PPM uses in a rudimentary way.

More sophisticated uses of the PPM within these three categories however do seem to require the influence of a PPL. For example, several participants identified professional practice roles as essential to supporting and enabling the translation and consistent use of evidence based standards at the point of service delivery. One participant noted "areas that have really embraced…those professional practice [liaison] roles have, I think, further driven the enhancement of review of best practices". Further to this, the level of the organization at which PP leadership roles are positioned also influences the degree of sophistication and complexity of use. For example, if the PPM structure positions a PPL at a senior administrative level, then interprofessional practice can be enhanced and enabled at that strategic level through partnership with the Chief of Medical staff as well as within the foundational governance structures and locally within

clinical teams providing service. If the PPM doesn't position PP leadership at this level then it is unlikely that interprofessional practice will fully permeate the organizational culture.

This also appears to be the case with the increasingly sophisticated PPM uses of enhancing professional accountability and enabling patient centred care. If the PPM values framework clearly identifies these as core commitments, then they are more likely to be realized in the organizational culture. As noted previously, PPMs, and particularly governance structures within PPMs, give voice to professional accountability in a budget driven operations environment in a way that doesn't occur in organizations that do not have such structures. The level of penetration of this effect in the organization is dependent, in part on how the PPM structures PP leadership.

Again, the structural positioning of PPL roles at progressively more senior administrative levels may enable the permeation of PPM core values such as professional accountability and patient centredness at more and more strategic levels. The effectiveness of actualizing this structural potential to permeate core PPM values deeply into the organizational culture in turn depends on how well the PPL functions in the role and also on the level of organizational support that exists. To reiterate one participant's illustrative comment, "patient centred care is part of our model, and it speaks to everything we do. At every senior team discussion, we talk about the impact on the patient…We actually are considering a measurement of our own abilities at the senior team in which we measure the percentage of our time that's spent discussing patients". Model structure, professional practice leadership and organizational support work

synergistically to enable the expression and actualization of the PPM core value of patient centred care at the most senior administrative level of this organization.

Model structure and design also influences the creation and strengthening of linkages use of the PPM. The type and composition of practice governance structures directly influences the types of linkages created within and across professional groups within the hospital. This influence has largely been addressed in the discussion of enabling interprofessional practice, a fundamental use of the PPM.

If the PPM governance structure includes unit level councils as well as corporate level councils, then vertical linkages are possible between these two levels of practice governance within the organization. One participant noted, "at a local level our unit councils are being identified as valuable resources…more and more we're beginning to see those unit councils being conceptualized as part of the professional practice structure…trying to anchor a linear sort of accountability process that are all connected through the organization". In this example, we see that the more complex and sophisticated use of the PPM, creating and strengthening linkages includes the earlier identified use of enhancing professional accountability.

Again, the positioning of PPL roles within the PPM influences the extent to which the PPM can be used to create and strengthen linkages. A PPM that aligns PPL roles to corresponding operational leadership roles creates the potential to enable cross linkages and networks to be created between the practice and operations leadership structures. Having PPL roles positioned at increasingly senior administrative levels enables the potential to expand this network of linkages across the organization and to the highest

levels, akin to a telescope opening to its fullest length. If the highest level of professional practice leadership in the PPM is at the coordinator/manager level, then that is likely the level at which the linkages between the practice and operations structures will stop. Add a Director level PPL and the potential for linkages increases and likewise for PP leadership at the most senior level. This was well illustrated in the creating linkages use category discussion wherein a participant described a cascade of partnership linkages between the practice and operations structure; clinical director to medical director, operations directors to PP director, and educational resource to program manager. Such linkages also cascade to include more point of service practice level with linkages among members of different professions and intraprofessionally between RNs and RPNs.

The strategic positioning of professional practice within the organization is influenced in a very similar way by the PPM structure. The level of influence of the model on the organization's strategic direction mirrors the level at which the PPM positions PPLs and the network of linkages that have been created by those leaders. The fullness of this PPM use ranges from prioritizing professional practice work and positioning it as a distinct entity among the other hospital functional areas through equalizing the power of the professional practice voice with the operational voice to directly influencing and shaping the strategic vision and plan of the hospital. One participant spoke about the strategic importance of positioning the PP leader within the model. "I think that seeing it [PPL] at a director level, and seeing it as being across professions talks to the organization valuing that professional practice or, frankly, practice is at the same level and the same importance in the organization as operations".

The PPL who is positioned at the senior administrative table represents the PPM and all its content at that level in all discussions. "In our organization, I would speak to it and they look to me as the expert…the other members of the senior team, while they could tell you somewhat of the strategic plan for interprofessional practice…but I'm not sure that anyone but myself, you know…would speak to the model per se". Fully engaging and extending this most sophisticated use of the PPM enables full realization of all its uses and aligns the values and commitments of the PPM at the level of hospital strategy.

While the model's design/structure is not the most important element in realizing the fullest use of the PPM, it can be the hard stop to its realization. A PPM design that doesn't include senior level professional practice leadership representation almost certainly guarantees that the use of the PPM, including the strategic positioning of professional practice will stop at the highest structural level of professional practice leadership. While a director level PPL will have some influence with the senior administrative team, directors may not routinely function at this level. The type of integration articulated by study participants that occupy senior PPL roles, such as monitoring the amount of time at senior team meetings spent discussing patients, may not be possible without a fully present senior level PPL and a level of organizational support to acknowledge and heed the importance of the voice of that senior PPL. Using a telescope analogy once again, the three structural elements, model structure and design, PP leadership and organizational support work synergistically to enable the fullest use of the PPM within the hospital.

Professional practice leadership. PP leadership roles are a structural design element of the PPM and as such have been discussed in some depth in the previous section. That discussion was very much about the structural positioning of the PPL roles within the model; an essential consideration and influence on PPM use. However, the leadership function actualized by these roles has perhaps the greatest influence on the experience of PPM use of the three structural elements identified in this study.

Study participants described how the PPM influences how they enact their PP leadership role. Professional practice is first and foremost about clinical practice and one participant spoke passionately about how that primary PPM commitment guides living the PPL role to model the essential nature of professional practice in clinical practice.

> Professional practice and about being a practitioner…it defines me, and always has in everything I do…it's something that I believe very strongly that I need to stay connected with because it is, because I'm in a caring profession, and I'm in a service profession, and I think it also models the fact that it is at the interface with patient and family that all of this happens, and not anywhere else…and so I go on to the clinical units very often…and I'll ask questions…it guides me in how I live the role, but it also guides me in what I hope is modeling for other people around what they do in their every day is around professional practice. It isn't something that is the once a month meeting, or isn't something that you review and sign off for your annual registration. It is something that you do every day.

Another participant discusses how the formalized structures and processes embedded in the PPM enable role engagement and communication with professional

issues across the organization and then linking this back to the senior administrative team. "As the senior [PPL] in the organization, it's [the PPM] invaluable because that's the group I go to, to get my finger on the pulse of what is going on in professional practice in their profession…I'm talking to the frontline staff, but it's the formalized process that allows me to be with those individuals and be present to what they're experiencing, and that's my way of getting that back to the senior team".

A participant whose PPL role was positioned at a coordinator level within the PPM echoed this core leadership role function; "it allows me to be really in touch with what the frontline staff are facing and what their needs are, but it also allows me to become that mediator between senior management and the frontline staff around practice areas, about how we build professionalism in our staff, and how do we create those things together, so the model works well because I get used as a kind of an expert from both sides…and I can advocate for both sides".

Although these two PPLs' roles are structurally different, the leadership function that they each describe enacting is essentially the same; communicating and navigating across the levels of the PPM and the organization to enhance the understanding and broaden the use of the PPM within the hospital. "That sort of mediator role is, you know, that's how kind of we use the structure". "We're like one or two steps ahead of everybody else…we have a broader vision, or a broader understanding of how the dots get connected…we need to have that understanding of the different levels to help find the opportunities to help other people understand it". Every participant in the study described this leadership function at some point in the interview process. It is an

essential component of maximizing the use of the PPM in the hospital outside of the governance council structure. The PPL navigates the organization and enables the more complex and strategic uses of the PPM.

Study participants also described how they function as living embodiments of the PPM in their hospitals. "The PPM is really operationalized through the corporate [PPL] resources…that is probably the leading edge of professional practice in the organization. That would be generally what the rank and file would most likely identify as professional practice, along with the Chief Nursing Executive/Chief of Professional Practice…these are the folks that speak to it at where ever it is we are, at whatever table". Another participant noted that in a major operational restructuring project, although not accountable for the actual work of the project, her leadership presence was none the less required. "I'm representing the model at that table, but the purpose of me being there is to make sure…kind of that check and balance to make sure we're not missing anything…I was looked to in terms of leading the transition from kind of a human perspective in terms of what needed to be done from a professional perspective". So, in much the same way that the practice governance councils in the PPM structure represent the professional voice amid the operations structures, the PP leader functions as the voice of professional practice at the operations leadership tables.

As much as the PPM guides the PPL in role enactment however, the reverse is also true. The PPL is instrumental in guiding and directing the PPM's emergence and dynamism and in fact, the PPL even shapes and influences the PPM structure and design to enable use. Several participants spoke specifically about how they have been

instrumental in changing or evolving their PPMs or about their efforts to do so. One participant described advocating for a change in the position of PPL role within the PPM. "I've been in a 12 month battle to get the name of my position change to a director of professional practice. I don't expect a raise, but the reason I'm fighting for that is…to me a PPL is a term that reflects a dedication to one particular profession. So in *my model* [italics added for emphasis] there should be a director of professional practice and the practice expert [lead] in each profession should have some sort of a matrix reporting relationship [to the director]".

Another participant talked about evolving the structure of the PPM by adding additional PPL roles to the existing model in order to strengthen the professional practice presence at the practice interface. "I've just hired [two new PPL positions]…and that was taking a lot of business cases to the senior team. Why?…within this department, we needed to have some capacity to be in the clinical areas…and focus in on clinicians around using evidence in the every day, working with clinicians about understanding interprofessional education both for students and for staff…so I've been able to actually put the structure in place to help support that".

Several of the hospitals were in the process of seeking teaching hospital affiliation status and this driver required renewal of the PPMs in those organizations. Participants identified how they led processes in their respective hospitals to remodel the PPM to enable this strategic goal. For one participant this involved leading the development of an interprofessional education framework based on and supplemental to the principles of interprofessional practice outline within the PPM. Another participant described the

process of refreshing the interprofessional governance council to include a specific focus on interprofessional education and as well the process of creating new linkages between that council and both a new medical education council and the existing unit level councils in order to enhance connectivity and accountability within the hospital. "Certainly I led that piece of the process around taking the various elements, tying them into more of a conceptual model and looking at how we had operated with a number of pieces, but we needed to bring those pieces together into a coherent whole…I pushed hard to have them anchored into our [new structure] and to build in accountability structures".

The relationship between the PPM and the PPL is an intimate and a reciprocal one. The model guides the PPL role enactment and the PPL embodies the model and navigates across levels and departments within the hospital weaving networks and communicating and enabling understanding and application of the model beyond the reach of the PPM governance councils. The PPL helps the PPM to evolve and facilitates its growth to meet the emergent needs of the hospital in ways that other people in the organization wouldn't have the knowledge to do. However, as has already been discussed, the model's design and structure influences and can limit the effectiveness of the PPL to maximize the model's use within the hospital as can the third structural element, organizational support.

Organizational support. An organization can demonstrate support for the PPM in a number of ways, including the design and structure of the model and the PPL roles within the model. As has already been discussed, this support impacts the extent of the use of the PPM. Additionally, study participants identified that the resourcing of the

PPM was one fundamental way in which organizations demonstrate, or don't demonstrate support for the PPM. As was noted above, one participant described how repeated business case presentations to the senior team resulted in increased resourcing for PPL roles within the PPM and that this in turn enabled expanded use of the model at the practice interface.

Others however expressed frustration at being unable to influence financial investment in the PPM and noted how this impacted the effectiveness of the model's use. " I think that we are still looking for some senior, high level leadership around advancing the model, around funding it in an appropriate way [so that profession leadership roles have full time equivalents allocated], around putting accountability structures in place, around a communication plan". Another participant notes that after a loss of professional practice leadership at the senior team level, support for the profession leader role became optional and each department made its own decision about whether that role commitment. "Because of the changes at the top, things began to slide a little bit…and there's varying levels of degree of support in terms of time…so departments that really understand the roles have chosen to embrace them, you know, have protected the time allotment of those roles…they treat patients, but they have dedicated time to do the professional practice side of things". She notes that those departments are the ones in the hospital that have most developed a best practice approach to interprofessional clinical care.

Another fundamental way in which organizations demonstrate support for the PPM is by setting corporate expectations for participation in the activities of the PPM as

essential components of the organization's strategic plan deployment and then aligning accountability structures such that each level of the organization must report on how well it is meeting those expectations. In some organizations, the professional practice governance structures report and are accountable through senior level PPL roles to the senior administrative team. Designing a PPM with this kind of accountability structure demonstrates a high level of organizational support for the PPM.

One area of particular concern to participants was the ability to fully integrate physicians into the PPM. "In my organization, the biggest challenge or hurdle that we have is incorporating medicine into the process". This participant noted that the senior physician administrator, although a member of the senior team isn't held accountable for participation in the PPM. "I get lots of lip service – 'Yes, absolutely, it's important and I'll get right on that' – and here I am six months later still following up…it's a difficult sell to say that we're the professional practice systems team if I don't have a medical representative". The lack of senior level PP leadership and lack of senior level accountability reporting for the PP governance structure pose significant organizational support challenges to the use of the PPM in this hospital.

As with model design and structure, the level of support an organization demonstrates for the PPM can function as a hard stop to full realization of the potential of the PPMs use in the hospital. One of the study participants summed this up graphically.

> The fish stinks from the head, and I think if a senior team and a Board, an organization doesn't set up the expectations of everybody including the physicians, and isn't willing to take on some very difficult discussion and very

> difficult arguments, then you and I, even with all our passion and all our expertise and all of our wisdom, you may get a couple of people on board, but if the organization doesn't say, 'This is the expectation', and lives it, then either physicians will be left behind because everybody else will go on forward and they'll be outdated, outmoded and whatever, or you'll only go so far and then hit a brick wall.

Summary

The three structural themes identified in this study (model design and structure, professional practice leadership, and organizational support) work individually and synergistically within and across the descriptive categories of model use to enable fuller and more complex and sophisticated experiences of PPM use. PPMs can function in a rudimentary fashion to achieve basic goals related to all the categories of model use described in this study with very little in the way of organization support, with a basic model structure and with a PPL positioned at a lower administrative level (Figure 4a). This is particularly true with the more concrete and fundamental PPM uses such as creating alignment and consistency, supporting evidence based practice and enabling interprofessional practice. However, the achievement of greater depth and complexity of the more basic PPM uses within the professional practice governance structure, the fuller organizational penetration of PPM values and the achievement of higher level uses outlined in Figure 3 (Categories of PPM Use) outside of the council structure can only be experienced under increasingly intense levels of influence from the structural thematic elements (Figures 4b and 4c). Professional practice leadership is critical to the creation

and strengthening of linkages that are then used to more fully penetrate the values of the PPM and strategically position professional practice within the hospital. The level of structural positioning of the PPL within the PPM determines the extent and level at which these linkages occur and so has a direct influence on the efficacy of the PPL. However, ultimately, the degree of organizational support that is demonstrated for the PPM either enables or constrains the full realization of the use of the PPM within the hospital.

The series of schematics below illustrates that progressively fuller and more complex use of the PPM occurs under the increasingly intense influence of the three structural themes. This schematic series constitutes the study's final outcome space.

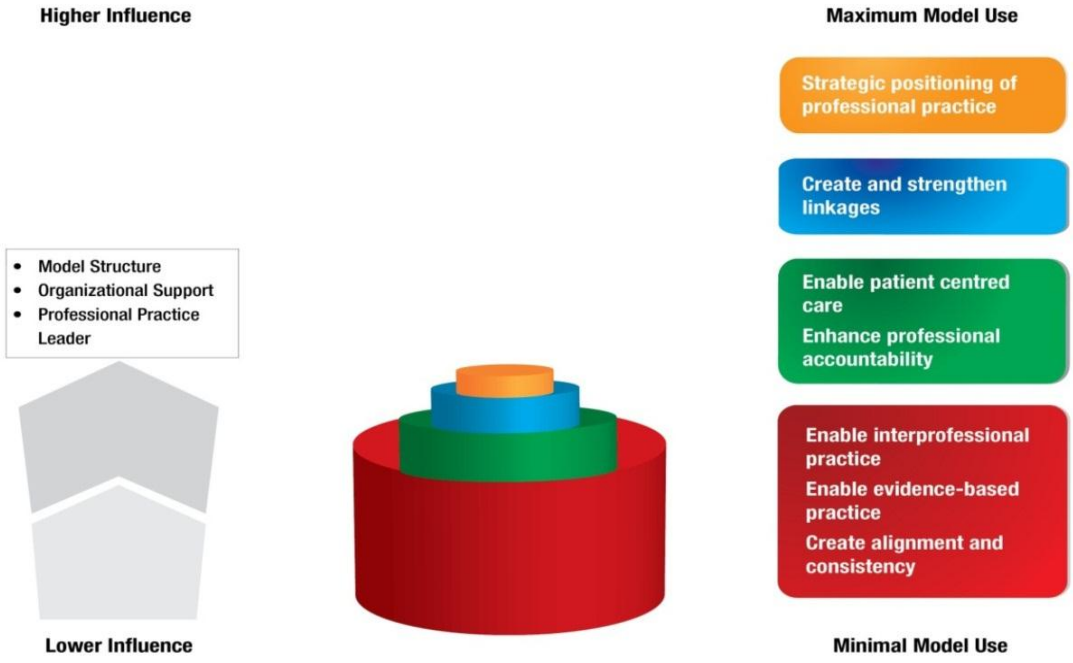

Figure 4a. Outcome Space Schematic 1

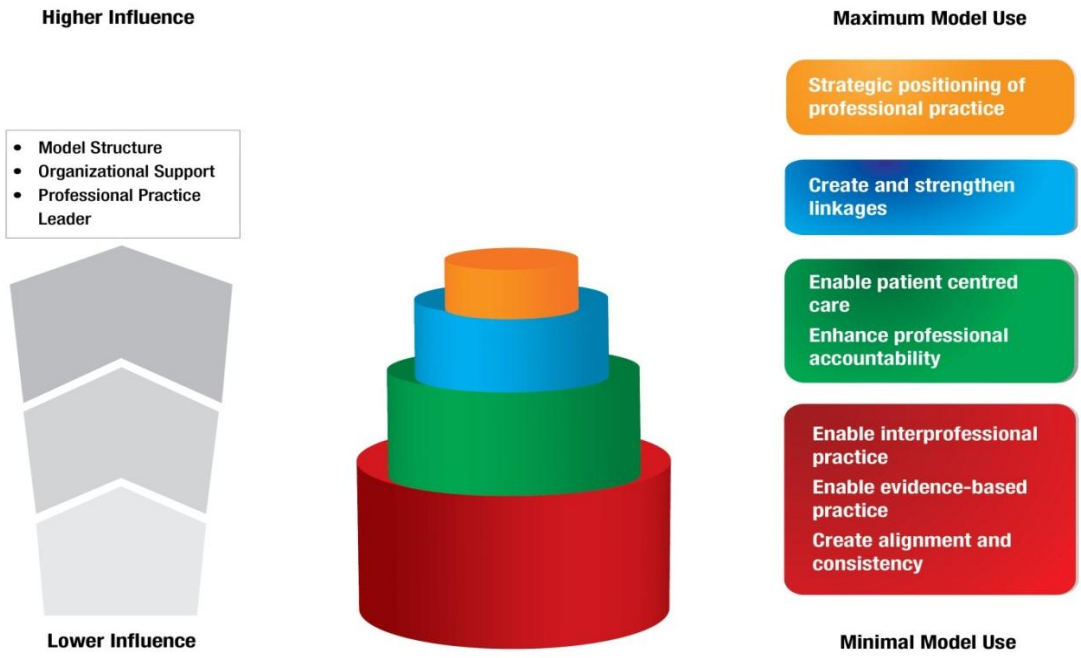

Figure 4b. Outcome Space Schematic 2

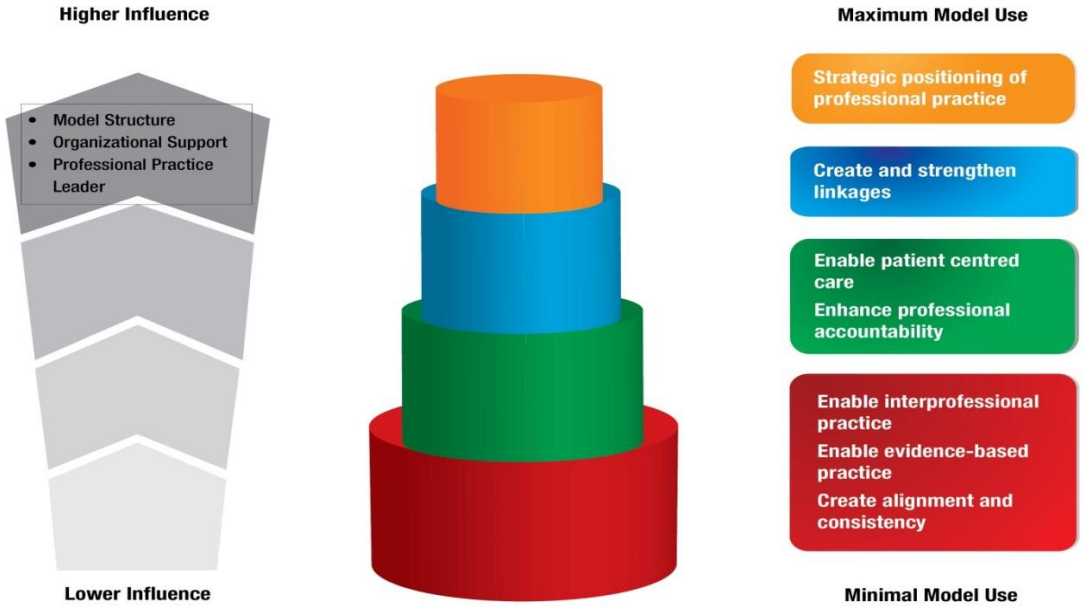

Figure 4c. Outcome Space Schematic 3

Chapter 5

Discussion

This study examined professional practice experts' experiences implementing and using PPMs in Ontario acute care hospitals. The findings of the study support several of the concepts and ideas that were outlined in the introductory and literature review chapters.

Model Elements and Design

Although not the primary focus of the interview questions, details about the PPM elements and design did emerge in data collection interviews and two participants provided additional written information about their PPMs. All the PPMs in the participants' hospitals had three common elements (a) a framework with a core set of values or principles, all of which included patient centered care and interprofessional collaboration; (b) a practice governance structure, and (c) professional practice leadership role(s).

The Hoffart and Woods (1996) PPM has been previously described to include the most typical elements of many PPMs represented in the literature. When compared with the five elements outlined in the Hoffart and Woods model, the three elements identified in this study align by including a focus on professional relationships, the existence of both a practice governance model and a core framework of professional values. A defined care delivery system is also one of the five elements in the Hoffart and Woods model. Although there was little specific mention of care delivery models from study participants, there was a frequent and consistent emphasis on Interprofessional

collaboration and realization of full professional scopes of practice in the delivery of patient care, indicating strong group preference for these elements in care delivery systems. There was a total absence of identification of any PPM element addressing compensation or reward, which is the final element of the Hoffart and Woods PPM. This finding is consistent with the Ontario/Canadian literature reviewed which also showed an absence of content related to remuneration system as a core PPM element.

The findings of this study supported the study's literature review with respect to a predominant focus on interprofessional PPMs found in the Canadian literature. The contrast between this and the US focus on nursing practice systems is worth reflection and discussion. All the PPMs described by participants in this study included an interprofessional focus. The nursing system focus present in the US reflects years of magnet hospital research (Kramer & Schmalenberg, 1988a & 1988b) and a commitment to the nursing system as the primary department in "product line" of patient care in hospitals. There is some evidence of improved satisfaction and patient outcomes with respect to interprofessional collaboration (Nolte & Tremblay, 2005). However, the relative effectiveness of interprofessional versus nursing focused PPMs has not specifically been examined.

Anthony (2012) reviewed interprofessional education literature from a feminist poststructuralist perspective and noted that "although contemporary nursing has developed a professional knowledge base, nurses' subjective experience, inculcated by contextual discourses, continues to be informed by nurses' struggle to develop a professional identity inclusive of a strong sense of professional capability and genuine

equality" (p. 35). If this is true in the realms of interprofessional education (IPE) and results in a diminished nursing academic presence with respect to IPE as Anthony concludes, then it follows that the same may also be true in the interprofessional care context. The absence of a strong and confident nursing professional identity within the interprofessional team is likely to be a barrier to effective interprofessional collaboration based on Anthony's analysis of its impact within the academic world. That nursing continues to suffer from a professional identity crisis is hardly questionable given the ongoing dissent within the profession between RNs and RPNs, at least in the Ontario context (ONA, 2011; RNAO, 2010). Certainly this is an area in which further and specific evaluation studies would be of benefit.

There is strong alignment between the elements identified by study participants and essential elements described by Matthews and Lankshear (2003) which are summarized in Appendix A. Specifically, (a) the existence of professional practice councils at different levels in the organization (corporate level inter and intra professional, plus or minus unit-based councils), (b) interprofessional practice structures and roles, and (c) a focus on client centred care were all identified in both instances. It should be noted however, that the participants in the focus group reported by Matthews and Lankshear and the participants in this study all had affiliation with the PPNO. These participants are highly representative of PPLs in Ontario and although several years had passed between Matthews' and Lankshear's work and this study, it is possible that there were common participants in both.

All but one of the PPMs described in this study were "home grown" designs born out of processes that included both literature review and internal and external consultation. This is reflective of a similar process outlined by numerous references found in the literature (Cava, 2008; Davis, Heath, & Reddick, 2002; Girard, Linton, & Besner, 2005; Ingersoll, Witzel, & Smith, 2005; Lake, Keeling, Weber, & Olade, 1999; Mathews & Lankshear, 2003; Miles & Vallish, 2010; Wolf, Boland, & Aukerman, 1994). The one model that was adopted directly from literature review also underwent modification based on internal stakeholder review. The concept of organizational fit was articulated as essential by several participants echoing the sentiments of Miles and Vallish (2010), "achieving a good fit into an existing culture is more difficult when adopting rather than creating a practice framework" (p. 180). None of the participants discussed an evidence base in relation to the model design process. They did not articulate choosing specific elements because evidence suggested that it was more effective to accomplish a specific goal. However, some did discuss particular goals that drove these design processes. Mostly these goals reflect the more fundamental and concrete PPM uses described by participants; creating alignment and consistency, supporting interprofessional collaboration, shared practice decision making/professional accountability and enhancing evidence-based and patient centred care.

The inclusion of a participative governance structure in the PPM was an intentional choice of all of the participant hospitals in support of attaining these goals. All participants in this study described corporate level governance structure implementation in the PPMs in their hospitals. Some described unit level councils in the governance

structure but this was not a consistent structural design feature across all participants' PPMs. The findings of this study therefore support the earlier description of differences between US and Ontario, Canada PPM implementation (see Table 1). As well, the inclusion of articulated values or principles related to collaborative interprofessional practice, evidence based and patient centred care in the PPM framework was intentional and designed to shape the practice culture to be increasingly reflective of these values.

Several participants also described intentional PPM design elements related to the more sophisticated and complex PPM uses creating and strengthening linkages and strategic positioning of professional practice. Echoes of both of these are included in the essential professional practice structure elements described by Matthews and Lankshear (2003) and are also identified by Ingersoll, Witzel, and Smith (2005). Well established linkages within the organization, senior administrative linkages, linkages with physicians, model purpose with a corporate/strategic view and clear linkages to organizational mission and vision are all noted as essential elements by Matthews and Lankshear (2003) and seem to directly relate to the uses described by participants. However, several participants in this study described that these design elements were emergent ones that were not necessarily included at initial implementation of the PPM but arose in the growth process of the model. Participants described that they were often directly involved in influencing the PPM redesign or renewal process, highlighting the intimate and reciprocal nature of the PPM-PPL relationship and the need for ongoing "tending" of the PPM.

The structural positioning of the PPL within the PPM was of significance to several participants and they described their efforts to influence and change this to enhance the effectiveness of both the role and the model. Recent research (Lankshear, 2011) examining the PPL role has suggested the reporting structure of the PPL can positively or negatively impact the degree of organizational power the PPL has available to direct the accomplishment of his or her role accountabilities. In her research study, Lankshear (2011) reported that PPL reporting structure demonstrated statistical significance to role empowerment in that PPLs that report to managers described relatively less role empowerment than those reporting to Chief Nursing Executives. The findings of this study support Lankshear's findings but identify this, in part as an issue of PPM design. Given that the PPL has been shown in this study to be an essential enabler to the development of the full utility of the PPM, the need to position the PPL within the organization to maximize the potential for full role enactment becomes a strategic and operational necessity. As identified in the introductory and literature review chapters, it is essential that organizations approach the implementation of a PPM realizing the need for intentional design with consideration of the PPM goals and utility.

This study appears to be unique in identifying the nature of the relationship between the PPL and the ongoing health and vitality of the PPM. Although it seems somewhat obvious in retrospect, this relationship has not been noteworthy in the literature and awareness of its nature and importance may hold implications for organizations in terms of how they design and structure PP roles within the model and in terms of how they view the PPM.

PPM Implementation

Participants in this study described the process of PPM implementation as dynamic, emergent and somewhat cyclical. They noted that the process of implementation is longitudinal, rather than a onetime event and that there are natural ebbs and flows in the process. Jost and Rich (2010) noted that PPMs are dynamic and transformative as they are lived out in the day to day interface of practice and certainly the findings of this study reflect this phenomenon of dynamic emergence. Participants described how the influence of both internal and external drivers such as loss of existing leaders, introduction of new leaders, operational mergers, strategic goals such as achieving teaching hospital designation and BPSO designations prompted new cycles of growth and renewal for existing PPMs. They also described the central roles that these drivers play in these cycles of renewal and growth and the ways that they function to embody the PPM across the levels of the hospital.

Given the dynamic nature of the PPM, it may seem prudent for organizations to anticipate and perhaps plan for evaluation phases in the life of a PPM as well as phases of planned growth or renewal phases to ensure that PPM growth and function continues to meet the strategic and operational goals of the hospital. However, none of the participants described phases of planned evaluation and growth beyond the initial implementation phase. To the contrary, they describe processes in which they and the organization seem to respond and, to a certain extent, make the most of the environmental drivers that present themselves. This lived experience is perhaps reflective of non-linear nature of change in a complex organization wherein change occurs “at any point in the

system, not merely in specific predetermined processes" (Beeson & Davis, 2000, p. 183). From this perspective, change is an inherent and dynamic process within a complex system. The actions of individuals engaged in their everyday work contribute to the continual process of change management. The PPL, in constant interaction with the people, systems and processes of the PPM is continually positioned to facilitate change within that system and within the organization as a whole. It is a natural aspect of the life and workflow of the PPM and the PPL. The PPL plays a pivotal role in organizational change relative to the PPM and the goals of its implementation and use; how this role contributes to organizational change is an important area for future research.

PPM Utility

At the conclusion of her study of the PPL role, Lankshear (2011) defined professional practice as follows: "the utilization of specialized knowledge combined with the ability to exercise legitimate control over practice in order to provide collaborative, ethical, client centred care" (p.134). The first five of the seven categories of PPM use described by this study's participants (creating alignment and consistency; supporting evidence based practice; enabling interprofessional practice; enhancing professional accountability; enabling patient centred care) are certainly reflective of this definition, with perhaps the addition of the word "consistent" to the descriptors of care. Furthermore, these categories are reflective of the literature reviewed which describes PPM goals and outcomes including enhanced professional relationships, patient centred cared and accountability for practice and decision-making (Arford & Zone-Smith, 2005; Barden, Quinn Griffin, Donahue, & Fitzpatrick, 2011; Cava, 2008; Davis, Heath &

Reddick, 2002; Girard, Linton, & Besner, 2005; Hoffart & Woods, 1996; Latta & Davis-Kirsch, 2011; O'Rourke, 2003 & 2006; Wolf, Hayden & Bradle, 2004).

Creating alignment and consistency in the application of knowledge and standards was one of the most fundamental PPM uses identified by the PPL participants in this study. This concrete application of the PPM gives rise to a need for appropriate linkages to be created throughout the organization, both horizontally across clinicians, professional groups, teams, programs and departments and vertically, crossing administrative levels. The practice governance structure provides a certain level of this sixth identified use, depending on the membership and reporting structure of the councils and the level in the organization at which they are situated. As well, professional practice is to a certain degree strategically positioned within the organization depending upon the trueness of the alignment of the PPM values and principles with the overall organizational strategic plan. It appears as well that strategic positioning of professional practice within the hospital is influenced by the reporting proximity of PPM governance structure accountability to the senior leadership team.

However, the findings of this study have demonstrated that in order to fully actualize the potential of the PPM in all seven of the identified uses, the PPL role and organizational support are essential. These findings again support those of Lankshear (2011) with respect to the role enactment of the PPL. Lankshear (2011) noted that "the success of the PPL role relies on the extent of organizational power ascribed to the role and the ability of the PPL to influence key stakeholders" (p. 3). The focus of Lankshear's study was nursing PPLs and she identified key stakeholders to the PPL role to include

unit managers, senior nursing leaders and nursing staff. Participants in this PPM use study reported that the stakeholders that they engage when creating and strengthening linkages are a much broader group, which includes all of those identified by Lankshear *plus* non-clinical managers, directors and senior team members and members of all the clinical professional groups, including physicians.

Participants specifically identified issues with being able to adequately engage stakeholders at different levels in the organization, dependent upon their own level of positional authority. This may indicate that they do not have the appropriate level of organizational support in terms of access to resources, information and opportunities to fully enact their role function. All these factors were identified as components of organizational power and essential to PPL role empowerment by Lankshear (2011) and Spence Laschinger (2008).

Study participants described how they function as 'mediators' vertically and horizontally within the organization. They broker knowledge and enable others to have deeper levels of understanding of the PPM beyond the reaches of the PPM governance structures and further position professional practice within the organizational strategy. These findings support the work of Matthews and Lankshear (2003) who reported that linkages between PPL roles and structures and the brokering of information between and across organizational levels were identified as essential elements to an effective PPM. As well, Lankshear (2011) found that the ability of the PPLs to position themselves as the legitimate source of knowledge and direction on matters of professional practice and the ability to help others to see the connections between professional practice initiative and

the organizational strategic plan were both strongly correlated with PPL perceptions of role achievement.

The findings of this study do not merely support the work of others but also build upon this work. The structural analysis of the phenomenographic approach used in this study provides new information about the relationships within and among the categories of PPM use described by participants. This information has the potential to enable a more powerful understanding of the phenomenon of PPM use than has been previously described in the literature. In addition, the information provides much needed, albeit preliminary insight as how organizations might maximize effectiveness and their return on investment in PPM implementation.

Maximizing PPM Utilization

The findings indicate that participants' experienced a synergistic relationship between PPM design and structure, professional practice leadership and organization support in maximizing the utilization and potential impact of the PPM. This was evident both within and across the categories of use described by the study participants. The primary purpose of implementing a PPM is to strengthen the practice environment. Findings from this study indicate that a small group of professional practice experts believe that the influence of the PPM must span from individuals and teams at the point of care to senior hospital administrators in order to achieve this fundamental purpose. This perspective echoes the perspectives of the participants in Mathews' and Lankshear's (2003) focus groups who clearly identified the necessity of linkages to the senior administration team as well as professionals at the local practice level.

Lankshear (2011) reported that 86% of the 45 organizations that participated in her study reported the existence of only one nursing PPL role. Lankshear notes that "it may be unrealistic to assume that initiatives led by one person would directly impact the practice environment of several hundred or perhaps several thousand nurses" (p. 122). Lankshear further noted that the visibility of the PPL was problematic given that only 31% of nurse respondents in the study correctly identified the existence of their PPL despite the fact that 85% of their organizations had one. This seems to indicate that the point of service interface may in fact be beyond the reach of an individual PPL. Lankshear (2011) suggested that the focus of future research should be on impact of the professional practice portfolio but she did not specify whether or not this would include the traditional elements of the PPM. However, the findings of this study lend support to future research that evaluates the impact of not only the elements of the PPM but the synergistic relationship between the PPM and the PPL.

The findings from the current study provide some evidence that PPLs were aware of the limits of their personal reach and relied upon, supported and directed or, in fact altered the PPM to accomplish a portion of the work while focusing their attention to the more sophisticated and complex PPM uses that were beyond the reach of the practice structures and other PPM roles. Based on this finding, in order to maximize PPM utility and impact, organizations must develop an awareness of how the PPM elements and the PPL work together to influence the practice environment. As well it is important to implement a comprehensive model design and assign an appropriate amount of

accountability to those different elements, rather than developing an over-reliance on either the PPL or the governance structures to achieve the aim.

Additionally, both the PPM and PPL require adequate levels and types of organizational support in order to function to maximum potential within and across the categories of use. A fully developed and functional practice governance structure at both the corporate and unit levels can be an expensive endeavor as it by design includes clinicians as primary members who must be relieved and replaced from their clinical duties in order to participate in professional practice activities. Organizations must be prepared to adequately finance the PPM, including both the structures and the PPL roles.

As has been discussed previously, PPL roles need to be positioned within the PPM at an administrative level commensurate with the expected role function. If an organization wants to fully integrate its PPM into the strategic vision and plan, then there must be a PPL role situated at either a Director or preferably a Vice President level, corresponding to the operations leadership roles at those levels. Likewise, if the organization visualizes full integration of physicians and other credentialed affiliates into the activities of the PPM and into a collaborative interprofessional model of care, then it must position PPL leadership and physician leadership in alignment and set clear expectations and accountabilities related to their involvement and identify deliverables in support of that vision.

The synergistic influence of the three structural themes enables the fullest expression of the seven PPM uses described by professional practice expert participants in this study, thereby expanding and deepening the impact of the PPM. The image of an

expanding telescope has been used to describe this effect. The relationship between the PPM and the PPL is intimate, dynamic and reciprocal; emergence and change is lived in the everyday interchange between them. Organizations can be advised to choose to anticipate, create opportunity for, and celebrate this dynamic phenomenon, rather than choosing to exert bureaucratic control over the disruption that it may cause. As the participants of this study illustrated, those cycles of change, growth and emergence regularly happen in response to, or anticipation of events of strategic importance to the organization.

Finally, the framework of values or principles within the PPM needs to align with and support those contained within the organizational strategic plan. An organizational strategic priority of improved patient experience is unlikely to be fully supported by a PPM that is focused on scope of practice development for clinicians. Likewise, a PPM value of client centred care is unlikely to be fully supported or realized in an organization that is entirely budget focused.

In summary, the following key recommendations related to maximizing PPM use in hospitals are provided:

1. Ensure an intentional PPM design aligned with articulated implementation goals.
2. Design PPMs to ensure that all elements work together.
3. Ensure PPM elements and implementation goals align with organizational strategic plan.
4. Commit to adequately resourcing all PPM elements to function optimally.

5. Design the PPM such that PPL roles are appropriately positioned within the organization to achieve implementation goals.
6. Set clear expectations related to participation in the PPM and ensure accountability is demonstrated.
7. Anticipate that PPM implementation is longitudinal and create space for and celebrate PPM growth, emergence.

Limitations

This study has several limitations that should be noted. Firstly, the sample size (n=7) while adequate for a Masters' level study using this methodology is very small and representative only of the participants' conceptions regarding the phenomenon of study, PPM use. Additional studies of the same phenomenon are recommended to add to the unique perspective that this study has offered.

Secondly, the sample of participants while targeted, was entirely voluntary and is not necessarily representative of the maximum variation possible within the population of professional practice experts within the PPNO. It is possible that the study participants share some attribute that made them more likely to volunteer for study participation and as well influenced their conceptions of the phenomenon of study.

Thirdly, although the phenomenographic approach used in this study yielded a different and perhaps deeper understanding of the phenomenon of study, it was conducted by a novice researcher with no previous phenomenographic experience. Phenomenography is a challenging approach to master even for experienced qualitative researchers (Akerlind, Bowden, & Green, 2005) and so the likelihood of methodological

errors does exist. As well, the phenomenon of study was professional practice experts' conceptions of PPM use. Phenomenography was selected as an investigative approach because it derives from a nondualistic epistemology which posits that knowledge is relational and constituted between thought, experience and the phenomenon of interest (Barnard, McCosker, & Gerber, 1999). In studying conceptions of PPM use, the assumption was that the reality of PPM use would be accurately reflected. This may be a unique application of the phenomenographic approach, the merit of which might be confirmed or negated with a concurrent ethnographic or action research or other observational study of PPM use in acute care hospitals.

Implications for Future Research

This study provides interesting and unique findings related to the understanding of PPM use in Ontario acute care hospitals and suggests several ways in which organizations might maximize the impact of PPM implementation based on this analysis of professional practice experts' conceptions. It does not however evaluate the effectiveness of PPM use in Ontario acute care hospitals or distinguish which elements of the PPM are most effective relative to the achievement of articulated implementation goals. Lankshear (2011) reported a statistically significant relationship between PPL role enactment and nurses' perceptions of PPE strength. There have been no Ontario studies to date evaluating PPM use and PPE strength. It would seem to make sense based on the findings of this and Lankshear's study that a fully implemented and utilized PPM, inclusive of PPL role(s) would have increased their ability to influence an organizational practice environment versus a single or even multiple PPL roles in the absence of a PPM.

Evaluative studies of this nature are essential to justify the continued expenditure toward PPM implementation in Ontario hospitals.

Additionally, this study has highlighted some of the unique characteristics of the relationship between the PPL and the PPM. This appears to be a unique and important finding that warrants further research in order to assist hospitals with PPL positioning and selection.

Conclusion

This study is the first to examine professional practice experts' conceptions of PPM use and it offers unique and preliminary insight into the complexity of this phenomenon. This insight may be helpful to inform organizations' PPM implementation initiatives in order to maximize their return on investment, improve the quality of practice and achieve the organizational implementation goals they have identified.

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Appendix A

Essential Professional Practice Structure Elements and Descriptions, Grouped by Theme

Theme 1: Structural Supports	
Essential Element	Description
1. Formal Communication Lines	Clearly defined and outline expectations for consultation and collaboration in decision making
2. Well-established linkages within the organization	Roles and structures are effectively linked to promote effective communication
3. Council structures in place	Professional practice councils exist at different levels in the organization to enable local and corporate, uni- and interprofessional decision making
4. Clearly defined authority	Accountability and authority are clearly defined and synchronous
5. Senior administrative support and linkages	Clearly defined linkages to senior management through formal and informal reporting relationships
6. Purpose with a corporate/strategic view	Roles and structures maintain macro and micro perspective and function to convey information continuously between and across organizational levels
Theme 2: Cultural Supports	
Essential Element	Description
7. Supports in place to assist with culturechanging	Focus to address mental models, assumptions and cultural mores
8. Clear linkage to organizational mission and vision	Purposes for professional practice roles and structures are clearly linked to the overall corporate mission, vision and scorecard indicators.
9. Consideration of context of practice setting,work environment	Recognition of impact of practice setting and work environment on ability to meet client needs. Intentional focus on quality of worklife from the clinician perspective

10. Promotion of staff competency	Proactive, anticipatory focus and initiatives to ensure ongoing competency that goes beyond training
11. Flexible, non-silo approach	Expectation to analyze and address issues across programs, services, professions and within and outside the organization; big picture approach is cultivated
Theme 3: Interprofessional Collaboration	
Essential Element	Description
12. Interprofessional structure and roles	Al regulated and non regulated professions are reflected in professional practice structure and roles
13. Collaborative practice principles	Established partnerships between professional practice areas, programs, services. Commitment to working together on intra and inter professional issues
14. Linkage with physicians/Medical Advisory Committee (MAC)	Professional practice leadership on MAC, medical representation on interprofessional groups
15. Multidisciplinary roles	Specific FTE allocation for roles that reflect the multidisciplinary nature of the organization
Theme 4: Client Centred Care	
Essential Element	Description
16. Client Centredness	Intentional focus on client care and outcomes within professional practice structure

Note. From "Describing the Essential Elements of a Professional Practice Structure" by S. Mathews, & S. Lankshear (2003), *Nursing Leadership*, *16*(2), 63-73. Copyright 2003 by Longwoods Publishing.Adapted with author permission.

Appendix B

Letter of Study Introduction

Date:

Dear Professional Practice Colleague,

I am currently completing my Masters of Science in Nursing degree at McMaster University. As part of my Masters program, I am conducting a qualitative study of professional practice experts' experiences with Professional Practice Model implementation and use. I am conducting this study with Professional Practice Leaders in Ontario acute care hospitals. The purpose of this letter is to ask for your participation in this study. If you are not a Professional Practice Leader with accountability for the Professional Practice Model at use in your hospital, I would be most grateful if you would pass this introductory letter along to the person most responsible for this in your hospital.

If you agree to participate in the study, you will be asked to be part of a 90-minute focus group discussing Professional Practice Model use. You may participate in that focus group in person or by teleconference. You will also be asked to complete 2 one page information documents and you may be asked to do a 30-minute follow-up telephone interview.

If you are interested in participating or receiving more information about this study, please contact me by return email (barbarajones@sympatico.ca) or by phone 905-989-0965 or 705-238-2958.

Thank you very much for considering this opportunity to participate in the generation of new professional practice knowledge.

Best regards,

Barbara Jones, RN, BScN, MWS, MScN (candidate)

Appendix C

Letter of Information

……2009

USING PROFESSIONAL PRACTICE MODELS:

A PHENOMENOGRAPHIC STUDY OF PROFESSIONAL PRACTICE EXPERTS' CONCEPTIONS

Student Investigator: **Barbara Jones, RN, BScN, MWS, MScN (candidate)**
705-238-2958 or 905-989-0965

Principal Investigator: Dr. Colleen McKey
Faculty of Health Sciences, School of Nursing
McMaster University
Hamilton, Ontario, Canada
(905) 525-9140 ext. 22318;

Purpose of the Study

This study, will explore how professional practice models are used in Ontario acute care hospitals. To do this, there will be interviews with experts who are professional practice leaders in Ontario hospitals.

Procedures involved in the Research

You will be asked to participate in a focus group to discuss your perceptions of professional practice model use in your hospital. You will also be asked to complete 2 very short documents, one asking for basic information about you and your work experience and the other as a follow-up to the focus group asking for some additional information. You also might be asked to participate in a short (30 minute) telephone interview following the focus group. The focus group and the interview will be recorded with a digital recording device so that what you say is captured accurately.

Potential Harms, Risks or Discomforts:

It is not likely that there will be any harms or discomforts associated with participation in this study. You do not need to answer questions that make you uncomfortable or that you do not want to answer. You may withdraw from the study at any time

Potential Benefits

The goal of this study is to generate a better understanding of the value of professional practice models for Ontario hospitals. This may help professional practice leaders such as yourself to use these tools more effectively in your workplace. You may benefit from this knowledge, but there is a possibility that the knowledge generated by this study may not benefit you directly.

Payment or Reimbursement:

You will not receive payment for your participation in this study. However, you will receive a $10 gift certificate as a small token of appreciation for your participation.

Depending on the location of the focus group, you may have to pay for travel and parking. There will be an option to participate by videoconference, or teleconference. You will not be reimbursed for expenses.

Confidentiality:

Anything that you say or do in the study will not be told to anyone else. Anything that the researcher finds out about you that could identify you will not be published or told to anyone else, unless you give your permission. All information that you provide will be anonymous in any reports or presentations. Only the researcher will know that you provided the information. Your privacy will be respected.

The researcher will ask the other members of the focus groups to keep what you say confidential, but cannot guarantee they will do so.

The information obtained from you will be kept securely (locked filing cabinet and password protected computer files) and will only be available to the researcher. The information will be destroyed in a confidential manner 5 years following the completion of the study but may be used for other analysis after this study is completed. Any information made available to any partnering researcher will be anonymous and your privacy will be protected.

Participation:

Your participation in this study is voluntary. If you decide to participate, you can decide to stop at any time, even after signing the consent form or partway through the study. If you decide to stop participating, there will be no consequences to you. If you withdraw from the study, any data you have provided to that point will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

Information about the Study Results:

The researcher will provide you with a report or presentation of the study results at your request.

Information about Participating as a Study Subject:

If you have questions or require more information about the study itself, please contact Barbara Jones or Dr. Colleen McKey at the numbers listed on the top of this form.

This study has been reviewed and approved by the McMaster Research Ethics Board. If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact:

McMaster Research Ethics Board Secretariat
Telephone: (905) 525-9140 ext. 23142
c/o Office of Research Services
E-mail: ethicsoffice@mcmaster.ca

CONSENT

I have read the information presented in the information letter about a study being conducted by Barbara Jones and Dr. Colleen McKey, of McMaster University. I have had the opportunity to ask questions about my involvement in this study, and to receive any additional details I wanted to know about the study. I understand that I may withdraw from the study at any time, if I choose to do so, and I agree to participate in this study. I have been given a copy of this form.

_____ _____

Name of Participant Signature of Participant

_____ Signature of Researcher

Appendix D

Demographic Data Sheet

Name:
(Data will be anonymized)

Gender: Male Female
(Please circle one)

Age:

Professional affiliation:

Highest level of education attained:

Current employment title:

Current Employer:

Number of years in current position:

Number of years in Professional Practice Leadership:

Where you directly involved in the design and/or implementation of the current Professional Practice model in your hospital?

If yes, briefly describe your role:

Thank you for your participation in this study!

Appendix E

Interview tool

Introduction, purpose of the study, use of data

Tape, transcription, anonymity

1. When your organization was developing and implementing its Professional Practice Model (PPM) where there specific goals articulated and if so, what were they?

2. Can you describe the implementation and use of the PPM in your organization?

3. Can you give me a concrete example of how the PPM is used in your hospital?
   Possible follow ups: How did you go about that?
   Why did you do it that way?
   What did you gain or hope to gain from this?

4. In your experience as a PP leader, how is the PPM helpful to you?

5. Can you give me a concrete example of how you use the PPM in your organization?
   Possible follow ups: How did you go about that?
   Why did you do it that way?
   What did you gain or hope to gain from this

6. Are there any other ways you can think of that the PPM is utilized in your hospital?

7. I'd like to start to wrap up our conversation. Earlier, I asked about goals related to the implementation of the PPM in your hospital and we've talked about how the PPM is used in your hospital. I'd like you to reflect for a moment and summarize for me how the use of a PPM is helping your organization to move toward its PP goals.

8. Before we finish, is there any else you'd like to add about PPMs and your experience with their use?

Appendix F

Supplemental Data Sheet

Thank you for participating in the focus group examining Professional Practice Model use in Ontario acute care hospitals. I would appreciate your responses to the following:

1) Can you please describe the PPM in use within your organization? (you may append diagrams or other documents to aid your description)

2)Please highlight what you think is the most important information about using PPMs.This could be from the focus group, or things that you didn't get a chance to say.

Thank you again for your participation.

Please email this form to Barbara Jones at barbarajones@sympatico.ca
Or mail to Barbara Jones, 214 Bayview Avenue, Keswick, ON, L4P 2T2