Effective nursing leadership is key in providing quality patient care. Widespread changes in the healthcare delivery system have prompted nurses to develop leadership skills to manage the challenges of shorter hospital stays, high patient acuity, and reduced nurse staffing. Advance practice nurses (APNs) are in a unique position to influence practice and implement change as intervention nurses.

The purpose of this article is to describe the author’s role as an intervention APN and the ways in which the experience illustrates leadership and professional development from hospital discharge to home. The content is divided into three main topics:

- Background issues related to the definition of leadership and research projects
- The APN in a research role
- Clinical experiences during the research process

Background

Covey (1992) described people in leadership roles as individuals who can bring about change while including others in the creative process. Behaviors of effective leaders include critical thinking, problem solving, respect for others, and proficiency in communication (Tappen, Weiss, & Whitehead, 2001). APNs are adept at developing innovative ways to deliver specialized patient care using these leadership skills in cooperation with patients, families, and the healthcare team.

Research Projects

During the past eight years, the author has performed various roles as an APN and site coordinator in two research projects (McCorkle, Pickett, Malkowicz, & Robinson, 1998; McCorkle & Strumpf, 1992). She managed the care of numerous physiologic and psychological consequences of disease experienced by patients and families. In her capacity as research nurse, she was responsible for enrolling study subjects from one of two study sites, abstracting medical records, collecting study materials, and disseminating completed study results.

The first project, Nursing’s Impact on Quality-of-Life Outcomes in Elders (McCorkle & Strumpf, 1992), was supported by the National Institute of Nursing Research. The researchers recruited 375 elderly patients ages 60–92 who were treated surgically for newly diagnosed solid cancers between February 1993 and December 1995 and their family caregivers. Subjects were assigned randomly to either an intervention group or a control group. The control group, also called the usual care group, received only the services that typically were provided to patients by the institution. The intervention group received additional expert nursing care. The author was one of several APNs with specific geriatric or oncology education or experience who provided care to the intervention group only. The primary aim of the nursing outcomes project was to compare the length of survival between patients in the two groups. Additionally, survival was assessed through examination of other variables, including depressive symptoms, symptom distress, functional status, comorbidities, length of hospital stay, patient age, and disease stage (McCorkle et al., 2000).

A standardized nursing intervention protocol (SNIP) was developed to guide the delivery of patient care during home visits and telephone calls. The goal of the SNIP was to improve patient outcomes, enhance surgical recovery, and ensure that all subjects in the group received the same nursing care. The SNIP consisted of a preset schedule of visits and calls, management and assessment guidelines, and information about recovery, treatments, and psychological issues. Care was delivered over a four-week period during which each patient and caregiver dyad received three home visits and five telephone contacts. APNs provided various services, including physiologic and psychological assessments, direct care, and teaching for both the patients and caregivers.

The second project, Nursing’s Impact on Quality of Life Post-Prostatectomy (McCorkle et al., 1998), was proposed and developed to extend the work of the previously described study. Similarly, this project examined the effects of a SNIP on quality-of-life outcomes. Funded by the American Cancer Society, researchers recruited patients after prostatectomy for prostate cancer and their significant others in two urban institutions from 1997–2000. The primary aim was to examine the effects of the SNIP on various patient outcomes. The subjects were evaluated for quality-of-life measures, including anxiety, depression, and symptom distress; the researchers also studied the use of services by patients. Partners were evaluated for preparedness to care and caregiver demands. Measures were taken at baseline, three months, and six months after prostatectomy. Findings from the first project (McCorkle & Strumpf, 1992) demonstrated the need for additional psychosocial support to manage changes in intimacy and sexuality and potential incontinence experienced after prostatectomy. Therefore, the SNIP for the second project was revised to address those specific psychosocial issues for men and their partners, increasing the frequency of home visits to seven and telephone contacts to eight over two months. APNs provided services comparable to those in the first project, including in-depth physiologic and psychosocial assessments, limited direct care, and extensive teaching and counseling.

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