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Role of Dutch internal policy advisors in a hospital quality improvement programme and their influence on nurses' role development: a qualitative study

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ABSTRACT

Objective Nurses are vital in providing and improving quality of care. To enhance the quality improvement (QI) competencies of nurses, hospitals in the Netherlands run developmental programmes generally led by internal policy advisors (IPAs). In this study, we identify the roles IPAs play during these programmes to enhance the development of nurses' QI competencies and studied how these roles influenced nurses and management.

Design An exploratory ethnographical study comprising observations, informal conversations, semistructured interviews, focus groups and a strategy evaluation meeting.

Setting A teaching hospital in an urban region in the Netherlands.

Participants IPAs (n=7) in collaboration with four teams of nurses (n=131), team managers (n=4), senior managers (n=4) and the hospital director (n=1).

Results We identified five distinct advisory roles that IPAs perform in the hospital programme: gatekeeper, connector, converter, reflector and implementer. In describing these roles, we provide insights into how IPAs help nurses to develop QI competencies. The IPA's professional background was a driving force for nurses' QI role development. However, QI development was threatened if IPAs lost sight of different stakeholders' interests and consequently lost their credibility. QI role development among nurses was also threatened if the IPA took on all responsibility instead of delegating it timely to managers and nurses.

Conclusions We have shown how IPAs' professional background and advisory knowledge connect organisational, managerial and professional aims and interests to enhance professionalisation of nurses.

INTRODUCTION

Nurses are important for ensuring and enhancing the quality of patient care.[1 2] The educational level and competencies of nurses affect patient satisfaction[3] and outcomes,[4] including mortality,[5 6] hospital-acquired infections[7] and length of hospital stay.[8] Nurses can

Strengths and limitations of this study

► An ethnographical design allowed the authors to analyse in detail the roles internal policy advisors perform in a hospital programme and their interaction with nurses and managers.

► The use of five different data collection methods strengthens the validity of the study.

► The results obtained during observations and informal conversations were verified in the interviews and focus groups.

► As always in ethnographical studies, there were chances of 'going native', and we tried to prevent this with ongoing reflection in the research team.

improve patient care by blending evidence-based practices and quality improvement (QI) tools into daily practices.[9 10] However, nurses sometimes lack the knowledge, skills or opportunity to perform these tasks.[11–13]

To address this problem, national governments are developing educational programmes to help nurses enhance QI.[14–17] In addition, healthcare organisations are starting programmes to help nurses develop QI roles.[18–21] In the Netherlands, these programmes are created and run by internal policy advisors (IPAs). IPAs are employed in every Dutch healthcare organisation and play an important role in supporting management and professionals in QI work. Most IPAs have a masters in human resource management, healthcare management, healthcare economics or health sciences. Like a business consultant, they provide formal and informal advice to management, and support and mentor all healthcare professionals in QI work. IPAs were mentioned for the first time in formal Dutch policy documents in the 1970s. Nowadays, IPAs do not have formal

hierarchical 'power', but based on their expert role they play an important role in steering, supporting QI projects and mentoring healthcare professionals in their QI work. However, it is not clear how IPAs contribute to nurses' role development. Nurses are currently in the spotlight as they ensure quality and safety of patient care in the fight against a global pandemic. More insight into the role of IPAs will help to enhance the support and professionalisation of nurses to increase the quality and safety of healthcare.

The role of IPAs in healthcare and nurses' role development has not been properly defined. In the business and management literature, IPAs are described as internal consultants,[22–24] in-house consultants,[25] organisational development practitioners,[26] quality experts[27] and 'employees who apply broad-based knowledge and experience about a specific area of the business to help develop and implement strategic improvement plans, identify performance gaps, and develop and support the implementation of a recommended plan of action to close the gaps and provide for long term sustainability of the initiative'.[28] Without the authority to decide on policy and implementation issues,[29] they act as change agents,[22] boundary spanners,[30–32] intermediaries,[33] legitimisers[34] and/or influencers.[35] In these roles, IPAs have to find the balance between being an advocate and an advisor[36] or between performance and relationships, keeping their programme in pace with assimilation by stakeholders and giving individual stakeholders the support they need.[29 37]

In our ethnographical study, we investigated the roles IPAs undertake in healthcare to support nurses in enhancing QI competencies. We asked how IPAs collaborate with nurses and nurse managers to foster QI competencies among nurses.

METHODS

We studied the roles of IPAs in a nurse professionalisation programme that focused on QI in a Dutch teaching hospital (481 beds and 2600 employees including 800 nurses). We used exploratory ethnographical data collection methods to understand the roles of IPAs, including their patterns of action, meanings, accounts and relationships with stakeholders (such as the hospital board, higher management, team management and nurses).[38 39]

Setting and participants

The hospital studied was chosen for convenience; this hospital allowed the researchers to follow the nursing professionalisation programme. At the time, most hospitals in the Netherlands were involved in experimenting with distinct nursing roles in QI.[40] Our hospital is a representative Dutch teaching hospital. From July 2017 to January 2019, we observed a project group (consisting of seven IPAs) as they developed and implemented a programme to support nurses with QI work. We also investigated the project group's encounters with stakeholders (table 1). All IPAs were employees of hospital advisory departments, held a staff position, advised the hospital board and management, and were responsible for implementing QI and other professional development programmes. The project group and higher management selected four nurse teams (two from general wards and two from specialised wards) to take part in the programme. The four teams included vocational trained nurses, bachelor-trained nurses, nurse practitioners, specialised nurses and nurse managers.

The first author approached the participants by email or in person and informed them about the study aim and content, explaining that participation was voluntary and could be ended at will. All participants gave informed consent.

Data collection

We used five research methods over 19 months (table 1). The first author led the data collection and the second author attended the project group and reflection meetings. Both authors maintained the observer-as-participant perspective.[41] Observations and informal conversations during the development of QI competencies gave us in-depth insight into the opinions and beliefs of the respondents. Participating in four different meetings showed us the roles of IPAs, the aims of IPAs, the results of the programme and interaction patterns. During observations, conversations and meetings, we took brief notes that were shortly afterwards expanded to include full details to ensure data validity.[42] These notes were complemented by formal minutes and material presented at meetings, such as organisational documents, IPA policy documents, activity plans, reports and information letters.[43] We also conducted semistructured interviews. The topic list, based on an analysis of the detailed notes and minutes, included the development of QI competencies, the way IPAs supported the development of QI competences, the influence of the programme on the developmental process, the interaction of IPAs with stakeholders (eg, nurses, managers, IPAs, director, external parties), distinctive roles the researchers observed, paradoxes based on the analysis and balance between these paradoxes. Interviews were audiorecorded, transcribed verbatim and anonymised, and helped us to deepen our findings. Finally, we held focus groups, a strategy meeting and reflection meetings to share our findings (member checking) and to evaluate the programme and the roles of everyone concerned. The focus groups were audiorecorded and transcribed verbatim.

The first and second author made reflective notes of their assumptions and feelings during fieldwork, which the research team discussed to prevent their 'going native'.[44]

Data analysis

We used a grounded theory approach to distinguish IPA roles.[39 45] After discussing the level of saturation, we began the analysis by reading the notes, organisational documents, detailed notes and transcripts to understand the

Table 1 Data collection methods

Hospital wards	Participants	Observations	Informal conversations	Interviews	Meetings
Neurology* Surgery* Oncology* Pulmonology*	Project group (n=7): 2 IPAs with a background in nursing and higher education in change management: 3 IPAs from Internal Training 1 IPA from HR 1 IPA from quality and safety Ward nurses: VNs, BSNs, senior nurses (n=131), team managers (n=4), senior management (n=4), board (n=1)	Approx. 65 hours	Approx. 15 hours	Top manager (n=1) Nurse managers (n=4) VNs (n=6) BSNs (n=9) Paramedics (n=2) 22 interviews, 60–90 min each.	► Kick-off meetings: team manager, project group members (n=2). ► Team meetings: BSNs, VNs, senior nurses, manager (n=15). ► Bimonthly interdepartmental meetings: two nurses per team, team managers, project group members (n=10). ► Project group meetings: nurse project leader, nurse project member, teachers/coaches, HR staff, researchers (n=20). ► Team focus groups (n=4; 19 nurses in total). ► Strategy evaluation meeting: board, higher management, IPAs incl. one from communications dept and one researcher. ► *Reflection meetings: project leader (IPA1) and IPA2, nurse advisory dept, two researchers (n=9). Total meetings: 57

*The purpose of these meetings was to reflect on the programme, progress, roles of stakeholders and preliminary research findings.
BSNs, bachelor-trained nurses; HR, human resources; IPAs, internal policy advisors; VN, vocational nurse.

raw and unstructured data. Then, the first author identified the IPAs' actions, instruments, influence, intentions and the impact on and reactions of the stakeholders. Next, the first author performed axial coding to compare single fragments, group codes and/or recoded fragments to distinguish patterns in actions and aims. After the research team had discussed and agreed on the axial codes, the first author coded selectively to reveal coherence between several group codes, iteratively comparing the findings with all data gathered to avoid forcing the data.[46] This selective coding allowed the research team to formulate five distinct IPA roles, which were then compared with the roles described in the literature.

Patient and public involvement

No patients or members of the public were involved in this study.

RESULTS

In the programme, we revealed five distinct roles for IPAs that aimed to develop the nurses' QI competencies. Here, we describe how the IPA statements reflect those roles and whether they help ward nurses become QI leaders.

The gatekeeper

IPAs designed the hospital programme to steer the development of nurses' QI competencies. We noticed that IPAs decided which information (sources and people) was incorporated. We observed how IPAs acted as gatekeepers by limiting the flow of information to avoid overwhelming nurses and how they framed the core messages to suit different stakeholders:

> In our hospital, the strategic focus is on professional leadership. The IPAs incorporated the national trend in enhancing the QI competencies of nurses in the ' Nurses' leadership' program. Subsequently, they present [the results] to the senior management team. (Nurses' leadership program 2017 – 2020)

This excerpt shows how the IPAs selected relevant themes (ie, nurse leadership, expertise and autonomy, task reallocation on QI improvement tasks) to endorse the hospital's strategy and policy.

The IPAs also decided when and how to share information about the programme and programme results with the outside world. They mentioned that sharing experiences too early could undermine the organisation's credibility, especially when things did not develop as anticipated. On the other hand, both internal and external public relations were important. As one IPA said: 'Let's shine in this meeting [with regional partners] and show them all the good we are doing here' (fieldnotes1). We noticed that exchanging information with third parties

influenced the ability of both the hospital and the sector to learn:

> At the presentation of the new job profiles, representatives of the hospital's frontrunners group [the studied wards] jumped to the conclusion that differentiating jobs based on complexity of care would not work, and that they needed to focus on QI work. We [IPA1] said: Let's just try it, to understand why it won't work (fieldnotes 2).

IPAs strategised the programme development, so were part of strategic discussions to learn about the professional developments, policies and challenges and to understand the relevance of these for both nurses and managers. This allowed them to connect different practices for the uptake of a nurses' QI role.

The connector
IPAs connected hospital units/wards and different hierarchical levels of the organisation to support shared decision making and adoption of new policies or relevant themes. They served as a linchpin for different stakeholders and themes. Respondents considered the role of connector important to creating synergy and eliminating obstacles between different organisational processes and stakeholders to support nurses' QI professionalisation.

> IPA1 reports that after senior management had approved the program, she was concerned about how to keep them involved and asked the director to discuss this with them: 'She did a good job here, in her position.' […] The project team was disbanded when the program was approved, but IPA1 said she would continue to hold informal meetings with team management, 'to keep them from going every which way' (informal conversation 1).

> and

> Team manager: 'I once had a conversation with IPA6 (internal training) and indicated: 'I really feel a bit sidetracked and I don't like that role.' IPA6 said: 'Well then we have to talk to each other. And we did. (…) And I don't feel the need to check the IPA, if the nurses have the feeling: we can get on with her, then I'm fine with it.' (interview 1).

These examples show that by maintaining and investing in interpersonal relationships, the IPAs bonded with people from different organisational levels. In this way, they prevented collusion or nurses and managers turning against one another.

Maintaining these extensive relationships gave IPAs access to privileged knowledge and confidential insight into the different needs, ambitions and interests of people and committees.

We noticed that a professional background in nursing increased the IPAs understanding of the needs and interests of nurses. To be a connector, IPAs must speak the language of nurses. They must, knowing what to keep confidential, be politically sensitive and aware of stakeholder influences.

However, our data revealed a fragile balance between meeting different needs and keeping information confidential. Listening too closely to only one party threatens the IPA's role as an independent advisor and disrupts relationships and progress of the programme. It leads to such questions as: 'Who do you [they] belong to?'. We observed that when IPAs turned into ambassadors, advocating a particular theme or activity, it put them in a position of supporting or defending a certain group's interests and/or receiving criticism meant for others. This threatened the IPA's independence and their role as a connector.

> IPA1 and IPA3 discuss how nurses can use information on quality (nurse-sensitive outcomes or patient satisfaction measurements) to develop their QI role as well as the QI tasks they are already doing on the ward (theme discussions, bedside teaching, EBP discussions). IPA3 is keen to give the nurses this responsibility. Both IPAs weigh the pros and cons and discuss how to boost it, for example by setting up a steering group. IPA3 suggests first sharing this idea with other stakeholders because steering QI is the task of team managers. Disregarding them could cause a hassle, she supposes (fieldnotes 3).

This excerpt shows how IPAs bond together to support and steer the development of the nurses' QI role. Together, they find ways to balance openness and transparency with keeping things confidential to avoid damaging people's trust or becoming an advocate for one party only (in this case only for the nurses). This allows them to maintain their connector role.

The converter
IPAs had informal conversations with nurses and managers, attended meetings, taught staff and wrote reports, activity plans and information letters to hold the interest of the various stakeholders. They modified information so different audiences could use and understand it. To engage effectively with their audiences, IPAs aligned their message on three levels: content, form and voice.

> IPA1 shares a presentation she prepared for a higher management meeting, showing some slides with key objectives, to inform and get commitment for the chosen direction. On the content level, she stresses the strategic positioning of the organization, using managerial vocabulary and areas of interest, e.g., strategy, operation, patient safety, and quality, and restructuring work processes. When presenting the information to nurses, she chose to present a ' news bulletin', allowing nurses to take the floor, and blending the plans with stories from practice. The Nurse Affairs Department arranged the event (fieldnotes 4, PowerPoint presentation/ news bulletin).

This excerpt shows that IPAs change their message, using different arguments, key words and tone of voice and placing emphasis on specifics relevant to their audience to get their message across. We observed them deliberately using 'the right language', to fit in better and gain support from nurses and managers for their programme. The excerpt also shows that IPAs collaborate with others who can help spread the information, such as formal communications and training departments and informal leaders in the target groups, such as the nurses speaking in the news bulletin.

We observed that, in their converter role, IPAs are not always objective information distributers/disseminators. During the interactions, they influenced people and (nursing) practices and sometimes translated a message for their own purpose. IPAs have power because of their formal position, network and resources inside and outside the organisation. This makes it easy to manipulate the flow of information, and influence different stakeholders. To act sincerely, they need to be aware of the paper-thin difference between adjusting information to make it easily understood and manipulating it in a specific direction. Ensuring sincerity calls for reflection, as we show in the next role.

The reflector

We observed that IPAs distanced themselves to observe, analyse and interpret organisational processes and daily practices and discuss their reflections. To encourage reflection, the IPAs asked critical and thought-provoking questions, thus professionalising nurses to take on a QI role.

In discussing a QI role with nurses, IPA5 asks: 'How is the patient put first? Is it 'providing direct patient care' ? Yes, you say, that comes first. But in a QI role, you're still putting the patient first, perhaps very powerfully, taking care of that patient by doing research. And yes, that takes time, but otherwise nothing will change' (fieldnotes 5).

Reflection sessions on QI skills and the content of improvement projects were held with nurses and management to discuss the development of nurses as QI leaders. To perform this role, the IPAs relied on their knowledge of organisational change, learning strategies, feedback mechanisms and mediation, as shown in a nurses' interdepartmental meeting:

The nurses say that they will start with a coordinating role to improve the quality and coordination of care. The nurses have written a [role] profile and want to experiment with it in the coming evening shifts. IPA4 asks if and how they will evaluate this experiment. The nurses admit that they haven't figured that out yet. The IPAs wonder which criteria the coordinating role should meet. How do the nurses want to evaluate this role? They urge the nurses to think about this in advance (fieldnotes 6).

We observed that too much reflection from the IPAs irritated nurses and managers. They perceived this as undesired feedback and intrusion in the team's progress. IPAs need to balance when and how (tone of voice and content-wise) to intervene and when it is not appropriate to get involved and leave it to professionals themselves.

The implementer

IPAs designed and guided the implementation of QI initiatives in collaboration with stakeholders. IPAs prepared an action plan that covered various milestones and required resources such as infrastructure, finances and training. We observed that IPAs often determine the unwritten rules, manners and ethics of QI work, in addition to more formal aspects like planning and finances, which higher management expect IPAs to enforce. However, we observed that enforcement was difficult as IPAs cannot rely on a formal position from which to issue orders. We also noticed a lack of sanctioning power. IPAs' strength and personal power is based on their being regarded an expert in the field, their understanding of comparable organisational processes across the entire organisation, and their close relationships with management.

IPA1: We kept the nurses' QI role really open, and that's okay, it's a change process. But at a certain point you have to get results.

Team manager 1: But be realistic and look [what's happening on] our wards. Nurses have just started discussing which QI project to do first. It's going well, but it's creating a fuss [in the team].

IPA4: I hear team managers saying, let it go, let them discover and learn for themselves.' Team manager 2: 'They have to carry it out themselves. I think that's vital (fieldnotes 8).

And

Director: You need to have confidence in your officers who are in control in the process. Confidence that they will leave it up to the teams, that they have the experience and insight into the profession, estimating well what is needed, being ambitious, wanting to achieve something, and dialoguing with them. Here, the people who are familiar with the workplace, have to provide the framework and guide the process. (…) Management, advisors and professionals, they are synergetic (interview 2)

The success of IPAs corresponded with the success of the programme. This intermingling had three consequences. First, IPAs increased their control on the QI project to safeguard the success of the programme, instead of keeping a distance to give nurses room to experiment with their roles and find their way in QI work. Second, focused on success, the IPA forced progress (including decision-making) instead of taking the time to get people on board with the programme. When IPAs became advocates for the programme, we observed they are no longer

able to step back, to reflect with the group (see also the reflector role), to help nurses to develop, and to let go if interests change. They became overly involved and formed vested interests that confused the means and ends instead of directing the programme.

> Guiding the implementation, the IPAs (1,2,5,6) look behind the scenes of the teams/managers at work. One IPA is critical of a team manager's performance. In her opinion, the team manager is not performing well, does not know what is required, is working without an improvement plan, and is choosing the 'wrong' people to take on a QI role. According to this IPA, the team manager is obstructing the development of a QI role for the nurses. The IPA puts pressure on the team managers and raises the topic in the project group and with the senior manager, who initially seems to agree with this opinion (fieldnotes 9).

As a result, the IPAs encroached on the managers' area of responsibility, which threatened their long-term relationship, and it became unclear whether the IPA was an ally. In our case, this confusion was discussed in an evaluation meeting between higher management and IPAs, reflecting on the importance of role integrity and clarity:

> IPA: The Nurse Affairs Department is part of line management.
>
> Senior manager: Is the Nurse Affairs Department a line manager?
>
> IPA Q& S:'Are you staff, supporting…? [It's about] nurses who are developing….'
>
> Team manager: The Nurse Affairs Department leads the way, hits the ground running, but the team managers aren't being heard. That's been expressed to the managers. It's a recurring pattern.
>
> IPA: I don't have end responsibility. The line decides, I'm not in the lead. But I feel that I've just been abandoned. […] I'm wearing different hats. Not getting your support. And we're not on the same page.
>
> Senior manager: I have to be kept informed, by line managers and staff. I only need some reflection from the IPAs to take on my responsibility. I don't need any judgment or stigma.
>
> Manager: The Nurse Affairs Department represents the nurses' voice. What they suggest comes from the nurses. I suppose. Or is that not true? Now, it feels like your own opinion (transcript of conversation 10).

Becoming an advocate for professional role development meant that IPAs—especially those with a professional background—lost their independence and credibility and overlooked the interests of others, especially when faced with opposing perspectives to their own on nurses' QI development. Moreover, as this excerpt shows, IPAs formed their own perspective, getting the critics from all parties together. Going too far threatened the whole trajectory as well as their own position;

they put themselves on the line by claiming ownership of something that does not belong to them (at the time), but to managers or nurses themselves. To succeed in implementing a quality enhancer's role in nursing, we learnt that IPAs balance between leading the implementation (process), facilitating the successful development of a nurses' QI role (content) and leaving responsibilities to managers and nurses when appropriate (ownership). They needed to maintain an advisor's position and prevent outright rejection of the programme, even if it temporarily hampers the development of the QI role.

DISCUSSION

This study investigated IPAs' roles in leading a hospital programme to improve the QI role of nurses, a topic seldom described in the current literature. We show that IPAs have five roles: gatekeeper, connector, converter, reflector and implementer. These roles help nurses to develop QI competencies because they shape the programme, frame information for different audiences, understand the needs and interests of nurses, and advocate for a QI role for nurses.

Our findings resemble those of general business and management studies on the roles of internal consultants.[47] We have defined the roles in which IPAs influence,[35] legitimise,[34] span boundaries[30–32] and stir up change,[22] to support QI role development in nurses. We have added to the literature by showing that, as gatekeepers, IPAs connect internal and external parties, protecting what comes in and goes out. As such, they act as boundary spanners[30–32] and boundary setters to protect the development of QI competencies in nurses. In the connector's role, IPAs are intermediaries[33] who partner with external[30] and internal stakeholders to align objectives and values and gain knowledge on how to support nurses. As converters, IPAs bring relevant information to different audiences.[33] This is not a neutral position. In contrast to others,[35] we have shown that IPAs develop the programme and frame information to exert influence. Business and management studies have not investigated the effect of a professional background on the IPA's role; here, we show that a professional nursing background helps the IPA to develop a QI role for nurses. By blending their organisational/advisory skills with their nursing knowledge, IPAs can support and steer the development of a nurses' QI role. In contrast to a recent study on the quality experts' role,[27] we found that IPAs can fulfil a strategising role. Their strategic position, nursing background and advocacy role[24] help them to make an important contribution to the professionalisation of nurses.

In contrast to previous studies,[25 32 36] we showed that IPAs must balance between organisational/managerial and professional interests, to meet the interests of all stakeholders rather than being the only decision-makers.[34] This presents several challenges. First, IPAs help nurses develop by advocating on their behalf and helping them reflect critically on their performance. Second, IPAs with

a nursing background can lose their independence and credibility if they identify too strongly with nurses and lose their connection with other stakeholders' opinions and interests.[30] Third, balancing between managerialism and professionalism means that IPAs must realise what is achievable and what is desirable in terms of professionalisation. Advocating too much for the programme threatens the nurses' QI role development and the IPA's position.[24 37] Keeping ownership in the wrong spot puts pressure on the relationship between IPAs and management[23] and nurses.

Four wards of one Dutch teaching hospital were included in this study, which might limit the potential of generalising our findings. A disadvantage of ethnographical studies is 'going native'.[48 49] However, we followed the suggestions of Maso and Smaling[50] to prevent this: (1) every month, the researchers isolated themselves from daily hospital practice to reflect with the whole research team, (2) researchers avoided getting involved in hospital commitments and obligations beyond data collection and (3) researchers understood the issue of confidentiality of relationships and preserved sensitive information to avoid betraying trust. Another limitation of our study was the focus on the role IPAs play in a nurse development programme. We paid less attention to collaborations with other professionals, management and healthcare processes or outcomes. Further research in this direction is needed.

CONCLUSION

IPAs are vital to the development of nurses' QI competencies. IPAs fulfil five distinct advisory roles: gatekeeper (actively involved in the interchange of information on nurses' QI development between the internal and external environment); connector (connecting themes and wards horizontally and stakeholders hierarchically); converter (adapting content, form and voice for different audiences); reflector (learning and reflecting with nurses about QI tasks and with management about developmental process and alignment with organisational goals) and implementer (designing and guiding implementation of QI initiatives in collaboration with stakeholders). In fulfilling these roles, IPAs use their knowledge of the organisation and their professional background to promote the professionalisation of nurses—especially in their QI. Simultaneously, IPAs must balance between organisational, managerial and professional aims and interests to prevent obstructions or delays in QI role development. We showed that development of the QI role is hindered if IPAs give precedence to their own perspective on the profession and lose sight of the different interests and opinions of internal stakeholders.

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REFERENCES

1 Altman SH, Butler AS, Shern L, eds. *Assessing progress on the Institute of Medicine report The Future of Nursing*. Washington, DC: National Academies Press, 2016.
2 World Health Organization (WHO). Nursing & Midwifery, 2020. Available: https://www.who.int/news-room/fact-sheets/detail/nursing-and-midwifery [Accessed 8 May 2020].
3 Aiken LH, Sloane DM, Ball J, *et al*. Patient satisfaction with hospital care and nurses in England: an observational study. *BMJ Open* 2018;8:e019189.
4 Lehr J, Vitoux RR, Evanovich Zavotsky K, *et al*. Achieving outcomes with innovative smart pump technology: partnership, planning, and quality improvement. *J Nurs Care Qual* 2019;34:9–15.
5 Audet L-A, Bourgault P, Rochefort CM. Associations between nurse education and experience and the risk of mortality and adverse events in acute care hospitals: a systematic review of observational studies. *Int J Nurs Stud* 2018;80:128–46.
6 Griffiths P, Ball J, Murrells T, *et al*. Registered nurse, healthcare support worker, medical staffing levels and mortality in English Hospital trusts: a cross-sectional study. *BMJ Open* 2016;6:e008751.
7 Coelho P. Relationship between nurse certification and clinical patient outcomes: a systematic literature review. *J Nurs Care Qual* 2020;35:E1–5.
8 Griffiths P, Ball J, Drennan J, *et al*. Nurse staffing and patient outcomes: strengths and limitations of the evidence to inform policy and practice. A review and discussion paper based on evidence reviewed for the National Institute for health and care excellence safe staffing Guideline development. *Int J Nurs Stud* 2016;63:213–25.
9 Hagle M, Dwyer D, Gettrust L, *et al*. Development and implementation of a model for research, evidence-based practice, quality improvement, and innovation. *J Nurs Care Qual* 2020;35:102–7.
10 Robert G, Sarre S, Maben J, *et al*. Exploring the sustainability of quality improvement interventions in healthcare organisations: a multiple methods study of the 10-year impact of the 'Productive Ward: Releasing Time to Care' programme in English acute hospitals. *BMJ Qual Saf* 2020;29:31–40.
11 van Oostveen CJ, Mathijssen E, Vermeulen H. Nurse staffing issues are just the tip of the iceberg: A qualitative study about nurses' perceptions of nurse staffing. *Int J Nurs Stud* 2015;52:1300–9.
12 Møller JE, Møller A, Ledderer L. Dilemmas in delivering health promotion activities: findings from a qualitative study of mental health nurses in Denmark. *BMJ Open* 2020;10:e036403.
13 van Schothorst–van Roekel J, Weggelaar-Jansen AMJWM, Hilders CCGJM. Nurses in the lead: a qualitative study on the development of distinct nursing roles in daily nursing practice. *BMC Nurs* 2021;20:1–11.

14 Meddings J, Greene MT, Ratz D, *et al*. Multistate programme to reduce catheter-associated infections in intensive care units with elevated infection rates. *BMJ Qual Saf* 2020;29:418–29.

15 Silvestre MAA, Mannava P, Corsino MA, *et al*. Improving immediate newborn care practices in Philippine hospitals: impact of a national quality of care initiative 2008–2015. *Intern Journ for Qual in Health Care* 2018;30:537–44.

16 Weggelaar-Jansen AM, van Wijngaarden J. Transferring skills in quality collaboratives focused on improving patient logistics. *BMC Health Serv Res* 2018;18:1–11.

17 White E. A comparison of nursing education and workforce planning initiatives in the United States and England. *Policy Polit Nurs Pract* 2017;18:173–85.

18 Plummer C, Ruco A, Smith KA. Building capacity in health professionals to conduct quality improvement: evaluation from a collaborative Interorganizational program. *J Nurs Care Qual* 2020;36:229–35.

19 Figueroa JF, Feyman Y, Zhou X, *et al*. Hospital-Level care coordination strategies associated with better patient experience. *BMJ Qual Saf* 2018;27:844–51.

20 Evripidou M, Merkouris A, Charalambous A, *et al*. Implementation of a training program to increase knowledge, improve attitudes and reduce nursing care omissions towards patients with dementia in hospital settings: a mixed-method study protocol. *BMJ Open* 2019;9:e030459.

21 Speroni KG, McLaughlin MK, Friesen MA. Use of Evidence-based practice models and research findings in Magnet-Designated hospitals across the United States: national survey results. *Worldviews Evid Based Nurs* 2020;17:98–107.

22 Buono AF, Subbiah K. Internal consultants as change agents: roles, responsibilities and organizational change capacity. *Organization Development Journal* 2014;32:35–53.

23 Holmemo MDQ, Powell DJ, Ingvaldsen JA. Making it stick on borrowed time: the role of internal consultants in public sector lean transformations. *The TQM Journal* 2018;30:217–31.

24 Scott B, Barnes BK. *Consulting on the inside: a practical guide for internal consultants*. Alexandria, VA: ASTD Press, 2011.

25 Schumacher T, Scherzinger M. Systemic in-house consulting: an answer to building change capacities in complex organizations. *J Organ Chang Manag* 2016;16:297–316.

26 Smendzuik-O'Brien JM. *Internal organization development (od) practitioners and sustainability. dissertation. Fielding graduate university*, 2017.

27 Liff R, Andersson T. Experts' contribution to strategy when strategy is absent. A case study of quality experts in hospitals. *Public Management Review* 2020:1–21.

28 Thomas S. Internal consulting in your organization. date unknown. Available: https://reliabilityweb.com/articles/entry/internal_consulting_in_your_organization/ [Accessed 25 Aug 2020].

29 Miller C, Subbiah K. A five-factor model for success of internal consultants. *SAM Advanced Management Journal* 2012;77:27:4–12.

30 Korschun D. Boundary-spanning employees and relationships with external stakeholders: a social identity approach. *Academy of Management Review* 2015;40:611–29.

31 Sturdy A, Wright C. The active client: the boundary-spanning roles of internal consultants as gatekeepers, brokers and partners of their external counterparts. *Manag Learn* 2011;42:485–503.

32 Wright C. Inside out? organizational membership, ambiguity and the ambivalent identity of the internal consultant. *Br J Manag* 2009;20:309–22.

33 Sin CH. The role of intermediaries in getting evidence into policy and practice: some useful lessons from examining consultancy–client relationships. *Evidence & Policy: A Journal of Research, Debate and Practice* 2008;4:85–103.

34 Bouwmeester O, van Werven R. Consultants as legitimizers: exploring their rhetoric. *Journal of OrgChange Mgmt* 2011;24:427–41.

35 Kim Barnes B, Scott B. The influential internal consultant. *Industrial and Commercial Training* 2012;44:408–15.

36 Whittle A. The paradoxical repertoires of management consultancy. *Journal of Organizational Change Management* 2006;19:424–36.

37 Ejenas M, Werr A. Managing internal consulting units: challenges and practices. *SAM Advanced Management Journal* 2011;76:14–22.

38 Hackett PM, Hayre CM, eds. *Handbook of Ethnography in Healthcare Research*. Oxon and New York: Routledge, 2021.

39 Rendle KA, Abramson CM, Garrett SB, *et al*. Beyond exploratory: a tailored framework for designing and assessing qualitative health research. *BMJ Open* 2019;9:e030123.

40 Van Kraaij J, Lalleman P, Walravens A, *et al*. Differentiated nursing practice as a catalyst for transformations in nursing: a multiphase qualitative interview study. *J Adv Nurs* 2021. doi:10.1111/jan.15001. [Epub ahead of print: 10 Aug 2021].

41 Baker L. Observation: a complex research method. *Libr Trends* 2006;55:171–89.

42 Atkins S, Lewin S, Smith H, *et al*. Conducting a meta-ethnography of qualitative literature: lessons learnt. *BMC Med Res Methodol* 2008;8:21.

43 Leslie M, Paradis E, Gropper MA, *et al*. Applying ethnography to the study of context in healthcare quality and safety. *BMJ Qual Saf* 2014;23:99–105.

44 Dwyer SC, Buckle JL. The space between: on being an insider-outsider in qualitative research. *Intern Journ of Qual Methods* 2009;8:54–63.

45 Glaser BG, Strauss AL. *Discovery of grounded theory: strategies for qualitative research*. New York: Routledge, 2017.

46 Corbin J, Strauss A. *Basics of qualitative research: techniques and procedures for developing grounded theory*. Sage publications, 2014.

47 Batiste RJ. *Multi-actor versus single actor consulting satisfaction in central California acute care hospitals. Dissertation*. Capella University, 2007.

48 Kanuha VK. "Being" native versus "going native": conducting social work research as an insider. *Soc Work* 2000;45:439–47.

49 O'Reilly K. Going 'native'. In: *Key concepts in ethnography*. SAGE Publications Ltd, 2009: 88–92. https://www.doi.org/

50 Maso I, Smaling A. *Objectiviteit in kwalitatief Onderzoek*. Uitgeverij Boom, Amsterdam, 1990.