AN EDUCATIONAL FRAMEWORK FOR DOCTORALLY PREPARED
FAMILY NURSE PRACTITIONERS

by

Leila Kissick

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A DNP Project Submitted to the Faculty of the

COLLEGE OF NURSING

In Partial Fulfillment of the Requirements
For the Degree of

DOCTOR OF NURSING PRACTICE

In the Graduate College

THE UNIVERSITY OF ARIZONA

2015
THE UNIVERSITY OF ARIZONA
GRADUATE COLLEGE

As members of the DNP Project Committee, we certify that we have read the DNP Project prepared by Leila Kissick entitled “An Educational Framework for Doctorally Prepared Family Nurse Practitioners” and recommend that it be accepted as fulfilling the DNP Project requirement for the Degree of Doctor of Nursing Practice.

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Final approval and acceptance of this DNP Project is contingent upon the candidate’s submission of the final copies of the DNP Project to the Graduate College.

I hereby certify that I have read this DNP Project prepared under my direction and recommend that it be accepted as fulfilling the DNP Project requirement.

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STATEMENT BY AUTHOR

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SIGNED:  Leila Kissick ____________________
ACKNOWLEDGMENTS

I would like to acknowledge the efforts of my committee members, Dr. Terry Badger, Dr. Janice Crist, and Dr. Audrey Russell-Kibble in their determination to help me finish this DNP Project. Without their hard work in helping with the completion of this project the Kissick Framework would never have come to fruition.
DEDICATION

This DNP Project is dedicated to my husband Todd, daughter Tessa, and son Ian for their unwavering support and understanding while I trudged through this.

This is also dedicated to my sister Melanie for her shoulder to cry on and her ability to commiserate. Her words of encouragement helped me as I worked through this project.

Finally, to my father, Marshall, Dad I did it.
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ABSTRACT

The purpose of this Doctor of Nursing Practice (DNP) Project was to establish preliminary evidence for validity of the Kissick Framework for DNP education and practice of Family Nurse Practitioners (FNPs). The history of the education of nurse practitioners (NPs) was explored to determine which frameworks should be considered in planning future curricula. The current need for more primary care practitioners due to the Affordable Care Act and the response in nursing to increase the number of primary care providers is discussed.

The role of the NP has expanded and in 2004 the American Association of Colleges of Nursing (AACN) endorsed the DNP as the terminal practice degree to replace the Masters’ of Science in Nursing (MSN) requirement for NPs. Frameworks for education and practice of doctorally prepared FNPs were examined and compared to the Kissick Framework.

The Kissick Framework integrates the Essentials of Doctoral Education for Advanced Nursing Practice recommended by the AACN, the National Organization of Nurse Practitioner Faculties (NONPF) Core Competencies, and Ida J. Orlando’s Theory of the Nurse-Patient Relationship. Preliminary evidence supports consideration of the Kissick Framework for the education of doctorally prepared FNPs and as a guide for practice.
CHAPTER I: HISTORY OF NURSE PRACTITIONER EDUCATION

The purpose of this Doctor of Nursing Practice (DNP) Project was to establish preliminary evidence for validity of the Kissick framework for DNP education and practice. In Chapter I the history of nurse practitioner (NP) education and practice are discussed. The history of the education of NPs was explored to consider frameworks to include in future curricula. The current need for more NPs due to the Affordable Care Act and the response in nursing to increase the number of primary care providers is presented. Frameworks for practice are examined and finally the Kissick Framework is compared to these frameworks.

History of Nurse Practitioners

The NP role originated in the United States (U.S.) during the 1960’s to improve the quality and access to primary health care in under-served communities (Carryer, Gardner, Dunn, & Gardner, 2007). In 1965, Henry Silva, MD and Loretta Ford, a Public Health Nurse created and developed the role of the NP to increase the number of primary care providers for children living in health care provider shortage and medically underserved areas of the United States (Arcangelo, Fitzgerald, Carroll, & Plumb, 1996).

The term advanced practice nursing first appeared in nursing indexes in the 1980’s (Oberle & Allen, 2001). The advanced practice registered nurse (APRN) is distinguished from nurses who practice at the entry level with a registered nurse (RN) license (Sheer & Wong, 2008). An APRN is able to practice across multiple settings with independent decision making, perform case management, direct bedside care, supervise support personnel, while guiding and educating patients in practices that promote good health (AACN, 2000). Advanced practice refers to the highest level of nursing practice and includes nursing involvement that impacts
health care outcomes including diagnosis, treatment, and providing management of disease and wellness for a variety of populations (Diggins & Schoonover-Shoffner, 2012). In the United States those professions encompassing the realm of the APRN include nurse practitioners, clinical nurse specialists, nurse anesthetists, and nurse midwives (Sheer & Wong, 2008).

The 1990’s introduced the Masters’ of Science in Nursing degree (MSN) as the standard preparation for the NP. As the MSN became the standard in the field of practice, NPs who were not MSN prepared were “grandfathered in” with continued recognition as NPs.

In 2004, the American Association of Colleges of Nursing (AACN) endorsed the Doctorate of Nursing Practice (DNP) as the practice degree to replace the MSN degree as the terminal advanced practice degree for NPs (Sperhac & Clinton, 2008; IOM, 2001, 2003). The DNP would address the changing demands of health care and establish additional skills and competencies for NPs to utilize in practice (Sperhac & Clinton, 2008). In addition, a 2005 report by the National Research Council of the National Academies, discussed the need for nurses to be doctorally prepared in a degree similar to the MD and PharmD, but retaining the values of nursing (Sperhac & Clinton, 2008). NPs describe elements of their practice as demonstrating nursing competencies in novel and complex as well as familiar situations; being creative and innovative; knowing how to learn; having a high level of self-efficacy; and working well in teams (Gardner, Hase, Gardner, Dunn, & Carryer, 2007).

Currently DNP programs are offered in 49 states (AACN, 2015a) with 264 DNP programs in existence and 60 in the planning stage in the United States (AACN, 2015b). Practice-focused programs such as the DNP programs in comparison to PhD programs include less theory and meta-theory, an emphasis on clinical use of research rather than conducting
research, scholarly projects rather than theses, residency and clinical practice hour requirements, and scholarly practice (Bartels, 2005). The AACN recognizes the DNP as the highest level of education preparation for clinical nursing practice (AACN, 2004; Bartels, 2005).

The role of the NP, as an advanced practice nurse, has expanded and the care given has proven to be cost and clinically effective (Sheer & Wong, 2008). Resistance to the role of the NP can be attributed to the differences in status of different health care professions and the entrenched nature of those professions, their paradigms and cultures. This includes the ordered nature of the physician-nurse relationship that can impede the exchange of information between the physician and the NP (Andregard & Jangland, 2015). NPs sometimes encounter barriers to independent practice that include pressure from the medical profession to control independent nursing practice, prescribing restrictions that vary by state, and the physician’s inability to discern the RN role from that of the advanced practice nurse (Nardi & Diallo, 2014; Weiland, 2008).

Primary care NPs care for patients and their families, assisting them to remain healthy, treating illness while attending to patients’ social and emotional needs, which is key to holistic comprehensive care (Arcangelo, Fitzgerald, Carroll, & Plumb, 1996). According to Bryant and Graham (2002) there is no difference in patient satisfaction when comparing NPs and physicians. Doctoral level nursing education promotes credibility to the role of the NP in clinical practice.

The advent of statements from documents such as the Institute of Medicine’s (IOM’s) Crossing the Quality Chasm (2001) and organizations such as the AACN brought the problems of accessibility of quality health care to the forefront of our national consciousness. The Affordable Care Act has created an increase in need for expanded health care for more of the
population in the United States (Ketefian & Redman, 2015). The shortage of primary care physicians in the United States has allowed for an increase in the number of NPs providing primary care. In 2010, there were approximately 205,000 primary care physicians and 55,400 primary care NPs in the United States (HRSA, 2013). In looking at the current utilization of primary care services the projected demand for primary care physicians by the year 2020 is projected to grow more rapidly than physician supply (HRSA, 2013). Fewer U.S. medical graduates are joining primary care practices leaving a gap doctorally prepared FNPs can fill. The number of primary care physicians in 2020 is projected to be 220,800; an 8% increase that falls short of the projected need for a 14% increase (HRSA, 2013). Additionally, the primary care NP workforce is projected to grow more rapidly than physician supply with an estimated increase of 30% to 72,100 by 2020 (HRSA, 2013).

Together with population aging and growth, the demand for primary care services is expected to continue to increase (HRSA, 2013). The DNP degree and expansion of DNP programs is helping to relieve the strain of a lack of primary care providers for the influx of patients (Ketefian & Redman, 2015). Lis, Hanson, Burgermeister, and Banfield (2014) state that educational programs must prepare advanced practice nurses with appropriate knowledge, skills, and abilities to continue to evolve in an ever-changing health care environment. With an expanding population of people seeking health care, advanced practice nurses must make patient advocacy and the ability to form relationships with individuals and families a focus for practice (Lis, Hanson, Burgermeister, & Banfield, 2014). Advanced practice nurses must develop good communication skills to enhance the patient experience and help the patient express their needs (Lis, Hanson, Burgermeister, & Banfield, 2014).
NPs of today are more intensely prepared than in the past, reflecting the length and complexity of advanced practice nursing education that includes new scientific knowledge, evidence for practice, and information technology (AACN, 2015a). The DNP graduate’s training incorporates the essential competencies as well as a residency requirement and expanded curriculum to reflect evidence-based practice and chronic care management that is based upon population needs (AACN, 2015a).

The U.S. health care system is in upheaval and DNP-prepared clinicians are particularly needed now (Vincent, Johnson, Velasquez, & Rigney, 2010). The scarcity of physicians caring for the underserved and disadvantaged populations has given NPs an opportunity to aide in the reduction of these inequities (Horrocks, Anderson, & Salisbury, 2002). In addition, NPs are ready for the expanded clinical opportunities that have arisen in the primary health care field (AACN, 2015a). However, NPs have very few true nursing practice frameworks to follow in practice and often fall back on the medical model to guide their clinical practices. The medical model does not include core elements essential and unique to advanced nursing practice.

**Frameworks for Guiding Doctorally Prepared FNP Education**

Frameworks having potential to guide the education and practice of doctorally prepared FNPs were reviewed. Four prospective frameworks were reviewed to create the Kissick Framework including: (a) the Complex Adaptive Systems conceptual framework (Lis, Hanson, Burgermeister, & Banfield, 2014); (b) the Patient Care Delivery Model (O’Brien-Pallas, Meyer, Hayes, & Wang, 2010); (c) the Capability Framework (O’Connell, Gardner, & Coyer, 2014); and (d) Ida J. Orlando’s Theory of the Nurse-Patient Relationship (Orlando, 1987).
Complex Adaptive Systems Framework

The Complex Adaptive Systems Framework involves concepts of creative inquiry, leadership, and relationship care (Lis, Hanson, Burgermeister, & Banfield, 2014). The concepts are interdependent and open and all are equally important. The concepts are interconnected and interrelated. The major concepts underpinning the Complex Adaptive Systems Framework include the importance of relationships with patients, physicians, and other health care professionals. The Complex Adaptive Systems Framework discusses the power of forming relationships with patients, families, and colleagues. Patients are central to this framework with empathy being key to the relationship.

Patient Care Delivery Model

The Patient Care Delivery Model (PCDM) (O’Brien-Pallas, Meyer, Hayes, & Wang, 2010) is a model that clarifies the dynamic multilevel relationship between inpatient hospital nursing units and other organizational structures. There are inputs to the relationship including the patient, nurse, system characteristics, and system behaviors. There are outputs from the relationship that include the patient, nurse, and system outcomes.

Capability Framework

In the Capability Framework (O’Connell, Gardner, & Coye, 2014) competency standards for clinical practice are proposed. The Capability Framework reviewed advanced care capabilities that recognize the complexity of clinical practice at the advanced nursing practice level. The capabilities are matched to conceptual themes including: modes of practice, sorting, troubleshooting, translation, resolution, and collaboration.
Ida J. Orlando’s Theory of the Nurse-Patient Relationship

The Ida J. Orlando Theory of the Nurse-Patient Relationship (Orlando, 1987) (Table 1) outlines interactions between the nurse and the patient. In Orlando’s Theory nursing process is defined as the needs of the patient with the response of the nurse and nursing actions being interrelated.

TABLE 1. Ida J. Orlando’s Theory of the Nurse-Patient Relationship.

<table>
<thead>
<tr>
<th>Interactions Between Nurse and Patient</th>
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</thead>
<tbody>
<tr>
<td>The discourse between the nurse and patient that occurs when the patient seeks treatment.</td>
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<table>
<thead>
<tr>
<th>Needs of the Patient</th>
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<tr>
<td>The needs of the patient for treatment with health care concerns.</td>
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<table>
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<tr>
<th>Nursing Actions</th>
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<tr>
<td>The actions of nurse in response to the patient’s health care concerns.</td>
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</table>

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<tr>
<th>All Aspects are Interrelated</th>
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<tbody>
<tr>
<td>The interactions, needs of the patient, and nursing actions are all interrelated and one of these does not stand alone.</td>
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</table>

<table>
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<tr>
<th>Interactions are Unique, Complex, Dynamic</th>
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<tbody>
<tr>
<td>The nurse-patient interactions are described as unique, complex, and dynamic.</td>
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<tr>
<th>Nursing Practice is Independent</th>
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<tr>
<td>The nurse is responsible for decisions and actions related to the patient interaction and the decisions made are independent based on knowledge and experience.</td>
</tr>
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<table>
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<tr>
<th>Accuracy of Perception, Thoughts, and Feelings of Interaction</th>
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<tbody>
<tr>
<td>The nurse in the interaction with the patient reviews the interaction mentally and determines if the perceptions, thoughts, and feelings of the interaction are accurate.</td>
</tr>
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</table>

Kissick Framework

The operational definitions of the medical model and the nursing model are key to understanding the difference between the two practices and ultimately the importance of a nursing model to impact doctoral level FNP education and practice. The medical model is defined as focusing on defect or dysfunction in relation to the patient with a problem solving approach while using medical histories, diagnostic tests, and physical examinations to support its practice (Medical Dictionary, 2015). The focus of the medical model is on physical and biologic
aspects of conditions and specific diseases (Medical Dictionary, 2015). Iton (2008) defines the medical model as discrepancies in rates of death and disease within groups explained by differences in clinical risk factors and behaviors, to include health care seeking behaviors.

Frameworks for nursing practice focus on health promotion, restoration, and maintenance across the lifespan (Diggins & Schoonover-Shoffner, 2012). The frameworks for advanced nursing practice outlined in this chapter include neither the Essentials of Doctoral Education for Advanced Nursing Practice (DNP Essentials) (AACN, 2006) nor the National Organization of Nurse Practitioner Faculties (NONPF) Core Competencies (Thomas et al., 2012). Underpinning this DNP Project and a nursing framework for education of doctorally prepared FNPs is the inclusion of the DNP Essentials (AACN, 2006): (a) scientific underpinnings for practice; (b) organizational and systems leadership for quality improvement and systems thinking; (c) clinical scholarship and analytical methods for evidence-based practice; (d) information/systems technology and patient care technology for the improvement and transformation of health care; (e) health care policy for advocacy in health care; (f) interprofessional collaboration for improving patient and population health outcomes; (g) clinical prevention and population health for improving the nation’s health; and (h) advanced nursing practice (Table 2). In addition, the NONPF Core Competencies in (a) scientific foundation, (b) leadership, (c) quality, (d) practice inquiry, (e) technology and information literacy, (f) policy, (g) health delivery systems, (g) ethics, and (h) independent practice are essential to guide a nursing framework for the education and practice of doctorally prepared FNPs (Thomas et al., 2012) (Table 3). Omission of the DNP Essentials and the NONPF Core Competencies from known nursing frameworks for advanced
practice nursing was identified during the search for a framework for education of the doctorally prepared FNP, leading to development of the Kissick Framework.

TABLE 2. The Essentials of Doctoral Education for Advanced Nursing Practice.

<table>
<thead>
<tr>
<th>Scientific Underpinnings for Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principles and laws that govern the life-process, well-being, and optimal function of human beings sick and well using nursing actions or processes by which positive changes in health status are affected.</td>
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</table>

<table>
<thead>
<tr>
<th>Organizational and Systems Leadership for Quality Improvement and Systems Thinking</th>
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<tbody>
<tr>
<td>Develop and evaluate care delivery approaches by employing principles of business, finance, economics, and health policy.</td>
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<tr>
<th>Clinical Scholarship and Analytical Methods for Evidenced-Based Practice</th>
</tr>
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<tbody>
<tr>
<td>Use analytical methods to critically appraise existing literature and other evidence to determine and implement the best evidence for practice by applying relevant findings to develop practice guidelines and improve practice and practice environment.</td>
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</table>

<table>
<thead>
<tr>
<th>Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care</th>
</tr>
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<tbody>
<tr>
<td>Design, select, use, and evaluate programs that evaluate and monitor outcomes of care by analyzing and communicating critical elements necessary to the selection, use, and evaluation of health care information systems.</td>
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</table>

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<tr>
<th>Health Care Policy for Advocacy in Health Care</th>
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<tbody>
<tr>
<td>Critically analyze health policy proposals by developing, evaluating, and providing leadership for health care policy.</td>
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<tr>
<th>Interprofessional Collaboration for Improving Patient and Population Health Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employ effective communication and collaborative skills by leading interprofessional teams in analysis of complex practice and organizational issues.</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Clinical Prevention and Population Health for Improving the Nation’s Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analyze epidemiological, biostatistical, environmental, and other appropriate scientific data related to individual, aggregate, and population health.</td>
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</table>

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<tr>
<th>Advanced Nursing Practice</th>
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<tr>
<td>Conduct comprehensive and systematic health assessments by educating and guiding individuals and groups through complex health and situational transitions.</td>
</tr>
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</table>
TABLE 3. *National Organization of Nurse Practitioner Faculties Core Competencies.*

**Scientific Foundation**
Translates research to improve practice processes and outcomes by developing new practice approaches based on integration of research, theory, practice, and knowledge.

**Leadership**
 Assumes complex and advance leadership roles to initiate and guide change by advocating for improved access, quality, cost effective health care.

**Quality**
Uses best evidence to improve clinical practice to evaluate relationships between cost, quality, and safety and organizational structure impacts of quality of health care.

**Practice Inquiry**
Provides leadership in the translation of new knowledge into practice by generating knowledge from clinical practice for improved patient outcomes.

**Technology and Information Literacy**
Incorporates appropriate technologies for knowledge management to improve healthcare by using technology systems that capture data on variables for evaluation of nursing care.

**Policy**
Analyzes ethical, legal, and social factors influencing policy development by contributing to the development of health policy.

**Health Delivery System**
Facilitates the development of health care systems for a culturally diverse population by analyzing organizational structure, functions, and resources to improve delivery of care.

**Ethics**
Integrates ethical principles in decision making by evaluating the ethical consequences of decisions.

**Independent Practice**
Provides patient-centered care recognizing cultural diversity and the patient as a partner in decision-making.

Concepts from the Ida J. Orlando’s Theory of the Nurse-Patient Relationship (Table 1), the DNP Essentials (Table 2), and the NONPF Core Competencies (Table 3) were integrated into the Kissick Framework (Table 4). The focus of the Kissick Framework is on the patient (Figure 1).

The Essentials of Doctoral Education for Advanced Nursing Practice
NONPF Core Competencies
Ida J. Orlando’s Theory of the Nurse-Patient Relationship
Nurse’s Thoughts, Feelings, Perceptions of Patient
Connecting Perceptions with Patient Needs
Effectiveness of Interventions
Focus on Patient

FIGURE 1. Kissick Framework.
The major difference between previously discussed frameworks and the Kissick Framework is although focusing on relationships between patients and providers, and relationships between providers and other staff, there is no discussion of the training of NPs in regards to the nurse-patient relationship in the frameworks compared. The Capability Framework does discuss matching capabilities with conceptual themes, but not specific training in NP programs, as does the Kissick Framework. Of the frameworks reviewed, Ida J. Orlando’s Theory of the Nurse-Patient Relationship was the most comprehensive and fit most closely with the Kissick Framework. The Kissick Framework’s emphasis on the patient as the primary concern of the nurse makes the Kissick Framework more comprehensive for the future employment and experiences the doctorally prepared FNP student will encounter after education and training.

Pertinent educational preparation is vital for the success of the DNP degree with FNP specialty (AACN, 2015a). Some of the guiding premises for doctoral education of the FNP include the DNP Essentials, the NONPF Core Competencies, and nursing practice frameworks. Although these guiding premises are essential to doctoral education of the FNP they lack the vital component presented in the Kissick Framework where the patient is the central focus of advanced nursing practice. The Kissick Framework is proposed as a worthwhile option and adjunct to the DNP Essentials and the NONPF Core Competencies in doctoral education of the FNP.
CHAPTER II: LITERATURE REVIEW

In Chapter II a review of current literature available related to the topic of frameworks and guidelines for advanced nursing practice was reviewed and discussed. The search engines utilized for the literature review were PubMed, and CINAHL. The keywords used included: advanced nursing practice frameworks, frameworks for advanced nursing practice, guidelines for advanced nursing practice, and advanced nursing practice guidelines. The search focused on articles that mentioned frameworks for advanced practice nursing.

Articles were excluded if not presenting the frameworks in a general manner or not focused on primary care practice. Articles were also excluded from the review process if sufficient detail regarding a proposed framework or guideline was not provided. Articles were excluded that specifically discussed frameworks for clinical nurse specialists and advanced practice RN’s but not for NPs or DNPs. Many of the studies focused on infrastructure changes and not on patient or clinical settings. Of the articles outlining frameworks five were developed in New Zealand, Australia, and Canada and were not specific for the U.S. health care system. Because of the decentralized nature of the U.S. health care system, articles were excluded if they were specific to a foreign country’s health care system.

The ideal of patient-centered nursing is not new to nursing practice. What is new is the advent of advanced practice nurses assuming roles traditionally occupied by physicians. To incorporate tenets suitable to advanced nursing practice, frameworks need to be instituted that ensure the use of best practice guidelines to assure excellence in patient care (Bryant-Lukosius & DiCenso, 2004). Additionally, frameworks support reduction in role replication and help in care planning. Frameworks can help NPs warrant their practices in the primary care setting. At this
time, however, the use of clinical practice guidelines for research and evidence-based practice in
the primary care setting remains disjointed and erratic (Ploeg, Davies, Edwards, Gifford, &
Miller, 2007).

Articles that detailed frameworks for advanced practice nursing and specific settings were
retained from the search. Nine frameworks having application for advanced practice nursing
were reviewed.

Theory of the Dynamic Nurse-Patient Relationship

Orlando’s Theory of the Dynamic Nurse-Patient Relationship provides a conceptual
framework for patient care as well as nursing leadership (Table 5). Orlando (1987) posited that
nursing has an obligation to make the profession distinct from medicine and other professions.
Orlando’s ideals of utilizing perceptions, feelings, and thoughts along with assumptions for
nursing actions are good examples of the processes an advanced practice nurse employs in
practice and what makes nursing practice different from that of the medical model (Laurent,
2000). Whereas the focus of the medical model is based on disease and treatment of disease,
Orlando’s Theory recognizes the nurse’s distinct attributes and enables the nurse to focus on the
patient’s needs and be competent about treatment (Potter & Tinker, 2000).

The essence of Orlando’s Theory is that patients feel a sense of helplessness in illness
and nurses can anticipate and respond through communication and effective nursing care (Parker
& Smith, 2010; Orlando, 1987). The single core concept of Orlando’s Theory is the needs of the
patient as the primary concern to the nurse. Nursing provides care for individuals based on the
individual’s experience and not the diagnosed disease process assigned to the patient (Orlando,
1987). Orlando’s Theory works as a model for the practice of nursing as well as a conceptual
framework for the care of the patient and nursing leadership (Laurent, 2000). Orlando’s Theory merges competent nursing practice and customer satisfaction. In addition, Orlando’s Theory provides a well-defined and uniform approach, is personal, direct, and can be applied to simple and intricate situations (Potter & Tinker, 2000).

There are five concepts consistent with Orlando’s Theory. The concepts include: (a) the nursing process; (b) understanding patient behavior; (c) the interaction of the nurse and the patient; (d) function of the professional nurse; and (e) recognizing patient behavior as a plea for help (Parker & Smith, 2010).


<table>
<thead>
<tr>
<th>Concept</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Nursing Process</strong></td>
<td>The nursing process includes the needs of the patient, the reaction of the nurse, and the action of the nurse.</td>
</tr>
<tr>
<td><strong>Understanding Patient Behavior</strong></td>
<td>Understanding patient behavior includes the insights, views, and feelings of the nurse and the use of direct observation of patient behavior to validate the communication of the nurse and patient.</td>
</tr>
<tr>
<td><strong>Interaction of the Nurse and Patient</strong></td>
<td>The interaction of nurse and patient includes verbal and nonverbal communication within the interaction.</td>
</tr>
<tr>
<td><strong>Function of the Professional Nurse</strong></td>
<td>The function of the professional nurse is to find out the needs of the patient, meet the needs of the patient, and improve the immediate verbal and nonverbal patient behavior.</td>
</tr>
<tr>
<td><strong>Patient Behavior as Plea for Help</strong></td>
<td>The patient behavior as a plea for help describes those behaviors that the nurse needs to identify to have a successful interaction and ultimately help the patient.</td>
</tr>
</tbody>
</table>

The nursing process is comprised of the needs of the patient, the reaction of the nurse, and the action of the nurse (Parker & Smith, 2010). Schmieding (1990) lists major concepts of Orlando’s theory that include professional nursing’s function to: (a) discover the needs of the patient; (b) meet the needs of the patient; and (c) improve immediate verbal and nonverbal
patient behavior. The nurse is asked to recognize patient behavior that may be a plea for help. Understanding patient behavior includes the insights, views, and feelings of the nurse. The use of direct observation of patient behavior validates communication between the patient and the nurse. These interactions are a unique, multifaceted, and active process.

The application of theory to nursing practice has been recognized for many years (Laurent, 2000). Orlando’s theoretical body of knowledge was based on the observations of thousands of nurse-patient interactions that formulated a description of the characteristics of the nurse-patient relationship (Orlando, 1987). There is little evidence that Orlando’s Theory has been used directly in nursing practice, although nurses unconsciously use Orlando’s process in practice (Parker & Smith, 2010). Application of Orlando’s Theory to advanced nursing practice gives the profession a focus uniquely theirs and separates advanced nursing practice from the medical realm. Orlando’s Theory is a distinct, dependable approach to care that is useful in uncomplicated or complex situations, and engages the nurse with the patient and the patient with the nurse (Potter & Tinker, 2000).

**Know/Do/Be Framework**

Ford, Rolfe, and Kirkpatrick (2011) outlined the Know/Do/Be Framework. The Know/Do/Be framework utilizes concepts of broad understanding (Know), skills (Do), and states of being (Be) and was used as a tool for determining if evidenced-based practice and client-centered care were being utilized. The Know/Do/Be framework was utilized in a Canadian teaching hospital and focused on evidenced-based practice and client-centered care. The main objective of the Know/Do/Be framework was based on nurse’s individual narratives about practice and caring. The core of the Know/Do/Be framework is to help the NP have a greater
understanding of themselves and their practice. Issues encountered in review of the Know/Do/Be framework were noted as the framework itself being conceptually abstract and mainly conceptual toward patient-centered care. In summary, the final review concludes that more is needed than just a good attitude to ensure evidence-based practice.

**Patient Care Delivery Model**

The Patient Care Delivery Model (PCDM) (O’Brien-Pallas, Meyer, Hayes, & Wang, 2010) was applied in large-scale acute care facilities such as hospitals and nursing homes. The basic principles of the PCDM take into consideration the work environment and its impact upon clinical outcomes utilizing a systems perspective. The PCDM was not used in primary care settings where many FNPs practice.

**Person-Centered Nursing Framework**

The Person-Centered Nursing Framework (PCNF) is a combination of frameworks developed by McCormack and McCance (2006). The PCNF is based on four core ideals: (a) prerequisites-attributes of a nurse; (b) core environment-context of care; (c) person-centered processes-delivery of care; and (d) expected outcomes-results of nursing. The PCNF framework indicates that NPs would benefit from lifelong learning to help them convey their values, demonstrate knowledge, and feel free to take risks. The PCNF framework outlines a systematic approach to practice development that incorporates research, education, and policy development. The PCNF was undertaken in the acute care setting.
Participatory, Evidence-based, Patient-focused Process for Guiding the Development, Implementation, and Evaluation of Advanced Practice Nursing

The Participatory, Evidence-based, Patient-focused Process for Guiding the Development, Implementation, and Evaluation of Advanced Practice Nursing (PEPPA) framework was reviewed by Bryant-Lukosius and DiCenso (2004), as well as McNamara, Giguere, St-Louis, and Boileau, (2009). The PEPPA framework was adapted from two existing frameworks, and further developed by the Canadian Nurse Practitioner Initiative and launched in 2004. In 2003, the Canadian Nurses’ Act specifically allowed trained nurses to perform medical procedures typically performed by physicians (McNamara, Giguere, St-Louis, & Boileau, 2009). The PEPPA framework articulates coordinated care and collaborative partnerships within the health care realm (Bryant-Lukosius, & DiCenso, 2004).

The PEPPA framework is comprised of nine steps: (a) defining the patient population and describing the current model of care; (b) identifying stakeholders and recruiting participants; (c) determining the need for a new model of care; (d) identifying the priority of problems and goals; (e) defining the new model of care and advanced practice nurse role; (f) planning implementation strategies; (g) initiating the advanced nursing practice role implementation plan; (h) evaluation of the advanced practice nursing role and new model of care; and (i) long term monitoring of the advanced nursing practice role and model of care (Bryant-Lukosius, & DiCenso, 2004; McNamara, Giguere, St-Louis, & Boileau, 2009). Although the PEPPA framework includes elements of defining the role and population to be served, it does not specify the patient as the major focus. The PEPPA framework places an emphasis on the practitioner as opposed to the
patient and because of that lack of focus on the patient the PEPPA framework is not a viable option for use to underpin a framework for doctoral FNP education and practice.

**Five Drivers of Advanced Practice Nursing**

De Geest, Moons, Callens, Gut, Lindpaintner, and Spirig (2008) detail a framework consisting of five drivers of advanced practice nursing. The five drivers are outlined as: (a) population health and health care needs; (b) education of Advanced Practice Nurses; (c) workforce needs; (d) new models of care and patterns of practice; and (e) the context of policy and legal issues for advanced nursing practice. The five drivers of advanced practice nursing framework answers concerns regarding the type of patients to be served, their needs, the ability of the health care system to provide services, and the competency of advanced practice nurses to provide adequate care. The five drivers of advanced practice nursing framework is not adequate as a framework because its focus is not on the patient, as in the Kissick Framework, but on different aspects of advance practice nursing care and topics that concern the advanced practice nurse such as workforce needs, legal issues, and models of care. Each of these is important in the context of the advanced practice nurse, but not as important as recognizing the patient as the focus for the doctorally prepared FNP as outlined in the Kissick Framework.

**Integrative Nursing Theoretical Framework**

Schmieding (1990) details an integrative nursing theoretical framework combining the writings of nursing theorists, Ida J. Orlando and Virginia Henderson. The integrative nursing theoretical framework details Orlando’s contribution to nursing theory centering on the assertion that patients need the nurse to interpret their unspoken distress. It is up to the nurse to work with the patient to ascertain what patient behaviors mean, to work with the patient to help with what is
needed, and to determine if the help given was successful in the treatment of the patient’s problem. Henderson asserts that patients need help with activities until the patient can become independent to perform the tasks themselves. The nurse’s actions should assist with the goal of independence. The integrative nursing theoretical framework states that the nurse should determine the immediate needs of the patient. In addition, interpreting the verbal and nonverbal clues from the patient is necessary for the patient to receive help from the nurse. The main goal is to help the patient with independence through treatment from the nurse.

The integrative nursing theoretical framework comes close to the focus of the Kissick Framework in relation to patient focus but falls short as an acceptable framework for inclusion because it lacks the essential elements of the NONPF Core Competencies and the DNP Essentials. The NONPF Core Competencies and the DNP Essentials, working in concert with Orlando’s Theory of the Nurse-Patient Relationship, offer a focus for the doctorally prepared FNP to provide the most comprehensive experience to the patient as outlined in the Kissick Framework.

**Synergy Model**

Scarpa and Connelly (2011) explored a method for evaluation of advanced practice nurses that utilizes a criterion-based performance measure based in nursing theory. The use of the performance measure to evaluate advanced practice nurses underpins the foundation of the Synergy Model. The Synergy Model discusses relationships between the performance level of the nurse and the needs and details of patients. The connection of the characteristics of the Synergy Nursing Model, the role of the advanced practice nurse, and the level of performance of the nurse are explored. In addition to the Synergy Nursing Model, Benner’s progressive levels of
nursing practice performance are utilized in the model (Benner, 1984). The Synergy Nursing Model is not appropriate as a framework to contribute to the practice of the doctorally prepared FNP because it is used as a tool for evaluation of the advanced practice nurse. However, the Synergy Nursing Model could be utilized as a framework for the further education of NPs seeking doctoral level education.

In summary, the Kissick Framework is more comprehensive than any of the aforementioned frameworks. The Kissick Framework can be utilized as a tool for the education of the doctorally prepared FNP student and as a template for practice. The use of frameworks or guidelines in the practice of doctorally prepared FNPs is one that needs further exploration to guide the expanding field of advanced nursing practice.
CHAPTER III: METHODS

Introduction

In Chapter III methods used in developing or refining a nursing theory or framework are discussed. A review of literature was accomplished to explore DNP preparation and how this knowledge is utilized by the FNP in practice. Results of a brief survey to test for preliminary validity of the Kissick Framework are presented.

Study Design

The study design used a survey to obtain preliminary evidence for the Kissick Framework: a derived framework. Theory derivation occurs when integrated or interrelated concepts are moved from one theory to another and transformed to adapt to new thought (Walker & Avant, 2005). Concepts can be taken from either a similar field of research or a dissimilar field of research. Integrated or interrelated concepts can be used by the researcher by modifying and accepting the structure of the concepts adding to the body of knowledge that contributes to a rapid increase to the body of knowledge for the researcher (Walker & Avant, 2005).

First, a comprehensive literature search was conducted to determine if there were suitable theories available. No appropriate or useful theories were found, that included all elements of the DNP Essentials and the NONPF Core Competencies, therefore the process of theory derivation advanced (Walker & Avant, 2005). The central focus of the Kissick Framework is the patient along with inclusion of the DNP Essentials and NONPF Core Competencies for doctorally prepared FNP education and practice.

Selecting a theory as the primary theory to be used in the derivation was necessary (Walker & Avant, 2005). The primary nursing theory used for the Kissick Framework was Ida J.
Orlando’s Theory of the Nurse-Patient Relationship. Orlando’s Theory was utilized because it has the patient as a key component. The interaction of the patient and traditional nurse, not an APRN, is primary in Orlando’s theory. However, Orlando’s Theory could be adapted to include the patient-APRN interaction.

The entirety of Orlando’s Theory was utilized when the derivation was undertaken. Orlando’s theory was compatible to the Kissick Framework in that the patient is central to the essence of Orlando’s Theory as well as the Kissick Framework. All the concepts from Orlando’s Theory were accepted in the derivation and modification of the Kissick Framework.

Data Collection for the Framework Derivation/Modification

Data collection for derivation and modification of the Kissick Framework was accomplished over a number of months following initiation of the review of literature. Criteria were used to determine the inclusion or exclusion of information from the literature. Exclusionary data included hospital-based studies, studies that did not include DNP or FNP participants, too small of a sample, and studies from foreign countries where the current health care system was dissimilar from that of the United States. In addition, some studies did not cover topics of education or training or theory. Inclusionary data included information from the literature that discussed training and education, larger studies, studies that included information about either DNP or FNP practice, information about the medical model, and information about the nursing model. In addition, theory influencing nursing practice and patient care was included. Overall, finding information on the topic was difficult as there was not much information available. There are a limited number of studies regarding DNP or FNP training and influence on practice.
Results of Framework Derivation/Modification

The Kissick Framework (Figure 2) is a melding of the NONPF Core Competencies, the DNP Essentials, and the Ida J. Orlando Theory of the Nurse-Patient Relationship, with the addition of other elements vital for the NP to have a caring relationship with the patient. The elements of the Kissick Framework are interrelated with the patient as the central focus of the framework. The nurse-patient relationship and the elements that are related to that relationship are essential to the Kissick Framework. The relationship of the nurse and the patient from the beginning, during, and after the experience of the visit is central to the Kissick Framework. The Kissick Framework can be used for the education of doctorally prepared FNPs and as a model for doctorally prepared FNPs to use in clinical practice.

The concepts in the Kissick Framework shared with the DNP Essentials include scientific underpinnings for practice, leadership, and technology. The concepts in the Kissick Framework shared with the NONPF Core Competencies include scientific foundations, leadership, technology and independent practice. The concepts in the Kissick Framework shared with Orlando’s Theory of the Nurse-Patient Relationship include accuracy of perceptions, thoughts, and feelings of the interaction. The concepts unique to the Kissick Framework include: (a) the nurse perceptions, thoughts, and feelings about the patient; (b) the nurse connects perceptions with patient needs; and (c) the effectiveness of the intervention.
Validation of the Framework

At this stage of the DNP Project, a survey was used to test for preliminary validity of the Kissick Framework.
Sample

The sample was recruited from doctorally prepared faculty teaching in the DNP program at The University of Arizona, College of Nursing. A total of 15 members of the faculty responded to the survey. A final sample of nine members of the faculty meeting the inclusion criteria of holding a doctoral degree was included in the survey.

Of the nine participants, five held DNPs, three held PhDs in nursing, and one did not respond to the query specifically asking about type of doctoral preparation. Of the nine participants, the number of hours reported spent in a clinical setting caring for patients each week were 6 hours, 8 hours, 10 hours, 20 hours, and 100 hours. The 100 hours entry is possibly an error in entry, since it is a highly improbable outlier. Of the nine participants who responded to the question how many years have you been in the field of nursing, three answered 0-10 years, one answered 10-15 years, and five answered 15 or more years. For the response of how many years the participants have been in higher education, four answered 0-10, three answered 10-15, and two answered 15 or more years.

Protection of Human Subjects

The principal investigator and faculty committee members demonstrated completion of training in the protection of human subjects through the Collaborative Institutional Training Initiative (CITI) program required by The University of Arizona Institutional Review Board (IRB) Human Subjects Protection Program (HSPP) (UACON, 2014). The study was granted exempt status by The University of Arizona IRB (Appendix A). The data were collected through a secure electronic data collection system; Qualtrics survey software (UA, 2015) that provided anonymity to the participants. All data were kept in password-protected electronic files during
the study period. At the end of the project, the principal investigator transferred all documents to
The University of Arizona, College of Nursing, Room 410, where they will be kept for six years.

Survey

The survey focused on the Kissick Framework and its viability as an adjunct to the DNP Essentials and NONPF Core Competencies currently used to underpin doctoral education of FNPs. The survey consisted of 18 questions that were yes and no, multiple choice, and short answer (Appendix B). The first question obtained consent from potential participants. The next seven questions established whether the respondents met the inclusion criteria and outlined the backgrounds of the sample population. The last ten questions gathered information to contribute to preliminary validity of the Kissick Framework. The information gathering questions (Questions 8-11) were used to identify whether participants perceived assets in the Kissick Framework that would contribute to curriculum in the doctoral education of FNPs. The short answer questions (Questions 12-17) were used to gather subjective opinions from the participants regarding the Kissick Framework.

Data Collection and Data Analysis

Data were collected utilizing Qualtrics survey software. Data analysis was accomplished by review of the data from the survey. The first seven questions were reviewed to determine characteristics of the sample. The last 10 questions were reviewed to determine the participants’ perceptions as to the viability of the Kissick Framework as an adjunct to doctoral education of FNPs. Simple result reporting was performed.
Results

The first of the yes and no questions began with question number 8, “Is the Kissick framework easy to follow?” four participants reported yes and two reported no. Four participants responded yes to question number 9, “Do you think the addition of the Kissick Framework in addition to the DNP Essentials and the NONPF Competencies is helpful?” and two answered no. In response to question number 10, “Could you see yourself using the Kissick Framework?” four participants responded yes and two responded no. Five participants responded yes to question number 11, “Do you think this framework adds to the body of knowledge?” and one responded no.

The first of the short answer questions began with question number 12, “How would the Kissick Framework add to the body of knowledge for a DNP program?” the responses were as follows: “It’s awesome”; “Combines the DNP Essentials and NONPF competencies to influence DNP practice”; “It takes into consideration individual feelings/perceptions of nursing interaction with patients”; “It would be another model for faculty to use in a DNP program.” For question number 13, “How well do the DNP Essentials, NONPF Competencies, and Orlando’s Theory fit into the whole of the Kissick Framework?” the participants answered, “Great”; “They fit the framework”; “Well.”

For question number 14, “How will the Kissick Framework affect DNP practice?” the responses were as follows: “It’s awesome”; “It improves practice”; “It places value on the nurse as a person”; “I don’t think it will.” For question number 15, “Is the Kissick Framework viable and why?” the responses were: “The model incorporates the patient in the model”; “I think I
need some context about the model”; “When I look at this model I think Venn Diagram and relationships in the areas of overlap”; “Yes it may be useful for visual learners.”

For question number 16, “How important is including the nurse-patient relationship to the DNP curriculum?” the responses were: “The focus is on the nurse-patient relationship is the cornerstone”; “It provides a realistic view on how nurses are personally affected and invested in the DNP curriculum”; “Not certain I understand the question?” “Are you asking how important it is to include the nurse-patient relationship in the curriculum?” “Very important.”

Question number 17 asked, “What are your overall impressions of the Kissick Framework?” One participant responded to the final question stating, "It is important to the DNP practice".

**Discussion**

The results indicate that faculty teaching in the DNP program at The University of Arizona, College of Nursing who responded to the survey had a favorable attitude about the Kissick Framework. Most of the participants responding to the short answer questions agreed the Kissick Framework was easy to follow and would be a helpful addition to the DNP Essentials and NONPF Core Competencies. Most of the participants responding to the short answer questions agreed the Kissick Framework added to the body of knowledge for DNP education, and indicated the Kissick Framework would be a viable option for use in the DNP curriculum. Finally, those responding to the specific questions agreed addition of the Kissick Framework to the DNP curriculum may be important.
Study Strengths

The strengths of this study are the topic of DNP curriculum has not been well researched, and this project examined a new framework. The DNP curriculum generally consists of the NONPF Core Competencies and the DNP Essentials without an underpinning-nursing framework. The addition of the importance of the patient relationship to frameworks for curricula will enhance the education of the DNP. The development of a new nursing framework especially in the context of DNP education opens up possibilities for the future of DNP education.

Study Limitations

The major limitations of this study were the lack of clarity of terminology in the survey and sample size. Given the limitations of survey comprehension on the part of the participants due to some questions lacking clarity and the sample size, very preliminary evidence of validity was established, but confidence in the results is not strong. If repeated, the lack of clarity of terminology in the survey could be addressed by use of content experts to review construction of survey language that would promote confidence in the results. In addition, creating more precise short answer questions or combining some questions may have increased the number of participants completing the survey. Recruitment from a larger faculty sample, including other colleges of nursing from the state and country would contribute greatly to the validity of the study.

Implications for Further Research

The implications for further research include expanding the survey and the survey population. First, the survey needs revision and content validity established using experts in
theory development and DNP education. Second, a larger sample would give more insight as to the importance of the topic and the relevance of the framework.

**Implications for Education**

The implications for the education of doctorally prepared NPs include the expansion of the current curriculum to include the importance of relationships between NPs and patients. Teaching students information about treatment modalities and prevention is important, but including information about the NP-patient relationship in the curriculum has potential to enhance the new NP’s experience. As important as providers are, patients are the most important person in the relationship between the NP and the patient. Schools of nursing could use the Kissick Framework to impart knowledge to their students seeking doctoral level NP degrees to highlight the importance of the patient. Inclusion of current DNP students in discussion of the topic of the relevance of the use of a nursing framework for doctoral level NP education would expand the knowledge gained.

**Conclusion**

This study established very preliminary evidence for the Kissick Framework. The results, although from a small sample, give credence to the importance of an emphasis on the nurse-patient relationship in the curriculum of the DNP. The study left open many avenues for further research from the aspect of education, current practice, and the future of doctorally prepared FNPs. Overall, the discussion of adding a new framework to the current curriculum used in DNP programs is a topic that has opportunities to enhance the general body of nursing knowledge.
APPENDIX A:

IRB: THE UNIVERSITY OF ARIZONA CONSENT TO PARTICIPATE IN RESEARCH
The University of Arizona Consent to Participate in Research

Study Title:
A New Nursing Theory Model: A New Way to Think of Doctor of Nursing Practice Education

Principal Investigator: Leila Kissick

This is a consent form for research participation. It contains important information about this study and what to expect if you decide to participate. Please consider the information carefully. Feel free to discuss the study with your friends and family and to ask questions before making your decision whether or not to participate.

You may or may not benefit as a result of participating in this study. Also, as explained below, your participation may result in unintended or harmful effects for you that may be minor or may be serious, depending on the nature of the research.

1. Why is this study being done?
This study is being done to discover the usefulness of the Kissick Theory Model on the future of DNP education.

2. How many people will take part in this study?
The number of participants is 4-10 people.

3. What will happen if I take part in this study?
Your answers and opinions to the questionnaire and the focus group will be utilized as data for this study and help to further formulate the Kissick Theory Model. You will be asked to join a focus group in the College of Nursing building or by webinar and express your ideas and opinions regarding the Kissick Theory Model. During this focus group you will be audio recorded. In addition, you will be asked to fill out a questionnaire about the Model and its relevance to DNP education.

4. How long will I be in the study?
You will be in the study for 1-2 hours.

5. Can I stop being in the study?
You can stop being in the study at anytime. Your participation is voluntary. You may refuse to participate in this study. If you decide to take part in the study, you may leave the study at any time. No matter what decision you make, there will be no penalty to you and you will not lose any of your usual benefits. Your decision will not affect your future relationship with The University of Arizona. If you are a student or employee at the University of Arizona, your decision will not affect your grades or employment status.
6. What risks, side effects or discomforts can I expect from being in the study?
   There are no risks, side effects or discomforts by being in this study.

7. What benefits can I expect from being in the study?
   There are no direct benefits to being in this study.

8. What other choices do I have if I do not take part in the study?
   You may choose not to participate without penalty or loss of benefits to which you are
   otherwise entitled.

9. Will my study-related information be kept confidential?
   Efforts will be made to keep your study-related information confidential. However, there
   may be circumstances where this information must be released. For example, personal
   information regarding your participation in this study may be disclosed if required by state
   law.

10. What are the costs of taking part in this study?
    This study should cost you 1-2 hours in time.

12. What happens if I am injured because I took part in this study?
    If you suffer an injury from participating in this study, you should seek treatment. The
    University of Arizona has no funds set aside for the payment of treatment expenses for
    this study.

13. What are my rights if I take part in this study?
    If you choose to participate in the study, you may discontinue participation at any time
    without penalty or loss of benefits. By signing this form, you do not give up any personal
    legal rights you may have as a participant in this study.

    You will be provided with any new information that develops during the course of the
    research that may affect your decision whether or not to continue participation in the
    study.

    You may refuse to participate in this study without penalty or loss of benefits to which
    you are otherwise entitled.

    An Institutional Review Board responsible for human subjects research at The University
    of Arizona reviewed this research project and found it to be acceptable, according to
    applicable state and federal regulations and University policies designed to protect the
    rights and welfare of participants in research.
14. Who can answer my questions about the study?

For questions, concerns, or complaints about the study you may contact Leila Kissick FNP-BC leilak@email.arizona.edu.

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact the Human Subjects Protection Program at 520-626-6721 or online at http://orcr.arizona.edu/hssp.

If you are injured as a result of participating in this study or for questions about a study-related injury, you may contact Leila Kissick FNP-BC leilak@email.arizona.edu.

Signing the consent form

I have read (or someone has read to me) this form, and I am aware that I am being asked to participate in a research study. I have had the opportunity to ask questions and have had them answered to my satisfaction. If you have questions please contact Leila Kissick FNP-BC leilak@email.arizona.edu. I voluntarily agree to participate in this study.

I am not giving up any legal rights by signing this form. I will be given a copy of this form.

Printed name of subject

Signature of subject

Date and time: AM/PM

Investigator/Research Staff

I have explained the research to the participant or the participant’s representative before requesting the signature(s) above. There are no blanks in this document. A copy of this form has been given to the participant or to the participant’s representative.

Printed name of person obtaining consent

Signature of person obtaining consent

Date and time: AM/PM
APPENDIX B:

SURVEY
Consent Form

I have read (or someone has read to me) this form, and I am aware that I am being asked to participate in a research study. I have had the opportunity to ask questions and have had them answered to my satisfaction. If you have questions please contact Leila Kissick FNP-BC (leilak@email.arizona.edu). I voluntarily agree to participate in this study.

Yes
No

1. Do you teach in the DNP program?
   Yes
   No

2. Do you currently provide direct patient care in a clinical situation?
   Yes
   No

3. How many hours a week do you spend in clinical setting caring for patients?

4. What is your highest educational preparation?
   Master’s degree
   Doctorate
   Doctorate not in nursing field

5. What type of doctoral degree do you hold?
   DNP
   PhD
   DNS
   Other

6. How many years have you been in the nursing field?
   0-10
   10-15
   15 or more
7. How many years have you been in higher education?
   0-10
   10-15
   15 or more

Please review the following image and answer following questions

8. Is this framework easy to follow?
   Yes
   No
9. Do you think the addition of this framework in addition to the competencies/essentials is helpful?
   Yes
   No

10. Could you see yourself using this framework?
    Yes
    No

11. Do you think this framework adds to the body of knowledge?
    Yes
    No

12. How would this framework add to the body of knowledge for DNP practice?

13. How well do the DNP Essentials, NONPF competencies, and Ida J. Orlando’s Theory fit into the whole of the Kissick Framework?

14. How will the framework affect DNP practice?

15. Is the framework viable? Why?

16. How important is including the nurse-patient relationship to the DNP curriculum?

17. What are your overall impressions of the Kissick Framework?
The references in the document are as follows:


