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LITERATURE REVIEW

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An exploration of the levels of clinical autonomy of advanced nurse practitioners: A narrative literature review

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Abstract

Aims and Objectives: The aims of the review are to synthesise current evidence about advanced nurse practitioner clinical autonomy and consider how this may inform clinical practice and research.

Background: Clinical autonomy is one of the cornerstones of advanced nursing practice globally, yet there is limited synthesis of clinical autonomy in the literature.

Design: This is a narrative literature review.

Data sources: The databases Cumulative Index to Nursing and Allied Health Literature, EBSCO host, Cochrane Library, CINAHL and MEDLINE were searched for publications between 2005 and 2020 inclusive.

Review methods: A systematic approach was used to analyse the literature reviewed. Two reviewers undertook quality appraisal.

Results: Nineteen articles were selected. Four major themes emerged: (1) 'ANP Stepping Up'—moving into and accepting advanced nursing practice roles and clinical responsibilities; (2) 'ANP Living It'—ANPs' ability to act independently including an understanding of task mastery and self-determination; (3) 'ANP Bounce-back ability'—depicted in challenges that threaten their ability to practice clinically autonomously; (4) 'ANP Setting in Motion'—indirect care activities and service-level improvements.

Conclusion: A clearer understanding of advanced nurse practitioner clinical autonomy could help develop more in-depth knowledge. Research of advanced nurse practitioners' clinical autonomy would improve full utilisation in clinical practice.

KEYWORDS

advanced nurse practitioners, advanced nursing practice, autonomy, nurse practitioners, levels of clinical autonomy

Summary statement

What is already known about this topic?

- Advanced nurse practitioners can encounter challenges that threaten their ability to practice clinically autonomously due to a lack of understanding from other healthcare professional about their roles.
- Without clarity about the levels of clinical autonomy of advanced nurse practitioners in clinical practice, service-level impact will be undermined.
- Research related to the levels of clinical autonomy of the advanced nurse practitioner is sparse.

What this paper adds?

- Advanced nurse practitioners must take responsibility for 'stepping up', but this requires collaboration to demonstrate their advancing clinical responsibilities and in expanding their scope of practice to enhance healthcare provision.
- The literature identified 'living it' as enabling advanced nurse practitioners clinical autonomy within their working environments, which requires professional support.
- Advanced nurse practitioner clinical autonomy involves the need for 'bounce-back abilities' and 'setting in motion', which consists of developing self-determination skills, leading and driving quality initiatives and service-level improvements.

The implications of this paper

- The importance of clearly articulating advanced nurse practitioner clinical autonomy in clinical practice is essential to healthcare reform transformation to support full utilisation of the role in clinical practice.
- The narrative review highlights a gap in knowledge related to the perceptions of advanced nurse practitioner clinical autonomy.
- This narrative literature review identified that the advanced nurse practitioner actual clinical autonomy in practice requires further examination.

1 | INTRODUCTION

Over many decades, advanced nurse practitioners (ANPs) have been proposed as a solution to health access. However, the discourse of the levels of ANP clinical autonomy is limited (Park et al., 2018; Schober, 2017; Weiland, 2015). The ANP evidence has focused on reports of patient satisfaction, professional boundary challenges and role confusion (Begley et al., 2014; Cashin et al., 2014; Elliott et al., 2016; Gardner et al., 2016). ANPs themselves have narrated a 'straddling' in-between medicine, nursing and other allied health professions resulting in ANP clinical autonomy underutilisation in clinical practice (MacLellan et al., 2016; Ryder et al., 2019; Turner et al., 2007).

2 | BACKGROUND

The development and expansion of the ANP roles have been due to the global healthcare workforce challenges, shortage of staffing levels coupled with an ageing patient demographic (ICN et al., 2020; Steinke et al., 2017; Torrens et al., 2020). The International Council of Nurses (ICN) has defined the ANP role as 'registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and country in which s/he is credentialed to practice. A minimum of a master's degree in most countries is recommended for entry-level'. (ICN et al., 2020, p. 6). ANP clinical autonomy is associated with independence, collaboration and practising as professionals in their own professional right which includes maintaining active clinical practice (Cotter, 2016; Dempster, 1994; Turner et al., 2007). ANP clinical autonomy has been defined as 'a dynamic process demonstrating varying amounts of independence, self-governed, not controlled, or subordinate behaviours and sentiments related to relatedness, empowerment, actualisation and valuation for autonomous practice' (Dempster, 1994, p. 227). The title of ANP and nurse practitioner (NP) are protected role titles (ICN et al., 2020), and for this narrative review, ANP is used to cover ANP and NP collectively.

This paper employed a systematic review methodology to explore existing research relating to ANP clinical autonomy. A narrative review approach seeks to 'summarise, explain and interpret evidence on a particular topic or question' using qualitative, quantitative or both evidence (Mays et al., 2005, p. 11).

3 | THE REVIEW

3.1 | Aim and purpose statement

This review aims to identify and analyse the evidence about the clinical autonomy of ANP and consider how this evidence might inform clinical practice and research.

3.2 | Databases and methods

3.2.1 | Search limits

Original research and literature published between the years of 2005 and 2020 were searched using the following databases via EBSCO host: the Cochrane Library, CINAHL, MEDLINE and Web of Science using the keywords ANP or NP and clinical autonomy. Initial scoping of the keywords 'ANP clinical autonomy' found considerably limited papers. Therefore, the search was expanded using ANP, NP, advanced nursing practice, autonomy, clinical autonomy and professional autonomy. Papers of interest were written in English and were research papers examining ANP clinical autonomy. Keywords used in the search had 'ANP', 'NP', advanced nursing practice either together or alone, with a combination of clinical autonomy, autonomy, or professional autonomy.

3.3 | Inclusion criteria

- Date of publication 2005–2020 inclusive.
- English language papers.
- Original research.
- Primary research papers relating *only* to the title of ANP or NP's clinical autonomy.

3.4 | Exclusion criteria

- Papers relating to other advanced practice levels such as clinical nurse specialists, advanced clinical practitioners and physician assistants.
- All other nursing roles, specialist and nurse specialist roles.
- Not primary research reports, for example, conference abstracts, editorials and commentaries, discussion papers and systematic/scoping reviews of original research.

3.4.1 | Search terms

The PICO framework is commonly used in evidence-based medicine and nursing (Yensen, 2013) and was adapted and utilised to structure the narrative review's keywords. 'P' in the PICO framework refers to advanced nurse practitioners 'or' nurse practitioners. 'I' refers to an intervention (see Table 1). 'C' refers to comparison or control groups, which were not included in this narrative review. 'O' refers to the outcomes and included terms such as the impact of the advanced nurse practitioners. Search terms were searched in combination and on their own (Table 1). Boolean operators such as 'AND' and 'OR' were used to maximise inclusion. The following journals were hand searched for relevant articles: *Clinical Journal of Nursing*, *Journal of Advanced Nursing*, *Journal of Nursing Management*, *Journal for Nurse Practitioners*, *International Council of Nursing Review*, *Journal of the American Association of Nurse Practitioners* and the *Journal of the American Academy of Nurse Practitioners*. Reference lists of relevant articles were searched to identify related studies. The database searches and hand searches were undertaken following the PRISMA guidelines (Moher et al., 2009).

TABLE 1 PICO search strategy used for EBSCO host, Cochrane Library, CINAHL and PubMed (MEDLINE)

Question	PICO search terms
	P 'advanced nurse practitioner' AND/OR 'nurse practitioner' AND/OR 'advanced nursing practice.' I AND autonomy AND/OR professional AND/OR clinical autonomy O AND/OR impact of Advanced Nurse Practitioner clinical autonomy, AND/OR in clinical practice ANP/OR levels of clinical autonomy
Search terms and combinations	S1: Advanced Nurse Practitioner or ANP 'AND'/'OR' nurse practitioner or NP 'AND'/'OR' advanced nursing practice S2: Clinical autonomy 'AND', 'OR' 'Autonomy' 'AND'/'OR professional autonomy S3: AND/OR impact of Advanced Nurse Practitioner clinical autonomy, AND/OR in clinical practice 'AND'/'OR' S1: 'advanced nurse practitioner' AND/OR 'nurse practitioner' AND/OR 'advanced nursing practice.' S2: AND autonomy AND/OR professional AND/OR clinical autonomy S3: AND/OR impact of Advanced Nurse Practitioner clinical autonomy, AND/OR in clinical practice S4: Change S1 and S2 S1 and S3 S2 and S3 S3 and S1 S1, S2 and S3

3.4.2 | Search process

The PRISMA checklist and flow diagram guided the manuscript development (Moher et al., 2009). Quality assessment was achieved by rating each paper using the appraisal tool from Hawker et al. (2002).

3.4.3 | Summary table of included articles and quality appraisal

After removing duplicated articles and non-research papers, 324 abstracts were scrutinised, and articles related to other nursing and non-nursing specialist roles were excluded ($n = 208$) (Figure 1). The remaining full-text papers were retrieved and reviewed by the two reviewers ($n = 116$), and the application of the inclusion criteria further limited the number of articles retained to 19. The two researchers independently assessed each article. According to PRISMA guidelines, the articles were categorised (Moher et al., 2009) (Figure 1). The PRISMA 2009 checklist was also utilised (Moher et al., 2009). Quality assessment was achieved by rating each paper and critically appraising the literature using Hawker et al.'s (2002) appraisal tool.

This checklist was used to extract and appraise abstract and title, introduction and aims, methods and data, sampling, data analysis, bias, results, transferability, implications and usefulness. The score for each paper was recorded when the reviewers reached a consensus (Table 2). The Hawker et al. (2002) tool scores derive from nine questions scored as very poor (1), poor (2), fair (3) to very good (4).

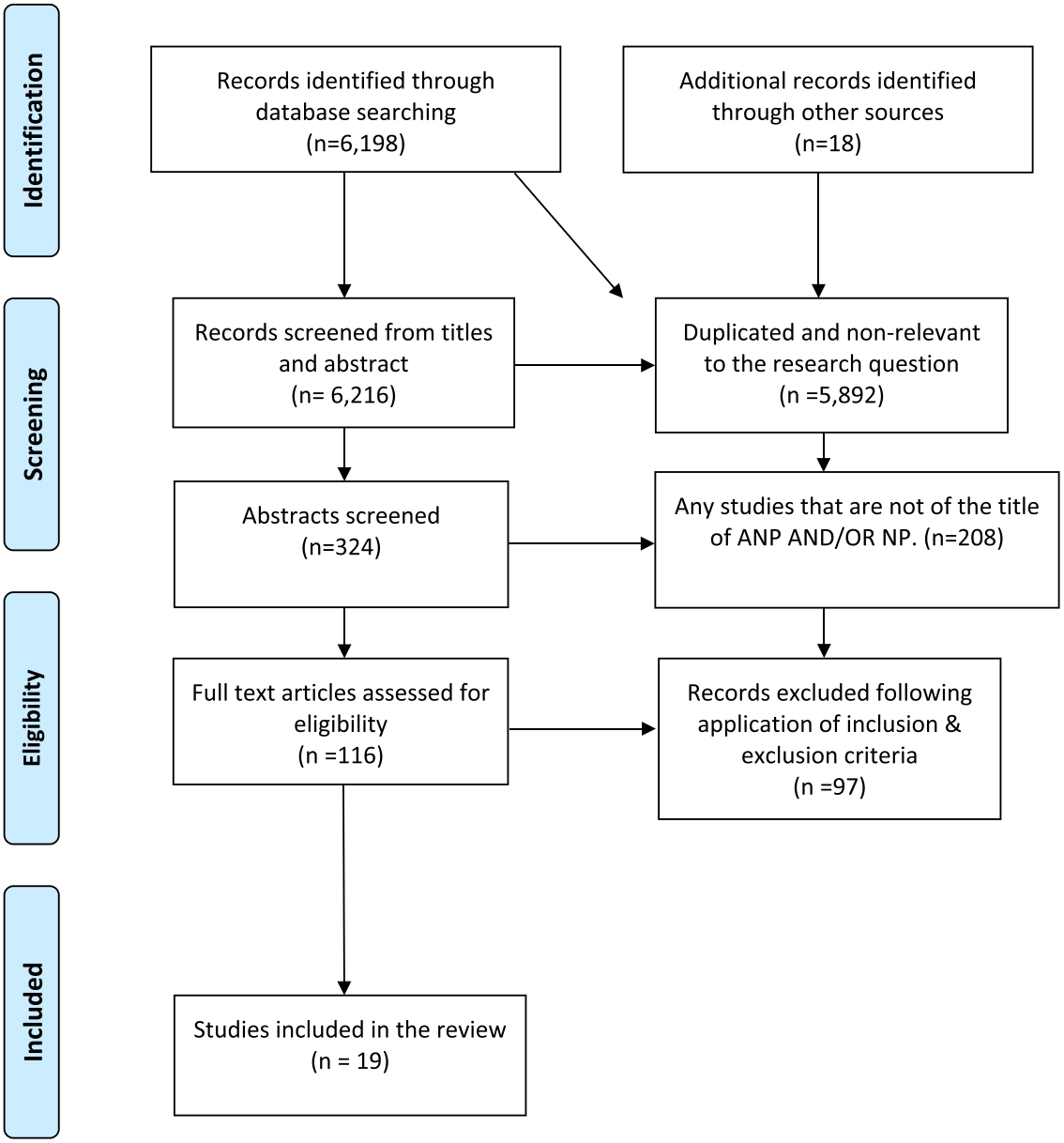

FIGURE 1 PRISMA flow diagram

TABLE 2 Summary of articles

Author and study design	Title	Sampling	Data collection	Data analysis	Major findings	Quality approved total score allocation max score = 36 Hawker et al. (2002)
Anderson et al. (2019), UK, ethnographic study	To consider professional nursing identity of ANPs.	ANPs ($n = 9$) and nursing colleagues ($n = 5$) across two primary care general practice organisations	ANP participant observation and semistructured interviews.	Thematic analysis and reporting were guided by COREQ.	Intraprofessional relationships negatively impacted by the nursing profession itself. Intraprofessional relationships and the broader nursing profession shape ANP. A weak professional identity was established by the ANP and their clinical autonomy lacked support.	36
Athey et al. (2016), USA, descriptive statistics	To gain an understanding of how important autonomy and work setting is to ANP job satisfaction.	National sample ($n = 8311$)	Survey	Bivariate and multivariate relationships using SPSS analysis	Autonomy is a key factor associated with satisfaction for ANPs impacting on staff retention. High levels of clinical decision-making skills were identified. The most predictive factor of satisfaction was when the ANP felt they were fully utilised in clinical practice.	35
Bahadori and Fitzpatrick (2009), USA, descriptive statistics	Level of autonomy of primary care ANPs.	Convenience sample ($n = 48$)	DPBS survey	SPSS analysis	The ANP struggled with clinical autonomy and empowerment due to limited legal prescriptive authority for controlled substances and being tethered to a collaborative practice agreement with a physician.	34

(Continues)

TABLE 2 (Continued)

Author and study design	Title	Sampling	Data collection	Data analysis	Major findings	Quality approved total score allocation max score = 36 Hawker et al. (2002)
Burgess and Purkis (2010), Canada, participatory action research (PAR)	To explore ANP implementation into the community and explore ANPs perspectives, how collaboration advanced the ANP role.	ANPs ($n = 17$) in 2 health regions	Data focus groups and action meetings were recorded.	Constant comparative analysis inputted into Nvivo	Collaborative of practice (CoP) enhanced ANP implementation and clinical autonomy. The CoP may assist ANPs in their requirements of ANP clinical autonomy.	35
Cajulis and Fitzpatrick (2007), USA, descriptive statistics	Levels of autonomy of ANPs in an acute care setting.	ANPs in differing specialties ($n = 54$)	DPBS survey	SPSS analysis	The overall mean autonomy score indicated high levels of autonomy. Results pertained to evidence of the level of ANP autonomy such as, providing direct patient care and clinical decision-making skills.	34
Cowley and Cooper (2016), UK, grounded theory	Semistructured interviews with members of the multidisciplinary team to explore the perceived effect and acceptability of the ANP.	Multidisciplinary team ($n = 8$)	Data were transcribed by an independent transcriber. Themes and codes were identified.	Thematic analysis	The development created some confusion of the role in regard to clinical autonomy. Role boundaries were reported as challenging. Confusion of the ANP role had a negative effect on the extent to which the ANP could deliver care. At the implementation stages, clarity of ANP clinical autonomy is lacking.	32
Fox et al. (2018), Australia, case study	To aim was to explore factors that influence sustainability of ANP services.	Survey 'nurse practitioner service pattern scale' ($n = 161$) telephone survey with ANPs ($n = 112$), interviews ($n = 12$) and document analysis ($n = 10$)	Survey and document analysis	SPSS and qualitative content analysis	Constraints ANPs reported a misfit of their identity, not fitting in the nursing or medical umbrella which was reported as isolation. ANP clinical	32

TABLE 2 (Continued)

Author and study design	Title	Sampling	Data collection	Data analysis	Major findings	Quality approved total score allocation max score = 36 Hawker et al. (2002)
					autonomy was subject to extensive appraising through review of diagnostic requests, prescriptions and consumer diagnosis and, reporting of key performance indicators.	
Kerr and Macaskill (2020), Ireland, narrative study	To explore ANP (emergency) perceptions of role, positionality and professional identity.	ANPs ($n = 10$), in-depth interviews	Bourdieu's concepts of habitus theoretical framework	Thematic analysis	Five key themes emerged: career pathways, personal and professional transitions, role dimensions and core concepts and position in the organisation, and emergency professional identity.	36
MacLellan et al. (2016), Australia, ethnography, informed by focused ethnography	To explore the power and politics in the transition of ANPs while adjusting to the autonomous role in Australia.	Newly endorsed ANPs ($n = 10$)	Observational, Carspecken's five stages of critical	Thematic analysis	Themes emerged: dominant themes were issues of power and politics dominating the participants observed. Power struggles of autonomy in practice were hampered by nurses overtly and covertly. Deliberate misuse of power frequently encountered constraining ANP to be autonomous. Many left and returned to RN roles.	35
Maylone et al. (2011), USA, descriptive statistics	To investigate the relationships between ANPs perceptions of collaboration with	ANPs ($n = 99$), convenience sample	DPBS survey	SPSS analysis	ANPs reported collaboration with physician colleagues as high apart from the	34

(Continues)

TABLE 2 (Continued)

Author and study design	Title	Sampling	Data collection	Data analysis	Major findings	Quality approved total score allocation max score = 36 Hawker et al. (2002)
	physician colleagues and level of autonomy ANP practice.				empowerment scale. Empowerment was the lowest, which indicated ANPs limitations to their prescriptive rights and scope of practice impacting on their ability to practice with full clinical autonomy.	
Park et al. (2018), USA, descriptive statistics	To explore the extent to which scope of practice laws related to the ANPs day-to-day practice autonomy.	US Health Resources and Services Administration (HRSA) ($n = 12.923$) ANPs	National state survey	Regression analysis and SPSS analysis	Day-to-day practice autonomy was reported when they had prescriptive independence. CPA agreements and attachment to physicians was constraining to ANP clinical autonomy. This study reported reducing barriers to ANP clinical autonomy would improve capacity to make the ANPS more efficient and effective to patients.	34
Poghosyan and Liu (2016), USA, descriptive statistics	ANP autonomy and relationships with leadership affecting teamwork in primary care practices.	Cross-sectional survey ($n = 314$) ANPs	Data were collected using the autonomy-independent practice (AIP) and NP-administration relations (NP-AR) and the NP primary care organisational climate questionnaire (NP-PCOCQ)	SPSS analysis	ANP clinical autonomy was favourable when all members of the team understood the role, which improved leadership teamwork. Policy and organisational change should focus on promoting ANP clinical autonomy. Clinical leadership was reported as fragmented.	34

TABLE 2 (Continued)

Author and study design	Title	Sampling	Data collection	Data analysis	Major findings	Quality approved total score allocation max score = 36 Hawker et al. (2002)
Ryder et al. (2019), Ireland and Australia, mixed-methodology interpretive research	To explore Irish and Australian nurse practitioners (ANPs) implement leadership and research in their roles.	Mixed methods, an interpretive descriptive approach. Online survey ($n = 38$) ANPs and interviews ($n = 10$) ANPs.	An interpretive descriptive approach was used.	Thematic analysis. The criteria for reporting qualitative data COREQ	Four themes emerged innovative leadership, which includes the ANPs as trailblasers, optimism, incorporating pride in achievements, research which included ANP research roles, research challenges support and research leadership and resilience, which incorporates overcoming resistance, isolation and seeking positive support systems.	36
Sangster-Gormley et al. (2011), Canada, Yins case study	To explain the process of ANP implementation.	Data sources included semistructured interviews with participants ($n = 16$) key stakeholders and key documents.	Face-to-face interviews and one telephone interviews	NVivo 10 and thematic analysis	Interconnectedness of the concepts of intention, involvement and acceptance influences the implementation process and how the ANP is able to function in terms of clinical autonomy.	34
Schadewaldt et al. (2016), Australia, multiple case study	To examine the experiences of ANP and physicians working in collaborative practice models.	ANPs ($n = 6$) physicians ($n = 13$) and practice managers ($n = 3$)	Direct observation, documents, semistructured interviews and survey.	SPSS and descriptive analysis, thematic analysis and deductive analysis.	ANPs accepted the accountability and clinical autonomy and heightened decision-making skills. The ANPs' level of clinical autonomy led to an expansion of their scope of practice, and clinical decision-making skills. An overlap with the scope of practice of physicians, which led to blurred professional roles.	36

(Continues)

TABLE 2 (Continued)

Author and study design	Title	Sampling	Data collection	Data analysis	Major findings	Quality approved total score allocation max score = 36 Hawker et al. (2002)
Spetz et al. (2017), USA, descriptive statistics quantitative	To compare urban and rural ANP autonomy and satisfaction in rural settings.	Descriptive study, survey design ($n = 13\,000$) ANP	National sample survey of ANPs	SPSS analysis	ANP in rural settings reported characteristics indicating greater autonomy. These findings were due to the ANP being the main primary care provider. This was dependent on the state the ANP worked in; some ANPs reported being attached to the physician's collaborative practice agreements.	34
Weiland (2015), USA, Gadamerian hermeneutic study	To understand the meaning of autonomy as interpreted by ANPs through their lived experiences.	Purpose sample of ($n = 9$) ANPs	Face-to-face interviews	Gilligan's feminist perspective was utilised during interpretive analysis	Genuine ANP practice was the major theme, reflecting the participants' overall meaning of their autonomy. Practicing alone with the patient provided the context within which participants shaped the meaning of having genuine NP practice. Having genuine NP practice had four subthemes: relationships, self-reliance, self-empowerment, and defending the NP role.	36
Yee et al. (2013), USA, transcribed qualitative research	To examine the impact of state scope of practice and other market and organisational factors impacting on the role of the ANP.	Telephone interviews with ANPs, practice managers and physicians ($n = 30$)	Telephone interviews	Notes were transcribed with a 2-person researcher approach.	Restrictions to practice in the USA are varied between, no doctors oversight, doctors' oversight of the ANP and medical doctors oversight to diagnose, treat and prescribe.	27

TABLE 2 (Continued)

Author and study design	Title	Sampling	Data collection	Data analysis	Major findings	Quality approved total score allocation max score = 36 Hawker et al. (2002)
					Important factors were practice culture, policies and the level of ANP clinical experience.	
Turner et al. (2007), Australia, critical discourse analysis qualitative	To examine the spheres of influence or autonomy and policy a discourse analysis of the introduction of ANPs in rural and remote Australia.	($n = 2$ ANP and $n = 15$ ANP trainees).	Analysis was undertaken in texts of policy documents and observational field work, interviews and focus groups	Fairclough's approach and interpretation of discourse analysis.	Lack of understanding of the ability of the ANP autonomy implementation was complex. Policy and reality of ANP autonomy lacked clarity. ANP trainees some left the training and returned to general nursing due to the constraints to ANP clinical autonomy.	36

Note: This checklist is from Hawker et al. (2002).
Abbreviations: ANP, Advanced Nurse Practitioner; CPA, collaborative practice agreement.

The 19 papers scored satisfactorily on methodological rigour assessment, with no papers scoring less than 27 of a maximum score of 36. Details of the 19 papers and methodological assessment scores are provided in Table 2.

An iterative consensus-building approach was used to synthesise the literature and illustrate the social context of the findings. This approach consisted of papers that were read, reread, documenting repetition of the literature, read and reread whereby the initial development of subthemes were identified with final agreement on major themes (Jones, 2004).

4 | RESULTS

The 19 articles were from a variety of countries. There were nine from the USA, four from Australia, two from the UK, two from Canada, one from Ireland and one from Ireland and Australia. The research designs of all papers are included in Table 2.

The following themes emerged from the data analysed.

4.1 | 'ANP stepping up'

One theme of ANP clinical autonomy emerging from the literature can be summarised as 'stepping up'. The ANPs 'stepping up' is demonstrated by the nurse moving from their current role into a new ANP role (Fox et al., 2018; MacLellan et al., 2016; Poghosyan & Liu, 2016; Sangster-Gormley et al., 2011; Schadewaldt et al., 2016). Additionally, it referred to ANPs stepping up and accepting advancing clinical responsibilities and expanding their scope of practice to enhance healthcare provision (Fox et al., 2018; MacLellan et al., 2016; Poghosyan & Liu, 2016; Sangster-Gormley et al., 2011; Schadewaldt et al., 2016).

Ten papers referred to the inclusion of medical and nursing activities for patients as one major part of ANP stepping up, including independent history taking, diagnosis, independent prescribing of medications and ionising radiation, referral and discharge of patients without the need of a physician's consultation or assessment (Anderson et al., 2019; Bahadori & Fitzpatrick, 2009; Cowley & Cooper, 2016; Kerr & Macaskill, 2020; MacLellan et al., 2016; Park et al., 2018; Ryder et al., 2019; Spetz et al., 2017; Turner et al., 2007; Weiland, 2015). Eight papers similarly included ANP stepping up as physical examination, diagnostic and curative intervention, prescribing, admission rights, patient referral and discharge (Anderson et al., 2019; Cowley & Cooper, 2016; Kerr & Macaskill, 2020; MacLellan et al., 2016; Poghosyan & Liu, 2016; Ryder et al., 2019; Sangster-Gormley et al., 2011; Weiland, 2015).

Additionally, on referral or discharge of a patient, 'stepping up' ANPs clinical autonomy was discoursed as completing full episodes of care, including making the clinical decisions without conferring with a physician and commencing a treatment plan and diagnosis collaboratively or entirely without a physician independently (Anderson et al., 2019; Bahadori & Fitzpatrick, 2009; Burgess & Purkis, 2010; Cowley & Cooper, 2016; Kerr & Macaskill, 2020; Ryder et al., 2019; Weiland, 2015).

Some of the papers' focus was on depicting how activities could enhance ANPs' clinical autonomy. Diagnosing a patient, for example, was reported in five studies as an activity whereby ANPs use their cognitive deductive skills to independently identify their reason for referring a patient from primary to acute care or vice versa (Fox et al., 2018; Schadewaldt et al., 2016; Spetz et al., 2017; Turner et al., 2007; Weiland, 2015).

Four studies described the overarching goal of stepping up as providing timely care to patients, improving patient flow, initiating care pathways and continuity of services, which is cost-effective and ensures quality patient care (Athey et al., 2016; Fox et al., 2018; Kerr & Macaskill, 2020; Ryder et al., 2019). Additionally, nine studies reported ANPs clinical autonomy as stepping up regarding diagnosis, completion of full episodes of care with or without a physician's oversight (Athey et al., 2016; Fox et al., 2018; Kerr & Macaskill, 2020; Maylone et al., 2011; Park et al., 2018; Ryder et al., 2019; Schadewaldt et al., 2016; Spetz et al., 2017; Weiland, 2015).

Eleven of the 19 papers included in this review explore the use of complex decision-making skills as part of stepping up (Athey et al., 2016; Bahadori & Fitzpatrick, 2009; Cajulis & Fitzpatrick, 2007; Cowley & Cooper, 2016; Fox et al., 2018; Park et al., 2018; Poghosyan & Liu, 2016; Spetz et al., 2017; Turner et al., 2007; Weiland, 2015; Yee et al., 2013). Seven papers referred to ANPs clinical autonomy as practising from a deeper level of experience and understanding to support their clinically autonomous decision-making in clinical practice (Anderson et al., 2019; Bahadori & Fitzpatrick, 2009; Cowley & Cooper, 2016; Fox et al., 2018; Kerr & Macaskill, 2020; Ryder et al., 2019; Weiland, 2015). Finally, 12 studies reported continuing professional development as a key factor in developing clinical decision-making associated with ANPs' clinical autonomy (Anderson et al., 2019; Athey et al., 2016; Bahadori & Fitzpatrick, 2009; Cajulis & Fitzpatrick, 2007; Fox et al., 2018; Kerr & Macaskill, 2020; Park et al., 2018; Poghosyan & Liu, 2016; Ryder et al., 2019; Turner et al., 2007; Weiland, 2015; Yee et al., 2013).

4.2 | 'ANP living It'

Having an environment that enables the ANP to clinically practice autonomously formed a significant part of the literature reviewed. It is summarised under the theme 'living it'. ANPs described it in the literature as a sense of one's own ability to act independently and to exert control over one's environment, including an understanding of task mastery and self-determination (Athey et al., 2016; Spetz et al., 2017; Turner et al., 2007; Weiland, 2015; Yee et al., 2013). Similarly, ANP 'living it' was reported as enabling their clinical autonomy within their working environments giving them professional support and a sense of achievement (Athey et al., 2016; Spetz et al., 2017; Weiland, 2015).

ANPs' clinical autonomy was experienced as real when the ANPs felt supported in their clinically autonomous practice, including

managing their patient caseloads and acting as the first point of contact for their patients and relatives (Ryder et al., 2019; Schadewaldt et al., 2016; Spetz et al., 2017; Weiland, 2015). Two ethnographic studies reported that ANP clinical autonomy was when the ANP felt they had the authority to practice as professionals in their own right (Anderson et al., 2019; MacLellan et al., 2016). This was also reported by Turner et al. (2007) in a discourse analysis paper.

Organisational supports were identified in nine studies as enabling ANP to live their clinical autonomy in practice (Bahadori & Fitzpatrick, 2009; Burgess & Purkis, 2010; Cajulis & Fitzpatrick, 2007; Cowley & Cooper, 2016; Fox et al., 2018; Maylone et al., 2011; Park et al., 2018; Schadewaldt et al., 2016; Turner et al., 2007). Five studies reported organisational supports as an enabler of living it when all healthcare team levels advocate for ANPs clinical autonomy (Bahadori & Fitzpatrick, 2009; Cajulis & Fitzpatrick, 2007; Maylone et al., 2011; Park et al., 2018; Turner et al., 2007). The theme of living it was also reported in influences of behavioural change reducing constraints to ANPs clinical autonomy (Bahadori & Fitzpatrick, 2009; Burgess & Purkis, 2010; Cajulis & Fitzpatrick, 2007; Cowley & Cooper, 2016; Fox et al., 2018; Maylone et al., 2011; Schadewaldt et al., 2016; Turner et al., 2007).

However, six studies reported ANP clinical autonomy as complex within the organisation when implementing the role with interprofessional and intraprofessional relationships and role territory enforcing restrictions to ANPs living their clinical autonomy (Anderson et al., 2019; MacLellan et al., 2016; Sangster-Gormley et al., 2011; Schadewaldt et al., 2016; Turner et al., 2007; Weiland, 2015). Seven studies reported a fundamental lack of recognition of ANP clinical autonomy by other health professionals as an incapacitating factor of living it (Bahadori & Fitzpatrick, 2009; Burgess & Purkis, 2010; Schadewaldt et al., 2016; Weiland, 2015; Cowley & Cooper, 2016; Anderson et al., 2019; Kerr & Macaskill, 2020).

Improvements in the organisational context were reported when there was a collaborative working relationship, as opposed to a hierarchical structure, and this was depicted in six of the studies as empowering in terms of ANPs' clinical autonomy (Anderson et al., 2019; Bahadori & Fitzpatrick, 2009; Cajulis & Fitzpatrick, 2007; Kerr & Macaskill, 2020; Ryder et al., 2019; Weiland, 2015). Additionally, studies reported positive factors for the organisation of ANPs' clinical autonomy, such as advanced clinical decision-making and extensive ANP knowledge (Burgess & Purkis, 2010; Sangster-Gormley et al., 2011; Schadewaldt et al., 2016).

Thirteen papers indicated that a lack of policy implementation of ANPs' clinical autonomy had created role ambiguity and resistance to their clinical autonomy amongst healthcare teams (Anderson et al., 2019; Athey et al., 2016; Fox et al., 2018; Kerr & Macaskill, 2020; MacLellan et al., 2016; Maylone et al., 2011; Park et al., 2018; Poghosyan & Liu, 2016; Ryder et al., 2019; Sangster-Gormley et al., 2011; Schadewaldt et al., 2016; Turner et al., 2007; Weiland, 2015). Constraints to ANPs clinical autonomy depicted in the literature suggest that nurses in ANP roles require a 'bounce-back ability'.

4.3 | 'ANP bounce-back ability'

'Bounce-back ability' is another theme that was identified from the ANP clinical autonomy literature. It is depicted as the ANPs' ability to bounce back from challenges that threaten their ability to practice clinically autonomously, as discussed in the themes of stepping up and living it. ANP 'bounce-back ability' is required when ANPs encounter challenges that impede their ability to practice clinically autonomously (Bahadori & Fitzpatrick, 2009; Maylone et al., 2011; Poghosyan & Liu, 2016; Schadewaldt et al., 2016; Weiland, 2015; Yee et al., 2013). Four studies reported high levels of ANP satisfaction when their clinical autonomy was a reality in practice in terms of being utilised to their fullest capacity (Athey et al., 2016; Bahadori & Fitzpatrick, 2009; Cajulis & Fitzpatrick, 2007; Maylone et al., 2011). Additionally, four studies reported that a more liberal approach towards ANPs' clinical autonomy was linked to an element of trust that develops between physicians and ANPs (Bahadori & Fitzpatrick, 2009; Cajulis & Fitzpatrick, 2007; Maylone et al., 2011; Weiland, 2015).

The implementation of collaborative practice agreements (CPAs) in some countries were outlined in six papers as confining ANPs' clinical autonomy (Athey et al., 2016; Bahadori & Fitzpatrick, 2009; Cajulis & Fitzpatrick, 2007; Park et al., 2018; Spetz et al., 2017; Yee et al., 2013). Additionally, CPAs were used by physicians and other allied professionals to restrain ANPs' patient caseloads, prescribing activity and scope of practice (Bahadori & Fitzpatrick, 2009; Cajulis & Fitzpatrick, 2007; Maylone et al., 2011; Poghosyan & Liu, 2016; Schadewaldt et al., 2016; Turner et al., 2007; Weiland, 2015; Yee et al., 2013). Eight studies reported evidence of the level of ANP clinical autonomy such as providing direct patient care (Anderson et al., 2019; Athey et al., 2016; Bahadori & Fitzpatrick, 2009; Cajulis & Fitzpatrick, 2007; Cowley & Cooper, 2016; Kerr & Macaskill, 2020; Maylone et al., 2011; Ryder et al., 2019). One study reported gender as a significant factor influencing ANPs clinical autonomy in a sociocultural belief that ANPs have less autonomy due to their caring role in a female-dominated profession than the physicians' role in science and independent practice (Weiland, 2015).

A sense of bounce-back ability has been reported in the literature describing situations where ANPs regain control over their clinical autonomy despite experiencing sociocultural and service-level challenges (Bahadori & Fitzpatrick, 2009; Cajulis & Fitzpatrick, 2007; Maylone et al., 2011; Weiland, 2015). Five studies reported bounce-back abilities as required to stay in the position of ANP and to continue practicing at an advanced nursing practice level (Bahadori & Fitzpatrick, 2009; MacLellan et al., 2016; Spetz et al., 2017; Turner et al., 2007; Yee et al., 2013). Two studies reported ANP trainees leaving the positions due to an inability to keep having to bounce back in terms of restraint to ANP clinical autonomy (MacLellan et al., 2016; Turner et al., 2007). Similarly, four studies reported that ANPs are more likely to leave their positions without bounce-back ability and revert to roles with less clinical autonomy (Bahadori & Fitzpatrick, 2009; Cajulis & Fitzpatrick, 2007; MacLellan et al., 2016; Turner et al., 2007).

In five studies, ANP clinical autonomy was narrated as a balancing act of straddling in-between nursing and medicine with reports of ANPs feeling isolated in clinical practice (Anderson et al., 2019; Kerr & Macaskill, 2020; MacLellan et al., 2016; Ryder et al., 2019; Turner et al., 2007). Additionally, six studies reported that one of the main constraints of ANPs clinical autonomy was when intraprofessionals and interprofessionals incessantly challenged their confidence and competence creating an element of self-doubt in their knowledge base (Anderson et al., 2019; Burgess & Purkis, 2010; MacLellan et al., 2016; Schadewaldt et al., 2016; Turner et al., 2007). Reports of physicians lacking confidence in ANP education, clinical autonomy abilities and knowledge base were reported in three studies (Cowley & Cooper, 2016; Poghosyan & Liu, 2016; Schadewaldt et al., 2016).

The requirement imposed in many areas of being supervised by physicians was perceived to negatively impact ANPs' clinical autonomy and physicians' perceived workload (MacLellan et al., 2016; Poghosyan & Liu, 2016). Furthermore, qualified ANPs as well as physicians being a supervisor to ANPs in training was reported as positive to their ANP clinical autonomy development (Anderson et al., 2019; Kerr & Macaskill, 2020).

4.4 | 'ANP setting in motion'

The literature reviewed showed that ANP clinical autonomy also requires the 'setting in motion' of indirect care activities, quality initiatives and service-level improvements for quality patient care (Fox et al., 2018; Kerr & Macaskill, 2020; Ryder et al., 2019). Additionally reported was the ANP as the 'setter in motion', driving quality initiatives and leading service-level improvements to improve patient care (Cowley & Cooper, 2016; Fox et al., 2018; Kerr & Macaskill, 2020; Poghosyan & Liu, 2016; Ryder et al., 2019; Schadewaldt et al., 2016).

Apart from direct patient activities and expanded scope of practice, ANP clinical autonomy was demonstrated in six papers as engaging in nursing leadership, education of self and others, improved holistic approach to patient care and facilitation of collaboration within teams (Cowley & Cooper, 2016; Fox et al., 2018; Kerr & Macaskill, 2020; Poghosyan & Liu, 2016; Ryder et al., 2019; Schadewaldt et al., 2016). 'Setting in motion' was reported in six papers as ANPs initiating new care initiatives such as improvements in patient pathways, which reduced organisational cost and improved efficiency (Anderson et al., 2019; Cowley & Cooper, 2016; Kerr & Macaskill, 2020; Poghosyan & Liu, 2016; Ryder et al., 2019; Schadewaldt et al., 2016). Other studies reported the ANP being the 'setter in motion' to enhance patients quality of life (Fox et al., 2018; Kerr & Macaskill, 2020; Yee et al., 2013). Three studies reported senior nursing colleagues dismissing the ANPs' ability to set in motion operational activities and driving change and viewed them in a predominantly clinical role (Kerr & Macaskill, 2020; Poghosyan & Liu, 2016; Ryder et al., 2019).

Five studies reported ANP setting in motion as favourable when ANP relationships improved teamwork with all members of the healthcare team (Cowley & Cooper, 2016; Fox et al., 2018; Sangster-Gormley et al., 2011; Schadewaldt et al., 2016; Weiland, 2015). Four studies reported the need to focus on promoting ANPs' clinical autonomy to improve full utilisation of the role (Kerr & Macaskill, 2020; Park et al., 2018; Ryder et al., 2019; Spetz et al., 2017). ANP setting in motion was shown in eight papers as improving patient satisfaction and reducing patient waiting times (Athey et al., 2016; Cowley & Cooper, 2016; Fox et al., 2018; Kerr & Macaskill, 2020; Park et al., 2018; Poghosyan & Liu, 2016; Ryder et al., 2019; Schadewaldt et al., 2016). All 19 studies included in Table 2 reported implementation and full ANP clinical autonomy as enabling delivery of patient care when there is clear differentiation and understanding of the role with all members of the healthcare team.

5 | DISCUSSION

The four themes have contributed to a new understanding of the overall meaning of ANP clinical autonomy. The limited research in this area is a crucial finding of this review. One plausible explanation is that ANP clinical autonomy is an elusive concept: hard to grasp and difficult to measure (Dempster, 1994).

Evidence from the literature is that ANP clinical autonomy means more than just the shifting of medical tasks from one professional group to another, which is a view that has described ANP clinical autonomy in previous nursing literature (Maier et al., 2016). For example, the theme of 'stepping up' is a notion of advanced levels of nursing professional practice, including independent prescribing and diagnosis and expert levels of clinical decision-making skills (Anderson et al., 2019; Kerr & Macaskill, 2020; Ryder et al., 2019). 'Stepping up' has been reported as utilising a holistic approach to clinical autonomy in that ANPs incorporate nursing and medical activities such as being alone with the patient, health promotion and physical assessment, diagnosis and treatment initiatives (Kerr & Macaskill, 2020; Sangster-Gormley et al., 2011; Weiland, 2015).

However, the authors in some papers reported that the full capabilities of ANP clinical autonomy is not consistently implemented in clinical practice (Anderson et al., 2019; Kerr & Macaskill, 2020; Maylone et al., 2011; Poghosyan & Liu, 2016; Ryder et al., 2019; Weiland, 2015; Yee et al., 2013). All healthcare professionals are required to hold a level of education and professional qualifications to undertake their roles safely for the patient. Additionally, it appears that ANPs are a professional group, who are and will be challenged regarding their clinical autonomy in practice (Bahadori & Fitzpatrick, 2009; MacLellan et al., 2016; Poghosyan & Liu, 2016; Sangster-Gormley et al., 2011; Weiland, 2015; Yee et al., 2013). Indeed, some ANPs in studies within the narrative review reported that they left their training as ANPs and returned to their previous nursing roles due to an inability to 'bounce back' from restraints to their practice (Turner et al., 2007; MacLellan et al., 2016). The reported lack of knowledge of ANP clinical autonomy may link to the reported control over practice in the role resulting in a negative effect on their confidence and competence (Burgess & Purkis, 2010; Poghosyan & Liu, 2016; Schadewaldt et al., 2016; Turner et al., 2007).

The themes of 'living it' and 'bounce-back ability' have in some ANPs resulted in constraints in the form of the attachment of CPA agreements to physicians (Athey et al., 2016; Bahadori & Fitzpatrick, 2009; Fox et al., 2018; MacLellan et al., 2016; Maylone et al., 2011; Park et al., 2018; Sangster-Gormley et al., 2011; Schadewaldt et al., 2016; Spetz et al., 2017; Turner et al., 2007). This was particularly evident in some studies reporting ANPs having to agree their clinical diagnostics, prescriptions, referral and discharge decisions with a physician (Athey et al., 2016; Bahadori & Fitzpatrick, 2009; Cajulis & Fitzpatrick, 2007; Maylone et al., 2011; Park et al., 2018; Poghosyan & Liu, 2016; Weiland, 2015; Yee et al., 2013).

Additionally, 'setting in motion' is a theme identified as ANPs clinical autonomy to improve patient care pathways and service delivery. The 'setting in motion' of ANPs clinical autonomy is a significantly important part of their ANPs clinical autonomy (Begley et al., 2014; ICN et al., 2020; National Council of Nursing & Midwifery (NCNM), 2008).

The year 2020 was marked by the World Health Organisation (WHO) as the year of the nurse and midwife (WHO, 2020). However, at the time of writing this narrative review, the world is dealing with a pandemic. ANPs are valuable frontline decision-makers who do and will 'step up' and play their part in dealing with COVID19, including the diversification and desire to keep patients closest to their homes with a quality patient focus (ICN et al., 2020).

5.1 | Future research

There needs to be greater clarity about what is being explored regarding autonomy, as autonomy, nursing autonomy, ANP professional, and ANP clinical autonomy are all closely linked but are not the same contributing to confusion in the literature. However, the literature reviewed for this narrative review showed that specific tools developed to measure ANP clinical autonomy are sparse. Additionally, the ANP role is specific to high levels of clinical autonomy, which includes completing full episodes of care without a physician's oversight, including ANPs making a diagnosis, and independent prescribing. Furthermore, ANP clinical autonomy also includes leadership with a strategic operational position to drive and lead service provision this should be championed in all layers of healthcare. The title of ANP roles need to be recognised as a protected role in future research. Other specialist nursing and non-nursing functions under the same umbrella can add to the literature's existing confusion.

5.2 | Limitations

A narrative review can be undertaken where there are divergent data and an area of interest that needs to be identified (Onwuegbuzie & Frels, 2016). However, the diverse datasets, the variety of settings for the studies, the cultural influences and the context of qualitative and quantitative studies may have influenced the findings, making interpretation and generalisation about ANP clinical autonomy difficult.

6 | CONCLUSION

The review identified that ANP clinical autonomy includes a sense of self-determination in clinical practice and this requires support to prepare and strengthen future directions. The findings reveal that ANP clinical autonomy identifies being an individual practitioner as well as collaboration with other healthcare professionals. A clearer understanding of ANPs' clinical autonomy would help strengthen healthcare professionals' understanding and increase full utilisation in clinical practice. Further research into ANP clinical autonomy could help develop a more in-depth understanding and expand on the themes outlined in this review.

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CONFLICT OF INTEREST

The authors can confirm that all authors meet the authorship criteria and that all authors are agreed with the content of the manuscript.

AUTHOR CONTRIBUTIONS

E. L., D. L., M. R. S. and A. M. made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data. E. L., D. L., M. R. S. and A. M. were involved in drafting and revising the manuscript for intellectual content. E. L., D. L., M. R. and A. M. gave the final approval to the version to be published. Each author participated sufficiently in the work and took public responsibility for appropriate portions of the content. E. L. was accountable for all aspects of the work to ensure that the questions related to the work's integrity.

DATA AVAILABILITY STATEMENT

Data sharing does not apply to this article, as no datasets were generated or analysed during the narrative review.

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