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The role experience of advanced practice nurses in oncology: An interpretative phenomenological study

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Abstract

Aim(s): To understand the experiences of advanced practice nurses working in cancer care.

Design: Phenomenological qualitative study.

Methods: Three focus groups were held to collect qualitative data. Participants were recruited through theoretical non-probabilistic sampling of maximum variation, based on 12 profiles. Data saturation was achieved with a final sample of 21 oncology advanced practice nurses who were performing advanced clinical practice roles in the four centers from December 2021 to March 2022. An interpretative phenomenological analysis was performed following Guba and Lincoln's criteria of trustworthiness. The centers' ethics committee approved the study, and all participants gave written informed consent. Data analysis was undertaken with NVivo 12 software.

Results: Three broad themes emerged from the data analysis: the role performed, facilitators and barriers in the development of the role and nurses' lived experience of the role.

Conclusion: Advanced practice nurses are aware that they do not perform their role to its full potential, and they describe different facilitators and barriers. Despite the difficulties, they present a positive attitude as well as a capacity for leadership, which has allowed them to consolidate the advanced practice nursing role in unfavourable environments.

Implications for the Profession: These results will enable institutions to establish strategies at different levels in the implementation and development of advanced practice nursing roles.

Reporting Method: Reporting complied with COREQ criteria for qualitative research.

Patient or Public Contributions: No patient or public contribution.

KEYWORDS
advanced practice nursing, barriers, facilitators, interpretative phenomenological study, oncology nursing

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1 | INTRODUCTION

Changes in population health needs (Goryakin et al., 2020) require new health care strategies, including new professional roles such as advanced practice nurses (APNs) (Bryant-Lukosius et al., 2017; Tracy & O'Grady, 2018; Wheeler et al., 2022). According to the International Council of Nursing (ICN, 2008): 'An Advanced Practice Nurse (APN) is one who has acquired, through additional education, the expert knowledge base, complex decision-making skills and clinical competencies for expanded nursing practice, the characteristics of which are shaped by the context in which they are credentialed to practice'.

A concept analysis by Dowling et al. (2013) reveals the confusion surrounding the definition of APN, disparities in practice and educational requirements across countries and contexts, a variety of roles performed, a range of associated degrees and titles (including clinical nurse specialist, nurse practitioner, midwife and clinical nurse consultant) and difficulties in identifying the contributions of APNs in health care (Heale & Rieck Buckley, 2015; Unsworth et al., 2022; Wheeler et al., 2022). Despite these differences in the roles of advanced nurses identified by a range of authors (East et al., 2015; Hutchinson et al., 2014; Jokiniemi et al., 2012), they conclude that there are more similarities than differences in the role descriptions and that the differences are likely resulting from decisions at the organizational or individual level, rather than the national level.

2 | BACKGROUND

Today, cancer care requires new strategies, both to respond to the growing population affected worldwide by the increased incidence and longer survival (WHO, 2020), and to manage the increased complexity of care, linked to advances in treatment. Cancer care is thus undergoing important organizational shifts, such as the widespread implementation of multidisciplinary teams to provide efficient, high-quality, person-centered care (Borras et al., 2014; Selby et al., 2019; Winters et al., 2021) and the adoption of new advanced practice nursing roles (Prades et al., 2015; Serena et al., 2018; Westman et al., 2019).

In that line, APNs have the competencies to provide such care throughout the disease process. They are in charge of coordinating patient care, requesting tests, interpreting the results, educating the patient about the tests, monitoring the treatment, managing adverse effects, assessing clinical status, controlling disease-related symptoms and providing emotional and decision-making support (Davies, 2022; Schneider et al., 2021). Therefore, APNs provide holistic, specialized care that responds to the needs of cancer patients and improves quality of care in terms of information, accessibility and involvement in self-care (Kerr et al., 2021; Schneider et al., 2021; Westman et al., 2019).

The presence of an APN on the multidisciplinary team is associated with reductions in mortality, unscheduled admissions and anxiety, along with improvements in quality of life, satisfaction and the experience of the disease process (Alessy et al., 2021; Alotaibi & Al Anizi, 2020; Schneider et al., 2021; Stewart et al., 2021). However, the implementation of this role has been uneven: APNs are well-established figures in countries such as the USA, Canada, the UK and Australia, while elsewhere their role is still emerging and expanding. This development is characterized by significant variations in the scope of practice, responsibilities, nomenclature, training and regulation (Wheeler et al., 2022).

Authors like Lopatina et al. (2017) have shown that these roles have developed in specific ways depending on organizational needs, practice settings and the individual attributes of the APNs. Evidence from the field of practice indicates that contextual factors determine how these roles are implemented (Jean et al., 2019), and different studies have identified facilitators of and barriers to the implementation or development of advanced practice nursing roles (Casey et al., 2019; Fealy et al., 2018; Schirle et al., 2020).

The lack of a clear definition for the APN role (Cook et al., 2021) complicates its development, underscoring the need for job descriptions, a list of APN functions and a regulatory framework for implementation (Kobleder et al., 2017). In countries like the USA, Canada and the UK, where the APN position is already consolidated, it is subject to legal regulation and certification, while in countries that have begun to implement these roles more recently, such mechanisms are not yet in place (Unsworth et al., 2022; Wheeler et al., 2022).

In Spain, advanced practice nursing roles exist, although they are underdeveloped and unregulated (Gutiérrez-Rodríguez et al., 2022; Manzanares et al., 2021; Serra-Barril et al., 2022; Sevilla Guerra et al., 2021; Sevilla-Guerra, 2018). The implementation and development of these roles in potentially unfavourable contexts requires research with a variety of approaches. Among the current knowledge gaps, there is a need to better understand the experience of oncology APNs and to identify hindering and facilitating factors in the implementation of their roles.

3 | THE STUDY

3.1 | Aims

The overarching aim was to understand the lived experience of oncology APNs in the implementation and performance of the role. The specific objectives were to describe the functions that define the APN role and to identify the factors that favour and hinder its implementation and performance.

4 | METHODS

4.1 | Design

This study is part of a larger, three-phase, mixed-methods study. The first phase explored the competencies developed by the APNs; the second, the perceptions held by doctors and patients around

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the APN role and the third, reported here, the perceptions of nurses themselves. It uses a qualitative interpretive design, following the COREQ-32 criteria (Tong et al., 2007), and a hermeneutic phenomenological method, from the Heidegger school of thought (Heidegger, 1962; Rodriguez & Smith, 2018; Tuohy et al., 2013). Focus groups were used (Bradbury-Jones et al., 2009), as they enable an understanding of how APNs perceive both their practice role and the factors that favour or hinder their performance in cancer care.

4.2 | Theoretical framework

The study is framed in the constructivist paradigm, in which reality is seen as a set of different mental constructions, with subjective validity relative to the frames of reference. Socially and experientially based constructions are considered to be local in nature and specific in their form and content. Knowledge is created through the interaction between the researcher and those who respond to them, and the constructions are interpreted using hermeneutical techniques, comparing and contrasting through a dialectical exchange until reaching a more informed and sophisticated construction than the previous ones (Guba & Lincoln, 1994). Exploring the nursing role requires the recognition of nursing as a discipline. The components of a qualitative research design, informed by the disciplinary epistemology of nursing, will help ensure a logical line of reasoning in our investigations that remains true to the nature and structure of practice knowledge (Thorne et al., 2016). Moreover, the study is of relevance both for the nursing profession and for the care of patients and families.

4.3 | Study setting and recruitment

The study took place in four tertiary level university hospitals in the public hospital network of Catalonia (Spain), whose oncology services included APNs. Clinical nurse specialists are part of multidisciplinary teams and provide specialized care.

The study population was comprised by nurses who were performing advanced clinical practice roles in the four centers from December 2021 to March 2022. Participants had to be providing direct care to patients with different cancer diseases and have at least 1 year of experience as an APN.

Theoretical, non-probabilistic sampling of maximum variation (Kleiman, 2004; Patton, 2014) was used, based on 12 profiles that considered professional experience (1–5 years, 6–10 years and >10 years) and center. The final sample size reached 21, at which point theoretical data saturation was achieved (Polit & Beck, 2022).

To recruit participants, we emailed the office of the Head Nurse in the participating centers, explaining the study and asking them to identify potential informants according to the profiles provided. The APNs they proposed were then contacted with a description the study and its aims along with an invitation to take part in the focus groups. If they were open to participating, they were sent more detailed information, an informed consent document, a confidentiality form and the date of the focus group. An invitation was also sent by post. Likewise, the participants were informed that they were free to drop out of the study at any time. None of the participants received any incentive—economic or otherwise—to participate.

TABLE 1 Focus group script.

1. With regard to the role of advanced practice nurse (APN), what are the functions that you consider define you as APNs in cancer care?
2. Based on your experience as an APN, could you explain what the performance of this role entails?
3. What factors or elements make it difficult for you to perform your role as APN?
4. Based on your experience as an APN, what factors or elements do you think help you perform your role?

4.4 | Data collection

The focus group was used as a data collection technique (Bradbury-Jones et al., 2009; Powell & Single, 1996; Tubbs, 2012). Each group was comprised of six to eight participants with heterogeneous profiles in terms of professional experience as APNs and workplace (Stewart et al., 2007).

The focus groups followed a script prepared according to the specific study objectives (Table 1), and they lasted 60–90 min. A moderator and an observer with no direct relationship to the health care teams were present in all the groups to follow the interactions and non-verbal communication between the participants. The moderator was familiar with the study aims and introduced the topics conversationally, allowing and encouraging the participants to express their experiences, ideas and thoughts; facilitating participation and preventing any one participant from dominating (Joyce, 2008).

The investigators were experts with extensive knowledge and experience in cancer services. During the study, the researchers did not have any type of employment or hierarchical relationship with the participants, since they worked in fields like academia, quality assurance or research.

Due to oscillations in COVID-19 incidence during the study, three different modalities were used for the focus groups. The first was face-to-face, the second had a mixed virtual-physical format and the third was completely virtual. The Microsoft Teams platform was used for the virtual convening, which allowed us to interact with the participants. In the context of the pandemic, the participants were used to holding meetings by videoconference (Stewart et al., 2007).

A recording device was used to collect data during the physical focus groups, and the Microsoft Teams platform was employed to record the interviews conducted by videoconference (Polit &

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Beck, 2022). Subsequently, the transcripts were returned to each participant for their consent. The participants also filled out a form with sociodemographic data. A field diary was used to record researchers' observations and reflections during the study, composed of theoretical, personal, descriptive, inferential and methodological notes (Taylor et al., 2016).

4.5 | Data analysis

All audio recordings were transcribed verbatim into a Microsoft Word document alongside the corresponding field notes. Data collection and analysis were performed simultaneously, using an interpretive phenomenological approach (Pringle et al., 2011; Quinn & Clare, 2008). The research team read the full transcript to obtain a broad overview, then recorded their first impressions in the field diary. A second line-by-line reading followed, where minimum units of data were fragmented and coded. From there, the categorization process began, which consisted of ordering and grouping the codes into subcategories and then larger categories. We then interpreted the categories to arrive at more abstract central themes (Burnard et al., 2008; Morse, 2008; Pope et al., 2000). Field notes were analysed concurrently with the interview transcripts to add more context to the findings. Two investigators independently performed the primary analysis, and their findings were subsequently reviewed by the remaining co-investigators, who were subject-area experts, and then contrasted with scientific publications on the topic (Birt et al., 2016). The handling and management of the data was carried out using the NVivo v.12 program.

4.6 | Ethical considerations

The directors of participating hospitals and the ethics committee of the University Hospital Bellvitge approved the protocol (PR277/18) dated 21 June 2018. The study complied with bioethics regulations (Declaration of Helsinki, 2013) and applicable legislation, including Organic Law 3/2018 on Personal Data Protection and Guaranteeing Digital Rights, and EU Regulation 2016/679 on General Data Protection. In compliance with current legislation, participants' confidentiality and privacy were protected through the anonymized coding of personal data along with data encryption and custody. All participants were informed in detail about the study, and prior to conducting the focus groups, they signed informed consent and a confidentiality form.

4.7 | Rigour and reflexivity

Lincoln and Guba's criteria (Guba & Lincoln, 2018) of trustworthiness were applied, as were quality criteria (Gastaldo & McKeever, 2000). Transcripts were returned to each participant to confirm their agreement. Performance of different study phases alternated between data collection, interpretation and systematization and triangulation among researchers, and participants were also given the opportunity to validate the results (Flick, 2018; Morse, 2018). In relation to quality criteria, the study was framed in the constructivist paradigm; the research question was contrasted with the methods, and the study design was adjusted accordingly.

A process of reflexivity was undertaken to cultivate the researchers' self-awareness of how they approached the phenomenon and self-critical awareness of how to better understand it (Langdridge, 2007). Researchers identified their status and role for the purpose of maintaining their neutrality during the performance of the study. The researchers' attitude and position were essential to maintain negotiated relationships during the research process that were favourable to the contexts and people studied (Moran, 2002). Throughout the research, the researchers were aware of the effect they could have on the study outcomes. They discussed their own subjectivity and their relationship to the object of research, as well as the impact of their interactions with participants. One way to minimize their impact during data collection was to show interest in what the participants said without expressing their own opinions. Reflections about the positionality and potential influence of the researchers on the research outcomes were recorded in the field diary.

TABLE 2 Participating APNs by type and size of center.

Type and size of center	$N=21$
General hospital <500 beds	3 (14.1%)
General hospital >500 beds	5 (23.8%)
Specialized cancer center	13 (62.1%)

5 | FINDINGS

5.1 | Participant characteristics

Twenty-one APNs participated in the study, all women, with a median age of 50 years (range 29–63). They had a median of 24 years' (range 7–35) professional nursing experience and 9 years' (range 1–19) experience as an APN. Regarding educational level, 76.2% had master's degrees and 23.8% postgraduate studies. They worked in four hospitals of different sizes and service profiles, as shown in Table 2. The distribution of APNs according to the type of patients attended is presented in Table 3.

5.2 | Thematic findings

Three major themes emerged from the data analysis: the role performed, facilitators and barriers in the development of the role and nurses' lived experience of the role (Table 4; Figure 1). In this section, we outline the themes and their corresponding categories and subcategories.

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TABLE 3 Number of participating APNs, by disease or specialty of service.

Disease or specialty	APNs ($N=21$)
Breast cancer	4
Neuro-oncology	1
Acute leukaemia and myelodysplastic syndromes	1
Lung cancer	1
Multiple myeloma	2
Haematopoietic stem cell transplantation	2
Lymphoma	1
Oncology clinical nurse	4
Haematology clinical nurse	1
Palliative care	2
Clinical trials	1
Genetic counselling	1

5.2.1 | Role performed

The first major theme is related to the role performed by APNs. The categories that emerged from the APN discourses in relation to their role were attributes, functions and contributions of the APN.

Attributes

Informants described attributes that defined them as APNs, including experience as well as specific, expert knowledge in oncology, which should be continuously updated: '*Nurses have experience combined with knowledge... you know the disease, the pathways*' (ID09): '*APN nursing knowledge is at another level compared to regular nurses … and evidence-based practice*' (ID18). '*You have to keep up to date about new drugs, care practices, and we have this desire to want to learn, to know, and want to advance*' (ID03). Moreover, they describe APNs as agile, with good problem-solving skills: '*We have a very agile and fast way of working to resolve patient situations as soon as possible*' (ID01). In addition, they specify the high level of responsibility and the ability to make complex decisions: '*We have responsibility, we continuously make complex decisions about treatments that are agreed upon with the team*' (ID09); '*The decision-making capacity that we have … and the independence to make complex decisions*' (ID02).

Other elements reported were how they exercised clinical and professional leadership: '*We lead patient care, within the multidisciplinary team we have our functions and competencies*' (ID16); '*We play an independent role*' (ID10); '*Nurses feel supported by you … we have greater knowledge, you are a leader for them*' (ID17); how they defended the advanced practice role: '*Well it's a struggle…you have to negotiate … defending your skills, and you gradually build a culture*' (ID16); and how they positioned themselves within the teams and the relationship of trust that they established: '*We have earned the recognition of the team and their trust*' (ID04); and how this trust determined the autonomy of the APN: '*You have the trust of the team and can be independent because you have it*' (ID16). They also linked independence to their expertise: '*What makes us independent? Training and experience, right?*' (ID06); '*There is knowledge … you can suspect a complication or a relapse and you can do visits, tests, etc*'. (ID21), and this autonomy was considered a quality of leadership within the multidisciplinary team: '*It is important to point out the word autonomy and the word leadership in the team*' (ID09).

Functions performed

Regarding the APNs' functions, five subcategories emerged: care, education, consultation, coordination and research. In terms of **care**, the APNs stated that they provided person-centered care, accompanying the patient and family and providing care throughout the entire cancer care process: '*From the beginning, from diagnosis and during the disease [process], sometimes until the end, … and not only the patient, but also the family … we put them in the center*' (ID03); '*We are with the patient and the family throughout this disease process*' (ID10). The APNs described providing comprehensive care, establishing a therapeutic relationship, creating a bond and a relationship of trust with the patient and family, providing support by telephone, and managing symptoms and the toxicity of the treatments: '*We are the only ones on the team who do a comprehensive assessment of the patient*' (ID12); '*There are intense moments … you create a bond*' (ID01); '*The patient trusts you a lot, for anything*' (ID20); '*They can call you either for a symptom or a question they have*' (ID01); '*Management of all medication related to pain and side effects*' (ID02).

In relation to the **education** function, the nurses provided health education to empower the patient and family: '*We have an educational role, for the patient and family, empowering the patient so that they know what their situation is and that they are as independent as possible in self-care*' (ID11), and they also worked to educate other professionals: '*There are many master's students who go through the service, and sometimes even newly recruited residents … we participate in clinical sessions*' (ID 09).

The **consulting** function is reflected in the fact that APNs were reference figures for professionals, patients and families: '*We are the reference person for the patient, they ask us questions and we guide them in the disease process*' (ID18). They also served as guides for the patient throughout the care process: '*Everyone identifies our figure as a person who understands the entire patient process, and they consult us*' (ID02).

The activities encompassed under the **coordination** function include serving as case managers and as the liaison within the teams and between different levels of care: '*We make sure that everything is coordinated: tests, results, visits and treatment*' (ID19); '*We are the link between the patient/family versus the rest of the team*' (ID10). In addition, they make referrals to other professionals: '*You see the patient's needs and you can refer them to the psycho-oncologist, nutritionist or other professionals*' (ID20).

Finally, regarding the **research** function, the APNs reported that they carry out studies and managed clinical trials. As detailed by the

TABLE 4 Categories, subcategories and emerging codes.

Role performed		
Attributes		Experience
		Specific knowledge
		Expert knowledge
		Up-to-date knowledge
		Problem-solving
		Agility
		Flexibility
		High level of responsibility
		Capacity to make complex decisions
		Clinical and professional leadership
		Defence of the role
		Team confidence
		Independence
Functions	Care	Person-centered care
		Accompaniment
		Care process
		Comprehensive care
		Bond
		Trust relationship
		Telephone support
		Toxicity management
		Symptom management
	Education	Health education
		Teaching
	Consultation	Reference figure
		Guide
	Coordination	Case management
		Liaison
		Referrals
	Research	Clinical trials
Contributions of the role		Accessibility
		Continuity of care
		Effectiveness
		Efficiency
		Optimal resource use
		Facilitator of teamwork
		Patient safety
Facilitators and barriers		
Facilitators		Professional attitude
		Willingness to advance
		Advanced training
		Decision-making protocols
		Team support
		Feeling part of the team
		Recognition of the role by the team
		Training stays
		Networks
Barriers	Organizational	Mismatched working hours
		Organization of workday
		Care overload
		Lack of workspaces
		Administrative tasks
		No job description
	Institutional	Lack of training support
		Lack of research support
		Lack of recognition
		Ignorance of the role
		Lack of professional development
		Lack of definition of the service portfolio
		Poor visibility of APNs
		Medicalized system
		Difficulty in evaluating outcomes
	Regulatory	Confusion about functions
		No delimitation of competencies
		Unclear role
		Lack of certification system
		Lack of a training system
		Lack of a legal framework
		No regulated training
		Training difficulties
Lived experience of the role		
Positive feelings		Empowerment
		Self-assuredness and confidence
		Satisfaction
Negative feelings		Fatigue with having to prove oneself
		Impotence
		Frustration
		Dissatisfaction
		Stress
		Hopelessness
		Demoralization

participant ID20, '*we collaborate in research studies, manage samples, and keep records*'.

Contributions of the APN role

The APNs stated that they facilitated the accessibility and continuity of care for patients through telephone support and early detection of complications, thus preventing patients from going to emergency services: '*In some way we improve the process, the care, right? Continuous care, preventing the patient from having to go to the emergency room, right?*' (ID03); '*We have the ability to detect many complications early*' (ID13). In the same way, they provide more effective and efficient care, avoiding duplication of visits, managing resource use and facilitating teamwork, with a positive cost benefit. They also contributed to the safety of the patient's cancer care process: '*APNs also bring together all the resources so that the patient can carry out a well-coordinated therapeutic plan*' (ID02); '*We are the link … the management of resources, … it's a cost-benefit, right?*' (ID04); '*You end up facilitating the work of the multidisciplinary team, if you manage a patient well … on the other hand, you share the work between different professionals*' (ID19).

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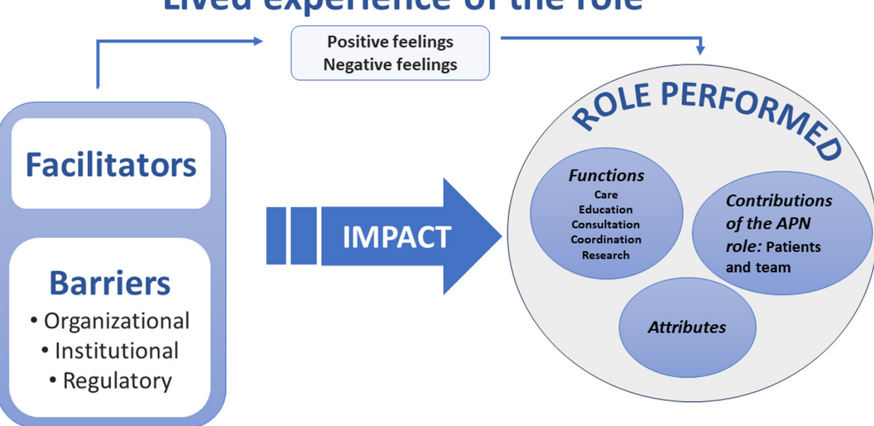
FIGURE 1 Relationship between emerging categories.



5.2.2 | Facilitators and barriers in the performance of the APN role

The second theme revolved around the factors that helped or hindered the performance of the role. The barriers are in turn divided into organizational, institutional and regulatory barriers.

Facilitators

As positive elements, the APNs described their professional attitude, their willingness to advance their profession, advanced training, protocols for decision-making, team support and feeling integrated and recognized: '*Our attitude, we're proactive…this desire to want to learn … to move forward*' (ID20); '*This desire to want to know, when faced with a new treatment, how to manage its side effects, it's an attitude that you either have or don't have*' (ID01); '*Deciding if the patient is a candidate for the administration of a treatment for toxicity … well, I feel comfortable, I am trained and there is a protocol…*' (ID18); '*Having the support and recognition of the team matters a lot and helps me*' (ID12); '*When your colleagues recognize this expert knowledge as an APN, you have your role and they will respect whatever you decide*' (ID16). They also believed it would make it easier for them to advance as APNs if they could carry out training stays in other centers and establish an APN network to share knowledge, experiences and training: '*I think that being able to go to other centers or exchange knowledge outside our institutions would enrich us professionally as APNs*' (ID11).

Barriers

The second category under this theme was barriers. Barriers mentioned by the participants included organizational, institutional and regulatory barriers.

Organizational barriers

One barrier at the organizational level was different working hours from the rest of the team, which made it difficult to attend the clinical sessions held outside their working hours: '*the scheduling difference with the team; the medical sessions, they are outside our schedule, but within theirs… and yes, I stay for the sessions*' (ID03). In addition, the organization of the working day, dedicated mainly to clinical care, does not allow them to carry out training or research during working hours: '*If you want to do research, you do it after hours because patient care swallows everything*' (ID11); '*You train a lot outside of your working hours*' ID04. At the same time, they describe a situation of care overload: '*We respond at the expense of our free time, right? Because I believe that we don't give 100%, we give more, I believe that the care burden is too much, there are many patients to visit in one day*' (ID03). They also explained that they did not have the right physical workspaces to visit patients and had to perform administrative tasks in inadequate settings: '*Having bureaucratic work or having to find space for consultations … the other day I ended up explaining a treatment in the waiting room*' (ID04); Finally, they believed their jobs and functions were not well defined: '*Well, it is a struggle … you have to negotiate … defend your skills, and you gradually build a culture*' (ID16).

Institutional barriers

The institutional barriers that informants identified respond to the lack of support from institutions in training and research: '*It's difficult for hospitals to train APNs in a specialized way*' (ID21); '*For research, there is a lack of dedicated time and support, at a methodological and financial level*' (ID20). They also described the lack of recognition for the role and functions they performed: '*There is a lack of professional recognition, and we are not recognized economically for our responsibility*' (ID03); '*They don't cover us for vacations, so we have double responsibility … the patient is left unattended and the work accumulates*' (ID14).

The participants also perceived a lack of knowledge about their role as APNs by professionals who were not part of the teams, including nurses: '*There is a lack of knowledge; management does not fully understand our functions, nor do other professionals or even nurses*' (ID10). Moreover, there was an unclear definition of the service portfolio and a lack of professional development: '*You come to a multidisciplinary team and nobody tells you what your functions are … and it depends on you and the team. The hospital management must define the functions of an APN*' (ID14).

Finally, the participants commented that there was little visibility for their role because the system is highly medicalized, and it is difficult to assess outcomes: '*The system is so anchored in the doctor that*

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they are even unaware that nurses make diagnoses' (ID10); '*We should demonstrate what we do, the value that the APNs provide, with satisfaction studies and clinical and economic outcomes*' (ID16). In relation to evaluating the activities carried out, the APNs reported difficulties, such as the lack of tools or defined indicators at the institutional level: '*In the records, sometimes we cannot reflect everything we do, and quantify, [for example], when I put down active listening or emotional support*' (ID01); '*It's difficult to identify all the activities, the steps taken, the patients who have not gone to the emergency room, extracting the data …*' (ID18); '*To assess the quality of care, we have few indicators, and the institutions should also define them*' (D20).

Regulatory barriers

Finally, some barriers were related to the lack of regulation of advanced practice. The APNs felt there was confusion about some functions, like nurse prescriptions, and about the delimitation of competencies, both in the role performed and the role that should be performed: '*I don't see the boundaries of our role, there is no defined limit, and this allows us to make very medical decisions, right?*' (ID02); '*Sometimes I have had to place boundaries on what my competencies are … I don't want to assume competencies that are not mine*' (ID03); '*One of the skills that I do not see us doing is the management of medication in terms of confirming a chemotherapy treatment*' (ID04). Expressing the need to have a certification, a training system, and a legal framework, one participant said, '*It's necessary to have accreditation, that I am qualified, and that's your legal umbrella*' (ID11). At the training level, the nurses reported difficulties in getting adequate training resources for their needs and that meant they had to participate in medical training: '*Sometimes we have to update ourselves in a self-taught way… to be able to carry out good management of toxicity…*' (ID17); '*I need to have more clinical knowledge, and sometimes I have tried to sign up for medical training, and as a nurse I can't always access it … my group does not offer the right level of training either*' (ID02).

5.2.3 | Lived experience of the APN role

Lastly, the focus groups discussed the lived experiences of the APNs when performing their duties, describing both positive and negative feelings. On the one hand, they felt empowered, self-assured and confident, as well as satisfied in their role and the care provided: '*Confidence in yourself, self-assuredness, knowing what you are doing and being able to respond to it*' (ID04); '*Before, people used to take over my consultation, now, I'm very sorry, I can't stand it… I mean… I think that the years give you expertise, right?*' (ID10) '*It is a self-satisfaction, that is, when I can do things well*' (ID01).

As for the negative feelings, informants spoke about the fatigue of having to constantly demonstrate their capacity, and the impotence and frustration arising from not being able to carry out all their functions: '*I am tired of demonstrating what I do as a nurse, of earning my space*' (ID09); '*It's a bit frustrating, we do research in our free time and without support*' (ID09). They also expressed feelings of dissatisfaction and stress from not being able to provide adequate care due to lack of time or care overload, feelings of hopelessness and a certain demoralization due to the lack of recognition: '*The number of patients, I am overwhelmed, so you have to leave something out, and badly, the patient needs it… but you can't do everything*' (ID02); '*Having to fight to have an office for visits is quite demoralizing, I think they don't value my work… so what am I doing?*' (ID18).

6 | DISCUSSION

The results emerging from our study of the perspective of APNs in the implementation and performance of their role in cancer care show a general consensus about the attributes of their role, typical of advanced practice, expert, problem-solving nurses, with specific and advanced expert knowledge, as well as the ability to make complex decisions and assume a high level of responsibility. These characteristics are similar to those of advanced practice nurses in other areas, as shown in several studies (Cook et al., 2021; Kobleder et al., 2017; van Kraaij et al., 2020) and also with those outlined by the International Council of Nurses (ICN, 2020). Our findings are an important contribution because they make it possible to understand how the APN role is developing in a context in which advanced practice is not regulated.

A key aspect of the development of the advance practice nurse role is the capacity for clinical and professional leadership, according to the review by Wong et al. (2013). Leadership is linked to the quality of care and outcomes for patients, professionals and organizations, according to Lamb et al. (2018). In our study, APNs linked aspects such as professional experience and clinical expert knowledge to their leadership capacity (see also van Kraaij et al., 2020). In our findings, several attributes and aptitudes stand out in the development of leadership. In particular advanced clinical knowledge emerged as an important factor that helped APNs take on more responsibility. Expertise was also linked to autonomous decision-making and how they performed both clinical and professional leadership.

In the development of their role, an important factor to emerge from our study is the position of APNs within teams: the ways in which APNs have had to defend the role of advanced practice, demonstrate their capacity and earn the trust of the professionals that form part of the multidisciplinary team, gaining recognition within their teams and autonomy in complex decision-making. These aspects have been key in the development of the APN role and the capacity to lead, in line with other studies (Ryder et al., 2019; van Kraaij et al., 2020). Our findings reinforce the notion that adequate leadership is crucial to the development of the APN role.

In performing the advanced practice role, key activities that our participants reported included direct clinical practice, consulting, coordination of the care process, interprofessional collaboration, research and education (Kerr et al., 2021; Schneider et al., 2021; Westman et al., 2019). The perception of participants in performing as APNs is congruent with that identified in other studies such as the review by Jokiniemi et al. (2012) and with the roles of advanced practice nursing that are defined by ICN (2020), which is also in line

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with the roles recognized for cancer APNs in other countries (Cook et al., 2021; Kerr et al., 2021; Westman et al., 2019). Our findings stand out in that they reveal that APNs saw themselves as reference figures both for patients and professionals. In terms of patients, the participants viewed themselves as essential in supporting the therapeutic relationship through trust building, often becoming a guide for patients throughout the care process. With respect to other professionals, the participants saw themselves as people who coordinate the care process and the needs of the patient, responding to complex situations, and who are recognized within care teams for their leadership and their importance for patients.

In addition, participants considered that APNs increased the quality and efficiency of care, facilitating its accessibility and continuity, averting the need for emergency services and promptly detecting complications, a finding that is congruent with other studies that reveal the contribution of the APN role in caring for cancer patients in multidisciplinary teams elements (Alessy et al., 2021; Alotaibi & Al Anizi, 2020; Schneider et al., 2021; Stewart et al., 2021).

We identified elements that facilitated the implementation and development of advanced practice roles, such as the attitude of APNs, as well as intrinsic professional factors, such as the willingness and desire to advance professionally (see Fealy et al., 2018). Our participants also considered essential the availability of decision-making protocols and the advanced clinical training of APNs, in line with findings by Fealy et al. (2018) and van Kraaij et al. (2020). Additionally, they pointed to the recognition of the APN role and support from the interdisciplinary team, the integration of APNs into teams and the relationships established with other professionals, also coinciding with other studies (Fealy et al., 2018; Rivera et al., 2023; Schirle et al., 2020). In contrast to our findings, some studies identify resistance and negative interactions with doctors, as well as an overlap in functions or little support from other professionals (Casey et al., 2019; Jean et al., 2019; van Kraaij et al., 2020).

Finally, being in contact with other nurses and establishing a network for sharing knowledge and experiences were facilitating factors, as also seen in studies by Casey et al. (2019), Rivera et al. (2023) and Wood et al. (2021).

The APNs were aware that advanced practice roles were not being developed to their full potential and that the performance of APN competencies could differ between or even within hospitals, for example in relation to prescribing. This finding is consistent with the literature, which shows that contextual factors influence the development and implementation of advanced practice. For example, studies such as those by Jean et al. (2019), Fealy et al. (2018) and Rivera et al. (2023) have identified barriers to the implementation and development of advanced practice roles.

Nevertheless, we must consider at the institutional and managerial levels how awareness is raised during the implementation and development of these APA roles, given that organizational problems such as heavy workloads, scheduling difficulties and ignorance of the APN role among professionals and administrators, in addition to lack of support, have been identified as barriers (Casey et al., 2019; van Kraaij et al., 2020). These factors make it more difficult for APNs to dedicate time to research, training and the development of the specific functions of the APN role. In line with Casey et al. (2019) and van Kraaij et al. (2020), our participants found these difficulties to have a negative impact on the development of the role, on the leadership capacity of APNs, on the optimization of APNs as a resource, on the evaluation of the outcomes of APN practice and, finally, on the quality of care.

The lack of definition of the APN role as well as the lack of clarity in job descriptions was identified as a barrier in how the APN role materialized, provoking confusion and difficulty in the recognition of the role and the functions of the APN among other health professionals and even among APNs themselves. The development of the APN role is conditioned by the surroundings, the team and APNs themselves, as reported in the revision by Fealy et al. (2018) and the study by Wood et al. (2021). The lack of definition and ambiguity in the APN role has been addressed in other studies (Casey et al., 2019; Woo et al., 2019). In our study, participants described the need to defend the role that they perform and its functions, while avoiding medical roles.

Difficulties were also reported in assessing APN activities and quantifying their contribution to patient care; these difficulties are related to the lack of clear evaluation systems by the institutions and the lack of nursing research, which are essential for evaluating the impact of these professional roles and in the recognition of the contribution of the APN to health care.

In our study, participants identified as a barrier the lack of access to wide-ranging training, which could limit their ability to perform the APN role, develop themselves professionally as APNs and acquire essential skills such as leadership, aspects also reported in Fealy et al. (2018) and van Kraaij et al. (2020).

On the other hand, our participants reported that institutional and legal restrictions can negatively affect the level of autonomy of advanced practice, as also seen in the literature (Fealy et al., 2018; Schirle et al., 2020; van Kraaij et al., 2020; Woo et al., 2019). We concur with our participants that a framework defining the scope of APN practice is essential, since nurses should not feel exposed to risk when they assume more responsibilities than a general nurse, in line with Geese et al. (2022) and Steinke et al. (2018). Therefore, at a regulatory level, as other authors have argued (Casey et al., 2019; Fealy et al., 2018), it is necessary to have a legal framework and a competencies framework, including an accredited training program and degree, which would constitute a legal umbrella for carrying out the role, determine the necessary training and make it possible to acquire recognized credentials.

Finally, the APNs' lived experience when performing their role had a positive side, in that the participants stated that they felt satisfied with the care provided to the patients and confident in themselves—positive factors related to job satisfaction (Bourdeanu et al., 2020; Geese et al., 2022; Steinke et al., 2018). In contrast, the lack of formal recognition, the absence of a competency framework, the inability to develop competencies specific to the role and the perceived need to have to demonstrate their capacity and defend the role generated negative feelings, such as frustration, fatigue,

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dissatisfaction and stress. These aspects are related to professional dissatisfaction, as shown in other studies (Geese et al., 2022; Steinke et al., 2018; Woo et al., 2019) and could have an impact on nurse retention and motivation and the quality of care. These findings suggest that administrators should keep in mind barriers that lead to unfavourable practice environments as well as consider how to establish strategies that facilitate the development of the APN role.

6.1 | Strengths and limitations

One possible limitation is that our sample was small and may have been subject to self-selection bias. We offset this risk by covering all 12 professional profiles proceeding with recruitment and data collection until data saturation occurred (no further relevant new information emerged).

The dynamics inherent to the virtual format of the focus groups could have led to a loss of spontaneity, as well as difficulties on the part of the moderator to manage the group (Stewart et al., 2007). Nonetheless, we managed to create an atmosphere of trust that favoured the participation of professionals, and the moderator's role allowed the participants the opportunity to express their opinion and experience in relation to the phenomenon.

Most of the professionals had extensive experience as APNs, in teams where this role was well established. A significant proportion of the participants had a career as an APN that stretched from the initial stages of role implementation to its consolidation. At the same time, difficulties were apparent in terms of the definition of the role, competencies, job description, training and legal status, so the development of the role is likely uneven. While the barriers and facilitators reported by the participants in the implementation of these roles are similar, we do not know how the context influenced this development.

6.2 | Recommendations for further research

Further progress in the study of advanced practice is crucial, including on contextual factors and training needs of APNs in the oncology field.

6.3 | Implications for policy and practice

Institutions must become aware of the development of the role of the APN and the value it brings to cancer care in order to facilitate and support its development and clarify the job description. Decision-makers must also understand the possible consequences of this lack of support from managers on the motivation of professionals, human resource retention, professional satisfaction and the quality of care provided. Finally, at the policy level, professional colleges and nurse associations must work to establish regulatory mechanisms to ensure training and define the legal and regulatory framework that supports the development of advanced practice.

7 | CONCLUSION AND RELEVANCE TO CLINICAL PRACTICE

This study sheds light on the experience of APNs involved in cancer care, as well as the facilitators and barriers in the implementation of the role. APNs are aware that they do not develop the role to its full extent, but they present a positive attitude despite the barriers encountered. This attitude, professional commitment and their professional and clinical leadership have allowed them to position themselves in the role of advanced practice nurses in unfavourable environments, so the ability to exercise leadership emerges as a crucial component of the role.

AUTHOR CONTRIBUTIONS

M. Antònia Serra-Barril, Llúcia Benito-Aracil, Cristina Sanchez-Lopez, Paz Fernandez-Ortega: made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; Marta Romero-Garcia, M. Antonia Martinez-Momblan, M. Antònia Serra-Barril: involved in drafting the manuscript or revising it critically for important intellectual content; Tàrsila Ferro-Garcia, M. Antonia Martinez-Momblan, Marta Romero-Garcia—given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; Tàrsila Ferro-Garcia, Paz Fernandez-Ortega—agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

PEER REVIEW

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DATA AVAILABILITY STATEMENT

Data available on request from the authors.The data that support the findings of this study are available from the corresponding author upon reasonable request.

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