Contemporary Nurse, 2024
https://doi.org/10.1080/10376178.2024.2363911

Advanced practice nurses' experiences of patient safety: a focus group study

Manela Glarcher [a,b], John Rihari-Thomas[b], Christine Duffield[c], Karen Tuqiri[d], Kate Hackett[e] and Caleb Ferguson [b,f*]

[a]*Institute of Nursing Science and Practice, Paracelsus Medical University, Strubergasse 11, 5020 Salzburg, Austria;* [b]*School of Nursing, University of Wollongong, Wollongong, NSW, Australia;* [c] *University of Technology Sydney, Sydney, Australia;* [d] *Prince of Wales Hospital, Sydney, Australia;* [e] *South Eastern Sydney Local Health District, Sydney, Australia;* [f] *Blacktown Hospital, Western Sydney Local Health District, Sydney, Australia*

(*Received 9 February 2024; accepted 30 May 2024*)

Background: Patient harm from unsafe care is an increasingly global phenomenon leading to death or disability. Drawing on their expertise, Advanced Practice Nurses provide the opportunity to improve care quality and safety.
Aim: To explore Nurse Practitioners and Clinical Nurse Consultants' experiences in patient safety.
Design: A qualitative design was used involving six audio-visually recorded focus group interviews. Participants working in an acute or community adult nursing speciality were involved.
Methods: Twenty-eight Advanced Practice Nurses (female 82.1%, mean age 47.5 ± 10 years) were recruited by convenience and snowball sampling. After transcription of interview data, qualitative content analysis was conducted.
Results: Six categories were identified: patient safety as the highest priority (1), special contribution to patient safety (2), patients/relatives role in safety (3), multidisciplinary team approach (4), government regulation in safety (5), and further needs to improve safety (6). Advanced Practice Nurses saw themselves as role models and leaders for other healthcare staff through their expertise and professional experience and thus able to see the bigger picture in health. They identified as change agents at the system-level due to their decision-making ability and multi-professional team connectivity.
Conclusions: This study emphasises the key position of extended nursing roles and the need for future development of patient safety strategies in hospitals and community care. As influential leaders, Advanced Practice Nurses are best placed to identify improvements. They play a central role in guiding the multi-professional team, the patient and their family, educating nursing staff, and identifying and addressing system-wide safety gaps to improve patient safety.

Keywords: acute care; advanced practice nursing; community care; hospitals; nurse practitioner; patient safety

*Corresponding author. Email: calebf@uow.edu.au, X:@calebferg

Impact statement

This study found that Advanced Practice Nurses are role models, leaders, and change agents for other healthcare staff. They are pivotal to improve patient safety in hospitals and community care settings.

Plain language statement

Patient harm from unsafe care is a global phenomenon in hospitals and community care. Enhanced competencies and skills of nurses in advanced roles play a pivotal role in ensuring patient safety and improving outcomes, but their special impact is not entirely clear. During focus group interviews in this study, key aspects of advanced practice nurses' role in ensuring patient safety have emerged. They are role models, leaders, and change agents for other healthcare staff and educators for patients and their relatives. Considering these findings, nursing educators, healthcare professionals and policy makers can develop patient safety strategies in hospitals and community care settings.

Introduction

Patient harm caused by unsafe care is an increasingly alarming global phenomenon, and a major cause of preventable death and disability (World Health Organization (WHO), 2021a). The term `unsafe care´ or patient safety-related `adverse events´ in the context of patient safety is defined as incidents that result in harm to the patient (Council of the European Union, 2009). It is estimated that one in ten patients suffers harm during hospitalization in high-income countries (Marcinowicz et al., 2021), caused by a range of adverse events that are preventable in almost half of all cases (de Vries et al., 2008). The Organisation for Economic Co-operation and Development (OECD) reported that the incidence of adverse events, 'an unintentional injury or complication resulting in disability, death or prolonged hospital stay […]' (McNeil & Leeder, 1995) is similar in low- and high-income countries (Slawomirski et al., 2017). In this context, patient safety has become a growing concern worldwide due to the increasing demand for healthcare under economic constraints, the evolving complexity of healthcare systems, the ageing population, and the rising burden of chronic diseases (Ash & Miller, 2016). For about three decades, a paradox has been observed. Although change is ever-present, healthcare performance remains consistent. About 60% of care follows evidence-based guidelines, 30% is inefficient or of low value, and 10% causes patient harm (Braithwaite et al., 2020).

There is a need for patient safety research and implementation to address the complexity of healthcare systems and to generate new knowledge to improve their ability to reduce patient harm and the resulting adverse events for patients and their families (World Health Organisation (WHO), 2021a, 2021b). Within acute and community care settings globally, the care of patients who are critically ill (Kaldan et al., 2019) or living with complex multimorbidity is becoming a growing focus due to global ageing (Mitchell & Walker, 2020). Initiatives to improve patient safety are particularly needed for vulnerable patients who are at high risk of safety incidents, such as patients with chronic conditions (World Health Organisation (WHO), 2021b).

Among health professionals, there is consensus that high-quality health services should be effective, safe, and person-centred (McCormack & McCance, 2006; International Council of Nurses (ICN), 2021). Moreover, to recognize the benefits of high-quality care, health service provision must strive to be timely, equitable, integrated, and efficient. High-quality care requires patient safety strategies including; evidence-based guidelines, leadership, data to improve quality and safety, qualified health professionals and effective patient involvement (World Health Organization (WHO), 2021b). Nurses, as the largest healthcare patient-facing craft

group, hold a critical role in safeguarding patient well-being and improving the quality and safety of healthcare delivery (World Health Organization, 2021b).

Meeting these escalating healthcare challenges require an advanced level of nursing practice and education (Kaldan et al., 2019; Lee et al., 2020). Internationally, Advanced Practice Nurses (APNs) are well-stablished, particularly in high-income countries (Kaldan et al., 2019), providing a solution to enhance healthcare quality and minimize risk of harm (Maier & Aiken, 2018).

In Australia, two roles are reflected within the threshold for APNs when using the validated Advanced Practice Role Delineation tool, the Nurse Practitioner (NP) and the Clinical Nurse Consultant (CNC) (Gardner et al., 2013; Gardner et al., 2016). The regulated advanced role is the Nurse Practitioner (NP), requiring a Master's degree and 5,000 h of recent advanced clinical practice within the RN scope, encompassing all five domains in the Strong Model of Advanced Practice, clinical care, support of systems, education, research and professional leadership (Mick & Ackerman, 2000). In contrast, the Clinical Nurse Consultant (CNC) role lacks a consistent national legal and regulatory framework (Gardner et al., 2016). Distinguishing between CNC and NP can sometimes be challenging, but NPs typically have greater clinical autonomy and more 'advanced' education (Baldwin et al., 2013). The APN in general functions autonomously within their scope of practice, supported by their extensive expertise, training and advanced skills, is found to go beyond the need for strict rules and guidelines, to effortlessly recognize the key nuances of complex clinical scenarios and to respond instinctively as described by the Dreyfus model of skill acquisition (Benner et al., 1992). International study results have demonstrated a positive impact of these roles on patient safety in various healthcare settings (Amaral & Araújo, 2018; Eriksson et al., 2018; McDonnell et al., 2015; Woo et al., 2017).

Although the special contribution of APNs to achieve high-quality, safe care could be presented, an in-depth examination is missing. Yet, this would help to improve understanding of the specific APN role and support education, training as well as nursing practice in both hospital and community care settings. Therefore, the aim of the study was to explore the perceptions and experiences of APNs in relation to patient safety. Accordingly, the research question was: "How do advanced practice nurses (i.e. nurse practitioners and clinical nurse consultants) in hospital and community care experience patient safety and their ability to improve it?"

Methods

This qualitative descriptive study is based on qualitative content analysis and focus group data collection. Qualitative studies usually take place in the natural environment of the phenomenon of interest to provide rich, more in-depth, and comprehensive information as this appears in reality (Polit, 2021). By using a qualitative process, researchers can integrate information to develop a rich description that helps explain the observed phenomenon (Geertz, 1973). Employing a series of moderated focus groups allowed for a comprehensive exploration of patient safety experiences among APNs, facilitating the observation, validation, and clarification of individual behaviours and beliefs in this dynamic process (Then et al., 2014).

Participant recruitment

Convenience sample followed by snowball sampling was used to recruit participants in two local health districts, a geographically defined grouping of hospitals and health services. Posters were circulated by nurse managers and emails were sent to key persons in the nurse practitioner/clinical nurse consultant workforce. A university mentor (CF) arranged contact with the directors of two local health districts. In addition, a short project overview and an outline of the aims of the study was presented to interested NP/CNC in each of the included hospitals or community

facilities. Criteria for inclusion consisted of NP/CNC working in an acute or community adult nursing speciality to ensure information from as many areas as possible and for all target groups of care. Nurses who were not working in the role of a NP or CNC or involved in the care of people under 18 years of age were excluded..

Data collection

Six focus groups were conducted, recorded, and transcribed verbatim by the first author (MG), who has extensive training and experience in performing qualitative studies with a strong research interest in patient safety. Mixed focus groups with NPs and CNCs were used; we did not separate the groups. Due to the COVID-19 situation in Australia at the time of study, all focus groups were conducted using Zoom video conference. Through a literature review, the investigators developed a semi-structured interview guide that was previously tested with APNs in a pilot interview. This tool included seven questions focusing on the importance for patient safety, specific activities as an APN, as well as patient/family and other healthcare professionals' role. Observation notes were obtained on the group during and shortly after the interview. Together with the video recordings, these supported the data analysis process.

Data analysis

The audio-visual focus groups were transcribed verbatim and anonymized after each focus group based on rules by Dresing and Pehl (2015). Following transcription by the first author, content analysis of all focus groups took place following the structure provided by Graneheim and Lundman (2004) using MAXQDA 2022 (VERBI Software, 2021). The analysis focused on manifest content, which highlights the explicit, visible content of the text, as well as the latent content, emphasizing the interpretation of meaning and the underlying meaning of the text (Graneheim & Lundman, 2004). After reading the interviews, several times to identify meaning units related to the study aim, condensed units are abstracted and provided with a code (Table 1).

Table 1. Examples of meaning units, condensed meaning units and codes.

Meaning unit	Condensed meaning unit	Code
patient safety has always priority and has to be embedded in everything we do, the heart of advanced practice is safety.	*patient safety as highest priority and heart of advanced practice*	*patient safety as highest priority in advanced practice*
being able to see the big picture and look for the bigger picture is really important, because, again we can't just be dealing at the micro all the time. So, whether that means we set up projects, whether that means we set up models of care or pathways around particular ways of doing things	*to see the big picture or look for the bigger picture to move away from the micro level*	*move away to see the bigger picture*
introduce patients to do their own care, to teach them do their own care, educate patients in all settings (hospital, community) about treatment side effects, to be aware of risks, have a good understanding of treatment plans and when to call	*educate and inform patients in all settings about treatment, side effects, risks and contact persons*	*educate and inform patients to take charge of their own treatment*

Based on differences and similarities, the various codes are compared and assigned to subcategories and categories by the first and last author. Supporting memos were written and used in the analysis together with the observation notes for reflection and data interpretation.

To gain a better understanding of the contribution of the individual focus groups to the overall result, percentages of the categories and subcategories were calculated.

Research rigour

To ensure trustworthiness of the study the credibility, dependability and transferability of the study were assessed (Graneheim & Lundman, 2004). Two researchers, experts in conducting focus groups and qualitative content analysis (MG, CF), evaluated the compliance of the study with the guidelines. A sample of transcripts were independently reviewed and coded by MG and CF to ensure credibility and reliability. The final focus group results were shared with all participants through a member check process (Lincoln & Guba, 1985) utilizing a pre-recorded video. Feedback from advanced practice nurses was provided via email.

Ethical considerations

Prior to the study, we obtained ethics approval (number 2022/ETH00070) in March 2022 and secured permission for the study protocol from two local health districts. Participants received an informed consent letter outlining the study's purpose, voluntary participation, data anonymity, security, and withdrawal.

Results

Six focus groups (FG) took place between April 12 and May 20, 2022, with an average duration of 71 min. The study involved a total of 28 APNs with diverse expertise in hospital and community healthcare settings, ensuring robust representation (Table 2).

Data analysis process shows six categories as well as 13 subcategories. Table 3 presents the percentages of categories and subcategories across focus groups. Notably, 'patient advocacy' for

Table 2. Characteristics of Advanced practice nurses.

Advanced practice nurses N = 28	Clinical nurse consultants N = 22	Nurse practitioner N = 6
Female N = 23 (82.1%)	Female N = 19	Female N = 4
Mean age = 47.5 years; SD ± 10	Mean age = 46 years; SD ± 9.3	Mean age = 53.2 years; SD ± 11
Full-time position = 75.0%	Full-time position = 81.8%	Full-time position = 50.0%
Employment as a nurse: Mean approx. 24 years; SD ± 11 years	Employment as a nurse: Mean approx. 22.6 years; SD ± 10.7 years	Employment as a nurse: Mean approx. 28.3 years; SD ± 12.1 years
APN in the current position: Mean approx. 7.2 years; SD ± 8.6 years	APN in the current position: Mean approx. 7.6 years; SD 9.6 ± years	APN in the current position: Mean approx. 5.9 years; SD 4 ± years
Advanced practice nurses expertise		
Aged care services		N = 4
Ambulatory and emergency care		N = 3
Special areas (e.g. continence, diabetes, respiratory, wound)		N = 14
Surgery and perioperative care		N = 5
Transitional/community care		N = 3

Table 3. Percentage of categories and subcategories in each focus group.

Themes	FG 1%	FG 2%	FG 3%	FG 4%	FG 5%	FG 6%	Total %
1. Patient safety as highest priority	14.0	27.9	23.3	23.3	4.7	7.0	100
1.1 Patients' ability to manage their care	55.6	0.0	0.0	0.0	22.2	22.2	100
2. Special contribution to patient safety	26.6	22.3	14.9	27.7	1.1	7.4	100
2.1 Being a role model in safety	7.7	30.8	0.0	23.1	0.0	38.5	100
2.2 Change agents/leaders	0.0	22.2	44.4	0.0	0.0	33.3	100
2.3 See the big picture	18.2	27.3	18.2	27.3	0.0	9.1	100
2.4 Expert knowledge	0.0	33.3	0.0	5.6	50.0	11.1	100
3. Multidisciplinary team approach	6.9	20.7	20.7	27.6	10.3	13.8	100
4. Patients/relatives role in patient safety	2.9	14.3	5.7	51.4	11.4	14.3	100
4.1 Decision making	0.0	66.7	33.3	0.0	0.0	0.0	100
4.2 Partnering with staff	0.0	20.0	60.0	0.0	20.0	0.0	100
5. Government regulation to ensure patient safety	20.0	15.0	5.0	35.0	5.0	20.0	100
5.1 National standards	7.1	17.9	21.4	35.7	17.9	0.0	100
5.2 Ticking boxes in assessment tools	8.3	8.3	8.3	66.7	0.0	8.3	100
6. Further needs to improve safety	20.0	7.5	25.0	27.5	12.5	7.5	100
6.1 Training of nurses	0.0	50.0	0.0	0.0	0.0	50.0	100
6.2 Availability of resources	11.8	17.6	11.8	17.6	29.4	11.8	100
6.3 Patient advocate	0.0	0.0	100.0	0.0	0.0	0.0	100
6.4 Open communication	87.5	0.0	12.5	0.0	0.0	0.0	100
SUM %	**16.6**	**19.6**	**16.3**	**27.1**	**9.5**	**10.8**	**100**

enhancing patient safety is only discussed in focus group 3. Focus group 4 had the highest contribution, while focus group 5 had the lowest.

Patient safety as highest priority

A uniform understanding of patient safety was reported including the delivery of 'the right care at the right time by the most appropriately skilled people within nurses' capabilities'. Patient safety was always of high priority and had to be embedded in every component of care, was perceived as 'the heart of advanced practice', and the 'basis of ethics'. It is more than 'do no harm'. It was viewed as the responsibility, the duty, to be on top of the evidence in expertise and aware of the risks in the healthcare process. They are vigilant, helping, guiding, and supporting other staff to maintain safety and ensure that their practice is conducted in a safe setting.

Patient safety meant identifying gaps in the healthcare system and finding solutions for all stakeholders to ensure safe care in an unsafe environment, especially in community care.

The hospital was seen as a setting where patient safety can be observed and controlled through the availability of healthcare staff and the optimal 100% standard where safety-controlled care can take place. Patients who did not want to stay in the hospital received special attention to ensure safe community care.

> 'Sometimes it's like, at least they're doing the best they can and you, sometimes got to go. I've given them the safest environment that they can do it in and that's what we can do, because they've got capacity, they've got the ability to say that they don't want to be in hospital. It's trying to give them the safest way to do it, rather than the hundred percent way, because at least they're happy.' (Focus group 1, L. 219)

Participants further explained patient safety as a combination of physical and psychological safety including feelings and 'seeing the patient as a whole'.

> 'Patient safety can mean lots of different things. And for me and for my patients, you know it also can encompass not just physical safety, but psychological safety and feelings, especially working in the area of sexual health (…) you know, we want to make sure that patients don't experience stigma. So it's making sure that we're looking at the patient as a whole.' (Focus group 2 L. 8)

It was a commonly shared opinion that 'patients' ability to manage their care' influenced APNs ability to ensure safety. Educating and informing patients to enable them to take ownership of their treatment was thought to be of central and high importance to achieve safety. Patients should have the opportunity to ask questions about their treatment and APNs make sure that they understand the answers.

> 'For me it's all about education. So, for me, patient safety is about letting patients know side effects of treatments, so that they are aware of the risks. And they have a good understanding if anything goes not to plan with their treatment, when to call the clinic, when to escalate and when to go to an emergency department.' (FG6, L. 18)

APNs special contribution to patient safety

This category is about making the most of APNs role, 'being a role model in safety' to other team members, especially junior staff, 'act as a change agent or leader' to others, have 'the ability to see the big picture' and 'expert knowledge' to ensure patient safety. Their 'special contribution as NPs or CNCs in patient safety was described as a particular ability to foresee and predict safety concerns, search for gaps/risks in the system, and translate and communicate these, making them understandable to all other healthcare teams. Their contribution included identifying and de-implementing practices without any evidence and balancing the priorities of the organization with the risks of maintaining the practice and the benefits of moving forward.

> **'**Most of my time is spent de-implementing (laughing around) crap that we have done for years, upon years and everyone's going why do we still do this oh? It's because no one's actually looked or, you know, it's just becomes, you know, the rituals, you know, that we do.' (Focus group 4, L. 38)

Participants reported activities like developing services and models of care, managing quality improvement projects, implementing guidelines, preparing/performing audits and/or accreditations, (organizational) risk assessments, working closely with key stakeholders, reviewing ethical aspects, infection control, and conducting patient audits using the clinical procedure safety checklist.

They further stated that keeping people safe means avoiding readmission to the hospital or the emergency department as a matter of principle, making faster and safer discharge plans in partnership with patients and their families, and being able to conduct home visits.

Advanced Practice Nurses see themselves as a '*role model'* who must make sure that the care team understands the importance of developing professionally and providing quality care. They described their role as creating a safe and supportive environment for everyone, where people can be curious, and not be afraid to ask questions. They also want to act as role models in dealing with incidents and adverse events.

> 'Someone has to role model to them. Our job is to make sure people practice safely and provide best care.' (Focus group 4, L. 107)

Another point described by the participants was the special '*ability to see the big picture'*, to see in detail what needs to be improved and to move from the micro level (task-oriented) to the

system level. To put the pieces together and see the bigger picture, they cite the need for a lot of experiential knowledge.

> 'Being able to see the big picture and look for the bigger picture is really important, because, again we can't just be dealing at the micro all the time. So whether that means we set up projects, whether that means we set up models of care or pathways around particular ways of doing things. But, that is pretty important. And for a lot of us there's not just the local things that are hospital, but there may be professional groups that we belong to.' (Focus group 2, L. 35)

They recognized their special contribution in 'clinical leadership' to make sure their team delivers quality care and experienced more autonomy and power to connect with the multidisciplinary team: '*to lead the project to, to some clinical nurse consultants who are passionate about their area, when you're leading that project in their coordinating, all those people together and things come up, then it's really fulfilling*.' (Focus group 3, L. 29)

Furthermore, they felt that they are 'change agents', for example in organizing multidisciplinary team meetings where the patient or even the caregiver can ask questions to the members of the team and define clear goals.

Another special contribution to patient safety was reported in having a deeper 'expert knowledge' and advanced experience to better understand patients' journeys and to empower people. Participants saw themselves to be more focused on a particular area of interest than the other staff on the ward and have more time for quality care.

> 'In my role in terms of maintaining quality and safety, I guess, the first part is having a big clinical presence and having that really strong level of expertise.' (Focus group 2, L. 32)

In detail, they described performing a comprehensive holistic clinical assessment or 'shift to shift safety huddles' to identify and manage risks. APNs categorized healthcare staff as a 'big safety net', which needs their special education as experts, also in generating research evidence.

> 'If we are using the very best and latest evidence, we can do more than just do no harm.' (Focus group 3, L. 15)

During their shift, they started to oversee the activities of educators to ensure evidence-based care was being practised. During meetings with the team, APNs discussed case studies/case scenarios. Another important task was described as teaching patient/family about the side effects of treatment, symptom control, medication, and devices using a variety of methods like the teach-back method, brochures or sometimes YouTube videos.

Multidisciplinary team approach

The participants discussed the ability to work with colleagues and create an environment that focused on quality and safety. Relationships with medical colleagues, allied health and therapists were very important, for them to ensure that everyone was on the same page and that the things are planned in line with the best interests of the patient. Patient safety in general has a high priority for all team members, but not all of them participate in the same way:

> 'In the majority of times that we're all on the same page regarding patient safety.' (Focus group 6, L. 83)

Some participants highlighted that quality and safety required a culture of trust created by both team members and leaders, including communication without blame.

Above all, communication during multidisciplinary team meetings seems to be important to gain insights, as all healthcare professionals want to achieve safety and quality patient outcomes:

> 'In my workplace, we are all encouraged to SPEAK UP for safety.' (Focus group 2, L. 64)

However, differences in communication within team members also were apparent:

> 'You start looking for research evidence and doing things like that. But having said that you still need the support of your colleagues. You still need support from your clinical managers.' (Focus group 3, L. 39)

To fulfil their tasks, APNs recognized the necessity of support by all team members, as each health care professional has her/his defined roles. Their specific feedback can serve as a starting point to strengthen patient safety, provide holistic care, and to support the patient and their relatives.

Patients and relatives role in patient safety

Participants highlighted two key aspects in the role of patients/relatives to achieve safe outcomes; participation in the *decision-making* process and *partnering with staff.* Reference was made throughout that patients are powerful consumers of healthcare and should be able to make informed decisions. Encouraging and empowering patients to give appropriate feedback about their needs can help achieve better health outcomes and quality care.

> 'The other part for patients is really that. It's not just around their understanding to make decisions, but to be able to set goals to be active partners in things.' (Focus group 2, L. 55)

In addition, their family members and relatives were seen as the key to keeping patients safe - acting as a substitute or proxy decision-maker when the patient 'has no voice' or is unable to understand the care process, especially in the community. In a non-English speaking environment, family often act as an interpreter, in acute as well as in community care settings.

In the community, all power and authority lay with the patient. In some areas, patients are well informed and knowledgeable about patient safety, as they have conducted a lot of reading via online sources. However, APNs also highlighted that there is a need to clarify the amount of patient engagement, as not every patient wants to take an active role in decision-making or patient safety. In this process, the participants saw their task of *partnering with* patients/relatives as *consumers* of healthcare and communicating and explaining care processes to them. They emphasized that family members are familiar with patients' needs and can offer valuable advocacy.

Due to the COVID-19 pandemic, some participants reported that the use of virtual technologies to engage patients and families, helping to raise awareness and providing information, has been shown to be an important tool for quality and safety.

> 'It's really an important way that we can have patient involved in their quality and safety, and equally the families. The best thing about COVID really has been a greater engagement with families, even if it's by phone or by video conferencing in a lot of the patient settings.' (Focus group 2, L. 55)

Government regulation to ensure patient safety

APNs were very aware of national patient safety policies and activities of the NSW Clinical Excellence Commission (Clinical Excellence Commission (CEC), 2023), providing different safety tools for teaching, assessments, accreditation programs or audits. In addition, *national*

standards (Australian Commission on Safety and Quality in Health Care, 2022) are integrated into daily work, enabling thinking outside the box and ensuring standards of care, safety and access for patients, but the importance of each depends on the nurse's personal risk assessment. Standards that include one's specialization are more clearly noted and prioritized. Finally, the participants stated that they perceive themselves as the only professional group responsible for the standards due to their heavier workload compared to others. Nevertheless, this should be everyone's responsibility.

> 'We talk about national standards and all those kinds of things, but, hey, where is this when it comes to certain patients? So it depends on the person who is at the door, you get the best treatment or you get the worst treatment.' (Focus group 1, L. 58)

In terms of clinical leadership, APNs are highly involved in listening to consumers, developing standards, auditing, and accreditations as 'nurses on the ward' are generally unable to focus on all safety/risk activities. Yet, they are somewhat critical of the fact that too much focus on a single project leads to other things being neglected. Participants stated that national standards are important, but for them as clinical experts, the content sometimes seems to be everyday knowledge that everyone already knows, so that the necessity of individual aspects is critically discussed (example: wash your hands before you go to see a patient).

> 'I was presented with this chart that I had to tick. To show that I'd actually walked into a patient's room every half hour or something and then I'd eyeball my patients and, unlike what I actually have to tick a box to demonstrate that I've done that. To me that was just absurd and at the end of one shift this nurse pulled me up and she said 'Oh, but you haven't tick the boxes'. And I said but I don't need to, I know, patients, I know what's going on with them, I see them.' (Focus group 4, L. 27).

Further needs to improve patient safety

Participants reported on several areas where patient safety could be improved, with a focus on *nurse education*, *resource availability*, *patient advocacy,* and *open communication* in the multidisciplinary team.

In community care, participants wanted to have more experienced nurse educators and highlighted that nurse-patient relationships are more important than ever for novice nurses due to a primary care workforce shortage. In particular, they emphasized the crucial role of senior nurses in bridging the gap between patient care and community support. More CNCs were thought to be needed as […] '*nurses form a unique bridge between maintaining patients safely in their environments, as well as providing expert knowledge and information, which would then lead to decreased unnecessary presentations to hospital, probably better symptom management and control.'* (Focus group 4, L. 98)

'*Availability of resources'* including staff, funding, and time as well as a complex skill mix in the community setting is a challenge for nurses. Especially in community care, APNs need to handle family dynamics and ensure collaboration, continuity of care and open communication.

> '[…] to improve patient safety in terms of being safe at home and keeping them out of the hospital. For me that is probably my biggest obstacle is the lack of services and, if I had the services available, I would use them.' (Focus group 5, L. 46)

Furthermore, long waiting times affect patient safety because APNs do not know what is going on with them during this time, as they have not yet been able to make contact due to delayed referrals.

In their advanced roles, participants wanted to be an '*advocate for their patients'* and the first contact person. As advocates, they introduced solutions such as patient-led virtual rounds during the COVID-19 pandemic and case conferencing to increase patient involvement. They sought greater involvement in decision-making, particularly in managing patient flow and discharge, and emphasized that there is '*no such thing as person-centred care'*. Due to their close relationships with patients and families, they believed that they had a deeper understanding compared to doctors, which fuelled their desire to be more involved in shared decision-making processes.

> 'So she's had EIGHT ward movements in three days, POST ICU. And she was a fine functioning independent 74 year old, who actually ended up with a biopsy of her thyroid. And I don't even wanna (want to) go. And I begged, I went down to bed management yesterday. I actually went to the team leader. Please do not move this lady. And I've come in this morning. And yeah, she tried to hang herself last night (..) in a delirium. She was moved at 2:00am in the morning.' (Focus group 6, L.107)

Improving **'***open communication'* between the different sectors of the healthcare system (e.g. hospital, community) was described as an important issue, especially concerning patients with complex health needs. Communication and cooperation with physicians could also be improved, helping to promote continuation of care and ensure patient safety through safe healthcare processes. Treatment pathways and responsibilities for admissions/transfers have to be communicated transparently to stakeholders to ensure continuity of care.

Discussion

This study aimed to explore and describe the perceptions and experiences of NPs and CNCs in patient safety and their ability to improve patient safety outcomes in hospitals and community care. Our findings show that APNs prioritize patient safety as integral to their advanced practice, encompassing both physical and psychological safety and a holistic approach to patient care. They champion patient-centeredness, empowering patients in self-management, and act as educators to facilitate patient autonomy in treatment. Their advanced education and expertise position them as leaders and role models in healthcare, enabling them to identify systemic gaps and effect change. According to this patient-centred care or holistic care (Frisch & Rabinowitsch, 2019), patient safety seems to be orientated towards patients, families, and the healthcare system's needs. Participants highlighted that their activities are aimed at leading multi-professional teams and fostering relationships with healthcare colleagues, patients, and families to improve patient safety.

APNs contribution to leadership in terms of being patient-, organization-, and system-oriented (Lamb et al., 2018), being the first to engage with patients, and acting as agents for change and quality improvement (Boucher et al., 2015) is well described. Working together closely among patients, caregivers, and nurses in hospitals, along with building strong connections within community partnerships, has been seen as a very important part of how safe patients feel. Advanced practice nurses in South Korea, especially those working in hospital-based home healthcare, believe that teamwork and collaboration are key to making sure patients stay safe and improving their overall safety (Lee et al., 2022). In addition, APNs should play a leading role in health policy and decision-making to improve health globally (Bryant-Lukosius, 2022).

However, participants also expressed their inability to focus on all safety and risk activities. Safety standards were perceived in a field of tension between external evidence and internal advice. Additionally, some APNs cite that meeting standards means making sure boxes (e.g. care assessments and checklists) are ticked. The participants in this study further explained that this task of 'box-ticking' cannot be associated with high-quality care per se and only

means that the activity, or care task/ assessment has been documented. Whether the underlying activity was conducted at all or how well it was done, cannot be directly verified.

Discussion of increasing 'safety overload' in healthcare organizations has been a focus of various studies due to the uncertain effectiveness of safety protocols.

In a comprehensive study that aimed to identify procedures that make a minimal contribution to patient safety, healthcare professionals specifically highlighted paperwork, duplication of work and intentional rounds as being of low value (Halligan et al., 2022). Meanwhile, contrasting perspectives were presented, with some suggesting that intentional rounds could have a positive impact on patient safety, but emphasising the need for further research to shed light on the underlying structures and processes (Ryan et al., 2019). The overarching conclusion drawn from these findings emphasizes the importance of careful evaluation of safety practices and, if necessary, the elimination of low-value procedures (Halligan et al., 2022). This requires a critical reassessment to streamline and optimize safety measures, potentially involving the elimination of procedures that do not contribute significantly to patient well-being.

Participants provided suggestions on several practice areas where patient safety outcomes could be improved, with a special focus on the availability of resources such as staffing, especially nurse educators, funding, and nursing time. How nurses spend their time was particularly important as there has been a priority focus on the reduction of 'low value care' that offer minimal or no benefit to patient outcomes in New South Wales. Future focus may include reducing non-evidence based patient safety practices or de-implementation strategies in some settings (Rietbergen et al., 2020; Rihari-Thomas et al., 2023).

With their close therapeutic relationship, Advanced Practice Nurses are key advocates and want to be more involved in shared decision-making. An aspect addressed in a study among registered nurses resulting in the need to pay more attention to the impact of the advocacy role on patient safety in the future (Choi et al., 2014).

During our focus groups, transition of care (e.g. hospital, community) was reported as an important issue. The value of established and open communication channels (including documentation) between different healthcare system, especially concerning patients with complex health needs or those living with multimorbidity, is essential. Documented discharge information can make a significant contribution to patient safety, but studies have identified a need for safe, timely, accurate and comprehensive discharge information, especially in dementia care (Parker et al., 2021).

Finally, APNs experienced themselves as a unique group of nurses whose scope of practice ranges from clinical patient care to policy development and that can be a link between micro and macro health systems.

Limitations

The limitations relate to advanced nursing roles in Australia, as in particular the CNC role is not recognized internationally. Therefore, findings cannot be generalized. In addition, the focus groups were conducted during the peak periods of COVID-19, limiting participant recruitment, and potentially biasing the sample towards those interested in the topic. Social desirability bias may have influenced focus group responses.

Nevertheless, it is worth highlighting that data saturation was successfully achieved for all categories.

Conclusions

Our study highlights the important role of Advanced Practice Nurses in promoting patient safety. With their special contribution, they are influential leaders being able to identify system-wide

improvements and gaps in safety measures. Through their advanced education, clinical and research skills, APNs play a central role in improving safety measures to prevent, detect and minimise adverse events and make an important contribution to ongoing patient safety initiatives. Advanced education and professional expertise are important elements for patient safety. Safety strategies focus on preventing, detecting and mitigating the effects of adverse events already in place, which can be fulfilled through the role of Advanced Practice Nursing. These findings offer valuable insights for nursing educators, stakeholders, and healthcare policymakers, serving as a solid foundation for the formulation of effective patient safety strategies within both hospital and community care settings.

Acknowledgements

We would like to thank all nurses who participated in this study and all contact persons in the Western Sydney Local Health District and the South East Sydney Local Health District who kindly helped with the data collection, with special mention to Marie Baxter and Caroline Farmer.

Funding

This research received two grants from the PMU (PMU FFF S-20/02/019-GLA, 2021-FIRE-001-Glarcher) and was performed during a short-term fellowship of the first female author at the University of Wollongong. Funding source did not influence the study at all.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Data availability statement

Data available on request from the authors.

ORCID

Manela Glarcher http://orcid.org/0000-0002-6807-6971
Caleb Ferguson http://orcid.org/0000-0002-2417-2216

References

Amaral, L. R., & Araújo, C. A. (2018). Advanced practices and patient safety: An integrative literature review. *Acta Paulista de Enfermagem*, *31*(6), 688–695. https://doi.org/10.1590/1982-0194201800094

Ash, L., & Miller, C. (2016). Interprofessional collaboration for improving patient and population health. In S. M. Denisco, & A. M. Barker (Eds.), *Advanced practice nursing. Essential knowledge for the profession* (3 ed., pp. 123–147). Jones & Bartlett Learning.

Australian Commission on Safety and Quality in Health Care. (2022). *The NSQHS Standards*. Australian Commission on Safety and Quality in Health Care. Retrieved May 1, 2023, from https://www.safetyandquality.gov.au/standards/nsqhs-standards

Baldwin, R., Duffield, C. M., Fry, M., Roche, M., Stasa, H., & Solman, A. (2013). The role and functions of Clinical Nurse Consultants, an Australian advanced practice role: A descriptive exploratory cohort study. *International Journal of Nursing Studies*, *50*(3), 326–334. https://doi.org/10.1016/j.ijnurstu.2012.09.013

Benner, P., Tanner, C., & Chesla, C. (1992). From beginner to expert: Gaining a differentiated clinical world in critical care nursing. *Advances in Nursing Science*, *14*(3), 13–28. https://doi.org/10.1097/00012272-199203000-00005

Boucher, N. A., McMillen, M. A., & Gould, J. S. (2015). Agents for change: Nonphysician medical providers and health care quality. *The Permanente journal*, *19*(1), 90–93. https://doi.org/10.7812/TPP/14-095

Braithwaite, J., Glasziou, P., & Westbrook, J. (2020). The three numbers you need to know about healthcare: The 60-30-10 Challenge. *BMC Medicine*, *18*(1), 102. https://doi.org/10.1186/s12916-020-01563-4

Bryant-Lukosius, D. (2022). Future leadership: Advanced practice nursing. *Investigación en Enfermería: Imagen y Desarrollo*, *24*, 1–5. https://doi.org/10.11144/Javeriana.ie24.flap

Choi, S. P.-p., Cheung, K., & Pang, S. M.-c. (2014). A field study of the role of nurses in advocating for safe practice in hospitals. *Journal of Advanced Nursing*, *70*(7), 1584–1593. https://doi.org/10.1111/jan.12316

Clinical Excellence Commission (CEC). (2023). *The Clinical Excellence Commission is the lead agency supporting safety and quality improvement in the NSW Health system.* Clinical Excellence Commission (CEC). Retrieved March 1, 2023, from www.cec.health.nsw.gov.au.

Council of the European Union. (2009). Council Recommendations of 9 June 2009 on patient safety, including the prevention and control of helathcare associated infections (2009/C 151/01). Retrieved March 1, 2023, from https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2009:151:0001:0006:en:PDF.

de Vries, E. N., Ramrattan, M. A., Smorenburg, S. M., Gouma, D. J., & Boermeester, M. A. (2008). The incidence and nature of in-hospital adverse events: A systematic review. *Quality and Safety in Health Care*, *17*(3), 216–223. https://doi.org/10.1136/qshc.2007.023622

Dresing, T., & Pehl, T. (2015). *Praxisbuch Interview, Transkription & Analyse. Anleitungen und Regelsysteme für qualitativ Forschende* (6 ed.). Dr. Dresing und Pehl GmbH.

Eriksson, I., Lindblad, M., Möller, U., & Gillsjö, C. (2018). Holistic health care: Patients' experiences of health care provided by an Advanced Practice Nurse. *International Journal of Nursing Practice*, *24*(1), e12603. https://doi.org/10.1111/ijn.12603

Frisch, N. C., & Rabinowitsch, D. (2019). What's in a definition? Holistic nursing, integrative health care, and integrative nursing: Report of an integrated literature review. *Journal of Holistic Nursing*, *37*(3), 260–272. https://doi.org/10.1177/0898010119860685

Gardner, G., Chang, A., Duffield, C., & Doubrovsky, A. (2013). Delineating the practice profile of advanced practice nursing: A cross-sectional survey using the modified strong model of advanced practice. *Journal of Advanced Nursing*, *69*(9), 1931–1942. https://doi.org/10.1111/jan.12054

Gardner, G., Duffield, C., Doubrovsky, A., & Adams, M. (2016). Identifying advanced practice: A national survey of a nursing workforce. *International Journal of Nursing Studies*, *55*, 60–70. https://doi.org/10.1016/j.ijnurstu.2015.12.001

Geertz, C. (1973). *The interpretation of cultures*. Basic Books.

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures' to achieve trustworthiness. *Nurse Education Today*, *24*(2), 105–112. https://doi.org/10.1016/j.nedt.2003.10.001

Halligan, D., Janes, G., Conner, M., Albutt, A., Debono, D., Carland, J., Sheppard-Law, S., Taylor, N., Middleton, S., McInnes, E., Ferguson, C., & Lawton, R. (2022). Identifying safety practices perceived as low value: An exploratory survey of healthcare staff in the United Kingdom and Australia. *Journal of Patient Safety*, *19*(2), 143–150. https://doi.org/10.1097/pts.0000000000001091

International Council of Nurses (ICN). (2021). *The ICN code of ethics for nurses. Revised* 2021. Geneva: International Council of Nurses. Retrieved October 10, 2023, from https://www.icn.ch/sites/default/files/2023-04/ICN_Code-of-Ethics_EN_Web_0_0.pdf.

Kaldan, G., Nordentoft, S., Herling, S., Larsen, A., Thomsen, T., Egerod, I., Kaldan, G., Nordentoft, S., Herling, S. F., Larsen, A., Thomsen, T., & Egerod, I. (2019). Evidence characterising skills, competencies and policies in advanced practice critical care nursing in Europe: A scoping review protocol. *Bmj Open*, *9*(9), e031504. https://doi.org/10.1136/bmjopen-2019-031504

Lamb, A., Martin-Misener, R., Bryant-Lukosius, D., & Latimer, M. (2018). Describing the leadership capabilities of advanced practice nurses using a qualitative descriptive study. *Nursing Open*, *5*(3), 400–413. https://doi.org/10.1002/nop2.150

Lee, G., Hendriks, J., & Deaton, C. (2020). Advanced nursing practice across Europe: Work in progress. *European Journal of Cardiovascular Nursing*, *19*(7), 561–653. https://doi.org/10.1177/1474515120917626

Lee, S., Lee, J. Y., Kim, H., Lee, K., & Lee, T. (2022). Advanced practice nurses' experiences on patient safety culture in hospital-based home healthcare: A qualitative descriptive study. *Risk Management and Healthcare Policy*, *15*, 2297–2309. https://doi.org/10.2147/rmhp.S388902

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry.* Sage Publications.

Maier, C. B., & Aiken, L. H. (2018). Expanding clinical roles for nurses to realign the global health workforce with population needs: A commentary. *Israel Journal of Health Policy Research*, *5*(1), 21. https://doi.org/10.1186/s13584-016-0079-2

Marcinowicz, L., Wojnar, D., & Terlikowski, S. J. (2021). Work activities of primary health care nurses in Poland: National survey results. *BMC Nursing*, *20*(1), 22. https://doi.org/10.1186/s12912-021-00541-2

McCormack, B., & McCance, T. V. (2006). Development of a framework for person-centred nursing. *Journal of Advanced Nursing*, *56*(5), 472–479. https://doi.org/10.1111/j.1365-2648.2006.04042.x

McDonnell, A., Goodwin, E., Kennedy, F., Hawley, K., Gerrish, K., & Smith, C. (2015). An evaluation of the implementation of Advanced Nurse Practitioner (ANP) roles in an acute hospital setting. *Journal of Advanced Nursing*, *71*(4), 789–799. https://doi.org/10.1111/jan.12558

McNeil, J. J., & Leeder, S. R. (1995). How safe are Australian hospitals? *Medical Journal of Australia*, *163* (9), 472–475. https://doi.org/10.5694/j.1326-5377.1995.tb124692.x

Mick, D. J., & Ackerman, M. H. (2000). Advanced practice nursing role delineation in acute and critical care: Application of the Strong Model of Advanced Practice. *Heart & Lung*, *29*(3), 210–221. https://doi.org/10.1067/mhl.2000.106936

Mitchell, E., & Walker, R. (2020). Global ageing: Successes, challenges and opportunities. *British journal of hospital medicine*, *81*(2), 1–9. https://doi.org/10.12968/hmed.2019.0377

Parker, K. J., Phillips, J. L., Luckett, T., Agar, M., Ferguson, C., & Hickman, L. D. (2021). Analysis of discharge documentation for older adults living with dementia: A cohort study. *Journal of Clinical Nursing*, *30*(23-24), 3634–3643. https://doi.org/10.1111/jocn.15885

Polit, D. F. (2021). *Nursing research: Generating and assessing evidence for nursing practice / Denise F. Polit, Cheryl Tatano Beck*. Wolters Kluwer.

Rietbergen, T., Spoon, D., Brunsveld-Reinders, A. H., Schoones, J. W., Huis, A., Heinen, M., Persoon, A., van Dijk, M., Vermeulen, H., Ista, E., & van Bodegom-Vos, L. (2020). Effects of de-implementation strategies aimed at reducing low-value nursing procedures: A systematic review and meta-analysis. *Implementation Science*, *15*(1), 38. https://doi.org/10.1186/s13012-020-00995-z

Rihari-Thomas, J., Glarcher, M., Ferguson, C., & Davidson, P. M. (2023). Why we need a re-think of patient safety practices. *Contemporary Nurse*, *59*(2), 83–87. https://doi.org/10.1080/10376178.2023.2200015

Ryan, L., Jackson, D., Woods, C., & Usher, K. (2019). Intentional rounding – An integrative literature review. *Journal of Advanced Nursing*, *75*(6), 1151–1161. https://doi.org/10.1111/jan.13897

Slawomirski, L., Auraaen, A., & Klazinga, N. S. (2017). *The economics of patient safety* (pp. 1–67). OECD Health Working Papers 2017 No.96. https://doi.org/10.1787/5a9858cd-en

Then, K. L., Rankin, J. A., & Ali, E. (2014). Focus group research: What is it and how can it be used? *Canadian Journal of Cardiovascular Nursing*, *24*(1), 16–22.

VERBI Software. (2021). *MAXQDA 2022 [computer software]*. In VERBI Software. www.maxqda.com.

Woo, B. F. Y., Lee, J. X. Y., & Tam, W. W. S. (2017). The impact of the advanced practice nursing role on quality of care, clinical outcomes, patient satisfaction, and cost in the emergency and critical care settings: A systematic review. *Human resources for health*, *15*(1), 63–63. https://doi.org/10.1186/s12960-017-0237-9

World Health Organization (WHO). (2021a). *Global patient safety action plan 2021–2030: towards eliminating avoidable harm in health care*. Retrieved June 6, 2023, from https://www.who.int/teams/integrated-health-services/patient-safety/policy/global-patient-safety-action-plan.

World Health Organization (WHO). (2021b). *Patient Safety. Key facts*. Retrieved October 21, 2022, from https://www.who.int/news-room/fact-sheets/detail/patient-safety.