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Doing Social Space as a Chacterestic of Clinical Leadership Based on Advanced Nursing Practice - A Qualitative Ethnographic Study

Katrin Blanck-Köster[1,2*], Uta Gaidys[2] and Martina Roes[1,3]

[1]*University of Witten/Herdecke/ Faculty of Health; Department of Nursing Science, Alfred-Herrhausen-Straße 50, 58455 Witten/Herdecke, Germany*

[2]*University of Applied Science Hamburg / Faculty of Economy and Social, Department of Nursing and Management, Alexanderstraße 1, 20099 Hamburg, Germany*

[3]*Deutsches Zentrum für Neurodegenerative Erkrankungen (DZNE), Witten, Germany*

[*]Corresponding author

Blanck-Köster K, University of Applied Science Hamburg/Faculty of Economy and Social, Department of Nursing and Management, Alexanderstraße Hamburg, Germany.

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ABSTRACT

Aim: The study aims to present and analyze the daily practices of Advanced Practice Nurses in hospitals and to reconstruct the constitutive spaces of action, especially in the context of clinical leadership. In doing so, a detailed picture of the prevailing social practices will be described.

Research Question: How can Clinical Leadership be interpreted in dynamic work processes and their interaction in the hospital?

Methods: An ethnographic research design including participant observation of nine Advanced Practice Nurses in two hospitals was conducted during the period 5/2020 to 8/2020. Data analysis included sequence analysis of participant observations. The study was classified as ethically unobjectionable.

Results: This study shows how Advanced Practice Nurses connect people in the hospital through spacing processes and how they influence clinical care processes. The findings paint a detailed picture of the recurring everyday social practices of advanced practice nurses that are interwoven in a bundle and help to constitute and occupy social space. The results are presented in the Doing social space model.

Conclusion: This process of reflection helps nurses and other health professionals to critically examine the conventions and rules that underlie their actions in clinical care and to explain the reasons for their actions. The findings should be of great interest as the actions of nurses can be explained and understood from both practice-based theoretical approaches and a spatial sociological perspective.

Keywords: Advanced Nursing Practice, Advanced Practice Nurse, Clinical Leadership, Ethnographic Study, Characteristic, Daily Practices

Introduction

Advanced Nursing Practice (ANP) can be described as the specialty of advanced, in-depth, and specialized nursing practice [1]. Hamric et al. define an advanced practice nurse (APN) as a registered nurse who has acquired expert knowledge, complex decision-making skills and clinical competencies for advanced and in-depth practice, the characteristics of which are determined by the context and/or country in which the nurse obtained their professional license [2]. A master's degree is expected as an entry requirement. The role of the APN is defined by the ability to manage complex healthcare situations autonomously and is associated with the qualities of clinical expertise, leadership, autonomy of action and development of one's role [3]. "A lack of consistency and clarity in title, role definition, reporting systems and access to professional development is also described" [4].

In German-speaking countries, few role models exist in practice and there is a risk that the benefits of APN roles associated with broader and deeper specialization in nursing practice go unrecognized [5]. In response to increasing demand and declining medical staff, the roles and competencies of health professions are being adapted internationally. An example of this is APNs in primary care [4]. However, there is evidence that ANP practice lacks acceptance and understanding, leading to underutilization. There are still uncertainties and gaps in the interpretation and attribution of one's role, including among APNs themselves [6].

The importance of ANP in Europe is associated with the development of individualized and thus differentiated and specialized care in complex care situations in hospitals [7,8]. The role of Advanced Practice Nurses (APNs) has become increasingly established mostly in university hospitals in Germany, especially for the specific clinical care of chronically ill patients [8]. The implementation and evaluation of APNs' roles in Europe and their competencies focuses on the health needs of patients through coordinated care and collaborative relationships between health care providers and health care systems [9]. In this context, the clinical leadership competencies of APNs within the care process become more important [10-12]. These competencies are associated with collaboration, cooperation, and coordination,

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which are described by the roles, leadership models and leadership domains of APNs in clinical practice and are linked to clinical leadership [11,13].

Leadership is focused on managing people and making decisions. Soft skills play a significant role in leadership in contrast to management. There is an ongoing controversy about the difference between leadership and management [14]. John Kotter of the Harvard Business School argues that leading and managing should be seen as two different but also complementary ways of operating in organizations [15]. Leadership is about managing change, while management is about managing complexity [15]. For Kotter the leadership process involves developing a vision for the organization, aligning people with that vision through communication, and motivating people to act through empowerment and meeting their basic needs. In leadership, leaders focus on people, pursue vision, empower colleagues, shape change, and influence [15,16]. In their study "Palliative Care Leadership," Dahlin et al. describe the importance of advanced practice registered nurse (APRN) leadership concepts in the context of interdisciplinary care, interpreting leadership as a prerequisite for all other areas of clinical care [17]. Although clinical expertise is assumed to be intrinsic to the role of the APRN, the aspect of leadership is equally central, particularly in effecting change in practice [18]. Leadership can be understood as the ability of APNs to support and encourage individuals, their families, but also nurses or entire care teams in their development with the goal of achieving better outcomes for patients [19].

Although the international literature places significant importance on APNs' clinical leadership competencies, research offers limited insights into how APNs exercise clinical leadership and clinical skills in clinical practice, and how their practices open necessary spaces for action. They are mentioned in argumentative contexts as conditions of everyday life, but not defined in more detail [20]. Research into everyday nursing begins in nursing historiography in the first years of the 21st century [21]. It focuses on issues such as working hours, living, and working conditions, the development of professionalization and remuneration, as well as hierarchies within specialized health care institutions of specialized health care [18,21,22]. Sandelowski has addressed the importance of objects when exploring the influence of technology on nursing action [23]. At "Desire and Devices", Sandelowski describes the relationship between new tools and the development of practices around 1900 in the United States where the professionalization of the nursing profession was already much more advanced than in Germany [23]. In the past there has been little research on APN practices describing clinical leadership.

APN clinical leadership is central to the provision of evidence-based and patient-centered interprofessional care in hospitals [24]. In the German-speaking world, however, there is little knowledge about how APNs exercise clinical leadership and about the rules and contextual conditions that underlie their actions on a day-to-day basis. How APNs succeed in influencing complex care situations is crucial. A critical role in this process is played by APN practices.

Practices refer to a set of related activities that can be experienced and understood as a meaningful unit [25]. Practices as phenomena are doing and saying which in turn give rise to other practices [26]. Schatzki assumes that human life takes place in such bundles [26]. The locus of the social is a set of interrelated practices and arrangements that are constantly changing over time. Practices, arrangements, and their bundles extend in time and space. The present study is based on a practice theory approach, which is based on routines that reproduce social orders and focuses on knowledge [27]. Accordingly, the study is based on the analysis of routinized APN practices that reproduce social orders. In doing so, APN actions are not viewed in isolation, but as interconnected and effective through the body and language [27].

Backround

APNs specialize in either a specific disease (e.g., dementia) and/or medical specialty (e.g., oncology) and/or specific clinical problems (e.g., delirium) [8]. International studies examining APNs in long-term care facilities showed that the effectiveness of APNs led to reductions in depression, urinary incontinence, pressure ulcers, restraint, and aggressive behavior. In addition, more residents were able to achieve their personal goals and more family members were satisfied with services [3,28].

The role of the APN is to implement advanced and specialized nursing interventions in interprofessional clinical care. In this process, APNs act as a liaison between different professional groups and advocate for patients and their families [13]. Patient and family education plays a critical role in this process. In contrast to traditional role models, such as state-certified critical care and anesthesia specialists, APNs have scientifically based competencies that come with expanded responsibilities and autonomy [8,24].

In Germany, there are no protected professional designations for APN qualifications and titles. Therefore, in a joint position paper, professional nursing associations in Germany, Austria, and Switzerland call for the registration of nurses, protected professional designations, and a qualifying master's degree to lead and qualify APNs (German Professional Association for Nursing, 2013,) [DBFK]. In the international context, APNs can be associated with the role of expert, consultant, clinical leader, and researcher in clinical care settings with specialized competencies. However, there are cross-national differences in health care structures and the degree of academization and professionalization of nurses [2]. In the practice of clinical leadership, there may be specific, individual, yet intertwined action practices at both the patient and organizational levels: Practices of autonomous management of care processes, practices of influence, practices of consultation/coaching/training, and practices of collaboration and cooperation [13]. In this context, APNs can develop and implement change strategies, manage complex care processes, lead practice development models, and advocate for diverse audiences, including patients, families, and staff [29].

In practice theory contexts, social processes are primarily attributed to conventionalized, physically performed patterns of action, including recurring patterns of action such as habits, routines, and practices [27]. Schatzki views the social world as a nexus of social practices and material entities that can be distinguished by people, organisms, artifacts, and things [30]. Accordingly, practices cannot be separated from their

corporeality, the people who perform them, and the material framework of their performance. They rely on implicit bodily knowledge and embedded knowledge and are difficult to explain linguistically [31]. Social practices represent spaces of our everyday reality whose nature can be reconstructed. They are based on relationships, interactions, and interdependencies and can be experienced as creating structure through human action [32]. Löw understands space as a relational arrangement of bodies that are constantly in motion [33]. Thus, space is also constituted in time. According to Löw the constitution of space is directly involved in the process of action [32].

There is also an institutionalized constitution of space, especially in everyday life. The French sociologist Lefebvre formulates s that social space is a social product and developed a three-tiered model for producing space [34]. This model combines the social, the cognitive and the material and reflects social relations. When space is produced through actions, the processes and their products are no longer independent of time. Accordingly, space and time become visible as social compositions.

For the study presented here, Löw's concept of space is used. According to this concept, space can be understood as a relational arrangement of objects, interactions, and people in places that are heterogeneous and changeable [33]. The creation and occupation of space can be understood as a process that expands one's scope of action, enables engagement with the environment, and functions as an attempt to gain recognition. The body itself has an important function in the processes of space appropriation and is tied to bodily activity, to the conditions of action in a concrete situation, and is influenced by habitus [34].

Aim and Research Question

This study focuses on the professional actions of APNs at the nursing level, particularly in specific hospital clinical care settings and practices, and specifically examines processes and practices related to clinical leadership competencies. Clinical leadership of APNs is central to the provision of evidence-based and patient-centered interprofessional care in hospitals. However, in the German-speaking world, there is little knowledge about how APNs exercise clinical leadership and what rules, and contextual conditions underlie their daily actions. It is crucial how APNs succeed in influencing complex care situations. The aim of this study is to present and systematically analyze the everyday actions of APNs in hospitals, to reconstruct constitutive spaces of action, especially in the context of clinical leadership competencies, and to draw conclusions for future ANP developments. In doing so, the aim is to describe and relate a detailed picture of the prevailing social practices of APNs and the significance of the sites used in these practices. This article answers the following questions: How can APN clinical leadership be interpreted in dynamic work processes and their interaction?

Methods

The following study is ethnographic in nature and relies on situational presence (of the researcher), assumes that social affairs can be observed, performed, and acted upon, and relies on synchronous monitoring of social practices [35-37]. This study aims to explore how APNs' social practices can be described, understood, and explained in daily clinical nursing practice. The data consist of field notes and observation logs.

Design

Ethnographic research is an integrated research approach that combines participant observation, ethnographic interviews, and writing processes. Ethnography is centered on observing and participating. The first authors use ethnography to describe and interpret APNs' social practices in German hospitals. The sociological ethnography study is based on Garfinkel's ethnomethodology Schatzki's practice theory and Giddens and Löw's spatial theory [27,33,37,38]. Part of the qualitative ethnographic study is field research with participant observation and shadowing of APNs during their daily routine (Figure 1). This study considers the recommendations for reporting qualitative studies according to the Standards for Reporting Qualitative Research (SRQR) [39].

Setting and Sample

The study identified two hospitals that supported ANP development and employed at least two APNs. APNs were required to have one year of post-master's degree experience and to work in a skilled nursing facility. Inclusion criteria included APNs with one year of post-master's degree experience, assignment to the hospital's nursing service, and implementation of the APN role based on Hamric's APN model [2]. Hospitals that employed APNs with whom the researcher had an employment relationship were excluded. APNs were contacted by the first author via hospital nursing directors via email and phone between November 2019 and February 2020 as potential participants for this study. Because of the professional activities of two of the authors at the University of Hamburg, students from this university were excluded from the study. Nine APNs from a university hospital (H1) and a general hospital (H2) in Germany with an average professional experience of 20 years were included in the observational study. Participants were recruited by written request from hospital management. All study participants gave written informed consent to participate in the study after being informed verbally and in writing about the study.

Researcher Characteristics and Reflexivity

A successful phase in the field requires a positioning of my own role as a researcher and the reflection of my personal and professional preunderstanding [40]. In ethnographic research, it is common to choose the first person form, as the researcher is personally in the field and part of the research process [35,41]. According to Gadamer the confrontation with my own preunderstanding, my prejudgments is recognized as a condition for understanding and is responsible for a methodical safeguarding of knowledge in science [40,42]. To observe in a focused manner, the author needs sufficient field knowledge [41]. Because I am familiar with the field due to my professional experience and expertise, I have a certain amount of field knowledge that enables me to navigate the field with appropriate confidence. I am aware that I am not familiar with the actors.

In situational observations, different forms of becoming involved in the field and assuming roles become necessary. On the one hand there is the danger of "going-native" if the researcher identifies too much with the field and on the other hand there is the risk of a lack of inclusion [41]. The author of the study ascribed the role of a researcher by the participants in the study because the researcher come to the group as a stranger and reveal the researcher role from the beginning [43]. The researcher's

own role in the field is reflected upon both during the research and afterward, especially when the new situation is created by the observer herself [43].

Data Collection

Participant observation of APNs represents a person-centered focus. I collected participant observation data directly in the field. Data collection is based on certain assumptions and follows certain rules [44]. Crucially, the field visit is planned so that certain phenomena and relevant situations have a certain probability of occurring [45]. The selection of situations and events emerged during the research process, like theoretical sampling [46]. I did not use structured observation guides. Specifically, the data consisted of APN-generated guidelines, artifacts, interview documents, voice memos, field notes, observation logs, and interview recordings. These data are embedded in the context of participant observation interwoven, and often recursive [35].

I recorded and transcribed eight of the ten interviews with APNs using a tape recorder. The resulting interviews and artifacts are published elsewhere. The observation phases were initially open-ended. As the research progressed, they became more focused and selective [47]. The spatial focus was on offices (primarily occupied by physicians or nurses) and wards (such as patient or meeting rooms). Situational observations were conducted after an on-site orientation and interviews with participating APNs. Observation was based on the principle of "watching what happens," although the complexity and speed of events in the hospital posed a problem for the observation process. Repetitive events (e.g., consultation situations) were observed multiple times. This was done primarily to fill gaps in knowledge and to capture an order and pattern in the situations observed. Everyday routines could usually be identified as such when something unusual happened [35]. Since round-the-clock observation was not possible, individual phases were observed on different days, which were then combined to form a typical daily routine. After the observations, logs were created within 24 hours and structured by chronological origin, weeks of observation, conversations by person, and date.

Data Analysis

I analyzed participant observation data by reconstructing everyday processes. This form of analysis, inspired by ethnomethodology, is based on explaining the rules of everyday interactions and includes the rules of sequential analysis [35,44,48]. These rules analyze individual utterances and actions of APNs in their temporal sequence. The body plays a significant role in conveying action and structure, which are interrelated. The analysis follows the documented course step by step, following both the implicit completion logics of the observed social practices and the completion rules of a particular practice [35]. In this way, the interpretation stays close to the text and the situation.

Data analysis helps to uncover complex practices [35]. It follows the scenes from APNs' everyday life step by step to uncover the implicit rules of this practice.

To achieve this, I applied the following analysis steps: Repeated reading of the data corpus, sorting and systematizing the transcripts and data by object of observation and date, selecting examples for detailed analysis that represent normality and then comparing them with other cases, identifying typical features of cases, reconstructing sequences of actions according to the rules of sequence analysis, analyzing sequences of actions in their temporal sequence and looking for constituent conditions, identifying social practices and their implicit rules of execution, and identifying relevant themes and typical cases (Figure 1) [35].

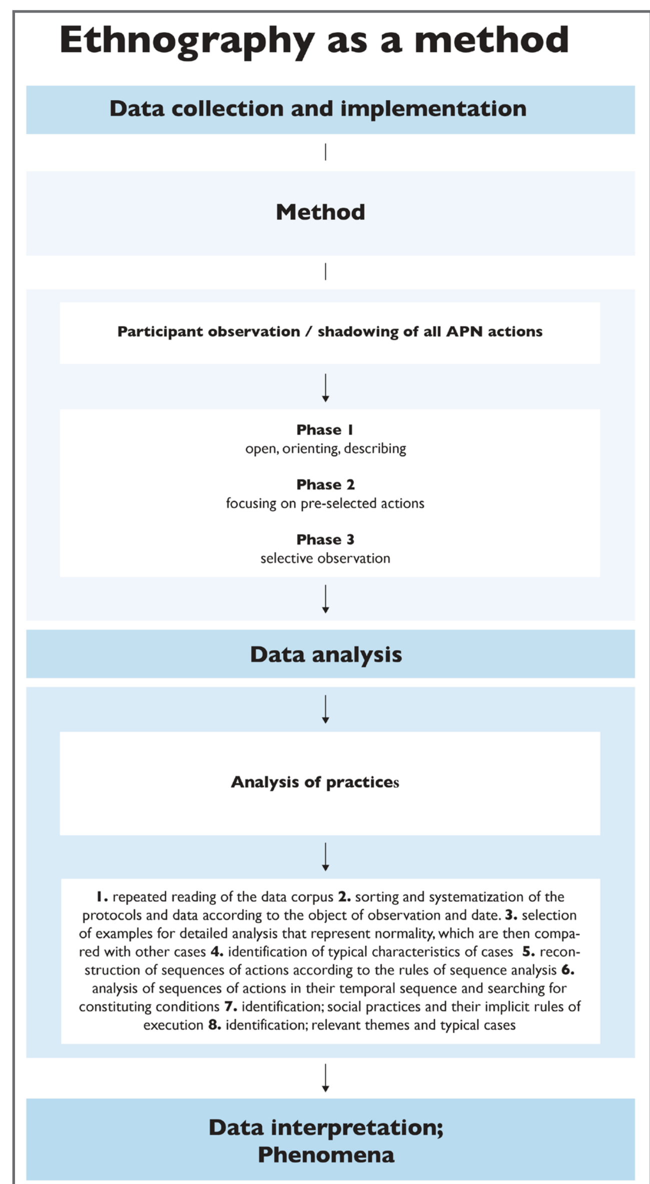

Figure 1: Ethnography as a Method

Qualitative Criteria

Qualitative research aims to gain access to the subjective perspectives of actors and to clarify human actions through dense descriptions in a way that would not be possible through standardized surveys [49]. To present what is typical of the APNs' actions, relevant sections from the observation protocols are quoted [50]. A characteristic of qualitative research is the iterative-cyclical logic that underlies all qualitative research processes, whereby data collection and analysis can still be understood as interrelated, interpenetrating processes [35]. In the article by Strübing et al. the thesis is put forward that criteria can be formulated based on various methodological and social theoretical approaches that can be applied across the board and contribute to the design of successful qualitative research. The quality of the present study is measured by the quality criteria formulated by

Strübing et al. of appropriateness to the subject matter, empirical saturation, theoretical penetration, content performance and originality, which are supplemented by the criteria of credibility and trustworthiness according to Lincoln & Guba as well as the criterion of reflection on social conditions [51-53].

Ethical Considerations

The study is conducted under the terms and conditions of the Declaration of Helsinki and the Guidelines for Good Clinical Practice [54].

Results

Between May 2020 and August 2020, a total of nine APNs (six women, three men) participated in the ethnographic qualitative observational study. The observed APNs worked in oncology, neurology, critical care, neurosurgery, and internal medicine. The ages of the APNs ranged from 36 to 54 years at the time of the study. Their average work experience was 21 years (Table 1).

Table 1: Participant Criteria

Criteria	Clinic 1 (University)	Clinic 2 (General Hospital)
Advanced Practice Nurses	5	4
Age/ in years (range)	42-54	36-51
Women (number)	4	2
Work experience/in years (median)	19,5	22
Specific clinical experiences/in years (range)	11-30	16-24
Master degree/in years (median)	6	5

To preserve the anonymity of the observed APNs, no further individual characteristics are given. In Germany, there are only a few hospitals that met the criteria of the study in 2020 (compare chapter 4.5). Therefore, it would be easy to draw conclusions about the clinics and the anonymity of the participants would not be preserved.

In this chapter, a detailed picture of the predominant social practices-bundles of APNs-and the importance of the sites used in these practices is drawn and related to each other. The practices bundles can be represented in relation to time and space in a model: the Doing social space in Advanced Nursing Practice model (DoSS ANP model in Figure 2). The focus of the analysis is on the recurring, everyday social practices of APNs. In what follows, we show how APN practices are woven into bundles that contribute to the constitution and occupation of social space. Each practice bundle contains key practices, some of which are also found in the other practice bundles but are strikingly significant at this point. In doing so, I do not claim to be exhaustive in describing APN practices. In this article the results from the participating observations are published. The results from the artifact analysis and the ethnographic interviews will be published elsewhere.

The chapter is divided into social practices and Practice bundles based on the analysis: Practice Bundle 1: Roadmapping - APN Office, Practice Bundle 2: Walking Around/Stairwells, Hallways, Practice Bundle 3: Logging and Waiting, Practice Bundle 4: Being on Site/Patient Room, Practice Bundle 5: Consultation/ Patient Room, and Practice Bundle 6: Collaboration/Working Space.

The results section takes the form of a chronologically ordered, unfolding report that uses small situations to reflect the depth of my empirical material as vividly as possible. This assumes that

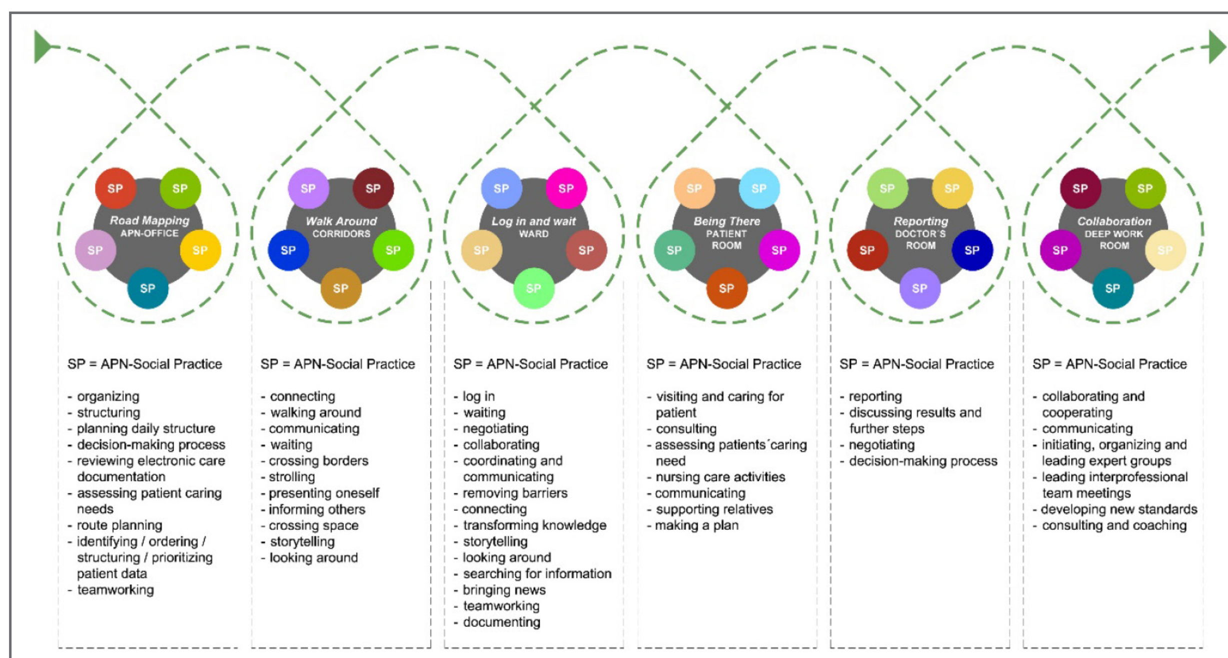

Figure 2: Doing social space in ANP (DoSS-model), Dynamic model of APN movement in (social) space in hospitals. Abbreviations: SP: Social Practice; APN: Advanced Practice Nurse

the field notes, field diaries, and field logs have been transcribed in the form of a thick description. These descriptions serve to describe the central phenomenon of "spacing," the active, recurring formation of space through the social practices of APNs in the hospital. This can be seen as a condition of APNs' influence in clinical care.

Social Practices

The everyday practices of APNs include organizing patient data; analyzing and structuring, consulting, and educating colleagues; treating patients; reporting and negotiating with physicians; communicating with hospital leadership; and initiating and supporting projects. To connect with health care professionals, patients, and their families and to engage in certain social practices, APNs move from one location to another. Social practices can be categorized into a spatiotemporal sequence of actions and are concentrated in six locations depending on the action. The results will be presented along the following analytical themes: Practices bundle 1: Road-mapping - APN-Office; Practices bundle 2: walk around/staircases, corridors; Practices bundle 3: log in and wait/ward; Practices bundle 4: being there/patient room; Practices bundle 5: consultation/doctors' room; Practices bundle 6: collaboration/deep workspace. In the protocols, the names were changed for reasons of pseudonymization.

Practices Bundle 1: Road Mapping - APN Office

I describe APN practices that can be grouped into the Roadmapping practice bundle, are interdependent, and help enable future practice bundles. The Roadmapping phenomenon includes practices such as organizing, structuring, deciding, telephoning, meeting with APNs, documenting, clinical assessment, planning the day's route, and prioritizing. In my study I understand Roadmapping as a thinking and clinical decision-making process. This includes the practices of planning, organizing, structuring, prioritizing, analysis, clinical judgment and decision, trade-offs, and critical thinking. The clinical assessment set the course for the daily walk-throughs in the clinic and the various APN actions. It can be considered analogous to the developmental pathways analyzed into the future. The following descriptions are based on the notes from the field protocols and describe the situations in the APN offices.

Using the digital patient record, APNs note patient names, diagnoses, wards, and room numbers-either on loose slips of paper or in small notebooks. Prophylactics are reviewed, and risks and complications are recorded and evaluated. (Observation protocol on Day 1, H1).

The practices observed in the APN office demonstrate how APNs make clinical decisions as part of an advanced nursing process. This is a cognitive process that uses clinical data to assess nursing and medical problems and the patient's situation to derive actions. These practices can be grouped under the practice bundle Roadmapping that takes place in APN offices. Accordingly, it is a characteristic of Roadmapping that this bundle of practices makes other (future) practices such as consultation, collaboration, and cooperation possible in the first place. By presenting the other bundles of practices, it is possible to show how these APN planning practices relate to other everyday practices, and what specific practices and particular order structures distinguish them.

Practices Bundle 2: Walk Around - Staircases, Corridors

After Roadmapping, APNs make their way through stairwells and hallways. In the following, I describe everyday situations as they occur in stairwells or hospital hallways. I summarize the situations and highlight those that the APNs also experience as significant. In particular, walking, seeing, moving, meeting, standing, connecting, communicating, crossing boundaries, positioning oneself, looking for work, opening and occupying social spaces are the dominant practices in Practice Bundle 2.

The APN Deb walks down the hallways, up the stairs, and down the stairs purposefully. We cross bridges that take us from one clinic to another. "We walk stairs, I always walk everywhere," Deb says to me. (Observation protocol on Day 6, H1)

Sometimes, however, the APNs take their time on their way to the wards, the walking then is strolling.

On the way to the ward, we meet patients who have lost their way in the stairwell and ask us for directions. APN Fanny kindly and patiently shows the patients the way to their admission ward. (Observation protocol on Day 12, H2)

As APNs move through the hospital corridors and hallways, they perform routine daily actions with planned routes. Because APNs cannot participate in more than one action at a time, they make decisions in advance about what action to take, when, and where, and follow a planned route to connect with patients, colleagues, and health care professionals. Once on site, they wait, occupy space, and position themselves in relation to others until they can implement their plans. The daily movements of the APNs go hand in hand through the temporal zones of the day, with movement being spatially constitutive.

Practice-Bundle 3: Log in and Wait - Ward

After passing through staircases, hospital corridors, and ward corridors, the APNs arrive at the various wards, outpatient clinics, and day clinics. Based on observation protocols, I describe the scenes that depict the arrival, especially on the wards and in the day clinics and outpatient departments.

On the ward, everyone seems prepared for APN Fanny's consultations. Sometimes the nurses and the APNs work together to care for the patients.

On a ward I observe a nurse exclaiming loudly when Fanny arrives on the ward corridor: "Ah, here she is, now we have the power to decide". After a short exchange of words between the APN and the nurse about the state of health of an elderly man with wound infections on his foot, the APN and the nurse visit the patient together. (Observation protocol on Day 5, H1)

Approximately six nurses are documenting and preparing medications and blood samples. In the apparent confusion, Deb is looking for Chris, the nurse in charge of Mr. M. We wait for Chris in the hallway. (Observation protocol on Day 2, H1)

The routes between the different settings in the hospital are planned in the APN office, with the APNs adjusting them in the day in case of unforeseen events. When visiting their patients in the wards, APNs aim to establish direct contact

with the coactors. These are usually planned consultations and counselling situations. When arriving on the ward, there are established practices of greeting, waiting, communicating, connecting, documenting, coordinating, and sharing knowledge.

To apply these practices and to facilitate the future practice bundles, the APNs need to be on the ground. They have a form of open communication that enables them to get in touch, build relationships, make themselves heard, share information, regulate responsibilities, connect, collaborate, and plan and initiate the next steps in an Advanced Nursing Process.

Practice-Bundle 4: Being There - Patient Room

After the APNs have registered with the nurses on the unit, a brief handover meeting is held between the charge nurse and the APNs. The APNs are usually well informed about the patient's health status. The APNs then visit the patients in their rooms, outpatient clinics, or day rooms. APNs introduce themselves to patients as nursing professionals and explain their planned interventions. Interventions typically include patient health assessments, history taking, pre-discharge interviews, counseling situations, wound care, or special assessment procedures. The discussions with the patients are also used by the APNs to assess the clinical situation. Together with the patients and their families, the APNs develop individual solutions for specific individual problems within the framework of the Advanced Nursing Process, which are then discussed and treated interprofessional. In the following, I describe case situations that illustrate how APNs work in the patient room.

"No, the pain medication is not enough," the patient tells APN Brooke (name is changed). Then she adds that the children are suffering greatly from their mother's cancer. Brooke is calm, taking her time and listening. Brooke assures the patient that she will consult with the doctor and contact a palliative outpatient organization. (Observation protocol on Day 2, H1)

The APN Fanny asks Sarah what aids she uses for inhalation and advises Sarah about certain breathing aids that could bring an improvement. Sarah reports that the social service is applying for a care level and is looking for a rehabilitation clinic for her. The APN explains the need for targeted mobilization of secretions and promises Sarah to seek a prescription from the doctors so that Sarah can get better aids for expectoration. (Observation protocol on Day 10, H 2)

The dominant practices in Practice Bundle 4 include: connecting, visiting, counseling, taking a history, making clinical assessments, performing clinical examinations, negotiating, counseling, listening, caring, sharing, supporting, communicating, making decisions, collaborating.

APNs have multiple visits with the same patients over the course of several days. By being there, APNs show that they care. After the consultations and care, there is an exchange with other experts or doctors to find a common solution or to submit a report.

Practice-Bundle 5: Consultation - Doctors' Room

After visiting patients, APNs then visit the charge nurse and/or attending physicians to report, share findings, and discuss what is next. Incorporating diverse expertise into patient care is an important goal of the exchange. The APN reports the patient's current health status upon arrival at the physician's office. They then discuss the next course of treatment.

The APN reports that the patient has lost a lot of weight, that pain management is inadequate, that she suffers from shortness of breath and that her son is completely overwhelmed with the situation at home.

Together, they discuss the extent to which care seems appropriate for the patient in the current situation. They agree that the patient needs better pain and breath and nutrition management. (Observation protocol on Day 10, H 2)

In practice bundle 5, practices that enable communication and gathering among HPs are important. These include coming together, collaborating, negotiating, making decisions. Information exchange between health professionals is reciprocal. It is like reporting, where major events and developments are systematically reported. APNs actively approach doctors and nurses to share information about the health status of their patients. Sharing information and knowledge is the focus of these discussions. APNs frequently take the initiative.

Practice-Bundle 6: Collaboration - Deep Workspace

In the interprofessional clinical care of chronically ill people, collaboration, cooperation, and communication between the health professions play a significant role. In this chapter I report on the processes of collaboration between APNs and other health professions. These processes include extensive organization, communication and learning processes. The transitions between the exchange of practice bundle 5 and practice bundle 6 are fluid and partly refer to each other.

In various scenarios, I can observe APNs initiating projects and meetings and leading guideline development groups.

APN Anna and I go to the interprofessional tumor meeting in H1. The meeting is attended by nursing experts, the physician, social services, physical therapists, and the hospital chaplain. Anna leads the meeting, documenting, and collating data from 36 oncology patients. (Observation protocol on Day 1, H1)

I am observing a situation on a surgical ward between an APN and a head of department in which a cross-departmental project on dementia is being developed together. In a first step, the APN and the head of department develop a training concept for the classification/screening of patients at risk of delirium in the hospital. The conversation takes place in a trusting, open and appreciative atmosphere. The APN opens the conversation, explains a procedure, and gives the head of department information on delirium assessment. Subsequently, various screening instruments are used. (Observation protocol on Day 11, H2)

The practices in practice bundle 6 include: being proactive, collaborating, cooperating, initiating change, cooperating, collaborating, negotiating, developing something new. The APNs take the initiative in the scenes and organize communities of knowledge and practice in the form of so-called communities of practice. They connect expert knowledge with each other and

develop something new. The topics to be worked on arise from practice and are worked on in interprofessional working groups, whose evidence-based findings are fed back into practice. The different specialties are involved in the process. APNs usually take the initiative, are open and engaged, and communication is at eye level and collegial. Managers usually lead discussions between APNs and management. Cooperation is based on trust, spatial mobility, physical presence, rapport, consideration, and acceptance.

Summary

I observed the social practices of APNs in their daily activities in the participating hospitals. These observations included a range of APN practices such as organizing and planning, establishing daily routines, communicating, collaborating, counseling, and educating colleagues and patients/families, designing interprofessional clinical care, initiating projects, and team meetings. In the process, APNs move from one place to another.

A spatiotemporal sequence of actions can be used to categorize the observed social practices. Depending on space and time, APN practices can be identified in the following locations APN office, hospital corridors, wards, patient rooms, physician offices, meeting rooms, and conference rooms.

Analysis of APNs shows that APNs divide spaces into regions that are characterized by different recurring practices depending on the time of use. APN offices are used to discuss and analyze digital patient data and consultation results, share experiences, set goals, and plan a route for the day (Roadmapping). Stairwells become meeting and waiting zones, and wards, patient and doctor rooms become boundary zones that must be penetrated and overcome with specific practices and rules. To improve interprofessional collaboration, APNs move from place to place, connecting with others, communicating, cooperating, and collaborating. In doing so, they fulfill the characteristics of clinical leadership by influencing people and clinical situations. These accounts provide access to the central phenomenon of spacing, which is the active, iterative creation of space through the practices of the APN. Spacing is made up of a variety of practice bundles. It describes how APNs occupy and recreate social space. Spacing is developed through intentional references and contextual conditions of people. Physical positioning can be seen as part of spacing and is relevant whenever people position themselves in relation to others through movement. The interaction depends on the "positioning" of the individuals in the contexts of action that are related to time and space. By influencing people and clinical situations, spacing can be understood as a feature of clinical leadership. Spacing is a phenomenon with multiple components of practices that are based on spatial-temporal references and thus contribute to the occupation and shaping of social space by APNs in and through everyday practice.

Limitations

As a participant observer in the field, I have been concerned with sources of error in the survey method to minimize bias. These include the Hawthorne effect and associated social desirability [55]. However, in an observational process, there are several sources of error that can compromise the quality criteria and validity of the observational study. I did not know exactly what to expect in the field and what I would learn about the daily lives of APNs at the beginning of the observation. This required a great deal of openness in the research process. I was able to recruit only a small number of health professionals and APNs. There are differences between clinics in terms of size and mission. APNs are comparable in age, work experience, and gender distribution. Thus, heterogeneity cannot be achieved. The question of what is and what is not considered everyday social practice in the analysis can be critically examined [31]. Only fragments of a practice and its spatiotemporally bound variant can be captured [25]. Thematic analyses derived from research data can lead to inconsistency and lack of coherence in developing themes [56]. As a participant observer embedded in the field, I had to deal with potential sources of error and was aware of potential biases and the associated social desirability (Hawthrone effect) and tried to avoid them as much as possible.

Discussion

In 2020, I was able to conduct participant observation with nine APNs in two hospitals in Germany. Despite the COVID-19 pandemic, I had the opportunity to take a direct look at the everyday world of hospitals and the work of APNs. I could not assume that this world I was exploring was waiting to be explored by me. I was primarily interested in the methods and practices that APNs use to create an order of things and the ways in which they perceive, describe, and explain the everyday world in the hospital. I was only able to examine the arrangement of APN practices, which I reconstructed in interactional references in a spatio-temporal structuring and discovered in this way, because these practices already existed and only needed to be made visible and described by me. The extent to which my analysis will have an impact on the field of action is not yet foreseeable. What I would like to point out at this point, however, is my perception that I never regarded the APNs I studied as "mere data providers", but rather always made an honest effort, in "eroepic" conversations, to show "appreciation" and "respect" for those involved in the study.

This study focuses on the professional actions of APNs, examining practices related to clinical leadership competencies and how they affect people and processes in the hospital. The findings provide a rich description of how APNs perform their daily work and how their activities shape structures and interactive processes as APNs connect individuals and groups in the hospital and influence clinical care processes through processes of spatial constitution. To our knowledge, this is the first study to take a different, innovative look at the actions of APNs in the hospital through the lens of a spatial sociological perspective that allows reflection on the existing conventions and rules that underlie their actions and provides different explanations and rationales for their actions.

Nursing is based on professional assessment of pathophysiological, psychological, and social data, focusing the whole person [57,58]. In my observations APNs synthesize complex data, implement care plans, provide leadership in patient care, and make science-based decisions [59]. These planning practices are mapped in the nursing process and reflected in the DoSS ANP model in the study (Figure 2). Our findings are consistent with other studies addressing the need to increase visibility of APN clinical leadership [5,9,11]. These studies describe clinical

leadership competencies of APNs in complex care settings in hospitals in the context of independently organized care processes, influencing care processes, developing/implementing projects, consulting/coaching/training projects, consulting/coaching/training, collaboration, and liaison with management [9,10,11,17]. However, there is no reference in these studies to the observation of APN practice with a focus on clinical leadership skills.

In this observational study, the first author identified the types of everyday social practices that APNs engage in. APNs' social practices (such as organizing and planning, setting a daily route, communicating, and collaborating, consulting, and educating colleagues, patients, and families, designing interprofessional clinical care, initiating projects, and team meetings) show high consistency and regularity characterized by autonomous decision making. The observed APN practices may be associated with clinical leadership competencies such as initiating care processes and are evident at both the patient level, counseling and education of patients and families, and organizational level, such as connecting and collaborating with others.

Social practices that enable interprofessional collaboration were identified during observations. These collaborations include actions that are interrelated at the functional level, such as when the APN discusses the patient's ability to be discharged at an interprofessional tumor board meeting.

APNs move through hospital hallways, stairwells, patient rooms, and conference rooms. Practices that can be assigned to Clinical Assessment take place in the APN's office (Roadmapping). Roadmapping is used to plan the daily path of APNs through the hospital. APNs cross physical boundaries to interact with, counsel, educate, and coach health care professionals. APNs treat, counsel, and support patients and their families. The study shows that APNs are engaged and competent to perform clinical care tasks. This connective role is often attributed to APNs [37].

It is through the routinized specific social practice of distancing as a key practice of APNs that practices such as collaboration, consultation, and connections between people become possible. APNs' recurring practices, characterized in and through practice bundles, create routines that help shape a daily structure in hospital organization that promises stability, regularity, and reliability [25]. Routines are intertwined at both the individual level and at the collective level. APNs have developed a set of habitual actions that help to influence people and clinical care, consistent with the characteristics of clinical leadership.

Using everyday social practices, APNs actively create social space. Practice in this context can be understood as the bodily enactment of social phenomena, whereby action takes place within the context of practices, in culturally pre-structured ways of acting, during which those acting become enmeshed in what they are doing [60] and have methods to accomplish this [36]. Through social practices, people bring into their practice what they themselves understand and make intelligible as the context for their actions. The observational data suggest that APNs structure complex everyday clinical actions and decisions. APNs also act entrepreneurially, whose practices can be classified as complex and highly active [60]. This means that APNs are responsible for complex actions, are self-directed, and act proactively. These actions meet the definition of clinical leadership [13].

APNs routinely walk or stroll through hospital hallways, stairwells, corridors, waiting rooms, patient rooms, and meeting rooms to connect, collaborate, and cooperate with health care professionals, patients, families, and leadership. By moving through physical space, APNs create social spaces that did not exist before. The design of the space is usually done from a practical awareness [38]. APNs facilitate collaboration and cooperation by serving patients, communicating with trust, actively listening, consulting, negotiating, and working interprofessional, especially across hierarchical and spatial boundaries.

Through their actions, APNs reproduce the conditions that make their actions possible and visible. Thus, frequent waiting in hallways can be understood both as an action and as a condition for an action. The formation of space as dynamic placement and positioning can be referred to as "spacing" [33]. Spacing is thus the moment of placement but also the movement to the next placement [33].

Space in the hospital is always considered contested in the context of hierarchical relations and can be understood as capital [61]. In reflexive processes, APNs can explain reasons for their actions; this also applies to the constitution of spaces [33].

The extent to which power can be understood as an effect of practices or social structures in which APN practices dominate other practices needs to be explored in further studies. In this context, theories of social practices gain importance, as they show that through the application of social practices, social structures in the hospital can (reciprocally) influence an organization [38]. However, it can be assumed that there is an interaction between routine APN actions and the development of structures. The extent to which these specific practices are consciously reflected upon, strategically employed, and experienced as significant by APNs and other health professionals need to be investigated in future studies.

Conclusion

The findings of this ethnographic research are of great interest in that the actions related to Clinical Leadership of APNs can be explained and understood from both practice-based theoretical approaches and a spatial sociological perspective. These theoretical approaches support a new perspective on the actions of APNs and their influence on other health professionals and clinical care. The DoSS ANP model could be of great interest to educators and could be incorporated into their APN curricula and later used for leadership training. Through constant movement, APNs structure their complex daily lives and develop structure. Action and structure are interrelated. Thus, structures are embedded in APNs' actions and exist only through these specific actions. Movement can be understood as a key practice in this context. Through their daily walking in physical space and their present actions in social space, APNs can exercise clinical leadership and be effective in clinical care processes, especially by connecting with others. In the future, this finding will raise questions about the extent to which APN practices intervene in,

influence, and redirect other practices and places. For APNs to be considered responsible for their actions, they need to think about their practices. In a praxeological sense, responsibility means recognizing oneself in one's own social context.

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Conflict of Interest
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