The influence of practice experiences on feelings of role proficiency in emergency nurse practitioners: A phenomenological study

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Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance for the research presented in this thesis has been approved. Approval has been sought and granted by the Faculty Ethics Committee and The Newcastle Upon Tyne Hospitals NHS Foundation Trust Research and Development Dept. external committee on 7/10/15 and 19/4/16 respectively.

I declare that the Word Count of this Thesis is 59133 words

Name: D Monk

Signature:

Date: 28/4/2021

‘Let’s get down to what matters!’ (van Manen, 1990. P184)

Abstract

The evolution of this research emerged from experiences in the researcher's clinical practice as a nurse practitioner in a variety of urgent care facilities, and the personal queries raised regarding the consistency of the level of practice and evidenced competency of clinical staff in emergency and unplanned care using the title "practitioner". These realities are apparent as at present in the UK no legislative requirement exists for nurse practitioners (NPs) to gain formal preparation or qualification. Guidance and direction have been seen in The Advanced Care Practice framework (HEE,2017), yet legislative protection remains absent. Such legislative protection is however seen in other healthcare systems across the world, such as Australia and the US.

This research looked at the journey towards proficiency, the competency to proficiency journey, that is experienced by NPs as they qualify to become NPs, and how they move on in that journey. It incorporated the concepts of role identity, competency, capability and confidence, all of which have been researched in relative isolation. This study explored the NP's practice experiences by bringing these concepts together, focusing on emergency nurse practitioners (ENPs), and how these experiences influence or effect their feelings of role proficiency, from the perspective of the autonomous and clinically proficient ENP. The research question "how do ENPs' experiences in practice influence their feelings of role proficiency?" was addressed with the objectives to examine and understand the meaning of role proficiency to ENPs, to identify practice experiences that influence role proficiency and identify and understand how these practice experiences influence ENPs' feelings of role proficiency.

A hermeneutic phenomenological methodological approach was used to interpret the lived experience of the ENPs in practice. A purposive sample of 10 ENPs was interviewed, and a

three-stage interpretive process was used to gain access to the object of investigation and interpret its meaning and lived experience for the ENPs.

Six themes emerged from the data extraction process: the meaning of role proficiency, relationships, confidence, learning and knowledge, exposure and experience, and care. An analytical category tool identified five key outcomes for discussion that linked the themes to the research question: being good at the job, central role of confidence, relationship issues, coping strategy and the influence of care.

This study highlights the need to give attention to the experiences that lead the ENP to feelings of proficiency and their inclusion in clinical educational programmes. The importance placed on the connection of the components required for being good at the job, and how this is constructed by the ENP and should be incorporated, will be presented. Attention was also paid to the influence of confidence and the impact that relationships have upon feelings of proficiency. An increased focus was given to the development and management of relationship experiences, alongside the traditional competency-based clinical achievement frameworks. A direct approach, assessment, enablement and focused development of emotional intelligence and coping strategies was found to facilitate and maintain feelings of proficiency. Acknowledgement is made that not only is care the focus from the patient's perspective but, alongside this, that care is the central motivating factor of the ENP, driving the elements that contribute to feelings of proficiency. This underpins the emotional intelligence required to perform the role and achieve feelings that allow the ENP to remain in their zone of proficiency to deliver the care the role focuses on.

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Acknowledgments

It is fair to say that this thesis, both in its writing and construction, has been one of the most challenging experiences of my career, whether clinical or academic. I have learned about myself in ways that I could not possibly have understood and eventually gained the confidence to believe I could achieve its submission. To those that have advised me on the way, you were all correct with your advice and its timing. Particular mention goes to the following people, who I owe a tremendous debt.

I thank the participants, without whose experiences there would be no data to analyse, and I would have been left forever wondering if there was a question to answer on proficiency.

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Chapter 1: Study introduction

1.1. Introduction

The purpose of this chapter is to outline the thesis, giving understanding to the reader of the development of the research idea and the research question that came to light as a result. This study was set in the context of the work of emergency nurse practitioners (ENPs) in the UK NHS service.

UK urgent care services provide approximately 25 million urgent, same-day patient contacts each year (CQC, 2018). Hill, McMeekin and Price (2014) report in their systematic review that ENPs are less likely to refer patients on to other services, reduce waiting times, attract high patient satisfaction and provide a service as good as existing services, thus improving the patient experience and delivering good quality care. Attendances to emergency departments continue to rise year on year (Crouch and Brown, 2018. Dall'Ora et al. 2017), with much of the work now being taken on by practitioner roles, the value of which is clear to see. The evolution of this research idea emerged from experiences of clinical practice as a nurse practitioner in a variety of emergency and urgent care facilities since 2004. During the latter days of my clinical career, I had the privilege of working with some of the most committed, efficient and professional staff I have worked with in my career, in one of the most pressured environments in the NHS, and I thank them for their support and friendship. This experience raised personal queries regarding the consistency of the level of practice and evidenced competency of clinical staff in emergency and unplanned care using the title "practitioner", with no national or local standardisation of qualifications, experience or practice to guide the role (Currie et al, 2007). This is not from a perspective that criticised the practice of others, but rather questioned, given the different backgrounds, both educationally

and professionally, and the subtle differences in the expectations of the ENP in different units, how did we end up practicing effectively in the same environment? These realities are apparent as, at present, in the UK no legislative requirement exists for nurse practitioners (NPs) to gain formal preparation or qualification, revalidate their role on a regular basis or undergo specific continuing professional development within the role of practitioner (Hoskins, 2011).

1.2. Background

The discussion regarding regulation has moved on little since the Nursing and Midwifery Council (NMC) proposed a framework for advanced practice in 2004 (NMC, 2004), with the UK Government clarifying its position to not develop regulation (DOH, 2010). Some progress was made in 2017 with the release of the multi-professional framework for advanced clinical practice designed to move advanced practice to the next level (HEE, 2017). However, this is a framework for a level of practice and an attempt to bring some standardisation to the level, rather than a regulatory process, although it may pave the way for further development of regulation. Advanced clinical practice is defined by Health Education England as:

> *'…delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making.' (HEE, 2017. P8).*

It goes on to further define the level of formal education expected of an ACP as:

> *'…underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence.' (HEE, 2017.p8).*

This characterises advanced clinical practice as a level of practice on the continuum of advanced practice, providing consistency and clarity of qualification alongside direction that

is not currently present in ENPs. It also moves advanced practice forwards distinctly from the early protocol driven origins of the ENP role. The interest in the topic developed further when examining the competence of practice in nurse practitioners and how this is achieved, leading to the derivation and investigation of the research idea; how is competence achieved in nurse practitioners? This was examined in a masters dissertation by means of a systematic appraisal that derived five themes arranged under three perspectives. The work discussed the themes from the stakeholder perspectives of educational, organisational and personal viewpoints to achieving competency. The themes derived related to assessment tools, capability issues, educational components and specialisation, role clarification and, finally, time (Monk, 2013). This work gave a foundation of interest and research skills to pursue further questions.

Work is clearly needed to define and clarify the process of moving nurse practitioners to the stage of competency (Gardner et al, 2006(b)). However, my Doctoral focus involved looking at the journey towards what is being termed in this study as proficiency, the competency to proficiency journey, that is experienced by NPs as they qualify to become NPs. It also discusses how they move on in that journey, which incorporates the concepts of role identity, competency, capability and confidence. This research will move the competence debate beyond these four terms towards how they connect or interact with each other in a practice experience context to form a proficient ENP. These topics have been examined and encountered in the literature and will be reviewed in more detail in the literature review presented in chapter two. These concepts tend to be reviewed independently of each other or by looking at aspects of how some of them relate to each other. My initial proposal looked at how these areas have a collective impact on the NP. This research will seek to explore the NPs' practice experiences, specifically focusing on ENPs, and how these influence or effect their feelings of role proficiency, specifically from the position of the autonomous and

clinically proficient ENP (Davis and Hase, 1999. Gardner et al, 2006(a)). It will incorporate role identity, competency, capability and confidence under the term proficiency.

For the purposes of this research, an ENP role can be defined as an autonomous nurse practitioner working in an emergency, urgent or unplanned care environment. There are a growing number of NPs and ENPs who pioneered and developed the initial NP role over the last 10-15 years and continue to do so, yet their voices are absent from the literature and have yet to be heard. It is this experience, and the experience of other ENPs in the role, that I wanted to explore in order to determine common themes that may give appropriate support and structure to the competence to proficiency journey and experience. Thus, this will enable further contribution towards the standardisation of this area, the role and the facilitation of the consistency of proficiency achievement. This need has become more apparent as the delivery of urgent and emergency care in England continues to change as a result of the new blueprint for urgent and emergency care across England, published by Sir Bruce Keogh, and including further role development and responsibility for ENPs (NHS England, 2013) and its update in 2014 by Prof. Keith Willett (NHS England, 2014(b)). These changes will continue to have an impact on demand for urgent care services and its staff, with the introduction of principles and standards of urgent treatment centres (NHS England, 2017(b)) and their further integration into systems, as highlighted by the NHS national medical director (NHS England, 2020).

1.3. Research question and objectives

The purpose of this research was to explore and understand the NP's practice experiences, specifically focusing on ENPs, and how these influence or effect their feelings of role proficiency, specifically from the position of the autonomous and clinically proficient ENP (Davis and Hase, 1999. Gardner et al, 2006(a)). It incorporated role identity, competency,

capability and confidence developing their relationship further under the term proficiency. For the purposes of this thesis, it is useful to provide a specific working definition of a NP, which is suitably supplied by the International Council of Nurses and used throughout this thesis:

> *'A Nurse Practitioner….is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice.' (ICN, 2008, p1).*

The context of the ENP for this thesis required that participants are working in an emergency, urgent or unplanned care environment, such as an emergency department, urgent care or walk-in centre.

Research questions develop from the initial idea, in this case to explore and understand the NP's practice experiences and the impact they have on proficiency. A research question is a specific query the researcher has, and wants to resolve, to tackle a research problem (Polit and Beck, 2018), and its formation will structure the method and study design. A number of questions should be asked of the idea to establish its potential for development into research itself. Pertinent questions to this idea are, is it something that can be researched, can it be conducted in the available time and would it appeal to a potential supervisor (Gerrish and Lathlean, 2015. Bloomberg and Volpe, 2016). My thoughts regarding this topic and an examination of the initial idea established that it was possible to answer these questions affirmatively. Silverman (2013) argues that there is no simple distinction between qualitative and quantitative approaches. This idea seeks to investigate and understand thoughts and feelings and, as a result, would fall under the qualitative paradigm. Further discussion relating to the methodological design is presented in chapter three.

The research question for this thesis developed through a number of iterations before arriving at:

'How do emergency nurse practitioners' (ENPs') experiences in practice influence their feelings of role proficiency?'

In order to approach the question, it is necessary to structure objectives for the research, particularly to describe what the researcher expects to achieve by undertaking the study. It is necessary to demonstrate an understanding of the underpinning concepts of role identity, competency, capability and confidence that may relate to the new concept of proficiency and how or if they relate to proficiency. This understanding will be demonstrated and examined in the literature review of chapter two. Three research objectives were proposed for this research, linked clearly to the research question allowing focus and clarity of thought and direction, and for the researcher to systematically address the various aspects of the problem. The objectives of this study were:

- To examine and understand the meaning of role proficiency to ENPs.
- To identify practice experiences that influence role proficiency.
- To identify and understand how discovered practice experiences influence ENPs feelings of role proficiency.

1.4. Study overview

The most difficult question to answer in many research pieces is which methodological approach will allow the research question to be answered. The strategies for research are found in broader frameworks and philosophical or theoretical perspectives, referred to as paradigms (Blaikie, 2007). This is a worldview that guides the actions of the researcher based on a series of philosophical beliefs and assumptions (Creswell, 2013). This worldview determines how to examine the research question. Nursing research approaches tend to be

broadly labelled as quantitative or qualitative, however these terms pertain to the method not the underlying assumptions on which the method is based. Many research paradigms are identified in the literature, such as constructivism, positivism, post-positivism and interpretivism. Broadly speaking the quantitative paradigm aligns research as a mapping or modelling exercise, representing the world as a series of measurements or numbers as a result of the testing of a hypothesis (Curtis and Drennan, 2013). Contrasting this is the interpretive paradigm worldview, where meaning is constructed from interpretation and interaction with the lived world. This approach places value in the subjectivity of experiences and interactions to develop understanding of them and their surrounding circumstances (Leavy, 2017). Referring to the research objectives stated in section 1.3 of this chapter, the researcher was seeking meaning and understanding as opposed to measurement, and it is for this reason that this research was conducted in the interpretive paradigm. The methodology and its underpinnings will be looked at in more detail in chapter three. Reflexivity is an important concept to consider. It is a critical review of the involvement of the researcher in the research and how this influences the research processes and outcomes (Bloomberg and Volpe, 2016). Given the insider researcher position of the researcher, this is given consideration throughout the research process. The researcher has a number of lenses through which to consider these research positions, as a clinician, an educator and researcher, will be discussed in chapters three and four, and seen transparently in the researcher CV of appendix ii. A research diary, personal to the researcher, will be used to record, direct the consideration and discussion of a reflexive stance during research encounters.

Chapter four will detail the methods employed within the methodology to obtain data to allow the objectives and research question to be investigated. The participants, as ENPs defined by the ICN (2008) of NPs, used two phases of data collection inspired by the work of Bedwell, McGowan and Lavender (2015). Phase one was a digital diary and phase two was a

semi-structured interview based on the participants' diary of clinical experiences. A three-stage data analysis model was utilised in the hermeneutical phenomenological approach underpinning this research (Lindseth and Norberg, 2004).

The findings will be discussed in chapter five of this thesis, and are presented in six themes that emerged through the data extraction as articulated by the participants. The descriptions of the participants will play a significant part in the discussion in order to remain as close to the lived experience as possible, which is in line with the methodological underpinnings of the research.

The use of an analytic category tool (Bloomberg and Volpe, 2016), designed to give a visual representation of how the discussion in chapter six traces the five key outcomes of this research back to the research question through the research objectives, will provide the reader with a clear idea of how the analytic categories have been formed. This process will aid the discussion organisation and transparency of its origins in order to answer the research question.

1.5. Summary

This chapter has given the background to the formulation of the research idea and the foundations of the research question derived from the clinical experiences of the researcher. Insight into the literature is provided with a summary of the current position that regulation and standardisation of ENP practice is absent, and that a gap in knowledge regarding the influence of practice experiences on the competence to proficiency journey has been found. The phenomenon of proficiency is highlighted as the object under investigation as a concept that moves the competence debate forward by examining and linking the relationship between the concepts of role identity, competency, capability and confidence under the term proficiency. The methods and methodology used to extract meaning and understanding of the

phenomena, and the influence of practice experiences from the lived experiences of the participants, are introduced. The use of a hermeneutical phenomenological approach was justified in this research, further detail of which will be provided in chapter three, and the interpretations under this philosophical position were briefly introduced.

The following chapter will highlight the literature relevant to the research question and objectives and highlight its influences on the research formation. It will examine and demonstrate an understanding of the terms role identity, competency, capability and confidence, that connect to the concept of proficiency. The lack of clarity and consistency, as well as gaps in some areas of research and operation of services in which ENPs practice, will be reviewed, as well as aspects of how their skills in practice are formed and presented to patients in their care.

Chapter 2: Literature review

2.1. Introduction

The purpose of this research was to explore and understand the influence of an emergency nurse practitioner's (ENP's) practice experiences upon feelings of role proficiency by answering the research question "how do ENPs' experiences in practice influence their feelings of role proficiency?" As has been mentioned, for the purposes of this thesis it is useful to provide a specific working definition of a nurse practitioner (NP), which is supplied by the International Council of Nurses:

> *'A Nurse Practitioner….is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice.' (ICN, 2008, p1).*

The context of the ENP for this thesis required that participants were working in an emergency, urgent or unplanned care environment, such as an emergency department, urgent care or walk-in centre. The purpose of a literature review is to demonstrate an in-depth knowledge and understanding of the topic area and work related to the research, to advance the understanding of what has been done before, to understand the literature within the field and, in the context of doctoral research, to build upon it and make a new contribution to an area of knowledge (Boote and Beile, 2005; Hart, 1998). A thorough literature review is a pre-condition for undertaking thorough research (Boote and Beile, 2005). Grant and Booth (2009) detail fourteen review types and methodologies during their literature review typology study, and highlight that the potential of a review may be lost in the plethora and variation of terms associated with literature reviews, with no standardisation of the conducting of a review, leading to variation in quality. Bettany-Saltikov and McSherry (2016) also express concern that a traditional literature review can tell any narrative that a review wishes. However, Booth

et al. (2016) argue that a systematic approach to a review will reduce the likelihood of bias and ensure that a comprehensive body of knowledge on the subject is identified.

It is important during the literature review to remain cognisant of the research question and objectives established in chapter one in order that focus is maintained on what is known and how this connects to and develops the phenomena of proficiency. The research question is

'How do emergency nurse practitioners' (ENPs') experiences in practice influence their feelings of role proficiency?'

And the objectives of this study are:

- To examine and understand the meaning of role proficiency to ENPs.
- To identify practice experiences that influence role proficiency.
- To identify and understand how discovered practice experiences influence ENPs feelings of role proficiency.

The review begins by giving an overview of the role of the ENP and its development situated in a political context. The components required to form the ENP as an autonomous practitioner in line with the definition of a NP are presented as they become clear themes within the literature. The key areas of each theme are evaluated and the limitations of each theme, as addressed by the literature itself, is reported. These themes represent the common components and expectations required of an ENP across the literature, and are broadly identified as role, competence, capability and confidence. The affect and effect of practice experience upon each theme is interweaved within each review area as it is addressed within the literature. Interestingly, the term proficiency is only fleetingly mentioned in the literature reviewed and not used as a term or concept to draw together the topics seen in this review.

2.2. Search strategy

The purpose of a literature search is to identify information for the research topic and discover gaps in the research that are worthy of investigation (Hart, 1998). This process also allows for an exposure to research methodologies that are most likely to yield results for the chosen research topic. It is recommended across literature concerning the conducting of a literature review, that a review be systematic in order to make sense not only of the large volume of research pieces available, but also to manage the process in a way that facilitates an appropriate, proportionate evaluation of the available literature in terms of quality, identification, analysis and synthesis of the literature related to the proposed research question (Booth et al, 2016; Bettany-Saltikov and McSherry, 2016; Hart, 1998). The overall aim of the search process is to gather a comprehensive collection of studies that will assist in the answering of the research question (Bettany-Saltikov and McSherry, 2016). A systematic literature review is essential when conducting research as without it the author will not acquire a suitable level of understanding of the topic in question (Hart, 1998). Gerrish and Lacey (2010) report that this phase of a research project is often neglected, and its structure is key in the minimisation of bias in the review process (CRD, 2009).

A systematic approach requires several methods and techniques that are designed to ensure the researcher has a comprehensive understanding of the literature surrounding the research question. Booth et al. (2016) recommend a useful five-stage process to assist in the search; scoping search, conduct search, bibliography search, verification and documentation. This has been applied to this research. A brief narrative of the search process as applied to this research follows.

The scoping phase was designed to familiarise the author with the topic and the volume of literature available utilising a limited number of databases that were expanded. The

expansion of databases incorporated the use of Web of Science, CINAHL and Medline, which were felt to cover the topic comprehensively. The scoping phase also identified the search terms to be used, which was added to in later phases of the search as the literature revealed other suitable terms. An example of the search terms utilised can be found in Appendix i on page 213. Search terms relevant to this study were quite familiar to the author as this topic had been examined in previous studies, as discussed in the introduction of this study. The initial concepts used as a basis for the early stages of the search were grounded in concepts identified during previous academic work and clinical practice discussed in chapter one. Specific attention was paid to an openness to expanding the literature examined to maintain the integrity and quality of this research and ensure a wide reach beyond that which was familiar to the researcher. Broad terms such as competence, capability and confidence were used and expanded upon as detailed in appendix i and developed during scoping, conducting and bibliographic stages of the search as detailed in this chapter. However, appropriate caution and reflexiveness was applied so as to ensure freshness to the search and avoid reliance on previous work.

The search itself conducted as the second stage of the process included the search terms as described in the databases mentioned and, in addition, searches for unpublished or grey literature were performed. This was covered in the databases to include items such as conference proceedings. Thesis databases were also included, such as EThOS, the e-thesis online service provided by the British Library. The inclusion criteria for the search consisted of:

- Years between 2004-2021.
- In English.

- Regions of UK, USA, Australia, New Zealand, Canada, Netherlands, Sweden, Norway.
- Literature where the search terms (appendix i) were identified in the topic area.

Parahoo (2014) discusses the widely held opinion that inclusion criteria should restrict search findings to a 10-year time period in order to remain up to date and valid. However, as is noted above, the timeframe used here exceeded this recommendation. This is a result of the work highlighted by the author in previous academic work, that informed the formation of this research idea and that is the foundation of this research. It was felt essential that this was included in the development of the concepts examined in this study, and reviewed in the appropriate review sections, so that the sources of knowledge were transparent along with the development of the concepts and ideas that form the research and its findings. The work is also considered by the author to have made a significant contribution within the field. The regional restriction is included to ensure enough of a similarity in the nurse practitioner systems in order to facilitate comparison (Currie et al, 2007). The language restriction demonstrates and supports the regional restrictions that comparatively developed health care systems are in operation and similar in their use of nurse practitioner-type roles (Pulcini et al, 2020).

Potential literature was initially highlighted by title and abstract review, followed by more detailed reading of the full article, from which themes in the literature emerged if the abstract appeared appropriate to the research topic. These themes, as mentioned in the introduction, form the structure of the remainder of the chapter after this section.

The third stage of bibliographic searching includes review of the references of the included studies and those found to be useful as primary rather than secondary references during the review process. This established a chain of references that linked the key texts in the field and

served as a cross reference that all key literature had been retrieved. This stage also reduced the possibility of key literature being left out of electronic searches as these can rely on the databases' ability to classify each study, which may differ between databases.

The verification stage involved contacting and discussing the subject with others, particularly experts in the field and interest groups, in this instance predominately via social media. In several cases this proved invaluable. Several blogs and discussion groups with both active and observational involvement presented and answered a number of queries.

Stage five is referred to as the documentation phase but is acknowledged by Booth et al (2016) as one that does not come at the end of the search, but is rather one that is embedded throughout the process. It is essentially referring to the record keeping of the search process to keep track of search terms, results, note taking, managing of documents and reference lists, among other tasks. Figure 2-1 is a consort diagram that demonstrates the search results applied to three key search terms competence, capability and confidence applied in the stage one scoping review as seen in appendix i, further search terms are also seen in appendix i.

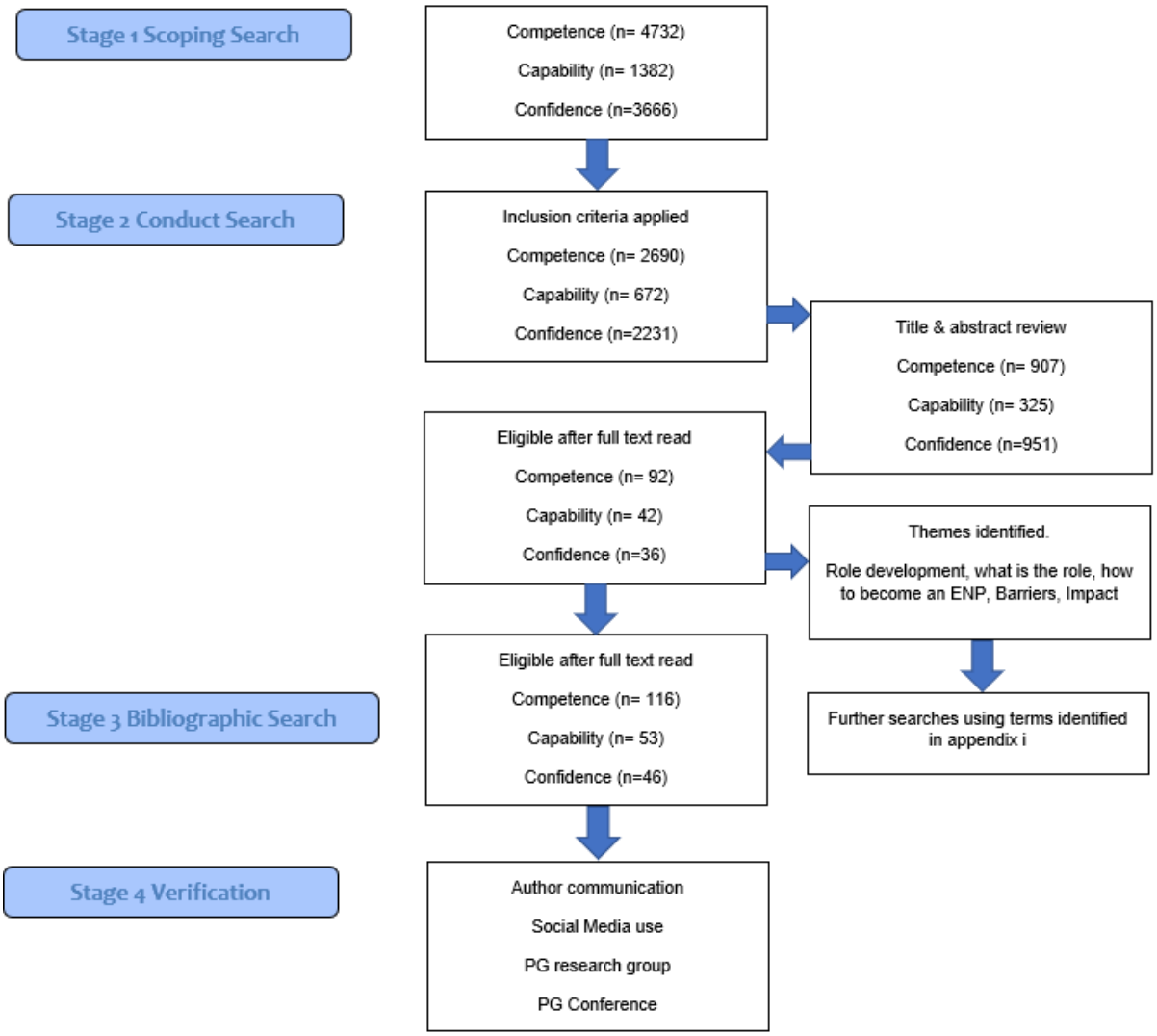

FIGURE 2-1 LITERATURE SEARCH KEY TERMS FLOW DIAGRAM

The frequency of the searches performed for this research should be noted as it is a process that was under constant review. The review is a part of the reflexivity of the researcher, where an account is made for analytical decisions and the retrieval of information processes that are involved in practitioner-researcher studies (Smith, 2009). Searches were performed at the project proposal and approval period (2015), annual progressions (2016/17 onwards) and throughout the research process, thus informing the analysis of data after collection in 2017. RSS feeds were utilised, along with automatic updates from search engines that highlighted new literature in each search term and combination. RDF Site Summary or Really Simple

Syndication (RSS) is a web feed that allows users to access updates to websites, in this instance publications, in a standardized format which is readable through email software such as Outlook. These feeds allowed the researcher to efficiently keep track of many different publications. The last comprehensive search was performed during the write-up period throughout 2020 into 2021, with updates performed leading into the viva.

2.3. Role development

The NP role seems to have originated in the US during the 1960s with the initial intention of improving quality access to primary care in poorly served communities. The role expanded quickly across the US, with educational programmes rapidly following. This paved the way for NPs in the UK that were implemented sometime later during the 1980s (Carryer et al, 2006). This was primarily due to cost of NHS service provision, an increasingly skilled workforce and the need to expand provision rapidly. Thus, nurses were ultimately perceived as the cheaper option, more readily available and keen for role advancement. The role within UK emergency departments expanded rather sporadically and inconsistently for a number of decades until the late 1990s (Lloyd-Rees, 2016). In 1999, plans were announced to pilot walk-in centre services which formalised the ENP's role in acute care but failed to identify how the staff would be trained or to what level (DOH, 2001. NHS Exec, 1999). This was the beginning of the adoption of advanced practice roles in secondary care that had begun to appear in North America in the 1960s and in the UK in primary care (Neville and Swift, 2012).

During the late 1990s and early 2000s a significant increase of job titles in use occurred, such as clinical nurse specialist, advanced practitioner, specialist nurse, emergency nurse practitioner and emergency care practitioner. Whilst other countries most commonly used the title of advanced practice nurse, and the US predominantly used nurse practitioner, the UK

continued to add confusion and variation by interchanging the term specialist with practitioner (Pulcini et al, 2010). A study by Leary et al. (2017) identified 595 job titles in use for specialist posts and highlighted that the titles had little relationship to other factors, such as education, and were primarily driven by pay band. This is more recently supported by Evans et al. (2020), who found that the development of advanced roles was significantly impacted by deployment, nomenclature, definition, governance and educational variation.

These titles, however, fail to define the required level of practice on a national level but were a narrative on the end product of a competent practitioner and, as a consequence, gave patients or staff little understanding of what to expect. This confusion largely continues to exist. This supports an earlier systematic review by Horrocks et al. (2002) found in the Cochrane Database of Abstracts of Reviews of Effects (DARE). The authors highlighted the ambiguity of the nurse practitioner title, with the introduction of other advanced nursing practice titles adding to the difficulty in understanding the nursing role definitions. The UK nursing regulatory body, The Nursing and Midwifery Council (NMC), recognised this and released the results of a consultation on their proposals for the standard of post-registration nursing. It supported the above discussion regarding the number of titles and their lack of relationship to competency (NMC, 2004). This consultation accepted that enforceable standards did not exist for this practice level and compared it to the GMC specialist register that was formed in 1995, an example which the NMC advised as necessary (NMC, 2004). This built upon domains of competency originally proposed in 2001 by the National Organisation of Nurse Practitioner Faculties (NONPF); adapted by the Royal College of Nursing (RCN) in 2002 (NONPF, 2001). The results of the consultation were in broad agreement with the proposed structure (Ball, 2005).

However, role evaluation has continued to prove difficult to attain with a lack of common approach and little consistency in the impact and education of the role (Neville and Swift,

2012). The systematic review by Watson et al (2002) highlights difficulties in the definition of competence, and that the confusion is complicated further by the fact that a clear relationship with performance has not been firmly established. This will be discussed in more detail later in this chapter, in section 2.5. The confusion is derived from a lack of agreement between statutory bodies and NHS Trusts on the role of NPs in the first instance and an application of consistency across the numerous titles in use, which is apparent in this literature review chapter. Despite the apparent early publication date on the work of Watson et al (2002), later work highlights a continuing problem with role clarification (McElhinney, 2010; Gardner et al, 2006(a)). Griffin and Melby (2006) highlighted that as few as 11% of the respondents had a clear understanding of the ENP role or what the ENP was expected to do. Even at the time of publication, this was not a new problem.

Rather dramatically, a systematic review by Andregård and Jangland (2015) described the journey of introducing the NP role in new teams as a tortuous one. This creates problems for UK academics attempting to design curricula to meet varying roles in practice (Mason et al, 2004), particularly when compared to the system in Australia where the NP title is protected by legislation and has defined core roles (Gardner et al, 2006(b)). At the time of writing, there still remains no plan to protect the practitioner title in legislation for any health care professional in the UK. The UK Government has not commented directly since their position statement of 2010 (DoH, 2010), which does not mention regulation but agrees with the confusion within the literature, covering advanced practice within the code of practice valid at the time (NMC, 2008). Meanwhile, both HEE (HEE, 2017) and the Royal College of Nursing's standards for advanced level practice (RCN, 2018) mention the development of advanced care or advanced level practice, but do not address legislative change. The NMC strategy 2020-2025 (NMC, 2020) does however include the intention to conduct a

comprehensive review of advanced nursing practice, including consideration of whether regulation is needed, although no detail is provided regarding when this may happen.

Health Education England (HEE) (2017) have consequently attempted to give clarity to the level of practice and educational structure of the nurse practitioner role under the level of advanced clinical practice (ACP), which is considered a level of practice rather than a title or role. This presented level of practice crosses the boundaries of all health care professionals, allowing a uniform level and inter-professional sharing of knowledge and expertise. This came about as a result of the challenges facing the NHS regarding an aging population and pressure on the workforce, resulting in retention and recruitment issues. The NHS England five-year forward view identified the need to develop and unlock the potential of the workforce (NHS, 2014(a)), while the next steps document (NHS, 2017(a)) identified support for a new 'role' of advanced clinical practice and the publication of the HEE (2017) framework specifically noted accident and emergency as a key high priority area. The framework (HEE, 2017) highlights capabilities required for ACP to be underpinned by four pillars of clinical practice, leadership and management, education, and research. The framework refers to masters level study or award, however only commits to full masters award for the apprenticeship route for reasons of process. This brings the UK NP/ACP workforce into line with the common international goal (Pulcini, 2010). Medicine remains significantly influential, providing specialist capability frameworks through the Royal College establishments, which causes a potential duplication of work between HEI and Royal Colleges for reasons of intellectual property ownership. It also does not address the consistency of ACP since no unified or agreed regulation to the capability frameworks is in place.

2.4. The clinical role

The literature regarding the clinical role, as the role actually performed by the nurse in practice and understood in this context to be the NP role, is addressed in four broad areas within the literature. The literature discusses the clinical context, asking firstly what is the NP role, how do you become and transition into an NP role, what are the barriers to and perceptions of the NP role and finally what impact does the role have?

2.4.1. What is the role?

There are some broad similarities in the NP role across the countries reviewed in the literature. Gardner et al (2010) studied a range of variations in the pattern of NP work across a number of different service areas and found that the role was almost evenly split between direct care, indirect care and service-related activities. Direct care accounted for one third and involved activities such as procedures, history taking, patient interactions, physical assessment, teaching, diagnostics and medication prescription or issue. This is associated with the view of the NP role that most NPs would see. Almost a third of their time, the NP would engage in indirect care activities such as documentation, care coordination, workspace setup, computer activity, discharge planning and handover activities, which appear to be clinically related but not directly involving patient contact. The remaining third is spent in service-related activities such as meetings, professional development of the NP or others, travel and research, which accounted for 1.6% of the recorded activity.

In contrast to the inclusion of seemingly non-clinical elements of the NP presented by Gardner et al (2010), a more recent study highlights a distinctly more clinically based scope of practice, not acknowledging non-clinical aspects, with a focus on what the study refers to as practice patterns and services provided by NPs (Lowe et al, 2018). Lowe et al (2018) refer to the role as consisting of diagnosis, diagnostics, prescription, therapeutic interventions and referral to and from the NP. It acknowledges that practice patterns vary greatly between

specialties and that the focus of the NP role across the specialties remained education and counselling during patient encounters, alongside the ongoing monitoring of symptoms. However, with 12 of the 20 participants practicing in the emergency department, the conclusion suggests a rather reductionist view of the role when compared to Gardner et al (2010).

A study from 2015 offers the opinion that a primary care-based NP role presents two distinct notions of primary health care and primary care (Carryer and Yarwood, 2015). The former is more about the pathway to achieving basic human rights, focusing on the social determinants of health with sectors collaborating to influence human health. Whereas primary care is the first point of entry into the health care system, and a personal request for direct personal medical care. The work suggests that NPs have much to offer the primary health care notion, with their extensive knowledge of the causes of human suffering, despite the movement away from the traditional nursing role to that of the more medical model focus of the primary care NP (Carryer and Yarwood, 2015).

Preceding all these pieces, the work of Christensen and Hewitt-Taylor made a number of key observations on the direction of nursing and its expertise (2005). In contrast to the role defined by a series of tasks, the authors refer to the hallmark of expertise as holistic care, rather than the ability to conduct a series of tasks proficiently. This is developed further when the UK government policy changes associated expertise in nursing with the following of protocols and guidelines, enabling them to extend their roles, and seeing this extension of role as a reward for expertise. Benner (2001), however, sees the use of protocols and guidelines as a lower form of practice than expertise, with nurses rather using guidelines and protocols to inform practice and decision making as opposed to being the entirety of the plan. Interestingly this study also refers to a move of the holistic focus of nursing from care to cure, introducing the positivist concept of cure in the form of protocol driven treatments which

exist in direct contrast to the traditions of nursing and offers a restriction of care rather than an enhancement of it (Christensen and Hewitt-Taylor, 2005). More than 20 years ago, research highlighted the difference between doctors' and nurses' attitudes to patients, where doctors focus on treatments whereas nurses focus on the patient's existence (Chiarella, 1998). It is about making the patient experience as tolerable as possible in the moment. This is suggestive of a difference in philosophical position and approach between the roles.

Shortly after this study came the work of Carryer et al (2007(a)), who attempted to illustrate the core role of the nurse practitioner through an interpretive approach of interviews, policy and publications of the time. The three identified conceptual domains that describe the role. These are dynamic practice, professional efficacy and clinical leadership, all of which give an interesting insight into the role, that continues to resonate with the more contemporary evidence of today. Dynamic practice describes the clinical elements of the work of the NP, incorporating the extensive and systematic clinical knowledge and skill required. Interestingly the NPs here did not differentiate between the physical and social aspects of assessment, which indicates a tendency to resist the move towards cure, and continues to employ care as an equally important aspect of the NP role. This resists a complete move towards a positivist concept of cure (Christensen and Hewitt-Taylor, 2005), and keeps the traditions of nursing care intact whilst incorporating new aspects, suggesting a building or development of the role rather than the adoption of a previously defined role in the domain of medicine. Professional efficacy discusses the significant autonomy and accountability the NP role requires grounded in a nursing model of care. This is characterised with a combination of a large range of technical skills that are delivered in a clear nursing framework. This maintains the therapeutic link between patient and NP, combining the decision making and responsibility of delivering autonomous diagnostic and treatment episodes in their entirety on the foundation of a distinctive well-being focused delivery that offers an additional layer that

other roles do not. The recognition of true autonomy, such as not asking permission from medical staff, rather just conducting a care episode, and telling them it has been done if necessary, is seen as a significant step upwards in terms of autonomous practice. The clinical leadership domain was seen very much as having been derived from a strong background of clinical experience and education. It is demonstrated in not only the skills and knowledge previously discussed, but in a role of guidance and responsibility of the behaviours of others, under the guidance and influence of the care systems in place at local and national levels. This demonstrates leadership both in the immediate clinical environment and the broader health service delivery contexts. A useful observation from this work relates to the hierarchical nature of the knowledge continuum that suggests that medicine lies at the top of the hierarchy at the potential expense of nursing, moving in a direction towards medicine. It is argued that it is not tasks that define a discipline, rather a philosophical approach guiding practice. This is consistent with much of the contemporary literature which defines advanced practice as a way of practice rather than a series of tasks or job titles (HEE, 2017). The work of Carryer et al (2007(a)) also indicates the fundamental elements of medicine and nursing combine in the NP, creating a holistic and potentially new, dynamic role.

2.4.2. How do you become an ENP and transition?

The educational requirements for the NP role have long been questioned. Some clarity has been achieved relating to ACP development since the release of the HEE framework (2017) and involvement of the Royal Medical Colleges with the formation of competency or curriculum documents and systems across a number of specialist areas, including emergency care (RCEM, 2019). The framework establishes masters level study or award as the standard. However, it only commits to full masters award for the apprenticeship route for reasons of process, falling short of the evidence seen in this subsection. The RCEM (2019) recommends a minimum level of post-graduate diploma. Pulcini et al (2010) conducted a survey that

identified that just 50% of the countries surveyed considered masters was the most prevalent credential. It has taken, however, a number of years to get to this point and many would argue that the point made by Gardner, Gardner and Proctor (2003), that there is little research-based knowledge about nurse practitioner education, may still hold some weight today with some similarities existing in ACP education models. Their work identified a tension in the balance between the core and specialist elements of the educational content of a curriculum and founded in the repeated problem of defining advanced practice and the NP role discussed earlier in this chapter. It was also found that contribution to the role by means of specialist assessment, autonomous decision making, clinical leadership and a sound scientific knowledge was of central importance to students. The students possessed a strong interest in learning through a range of opportunities from formal class-based learning through informal opportunistic learning to self-directed approaches.

An early study conducted in the UK concluded that, surprisingly to most, becoming an NP was actually more about non-educational matters, as although education was an important part the transition became about other factors. Nicholson, Burr and Powell (2005) found that the focus of the NPs revolved around how they put theory into practice, rather than the theory itself. The process of transition placed more importance in clinical experience, with the NPs regarding this as what would ultimately make them confident and effective practitioners. This was gained through day-to-day practical application and alignment of the taught and experiential theory, relying on the personality and background of the NP for development. It is acknowledged that this is rather an elusive component and difficult to capture. The study also talks of confidence being central, predominantly involving the management of the relationship interface between the NP and doctors. This was extended to an equal importance of relationship and role definition between the NP and other nurses.

Nicholson, Burr and Powell (2005) also found that there remained concern regarding how many of the skills required could be directly taught and how much of the transition was about personality. The implication here is that the theory seems to be derived from the individual's experiences, and the transition is more about the personality and how they establish themselves in practice. This would lead to an interesting and reasonable extension that it may be more about the right person, as opposed to their academic ability. This is also reflected in later UK-based work by Barton (2007) that suggests the student NP experience is more of a composite of social and cultural transitions than pure tangible and traditional educational experiences.

MacLellan, Levett-Jones and Higgins (2015) reinforce this point further in their work that agrees that the highly individualised experience of transition is dependent on the personality characteristics of the NP, inter-personal relationships between healthcare colleagues and the clinical and organisational support offered to the NP during the transition process. The concept analysis discusses a three-stage approach starting with an ending, moving into a neutral zone and completing with a new beginning as the NP moves from nurse to NP. The NP is most vulnerable as they move through the initial excitement of the ending phase where feelings of uncertainty, and crisis in identity exist as the NP seeks to let go of their previous identity without a full understanding of their new identity, an in-betweenness. Positive experiences of growth, reinvention and growth during the neutral phase change the dynamic of the NP and their position. However, they continue to experience feelings of vulnerability associated with lack of self-confidence, similar to the theory of imposter syndrome (Lewis, 2020), as they exist as an in-limbo feeling. This, in turn, gives way with reflection, to a new beginning where a successful transition can be seen in demonstrations such as autonomy, skill development, confidence, competence, capability, personal and peer acceptance of the role and an adoption of the values and attitudes associated with an NP. There remains a

degree of in-betweenness, however, as the NP remains in neither in a nursing nor medical role, between care and cure if you will, a concept described by Barnes (2015) as a shift from provider of care to prescriber of it. This was also seen in a study in Sweden about surgical NPs where the feeling of being between two roles created issues with a loss of identity and sense of guilt, describing it as a betrayal of experienced nurses (Jangland et al, 2016).

Further details of the concept and difficulties in transition are seen in the work of Barnes (2015), who also notes the change in professional identity as leading to a loss of self-confidence which, in turn, can hinder successful role development. The concept consists of four defining attributes. The first is the absorption of the role, defined as a time of high personal development and role learning as the transition takes place. Second, is the shift from provider to prescriber of care dramatically increases the autonomy and responsibility for the health care provision. Thirdly is the attribute of straddling two identities which occurs as the NP moves from no longer being in the RN role whilst simultaneously not being in the physician role. Finally, the attribute of mixed emotions, that includes excitement, anxiety, stress and frustration, is interestingly overwhelmingly negative, with 10 of the 11 reported emotions being negative. The pre-requisites for the successful or unsuccessful transition remain simply graduate-level education, which differs from previously stated academic levels seen in the literature, experience in terms of skill acquisition and competence, disengagement with the previous role and engagement to the new, and a desire to seek feedback on their work.

This was further seen in the work of Maten-Speksnijder et al (2015), whose insight into the NP transition also found that the transition can result in feelings of distress as they became accountable for the care of patients. The work, conducted in the Netherlands, draws comparisons to the work of Barnes (2015) with some role confusion and changes in relationships with both medical and nursing staff. The support of both groups of staff was

key, as well of that of healthcare managers, and detailed as the most influential factor in transition in the study. As this support connection developed, the NPs became more skilled at managing medical procedures and patients, thus improving confidence and feelings of appreciation and value from physicians and patients.

A meta-analysis by Andregård and Jangland (2015) conducted in Sweden found themes of professional boundary threats where nurses and doctors had differing opinions as to what the NP role should be, varying from physicians' assistants to middle-grade medical equivalents. This was identified as a barrier to transition. Once the NP became identified as a team resource during the transition, communication, collaboration and sharing of knowledge quickly gave the NP a cornerstone of the team feel. There existed, during the transition, a pursuit for autonomy and control of learning with the physician describing the NP role as dependant and in need of supervision. Whereas the NP felt that more autonomy was required, along with some control of their own learning, with support only required for the more complex cases, with an over supervision creating a reduction in independence. The ability to develop interprofessional collaboration was seen as a key trait of communication in the NP that was brought into the role from previous experience, as well as an ability to innovate and drive towards the successful transition into the new role. In the absence of NP role models in the new role, this drive was seen as key in the establishment and acceptance of the transition from RN to NP.

The educational elements of NP programme design are limited in terms of the research evidence available to evaluate what is needed from training programmes, their design and assessment methods (Sciacca and Reville, 2016). The concepts of competence and capability are discussed in the literature, and these will be discussed in later sections of this chapter in detail. The evaluation methods that NPs are required to achieve are numerous across programmes, with a lack of standardisation cited as a problem. These evaluation methods

include self-assessment, competency measures, mentoring, portfolio, simulation and written formats (Sciacca and Reville, 2016). Examples of assessment methods can be seen in those used by the Royal Medical Colleges (RCEM, 2019) and tend to replicate medical training requirements. Four themes are presented by Dover et al (2019) in a review of preparedness of ACPs in practice. First is consolidation, which incorporated a lack of both role definition and post-graduation support as significant in delaying the transition, resulting in consistent feelings of being an imposter in the role. The time required to consolidate varied, however most commonly a year post-graduation with a structured clinical internship and mentorship system was seen as most beneficial. However, there was evidence that were this not in place, transition was a longer process and the ACPs were less likely to work independently. This contrasts with the work of Andregård and Jangland (2015), discussed earlier, that suggested that NPs wanted more autonomy and less close supervision, unless requested for complex cases, in order to address the perception of dependence of the NP by medical staff. Dover et al (2019) seem to suggest that good supervision during a consolidation period improves transition to independent working.

The novice-to-expert transition is applied when addressing the second theme of the theory-to-practice gap. However, it is acknowledged that little research is available to support its application in advanced practice. It is seen that expertise develops when theoretical principles are applied in a practice setting, but that this often results in a transition shock as gaps will exist in what was initially learned as a student NP. Masters-level study, and therefore thinking, is identified as the UK standard (HEE, 2017), with simulation showing good support to the transition process, bridging the gap and reducing transition shock. Transition is further supported with a formal orientation programme, as discussed earlier by Barnes (2015). It is noted that orientation programmes tended to focus on skills, knowledge and decision making as the transition moves from care provider to care director, or care to cure,

with this concept contributing to an identity crisis for the NP (Christensen and Hewitt-Taylor, 2005. Barnes, 2015).

The third theme takes up the skills acquisition process as competency. This will be discussed in more detail later in the review and, as will be seen, skill acquisition can be perceived as rather reductionist in its simplest form. However, Devon et al (2019) present that it is used to incorporate skills across the spectrum, ranging from manual skill acquisition to decision making, by use of a variety of assessments. Despite this, these assessments are not well evaluated in the research evidence and often included inconsistently (Sciacca and Reville, 2016).

The final theme is mentoring. However, despite it being clear that mentoring is seen as valuable, little research evidence validates its use in NP transition and inconsistencies exist as to who is best positioned to offer this support, whether physician or experienced NP, with the absence of nursing role models an issue (Andregård and Jangland, 2015). The work that has been conducted is often in small sample groups from single courses, which limits its general application. The NMC (2018(c)) has moved away from traditional one-to-one mentorship models towards supervisor assessor relationships, with Trusts transitioning to operating a more team-coaching approach. This may be more challenging for advanced practice and is currently recommended for pre-registration students.

These transition themes are also seen in the synthesis work by Moran and Nairn (2017), that includes the work of Maten-Speksnijder et al (2015) and Barnes (2015), which found themes of experiences of changing work environments, role orientation and culture, mentorship, supported clinical skills development, clinical supervision and masters-level education. These themes lead to stages or phases through which the ACPs passed in order to assist transition into the ACP role. These are consistent with discussions earlier in this chapter, and

interestingly also highlighted the overwhelming nature of the move from expert nurse to novice ACP, often resulting in serious contemplation of a return to the former role. The challenge of transition is also seen in Swedish Surgical NPs (Jangland et al, 2016).

A study from the US by Pleshkan and Hussey (2020) makes the case for preceptorship of newly qualified NPs and suggests that poor educational preparation and a perceived lack of skill acquisition have an impact on transition to qualified NPs. It is also noted that, often, NPs who are newly qualified will go it alone almost immediately, with no additional support other than the assigned doctor from their educational programmes. It is also highlighted that doctors do not necessarily have the knowledge of the NP role or scope of practice, and the educational paradigm differences that exist between medicine and nursing that have an impact upon the relationship. It is also acknowledged that NP preceptors are scarce, even though they have a positive impact upon successful role transition shortly before and after graduation. Issues remain, such as inconsistency of preceptor preparation, an outdated model and over supervision, resulting in an over dependence on the preceptor, which reflects work discussed earlier in this chapter (Andregård and Jangland, 2015). Identity confusion was also found to be an issue where it was difficult, even after graduation, to not work in both the nurse and NP role in the same unit, similar to the identity crisis discussed by MacLellan, Levett-Jones and Higgins (2015).

2.4.3. Barriers and perceptions

There is a large amount of evidence that ENPs provide effective care and improve patient satisfaction (Hill, McMeekin and Price, 2014; Hoskins, 2011). However, some caution should be taken with data derived from patient satisfaction surveys due to their inerrant superficial nature and reliability of the methodology. Although there does remain some suggestion that the role is indirectly restricted by nursing and medical management, with the continued use of protocols in some areas of the UK (McConnell, Slevin and McIlfatrick, 2013). This is

replicated in Australia, where jurisdictional restrictions create significant barriers to the expression of the scope of NP roles, and hinder NPs from performing at their full scope of practice (Scanlon et al, 2014). There are broad similarities that exist in the literature relating to barriers and perceptions of the NP role. These can predominantly be associated with the perceptions of groups of staff and patients and are primarily concerned with what the role is and acceptance or rejection of nurses moving into a role that has been chiefly associated with the medical profession. As long ago as 1998, there existed contrasting opinions of nurses as practitioners, and some fear existed that nurses should be kept in their place. Resistance to the development of the NP role was chiefly from the medical profession, who were initially concerned that the level of education was not enough to allow for decisions to be made by non-medical personnel (Chiarella, 1998). This was addressed initially by the introduction of degree nursing at registration in 2013, however perhaps not as long ago as some may think. Chiarella (1998) also makes the interesting observation that it is not the tasks that nurses do that distinguishes them from doctors, rather it is the focus of the role.

Work by Norris and Melby (2006) presented the perceptions of barriers to the NP role in an emergency department as including conflict with doctors, resistance to change, poor renumeration for the role, lack of support from consultants or nursing leadership, patient reluctance, limited autonomy, litigation and professional jealousy. Contrasting this, contributions to perceived benefits of the NP role included reduced waiting times, increased patient satisfaction, improvements to communication with patients and the multi-disciplinary team (MDT), alternative and priority streams for treatments, ‘safer practice’, target achievement and improved morale. Consistency between the participants was seen where credibility would be improved by a specialist NP qualification, although the level was not discussed and, as previously mentioned, inconsistency has been seen in the level, quality and content of such programmes. This has been significantly addressed by the HEE framework

(HEE, 2017). The primary theme this work was inter-professional conflict, some of which was due to traditional and long-held perceptions by nurses that they are seen as handmaidens, an opinion that has been evident in the literature as a power imbalance for a significant period (Norris and Melby, 2006). This is contrasted by modern medical views that nurses were an underused resource, and that the suggestion that doctors would oppose the development of the NP role is outdated or, at the very least, on the way out. This is seen in a change in perception of nurse education, with the enhancement to degree in 2013 breaking the traditional mould. It is also argued that the drive to break down the barriers comes from senior expert speciality nurses who frequently fail to observe traditionally perceived boundaries for the benefit of patients and the expansion of the scope of nursing.

A study by Griffin and Melby (2006) continued to reiterate the point that the main barrier to the establishment of an ENP role remained a lack of clear role definition. It also revealed that the attitudes of nurses and doctors towards the ENP role, whilst complex and multidimensional, was positive overall. The main difference seemed to exist between hospital emergency staff and GPs, with GPs being less positive in their attitude towards the ENP role at the time. This was put down, once again, to the considerable uncertainty and vagueness of the role from the perception of health authorities and employers, which in this case chiefly consisted of GPs. In other studies, nurses themselves have been seen as a potential barrier to the implementation of NP roles as, although their reasons are not well documented, it is thought that the resistance is based in attitudes to change, and not wanting to lose experienced nurses to a ‘mini doctor’ role. A before and after descriptive study on the opinions of nurses to the establishment of a paediatric NP patient transfer service illustrated quite a contrast and culture shift (Davies et al, 2011). Prior to the introduction of the role, nurses agreed that it was largely a positive development for the profession, yet almost a third still felt an anxiety, fear and concern about working with them on the transfers. The conflict once again appeared

to be nurses doing doctors' jobs, the theme being mini doctor or maxi nurse. However, having established the role and having worked with the NPs, nurses' attitudes changed towards a position of trust and confidence in their abilities, citing improved team working, a trusting relationship and an intimate understanding of the role.

A study describing the experiences of the first NPs in Sweden drew some clear similarities to studies from the UK. The Swedish experience was also largely positive after its introduction, and the discussion moved towards the need to clarify the role, demark it from the medical and nursing roles and ensure the development of expanded rights, such as prescribing, to continue the expansion of the role (Lindblad et al, 2010). The prescribing issue in the UK was of course addressed and resolved with the introduction of non-medical prescribing (NMP) in the mid-2000s and the subsequent opening up of the formulary. Issues with confidence of the nurses themselves to undertake the role were seen, along with difficulties in transition from nurse to NP, which reflects previous discussions in this chapter. Confidence will be reviewed in the coming pages.

A review by Sangster-Gormley (2011) on factors influencing NP role integration in Canada again showed similarities to the experiences discussed in this chapter. Barriers to implementation were seen to occur at systems, organisational and practice level. Systems demonstrated a lack of legislation or regulation to support the role, which restricted it. Meanwhile, organisations demonstrated a lack of job description, conflicts of expectations, inadequate administrative support, workload and remuneration issues. Organisational culture included poor long-term planning and lack of NP autonomy, all of which contributed negatively to implementation. Practice-level barriers included medical staff resistance, a lack of understanding of the role from staff and limited direct contact between the NP and other staff.

Obvious similarities exist in the barriers to the role and its implementation across the nations in this work. The work identifies, as part of the review, three concepts to minimise the identified barriers. Involvement is defined as active participation of the stakeholders from an early stage; acceptance talks of a willingness to work with the NP and recognition for the role; and intention refers to a clarity of the role in its design, integration and interactions with other professionals. The restrictions that systems-level barriers placed on the autonomy of the ENP are further highlighted in a UK study (McConnell et al, 2013). The study showed that education or lack of knowledge were not perceived as a barrier to the role autonomy, but that factors beyond the ENP's control were. These included examples such as protocol use, imposed age restrictions on client groups, prescribing and referral abilities, and the wishes of medical or nursing staff presented significant obstruction to the achievement of the autonomy and effectiveness the ENPs perceived they were capable of. The study ultimately suggested that the ENPs were indeed not able to practice at advanced level as a result of the obstacles placed upon their role.

Bryson (2016) studied the perceptions of emergency department staff, concluding five main themes emerging from the data. Interprofessional relationships and attitudes found that all staff were positive about and supportive of the role. Perhaps unsurprisingly the NPs themselves were most enthusiastic and, whilst consultants described the NPs as effective care providers, the NPs themselves perceived that not all senior medical staff were supportive. Some interprofessional tension existed between nurses, relating to delegation and NPs being directed by other nurses to do jobs themselves, an instruction that would not be directed at medical staff. The idea of a mixture of roles, where the NP was neither a nurse nor a doctor and there was an expectation to undertake both nursing and NP roles, presented an operational issue when departments became busy or short staffed. This contrasts the medical perception that, whilst the NP was perceived to have less training than a junior doctor, they

seemed to have a more holistic approach to care and offer an added bonus to care within the department. Managing risk safely gave concern to medical staff, not that they were working unsafely, but more that the role itself was not well regulated and required more than the NMC working to scope position. Thus, this offered questions about indemnity and restricting the development of further autonomy accordingly, with an underlying agreement that further autonomy would improve efficiency for the NP and the department. It was, however, acknowledged that NPs did not work outside their level of competency, so perhaps the concern is unfounded.

The effect on patient care and services was perceived to be positive and, whilst it was not possible to place improvements solely onto the NP role as other systems were in operation, the role was perceived to be at worst cost neutral and at best cost effective, although statistics were not available to back this up. Reduction in the use of locum doctors and associated costs, along with a reduction in the frequency of retraining staff, were cited by medical staff as evidence. Finally, role development and factors affecting it were seen in the data. It was seen that clear definition and understanding of what the role is, and what it can and can't do, were cited by nursing and medical, staff both within and external to the ED. Other specialty staff were obstructive with referrals until this was more clearly established. Some importance was placed on a unique uniform to prevent NPs being pulled back into the more common nursing tasks and role.

These themes and findings were seen, albeit with different titles, in a study from New Zealand that drew similar conclusions with more support from NPs than physicians (Cameron, Shaw and Parsons, 2020). Although largely positive, the necessity of controlled role expansion with clear boundaries, and role clarity were seen in the data once again. This was also seen in work by Lloyd-Rees (2016), where interprofessional working issues were similar to the work of Bryson (2016), along with expanding the role and its future.

Interestingly, education was actually found to be a barrier whereby the time and cost of studying presented an issue. Staff were reluctant to pay for courses and study in their own time without the incentive of financial remuneration on completion by means of an increase in pay. The cost and sacrifice required to complete study, particularly in their own time, was seen as problematic and, in some cases, too great a barrier. It was however, clearly recognised that education was key to role progression and credibility, leaving staff with conflict as to how to progress in some cases. The work also introduced the concept of motivation, finding that appropriate remuneration for the role was associated with the value it was given, and this became increasingly important as ENPs recognised the crucial nature of the role within the service provision and the high quality of care that was provided.

These barriers are replicated in the ability to demonstrate leadership for NPs (Elliot et al, 2016) and persist in advanced practice roles (Casey et al, 2019), without seeming to improve or be changed according to the plethora of evidence seen in this review regarding barriers. Understanding of role, educational preparation and questions of range of autonomy persist in current literature and, although attitudes are largely positive, barriers persist in a similar pattern to the historical literature (Ruiz, 2018). Similar themes are again seen by Bagley (2018), but an interesting contrast exists that barriers of lack of time for CPD, inconsistent educational preparation and ENP perceived reasons for role expansion are regarded as less important than the positive effect of senior medical support for advanced roles.

More recent work acknowledged the opportunities for career progression along the clinical, rather than managerial lines, that NP roles offer, which is particularly relevant to those whose only option pre-1998 would be managerial roles within the ED. Experience gained over many years of ED work was perceived as of utmost importance to aid transition, although the move from managerial to student roles impacted both positively and negatively on the transition. The vision of an evolving role also provided motivation and challenge to their practice,

whereas literature previously reviewed focussed on remuneration for motivation. Collegial support from both medical and nursing director roles was again valued as significant in the role identity. However, interestingly, some staff who had held assistant director of nursing roles experienced a reduction in status when entering senior clinical, rather than managerial, roles. Thus suggesting that managerial roles are perceived as higher status than clinical roles, but that advanced roles are still emerging in their position and status (Kerr and Macaskill, 2020).

2.4.4. What is the impact of an NP?

It has been widely accepted for a number of years across a number of studies that nurses provide equivalent care to doctors, with similar health outcomes (Abraham et al, 2016). Some of the limitations of studies focus around areas that have been previously discussed, and mainly relate to the definition of what a NP is in terms of the role and its potential ambiguity. Horrocks et al (2002) found in a systematic review that, whilst NPs provided similar health outcomes, they mainly related to minor illness based in primary care, rather than more serious or rare illness. Thus, since minor illness was a relatively small part of the doctor's role, the conclusions were limited in their comparisons. It was found that patients were more satisfied with the care they received from a nurse, although it was not clear how this effect was achieved. It was also found that nurses took longer over consultations and carry out more investigations compared to doctors (Horrocks et al, 2002). A more contemporary systematic review found that NPs provided equivalent or better patient outcomes than comparators, and have the potential to be cost saving (Martin-Misener et al, 2015). This is also seen in a 2019 study of orthopaedic NPs which suggest that their work improves access to care, team communication, quality of care and patient satisfaction (Spence et al, 2019). Perhaps controversially, Mullinix and Bucholtz (2009) posited that NPs face continued opposition to independent practice based on unsubstantiated concerns for public safety that are often used

as a political tool to limit development, rather than address the issues. Equally, it could be argued that quality of care arguments are a substitute for a debate on addressing the dominance of medical over nursing care, rather than adoption of a collaborative approach. The focus on where the patients' best interests are served is obtained by marrying the medical biochemical and physical sciences with the social science and person-environment that nursing offers.

Neville and Swift (2012) suggest that it is increasingly difficult to evaluate the impact of the advanced practice role, again based on the variation of the role. They argue that impact is often measured in financial terms, whereas an alternative approach would be to look at added value. Commonalities should be used and, therefore, the bespoke nature of advanced practice across Trusts lends itself to difficulties in evaluation and useful comparisons. It is suggested in a study by Jennings et al (2017) that the data available to demonstrate impact using a cost model is based on poor quality data, and that the definition of what constitutes value is where the problem exists. The concept that more expensive care is better is questioned, and perhaps clinical outcomes should remain the focus. A literature review by Fry (2011) examined the impact of NPs in critical care, and concludes that, along with an agreement with previously discussed literature that satisfaction is often higher in patients compared to medical staff, a reduction in hospital stay, investigations, patient complication and readmission rates is also seen in evidence. Contrasting this is a pragmatic RCT conducted on ENPs in Australia that found no significant difference between the ENP and standard care groups regarding waiting times, length of stay, patients who did not wait, patient representation with 48hrs and use of evidence-based guidance. However, the study concedes that there is a lack of evidence regarding the effect of ENPs on key service indicators such as waiting times, and also that a reduction in waiting times was often seen in less contemporary studies (Jennings, 2015). There is broad agreement in a UK study regarding ECPs that concludes, after a systematic

review, that there is an equal quality of care delivered by ECPs and that a significant cost saving is seen, particularly in a pre-hospital setting, where less conveyance to hospital may either be the result of better decision making or that the group of patients that ECPs see may be less likely to require conveyance in the first place (Hill et al, 2014).

2.5. Competence

There remains much confusion regarding the definition of competence. Its origins are bound in the industrial era of the 18th Century, focussing on the improvement of factory lines as repetitive tasks. The concept rapidly moved on and became about professional associations of the early professions, such as medicine, law and the clergy, wishing to be defined by qualifying examination in order that its members were competent to distinguish from those who were not. This acts as an early nod to the concept of regulation of course and certainly an element of professional protectionism. Educational competency has been defined by Alspach (1984) as:

> *'A simultaneous integration of the knowledge, skills and attitudes that are required for performance in a designated role and setting' (Alspach, 1984, p655*).

Eraut (1998) made attempts to deconstruct the term to arrive at an accepted working practical definition, and found that it has different meanings dependant on how it is situated. The public image of competence would accept the definition that competency is:

> *'the ability to perform the tasks and roles to the expected standard' (Eraut, 1998, p129).*

This very much means that it can be applied to any point in the career of the individual, with the standard varying dependant on experience, and takes into account changes in the practice

of the tasks in which the individual is competent. It can also be considered as a continuum, with simply knowing how to do something at one end and how to do it well at the other, and competence falling somewhere in the middle. It is also rather reductionist, as it does not consider the complexities and relationships between multiple roles within a job. Instead, it deconstructs a role into a series of tasks and the associated competencies, rather than the consideration of the job as a whole. If it is considered in a politically negotiated and socially situated context, the public become taxpayers which leads to the idea of minimum competence complimented by minimum cost, particularly in public services. However, it could be argued that private industry would adopt a similar position from a different context to maximise profit. Employers are free in most industries to determine competence as satisfactory, where roles and tasks are performed within their own organisation.

This however becomes more complex when other parties, such as professional bodies, are involved in the definitions of what competency is and, to a degree, influence the economic element of the workforce and its currency. This then becomes a delicate balance between economics, output, regulation and policy. When individually situated, Eraut (1998) found that measures attributed to competence, such as academic aptitude and qualification, were in fact very poor measures and did not accurately predict performance or success at all. He concludes that professional competence is based on the assessment of two factors; the observation or inspection of performance and accounts, and reports or discussions about practice, which he interestingly associates with capability, which will be further discussed later in this chapter (section 2.6).

Ried and Douglas (2015) talk about experiential education in their work designed to examine an operational definition of competence for pharmacy students. They also describe two factors; to appraise student performance in the clinical setting and to determine if the student

is sufficiently competent to enter into professional practice. There is also acknowledgement that there is no widely accepted process designed to evaluate whether the assessment successfully discriminates between those that are competent and those who are not and continues to prove as hard to pin down for pharmaceutical education as they are in NP education. The work also introduces the phenomenon of the halo effect, where the assessor's general impression influences their ratings of performance or competence. This also acts in reverse in response to witnessed poor performance, where the halo effect can conversely influence the assessor that the witnessed behaviour was an anomaly rather than dig into its causes. This adds an interesting dimension to the position of the assessor in relation to their approval or disapproval of the behaviours of the student, and the influence of their general impression or comparison to other students. However, this is perhaps best examined in other work, as it is not the focus of this study.

The confusing terminology relating to the subject continues where terms such as competence and competency seem to be used interchangeably. The literature supports the concept that competence is a behavioural approach, with an expectation of job outcomes the focus. Meanwhile, the component parts of competence are seen as competency, that being describing the actions, outcomes or performance that should be demonstrated by the person attempting to show their competence (Davis et al, 2008).

A systematic review by Watson et al (2002) highlighted difficulties in the definition of clinical competence, describing it as a nebulous concept. They also argued this is further complicated by the fact that a relationship with performance had not yet been firmly established, with inconsistencies and difficulties in its measurement persisting. The implication is that competence requires something more significant than the demonstration of a task, particularly given that the flexibility required to deliver the often-unpredictable

demands of human care has to marry with a combination of technical and interpersonal psychological skills. This inconsistency is derived from a lack of agreement between statutory bodies and NHS Trusts as to a consistent and effective approach for the role of ENPs in the first place, and an inconsistent application of inconsistency across the numerous titles in use, which is evident in the literature. Despite the earlier date on the work of Watson et al (2002), later work supports the limited progress in this area by highlighting a continuing problem with role clarification (McElhinney, 2010. Gardner et al, 2006(a)). This creates problems for UK academics attempting to design curricula to meet varying roles in practice (Mason et al, 2004), particularly when compared to the system in Australia where the NP title is protected by legislation and has defined core roles (Gardner et al, 2006(b)).

Yanhua and Watson (2011), almost ten years after Watson (2002), continued to find the definition to be obscure, although they acknowledged that some progress had been made. Some movement towards a definition by regulatory bodies appears to have moved forward. The NMC (2010) used the term competence to describe the knowledge, skills, attitudes and values that underpin performance. In its standards of competency document (NMC, 2014), it specifically stated that these had not changed, although it does seem to avoid defining competence specifically. The most recent version of the standards document (NMC (2018 (a)) interestingly refers to proficiency rather than competence, whilst defining neither term in referencing a series of behaviours across several platforms. It should be noted here that these documents refer to standards expected of nurses at the point of registration, rather than at an advanced level. The NMC states that its post-registration standards are under review at the time of writing, however it appears to only mention specialist community public health nursing (SCPHN) and specialist practice qualifications (SPQ). The remaining documents refer to standards expected of educational institutions and their practice learning partners running NMC approved programmes (NMC, 2018(b)).

Competence is often viewed as a component of capability by many within the literature, where competence measures previous performance with capability looking at future ability (Gardner et al, 2007). This is developed in the work by Davis and Hase (1999) in the arena of human resource management and further by Phelps, Hase and Ellis (2005) in the field of computer user education. NPs should be informed by an approach to evaluation of the clinician that goes beyond competence. Competence is not sufficient in isolation. It was identified that the link between competence and capability needs further exploration when educating and evaluating NPs (Gardner et al, 2007. Gardner et al, 2006(a)). Work by O'Connell, Gardner and Coyer (2014) develops capability and its relationship with competence further, describing it as a combination of skills, knowledge, values and self-esteem, enabling individuals to manage change and complex, unpredictable work environments. Thus, taking capability beyond competence.

Competence remains an ambiguous notion and continues to be associated with the vocational educational and training sector in areas specific to manual jobs where skill sets are needed, and high-level critical thinking is not required. It also tends to be prescriptive and designed for stable environments possessing the ability to perform a nominated skill. Revisiting Eraut's work (1994), it is considered as a set of 'soft skills' that can be linked to the notion of productivity where competence may be preferred to excellence if it results in a quicker, cheaper service. Using Biggs (2003) hierarchy of knowledge they equate competence to the base level of declarative and procedural knowledge, which is clearly an age away from that of the practice not only for NPs but also of registered nurses (O'Connell, Gardner and Coyer, 2014).

Lejonqvist, Eriksson and Meretoja (2012) found competence to exist in practice as evident in an individual's ongoing actions and being itself. It consisted of encountering, knowing, performing, maturing and improving. Encountering is the interactions with patients and the

relationships that developed; knowing related to having the most up-to-date knowledge; performing was seen as having the confidence to care supported by experience and individually-tailored patient-orientated care; maturity being a growing in the profession, becoming more competent, and also including proficiency and a commitment to the patient; and improving is in line with a growth in knowledge and skills, seen as abilities to learn, share and teach. The work was focussed on nursing students, however is transferable to nursing as a whole as it demonstrated the ontological meaning, the very being of a competent nurse in a clinical context.

In a study in the Nordic countries looking at the scope of practice of advanced practice nurses, Nieman, Mannevarra and Fagerström (2011) found that advanced clinical competence is an expansion of the clinical competence found at and after registration. It is strongly associated with the nurse-patient relationship and both practical and theoretical knowledge are part of it. The work postulated that at an advanced level, clinical competence is characterised by responsibility and competence in autonomous decision making and judgments based on expanded clinical competence. Furthermore, that competence consists of more than simply advanced skills required to assess and treat patients, but also the creation of a safe, trustful relationship with patients and key collaborations with colleagues.

The American Urological Association offer a continuum, influenced directly by Benner (1984, 2001), where they talk through a series of competencies that bring the graduate NP to an experienced NP by means of a novice-to-expert continuum. This represents an attempt to bridge and acknowledge the theory-practice gap across three tiers of new graduate, experienced NP and expert. Each of the tiers is a synthesis of multiple national resources from within, and independent of, the urology specialty. The achievement of these competencies is clearly not a didactic process, although there is an element of this to establish

a foundation. Rather it is a series of behaviours and responsibilities designed to meet the needs of a specialist clinical population and intended to standardise and improve the education of the NP as a blend of the nursing and medical aspects of the role. This interestingly returns us to the role debate earlier approached in this chapter, as it reiterates that it must be responsive to the varied job roles and descriptions of the NP and, therefore, balance standardisation with role variability (Quallich, Bumpus and Lajiness, 2015).

Gaskell and Beaton (2015) looked at experienced practitioners using the Department of Health (2010) advanced level nursing position statement as a comparative framework to examine experiences of advanced midwifery practitioners in their competence development. The work looked at these experienced practitioners who had undertaken a new masters programme after a number of years of practitioner-level practice. In these practitioners, it appeared that a higher-level competency was demonstrated when practitioners engaged in the needs assessment, delivery and evaluation of the needs of practice of others in their area, as well as a robust assessment of their own higher-level skills. Of course, this could be as a result of the advanced knowledge and experience that was present before the formal recognition and evidence obtained in undertaking masters study.

A US-based study looked at recorded hours during an NP programme of study, and posed an interesting question: do accumulated hours of clinical practice or experience actually demonstrate or equal the development of clinical competence (Fulton et al, 2017)? Throughout the US, national certification of accreditation requirements deem that a minimum of 500 hours are undertaken as supervised clinical hours, however the work concludes that there is no evidence-based research that justifies this requirement. Many students logged as little as a third of their clinical hours, raising the question of what they were doing with the remaining two thirds. Furthermore, it was found that an assumption is often made that clinical

practice hours allow students to attain the knowledge and skills necessary for practice as an NP. Relying on student self-recorded hours was not a reliable method of assuring competence. Rather educators should know more of what the students are doing during these hours, specifically where they apply to the attainment of competence. They essentially concluded that experience doesn't necessarily bring competence, but instead the right kind of experience develops competence, suggesting that direct supervised patient contact may be a better measure. It is conceded that further study would be required to link this to activity that may improve competence undertaken outside direct patient contact.

It would seem a logical conclusion that it is the quality of practice hours, as is seen in the UK in focussed competence frameworks associated with the Royal Colleges such as RCEM (2019), that influence competence, rather than simply an accumulated arbitrary number of hours. The influence of medical education on competence and NP work will no doubt continue, and perhaps it should. NP and ACP practice continues to draw on its experiences of competence assessment, despite difficulties in evidencing the effectiveness of such assessment. However, few would argue at the effectiveness of medical education, given the standard of care and knowledge seen in medical consultants. Moore and Hawkins-Walsh (2020) acknowledge that there are gaps in understanding the best method for the assessment of NP competence, perhaps suggesting that a drop-in from a medical training model is the start rather than the end. However, they looked at the application of entrustable professional activities (EPA), evaluating their use as an assessment of competency in NPs in the US. EPAs are activities that a trainee can be trusted to perform without supervision. They are units of professional practice that translate competency into its operational context, rather than an individual list. Each EPA is an operationalisation of a number of competencies with discrete, observable and measurable activities. This pilot study developed an EPA-based grading rubric, evaluating its use with NP trainees, and comparing this against traditional

time-based requirements. The study concluded that the EPA-based grading rubric has the potential to identify curricular knowledge gaps over traditional time-based processes. It is acknowledged that further work is needed in this area, and revision of the tools will be needed.

The UK-based RCEM framework adopts a model similar to that expected of its medical trainees, which is a sensible option given the complexity and decision-making skills required of an advanced practice registrant. Standards should not be reduced to accommodate this workforce. The credentialing process sets the standard at the equivalent of ST3, expected of trainee doctors at year 3 of their specialist training. It is acknowledged that some NPs may have been working at a level that exceeds this standard for a number of years. However, it remains essential for credibility, longevity and patient safety that this process is undertaken. It is also acknowledged that the ACP option is not necessarily a cheaper one, with the supervision process being at least as much as would be expected for a junior doctor, combined with the higher education masters level required to run alongside is. With time allocated in the working week for both activities it is neither a quick fix nor a rapid qualification (Crouch and Brown, 2018). There is some potential conflict of course between higher education institutions, but the RCEM (2019) credentialling process and complementary e-portfolio is rightly protected and validated by the RCEM and the HEI's work with the HEE (2017) framework may result in some replication of work. HEE is establishing the centre for advancing practice (HEE, 2020), where the initial accreditation phase began in 2020 for HEIs already running ACP programmes mapped against the HEE multi-professional framework (HEE, 2017) and HEE Standards for Education and Training. The Royal Colleges are involved with critical care and mental health standards, as well as other examples. It remains to be seen how these established credentials will link to the HEE work, with a significant number in development as of October 2020.

According to an Irish study by Casey et al (2017) that looked at experiences and perceptions on the requirements to demonstrate the maintenance of professional competence in nurses and midwives, agreement was found with much of the literature that defining competence is a difficult task that is often associated with educational qualifications and practical abilities. As previously discussed however, Eraut's (1998) work considered that attributes to competence, such as academic aptitude and qualification, were in fact very poor measures and do accurately predict performance or success at all. Casey et al (2017) uncovered that participants found that they could more easily express the importance of why competence should be maintained, rather than defining competence itself. It was found that attempts to define competence focused on clinical skills development in the context of their work. The main motivators for maintaining competence included to satisfy public expectation and trust, and to respond to changes in clinical practice. This bears a close association with Eraut's (1998) claim of competence in a politically- and socially-situated context. Rather than provide a definition, competence is found in this work to be a series of concepts or attributes, as opposed to a single object, therefore allowing the flexibility it may need to be a contextual concept rather than existing as an object applicable across all areas and tasks. The participants declared that, whilst a meaningful definition would be helpful, it should be grounded in the context and specific to the role to which it is being applied. It was acknowledged that assessment of competence was imperative and a normal part of education and development, however difficult this was to implement. The key appeared to be a framework to which self-assessment could be applied with a variety of supervision and formal assessments, such as simulation or reflection, to be incorporated to offer a rounded perspective on the student. Shinners and Franquerio (2017) discuss that individual competence, whilst important, is only as useful as the collective competence of a team. They acknowledge the difficulties and complexities of defining competence but argue that both

individual and collective competence should remain a fluid process across time and be very much rooted against a contextualised background.

Taylor et al (2020) looked at advanced practice students' self-assessment of clinical competence. The work concludes that, despite criticism of self-assessment use in undergraduate programmes, its use in advanced programmes is well founded. The study found that the more clinically competent the advanced practitioner became through self-assessment, the more several behaviours were seen. They became increasingly aware of any knowledge gaps and how to fill them, particularly comparing themselves to medical knowledge. They maintained a good understanding of what training would be required, with a direct link between the highest-rated competency items and highest-rated training needs effectively being one and the same. There is also some criticism of the Dunning-Kruger effect (Kruger and Dunning, 1999), where poor performers over assess their competence, whereas top performers underestimate their competence, suggesting that their work undersold the accurate performance assessment of top performers. Taylor et al (2020) go on to say that experience is often presented as favourable as a criterion for entry to advanced practice. However, there is limited correlation between experience as an indicator for future performance in the advanced practice field. This supports the work of Fulton et al (2017) discussed earlier.

The work of Duff (2019) adds patient safety competence to a construct that develops role competence by the combination of three theoretical frameworks to examine the relationships between the frameworks. The construct combines the work of Kanter (1977), who proposes that a structural empowerment is required to be understood in order to develop learning and growth within an organisation, with Spreitzer's (2008) psychological empowerment work which discussed an individual's sense of control in their work or their intrinsic motivation

required for a job. Competency-based conceptual models are also combined with patient safety competence, that being the actions, attitudes and behaviours that demonstrate the best safe care practices across an organisation. Six hypotheses are posed that demonstrate the relationship between the frameworks. A cross-sectional survey design tested the hypotheses using a convenience sample of NPs. Of the six hypotheses, the most applicable to this work found that there was a positive link between structural empowerment and NP role competence, and there was also a relationship between structural empowerment learning environments and patient safety competence. Most interestingly, and perhaps unsurprisingly, there was found to be a direct relationship between NP role competence and patient safety competence. Thus, it can be concluded that empowerment on an organisational, psychological and individual NP competence level led to a positive and significant impact on patient safety competence.

It is clear that competence is a complex concept and certainly not best measured in isolation, based on the literature reviewed here. It is also clear that a sound measurement of competence may not even be possible given the complexities of the NP role. It is also clear that a number of stakeholders have influence over its definition, operationalisation, assessment and evaluation. Lundsgaard et al (2019) used a constructivist qualitative study methodology to explore how different stakeholder groups perceived the competence of trainee emergency department physicians and, thus, explore a definition of it. The stakeholder group included nurses, NPs, supervisors and senior physicians, leaders, administrators and patients in a focus group format. Four categories of competence were identified: core clinical activities, patient centredness, aligning of resources and code of conduct. It was found that there was a divergence of opinion and priorities between stakeholders, as each group added detail as well as complexity to the understanding of trainee competence, often based on their own needs. Conflict, whether direct or indirect, was not necessarily seen as negative and contained

learning opportunities relating to resource alignment and a meaningful contribution to competency frameworks. Core clinical competencies unsurprisingly included history taking, awareness of guidelines and accurate diagnosis. The study found that a greater emphasis was placed on patient centeredness, particularly when compared to physician-only derived frameworks. The inclusion of patients as a group certainly gave depth and diversification to the framework, and other perspectives on competence that may not have been extracted without them. Trainees were most concerned about the educational threat of the activities undertaken and missed opportunities, rather than value for other stakeholders, and were less aware of elements relating to patient centredness, which was the main focus of the patient group. Interestingly, physicians defined value as quality patient care, but also at the same time wanted to reduce the amount of unnecessary work for the supervisors by trainees not asking too many questions. There was also a further focus by nurses on quality patient care and promotion of a positive working environment, for example by emptying the staff dishwasher. Nurses, administrators and senior supervisors were most concerned by the concept that many individuals being responsible for assessment and feedback left no-one actually responsible for ensuring competence or otherwise.

This study (Lundsgaard et al, 2019) concluded that the importance of an individual was paramount, and that that individual should be supported and followed up by educators when faced with heavy clinical workloads. The study demonstrated that competence is a complex construct whose definition is multifaceted and swayed by perspective. It remains clear that it is not one-dimensional or task-orientated, as would be suggested in the earlier literature. Competence is perhaps a component of something far closer to what NPs require or aspire to in any specialty of practice, something beyond a single measure. It also raises questions whether competence is what should be used in isolation as an assessment of performance or,

in fact, that competence is a component of a concept often used interchangeably with competence, and perhaps capability (Gardner et al, 2007. Gardner et al, 2006(a)).

2.6. Capability

The issue of capability is a clear theme in the reviewed materials. It emerged in the mid-1980s as a result of the need for increasing competitiveness between organisations. Capability is a term that is often used interchangeably with competence and considered impossible to discuss without comparison to competence (Phelps, Hase and Ellis, 2005). The HEE framework (2017) refers to core capabilities and specialist competencies as the capabilities, using both in its definitions of ACP without defining either term. The RCEM ACP curriculum document (2019) mentions capabilities once in its curriculum, and competency on a number of occasions, without defining either. However, it is clear that the terms are interchangeable, and the direction and support available for the document is also clear, thus perhaps suggesting that definitions are not necessary. Capability is considered a measure of future performance and deems competence assessment as necessary, but only as an accurate measure of past performance (Gardner et al, 2007. Gardner et al, 2006(b)).

Thus, the approach should be to develop capability traits, with their awareness and focus being on elements of capable practitioners such as self-confidence, going beyond purely competency or task assessments (Alber et al, 2009). The coding used by Gardner et al (2007) reflects and supports the use of capability traits, as defined by Davis and Hase (1999) whose discussions of work-based learning in organisations seems key. It is however acknowledged that more work is needed on capability measurement (Alber et al, 2009; Gardner et al, 2007; Gardner et al, 2006(a)). Capability is defined by Davis and Hase (1999) as consisting of a number of components. A capable person knows how to learn, uses competencies in novel situations as well as familiar ones, is creative in terms of being able to think outside the box, has a justified self-confidence, can take appropriate risks and works well in teams. The work

talks of a shift in paradigm of workplaces and how they are conceptualised in order to make use of knowledge. This has become the major resource for businesses and refers to the work of Drucker (1993), who describes the secondary factors of production as land, labour and capital as something that can be obtained fairly easily as long as knowledge and the capacity to apply it exists. Davis and Hase (1999) also talk of competence, but as a component of capable people, in that they can be measured but are insufficient on their own and fail to empower people to be learners and demonstrate capability elements.

Fraser and Greenhalgh (2001) define capability as:

> *'the extent to which individuals can adapt to change, generate new knowledge, and continue to improve their performance' (Fraser and Greenhalgh, 2001. pp799).*

This is in contrast to competence being about what the individual knows or is able to do in terms of knowledge, skills and attitudes. They support the drive to educate for capability, particularly in complex environments such as patient care provision. Whilst there is acknowledgement of the importance of the checklist-driven approach traditionally associated with competence, particularly for patient safety, it is highlighted that these approaches are most useful when the problem itself has been understood. This requires imagination to develop, and non-linear methods such as competence do not allow for this. They postulate that doctors and nurses tend to embrace a situation in all of its complexity through storytelling, and clinical knowledge is stored in the memory as stories rather than discrete facts, for which they use the term 'illness scripts'. There is acknowledgement that further research is needed on the formal use of storytelling. This translates to the author's experiences of the classic duty room discussion, 'I had this patient who', as a means to discuss, learn, apply and adapt patient care experiences. Educating capability must allow for this by supporting learners to construct their own learning goals, receive feedback, reflect,

consolidate and avoid the rigidity of prescriptive content. This is well supported in the work of Gardner et al (2006(a)), who found that alongside a strong clinically orientated core of assessment and diagnosis, pharmacology and evidence-based practice, a capability structure should exist that applies the core to problem-solving, situated learning and experiential learning in flexible ways. The assessment of this capability includes strategies that require students to evidence this learning, experience and practice to demonstrate its future potential in the development of capability in the learner.

Stephenson and Yorke (1998) pose a definition of capability that is often used in the literature reviewed, appearing in many works. It reveals more of a type of person and traits, or a personality as opposed to a task or behaviour. They say that capability

> '*embraces competence but is also forward looking, concerned with the realisation of potential… Capability is an integration of knowledge, skills, personal qualities and understanding used appropriately and effectively – not just in familiar and highly focussed specialist contexts but in response to new and changing circumstance… to take actions in uncertainty and to see initial failure as a basis of learning how to do better' (Stephenson and Yorke, 1998 pp3).*

This is a definition that encompasses all that seems to appear in this review regarding capability and can be applied across work environments beyond healthcare. However, in relation to healthcare throughout the level of practice, it is relevant and transferable, despite being more than 20 years old in its origins.

Watson (2008), in his commentary on Gardner et al (2008), declared that their article was the first to get 'competence' and 'capability' into the same title with reference to nursing. He further describes his introduction to capability in 1998 as a revelation and liberation from the skills-based competence enforcements he described as being imposed on nursing by UK government to imprison the curriculum and separate it from the rest of education society. These are strong words and perhaps rather controversial. The work refers to competence as

inherently reductionist, with a limited view of an individual's professional practice and actually impeding their professional development. They use the Davis and Hase (1999) definition of capability and add a definition by Cairns (2000), who talks of capability as an individual having a justified confidence in their ability to problem solve in familiar, unfamiliar, varying and challenging environments. Cairns (2000) refers to capability as an all-round human quality, rather than measurable skills demonstrated and assessed against an agreed standard of competency (Phelps, Hase and Ellis, 2005). Cairns (1996) also suggests in an earlier opinion piece that critics of the concept tended to focus on its 'woolly thinking', as it was less precise than a measurable competence in a behavioural sense, likening the criticism to that the non-empirical nature of qualitative methodologies of the social sciences.

The work of Gardner et al (2008) looked at whether the concept of capability provides a useful framework to examine the characteristics of an NP in practice. A secondary analysis of interviews of NPs was used in an interpretive approach and found that the data supported the attributes of capability as defined by Davis and Hase (1999), Cairns (2000) and Phelps, Hase and Ellis (2005). It was found that 5 attributes of a capable NP were present. This included knowing how to learn, supported by Phelps, Hase and Ellis (2005), as a far more powerful indicator of capability than simple technical knowledge; the ability to work well with others, recognising how important this is to achieve outcomes; being creative, or not being afraid to take risks and pursue new ideas in a measured way; high levels of self-efficacy or self-belief that a particular undertaking will be successful with a particular behaviour; and finally an ability to apply competency to both familiar and unfamiliar situations or circumstances. This work was influential to the researcher in the formulation of the research question and its examination.

Conducted around the same time as the work of Gardner et al (2008), Carryer et al (2007(b)) looked at how controlling protocols diminish the capability of NPs. Interestingly, much of the

work around capability undertaken around this time included the same author team from Australia and New Zealand. Carryer et al (2007) identify capability using similar definitions to those provided above, however their discussion paper reveals from the literature that many NPs work under controlling protocols. There is acknowledgement that many terms for protocol are used, such as guideline, algorithm, and practice policy, but the distinction between protocol and guidelines exists as the latter aim to support practice, while protocols control it. This is seen to be borne from a fear for patient safety and a concern for the collaborative relationships often seen as essential for patient outcomes. Carryer et al (2007(b)) find that this is dismissed as unfounded in the literature, and that the use of protocols threatens the development of capability in NPs in the short and long term. They also argue that this approach also hinders the very flexibility that led to the development of the NP role in the first place and creates an increase in workload for non-NPs as a direct result. Essentially more control is less efficient and wasteful of resources, and time should be spent developing capability appropriately for the efficiency and flexibility required in the original purpose of the introduction of the NP role applied to the workforce.

O'Connell et al (2014) continue to highlight that as advanced practice is more established, new ways of teaching and learning, as well as assessing the practice of experienced staff, must take place in a move away from traditional competence approaches that is essential for the changing context in health care. They continue to work with the same definitions and constructs of capability, again repeating what much of the reviewed literature has suggested, particularly that the stability and predictability that competence assesses has little place in a modern dynamic healthcare environment. They conclude that capability incorporated the process of learning, that students should be supported in a good level of self-awareness and constructing their own learning goals, be in receipt and management of feedback and given the time to reflect and consolidate these learning goals. This is consistent with earlier works

examined in this review, seemingly with the discussion having not moved on far given that this piece was published in 2014.

A study by Bromley (2015) undertook an eDelphi method to determine capability requisites for postgraduate studies in neonatal intensive care. The definitions of capability used are consistent with works discussed in this chapter (Davis and Hase, 1999; Cairns, 2000; Phelps, Hase and Ellis, 2005). The work found 20 themes that contained a total of 422 capability requisites to be achieved in a postgraduate certificate programme of 12 months, with certain capability themes, such as knowledge, frontloaded in the first 3 months of the programme. This highlights the complexities of an advanced programme with a significant expectation on the students, highlighted in the study by the students themselves. Students indicated surprise at the level of skill expected in 9 months. However, panel members acknowledged that there should not be a push to get things done, the implication being that this is too close to competence attainment in its traditional sense. Rather the student should be supported in the learning process, and not be expected to complete proficiency by the end of the course. Instead, they should complete as a learner prepared to consolidate their learning, which remains close to the literature that previously been presented on the concept of capability.

Much of the reviewed literature discusses what capability is, what it consists of as a series of traits and how to get it, but overlooks what it looks like or how it is recognised in practice. Bromley (2018) looked at precisely this in student nurses undertaking postgraduate studies in neonatal critical care. The inductive grounded theory approach found that there were three themes seen in students who demonstrated capability in their work; professionalism, which incorporated problem-solving, analytical thinking, and using past experiences in new and dynamic contexts; interpersonal interactions incorporated qualities like openness to feedback and work allocations, communication between the professional team and interactions between the students and colleagues and the student and families; and knowledge and skills

which showed a demonstration of time management, confidence and willingness to ask and recognition of learning needs. This study uses Stephenson and Yorke's (1998) work, used earlier in this chapter (pp52), as the definition of capability, and encompasses this in its findings, demonstrating the value of this definition and answering the question of how it is seen in individuals.

There does remain some question on how best to capture the achievement of capability without reducing it to a series of competencies. The RCEM (2019) document talks of competency but, when evaluated, seems to lend itself to capabilities, demonstrating the interchangeability between the terms that persists in practice and other environments. The HEE (2017) framework makes a positive attempt to move towards defining capabilities as a term. There does persist some discussion regarding the theoretical framework and appropriate evaluation methods to assess competency and capability in NPs, however the RCEM (2019) seem to have adopted a variety of methods of assessment that are founded in its knowledge of training medical staff. Thus, they offer variety of methods designed to allow an all-round display of ability of a candidate for credentialling, dare it be said, a demonstration of their capability. Examples of assessment include work-based observations, formal courses, consultant-assessed consultation evaluation exercises, and case-based discussions, as well as traditional direct observation of procedural skills in a competency-type fashion.

The RCEM document (2019) clearly moves on from a list and incorporates capability demonstrations in areas such as communication with colleagues, relationships and decision making, alongside a comprehensive suite of speciality presentations. Thus, it leans towards a capability framework rather than a competency framework in line with the definitions and discussion in this chapter. The system uses an e-portfolio to capture the evidence, a method that is encouraged and supported in literature. Anderson et al (2009) advocate the use of such a method in either a spinal column or cake mix approach. That is an alignment between

evidence and evidence pieces to competency objectives or a reflective narrative tying evidence together, enabling a focus on personal learning journeys respectively. It appears that the cake mix approach aligns more closely with the capability approach based on this chapter sub-section. This is further supported by Sciacca and Reville (2016), who determine that portfolios integrate theory and practice whilst allowing the student an opportunity and responsibility to demonstrate progress. They call for a change of language both for the portfolios and reference to them from competency language to a language of capability. This allows individual dynamic assessments at various defined stages during the training, lining their work up to the work of Benner (1984), to allow for each capability to be reviewed individually at each stage to tailor the learning experience.

Hutchinson et al (2018) raise a discussion in their study about the importance of a nurse's ability to recognise emotion not only in themselves but also in others. This is known as emotional intelligence. It was looked at in the context of decision making and they noted that emotional aspects of human behaviour are discreet from cognitive rationality. They propose that these aspects are not given as much attention, if any, when compared to technical or cognitive elements of the decision-making process. Their work proposes an integration of emotional aspects of behaviour into capabilities in clinical nurses, and reflection on how they impact on decision making. This work was not undertaken with NPs, but it is interesting to see that it is related to intuition or 'gut feeling' that is often referred to in practice, just knowing what to do or recognition of a condition. Their linking to capabilities work opens the question of how this connects to knowledge and decision making, how it can be seen or controlled and what value it has, if any, in the process. This suggests that involvement of emotion in decision making recognises the ability of the human brain to integrate these processes and review their impact and contribution towards decision making behaviours as a

capability, rather than a technical skill. It may also be beneficial to research the impact of external influences upon emotion and decision making and how these are regulated.

2.7. Confidence

A common anecdotal discussion between NPs in practice is one concerning confidence and how this relates to how they practice. The concept of confidence and how this relates to role, competence, and capability is presented effectively by Bedwell, McGowan and Lavender (2015). Confidence is seen as an important factor in well-being and is associated with improved coping strategies, resilience to workplace adversity and enhanced job satisfaction. It is viewed as a positive attribute, and as improving an individual's self-esteem. It is conceded that its definition is varied and that the term self-efficacy is often used with a similar intent. The definition used relates to a belief in the capability of the individual to operate in, react to and manage unpredictable situations, as an overall belief in one's own abilities (Bedwell et al, 2015). The main factors positively impacting this confidence was found to be the influence of colleagues, familiarity in practice and environment, and perceptions of autonomy. Midwives placed a great deal of importance on confidence, which perhaps should be no surprise. However, they expressed the need to actively employ strategies to preserve feelings of confidence in their practice. Challenging relationships has an impact on confidence, with hierarchies particularly being significant. Units perceived higher in the hierarchy appeared to be able to have influence over lesser units, without invitation. This power extended to the staff in the higher units exerting authority, seen in examples in the communications between the units. Inter-colleague communications were also found to have an effect on confidence by simple and seemingly unintentional means perceived as implied criticism of practice. Interestingly, colleagues were also of vital importance when building confidence back up through peer support, and the fragility of confidence was plainly seen in the participants along with their resilience to sources that were

identified to impact on confidence. Conflict was a critical factor in creating a negative effect on confidence, often occurring between peers and colleagues with ideological differences. Whilst it was acknowledged that conflict was an inevitability, and would certainly affect confidence, it was also seen that strategies were employed to avoid, manage or give the illusion of compliance in order to seemingly protect the participant from its effects. Consistent to the previous discussion on capability, the participants had great skill in recognising emotion in peers, other staff, patients, and themselves. They also looked to use this skill to protect themselves somewhat from the vulnerability created when confidence was low or had taken damage.

Confidence in decision making for NPs is clearly of great importance. A study by Friedman et al (2005), looking at the confidence in the diagnostic decision making of senior medical students, found that confidence was higher when diagnostic decision making was deemed correct in laboratory conditions, and their confidence of the diagnosis was aligned to the correctness. Conversely when confidence and correctness was not aligned, the medical student was far more likely to be underconfident, rather than overconfident of the diagnosis. The Dunning-Kruger effect (Kruger and Dunning, 1999) suggests, in its simplest form, that unskilled people tend to overestimate their abilities because not only do they make a poor choice or decision, but their incompetence to make the correct decision in fact robs them of the ability to recognise it in the first place. Conversely, those who are more skilled or competent would tend to more closely and accurately identify their level of skill or limitations. Whilst the effect is rather more detailed than this, it seems to support the findings of Friedman et al (2005), suggesting that senior medical students had developed this cognitive ability to be confident and underconfident appropriately. A miscalibration of confidence in nurses can have an important impact on the quality of nursing care they provide. A study by Yang and Thompson (2010) found, when comparing students to

experienced nurses, that some inconsistency to the Dunning-Kruger effect existed. Miscalibration of confidence occurred where experienced nurses, perceived to be more skilled, had a tendency towards overconfidence. Whereas student nurses, perceived to be less skilled, generally tended towards under confidence. This contrasts the discussion in the competence sub-section of this chapter, where commonly hours of experience are used to determine competence or completion of accreditation, and often also used to determine who should attend courses leading to this accreditation. This, of course, supports the work of Fulton et al (2017), who conclude that there is no evidence-based research that justifies the requirement of an arbitrary number of hours justifying either competence or, quite probably, capability.

Chesser-Smyth and Long (2013) examine confidence in the context of undergraduate nursing students, seeking to gain understanding of the influences on self-confidence of a group of first years. It is identified that despite, being of importance to learning and underpinning the students' level of competence to deliver care, self-confidence is often impacted detrimentally by nursing environment. This is somewhat ironic given that this is the environment in which it is assumed learning should flourish. The topic of self-confidence is once again, in a theme that developed in this review, neglected in the literature. It was found that simulation performance was a great source of confidence to the first years. Other factors, such as observation of good role-modelling, verbal feedback from qualified staff and peers, being part of team and demonstrating teamwork were all positive influences on feelings of self-confidence for the students. It was clear that the feeling of self-confidence was a catalyst required to aid the development of competence. Interestingly, Chesser-Smyth and Long (2013) also attribute this to capability development that is evidenced in their research. They also refer to the work of Stephenson and Yorke (1998), as discussed in the capability sub-section of this chapter. Conversely there was evidence that some students viewed the clinical

environment with anxiety, stress and vulnerability which, in turn, prevented effective learning. Self-confidence, when fragile in students, was further eroded by factors that should not be a surprise, such as poor preceptor attitude and communication, and is associated with feeling undervalued. Thus, suggesting that the variation in approach and intensity of preceptorship should be looked at in more detail. The work also found that students did not have the confidence to contest the dominant nursing culture, leaving them with feelings of vulnerability and being forced to conform to the culture. The work goes on to suggest that this disempowerment risks the development of critical thinking, problem solving and decision making, and thus employs the strong term oppressive elements within nursing, which also go on to reduce self-confidence. This highlights the need to address self-confidence and its development early in student nurse education, which is not unconnected to NP's education.

An interesting study by Cashin et al (2014) examines the confidence in prescribing practice of experienced NPs who have undertaken the prescribing course. The NPs had high confidence regarding advice given to patients about medication, but far less confidence in prescribing medications themselves, particularly changing or altering doses of previously prescribed medications. It was thought that perhaps a lack of understanding or experience in prescribing and hierarchical structures had an impact on confidence, which is similar to the impact of hierarchies on competence in previous discussions in this chapter. The work concluded that further research is needed to examine the link between NP confidence and prescribing quality and safety in prescribing. Fry and MacGregor (2014) examined how confident emergency nurses were in undertaking extended roles and factors associated with confidence in practice. The participants reported that confidence supported the nurse's ability to act in extended role positions, and that they were confident to undertake the activities associated with the role. The selection of the nurses in the extended role was undertaken by experienced nurses, without a definition of this. However, as we have seen in previous

discussion, there is no data to support the link between time served and competence, although it persists as a selection criterion (Fulton et al, 2017). It was clear that the nurses felt the experience gave them appropriate understanding in many aspects of the extended role. The nurses were very confident with the role task elements, such as using analgesia with patients or cannulation. It was reported that contextual factors, such as policy and guidelines to support extended practice, provided defined boundaries and a medico-legal protection, and although the policies were occasionally seen as restrictive, which has been discussed (Carryer et al, 2007), there was general support and value given by all.

The researcher's observations more closely supported the previous discussion on protocols offering control (Carryer et al, 2007), which identified a tension between the policies, role expectations and the nurse's ability to meet the care demands of patients. Other factors impacting confidence included simple uncontrollable or unpredictable variables, such as high patient numbers and acuity in the waiting room, which linked to a loss of control or sense of not coping well. In turn, this eroded confidence and, in some cases, led to the nurses wanting to leave the department. Confidence was also influenced when patients fell outside the role policies and the nurse became unable to initiate the care they foresaw was required. Thus, confidence was negatively impacted when the nurse had to seek the doctor to advise or initiate care. This reinforced a feeling of a lack of confidence in the nurses. Self-confidence remains a difficult and complex construct, influenced by a number of contextual factors. Fry and MacGregor (2014) concluded that a lack of self-confidence can lead to burnout, dissatisfaction and compromise workforce sustainability.

2.8. Summary

This chapter has demonstrated an in-depth knowledge and understanding of the topic area under investigation, and work related to the research, in order to demonstrate understanding

of the literature within the field and in the context of doctoral research. Themes were identified and reviewed that represented the common components and expectations required of an ENP, identified as role, competence, capability and confidence. The role theme was substantial, from which subdivision was necessary to reveal understanding of what the role is, how you become an ENP and transition into the role, barriers and perceptions of the ENP and the impact of the ENP. The literature highlights issues created by inconsistencies in role definition, education, transition, barriers, perceptions of the ENP and their impact from differing perspectives. The competence debate, measuring previous performance, has been reviewed and advanced to competence becoming a component of capability. The importance of confidence is also evident in the literature, attributing factors that can be seen in role, competence and capability affecting confidence. A lack of progress was seen in these topics until relatively recently. Proficiency as a term or concept is fleetingly mentioned in the literature reviewed and not in any depth. The drawing together of these concepts under any term is not evident in the literature, and it is the intention of this research as a result of this review to extract from the ENPs themselves the experiences that influence feelings of role proficiency. The term proficiency will be applied to this research as an overarching concept that incorporates and encapsulates the terms and discussions reviewed in this chapter. Thus, it is possible to build upon it as a concept and make a new contribution to this area of knowledge. These terms have been considered separately in the literature and their collective inclusion under the term proficiency will be designed to allow freedom for the participants to consider the concept freely, in their own terms and in the context of their own experiences. This will be discussed in further detail in the following chapter three as the methodological approach is clarified.

Chapter 3: Methodology

3.1. Introduction

This chapter will justify and explain the approach employed and applied in order to answer the research question posed in this research. It details the early deliberations undertaken to arrive at the rationale for the methodological paradigm chosen to guide this work, before addressing the key elements of the chosen methodology. This research addresses the question:

How do emergency nurse practitioners' (ENPs') experiences in practice influence their feelings of role proficiency?

In order to approach the question a number of research objectives were proposed:

- To examine and understand the meaning of role proficiency to ENPs.
- To identify practice experiences that influence role proficiency.
- To identify and understand how discovered practice experiences influence ENPs' feelings of role proficiency.

It is also important to address the methodology, in order to demonstrate how research questions are articulated with questions asked in the field, and the conceptual framework from within which the researcher worked. Thus, it is possible to make clear the epistemological and ontological perspectives determining the worldview of the researcher and how the researcher approached the research (Clough and Nutbrown, 2002. Gerrish and Lacey, 2010). Methodology refers to the essential framework, assumptions and characteristics of the enquiry, and the exploration of the theoretical and philosophical underpinnings that are beneath the methods used to examine the research question (Koch, 1995). The research is justified by the literature review of chapter two that highlights separate

components that are thought to construct the ENP's competency to proficiency journey, the experience of which is examined in this research.

3.2. Research and paradigms

The strategies for research are found in broader frameworks and philosophical or theoretical perspectives that are most commonly referred to as paradigms (Blaikie, 2007). That is a worldview that guides the actions of the researcher based on a series of philosophical beliefs and assumptions (Creswell, 2013). It is defined as

> *"…a cluster of beliefs and dictates… that influence what should be studied, how research should be done, and how results should be interpreted" (Bryman, 2016. p694).*

This worldview determines how to examine the research question. Nursing research approaches tend to be broadly labelled as quantitative or qualitative. However, these terms pertain to the method, or the how, and not the underlying assumptions on which the method is based. Research is conducted with the aim of developing the knowledge base that underpins the stability and growth of the discipline (Mackey, 2005). The philosophical assumptions on which paradigms are based consist of the dual fundamental principles of the researcher's stance towards reality and its nature, known as ontology, and the nature of knowledge, how we know what we know, which is known as epistemology (Creswell, 2013. Blaikie, 2007). These stances are commonly separated for the purposes of understanding. However, they tend to emerge together as the research question methodology emerges and, thus, are difficult to consider independently of each other and considered as interrelated (Crotty, 1998).

The concept of ontology concerns itself with the existence of and the relationship between different aspects of the object under investigation, or the idea of the object's 'being'. In

qualitative research, the ontological outlook draws from the interpretive paradigm, particularly how the world is interpreted from the perspective of those experiencing the object. In contrast, the positivist paradigm sees the world as separate, existing distinctly from those experiencing it (Jupp, 2006).

The concept of epistemology is concerned with knowledge, and the possibility, character, sources and limitations of it. It positions itself by asking how we can have a knowledge of reality, or what is knowledge? Empiricism sees knowledge as derived *from* the world, whereas rationalism determines that knowledge is derived from human rationality and thought processes, thus is not simply limited to observable phenomena but also to observable appearances or perceptions (Jupp, 2006).

The researcher must have an awareness of the existence of the object under investigation, the reality of the object, how the object is, and its existence from multiple perspectives. In order to investigate the what, the researcher must also have a position on what is regarded as acceptable knowledge. The object identified in this research question is role proficiency relating to ENPs. The researcher must seek to understand role proficiency and its reality, or how it exists in the world, to thus understand its ontological position. The researcher must also address how they can have knowledge of the reality of role proficiency, that is its epistemological perspective.

Many research paradigms are identified in the literature, such as constructivist, positivist, post-positivist and interpretivist. Broadly speaking, the quantitative paradigm aligns research with a mapping or modelling exercise, representing the world as a series of measurements or numbers as a result of the testing of a hypothesis (Curtis and Drennan, 2013). The philosophical system underpinning this paradigm is originally formed in the natural sciences and focuses on the knowable reality that can be measured, the testing of claims and the

identification and testing of causal relationships. This paradigm values scientific objectivity, researcher neutrality and replication (Leavy, 2017). Contrasting this, the interpretive paradigm worldview is one where meaning is constructed from interpretation and interaction with the lived world. This approach places value on the subjectivity of experiences and interactions to develop understanding of them, and the circumstances that surround them (Leavy, 2017). Referring to the research objectives in the opening section of this chapter, the researcher sought meaning and understanding, as opposed to measurement, and it is for this reason that this research is conducted in the interpretive paradigm. Punch (2014) describes quantitative paradigms in terms of numbers, to express a quantity of something, thus requiring an imposition of the structure of numbers to the object under investigation. This research is not investigating the number of occurrences or magnitude of proficiency, but an experience, particularly from the lived perspective of those who are experiencing it first-hand. Nursing researchers have found the interpretive approach more likely to reveal the depth and multiplicity of nursing knowledge. This research paradigm allows for research to be conducted in a less structured environment and focuses on the meaning and understanding of the object under investigation, as opposed to a description or explanation of it (Mackey, 2005) and how many times it occurs. It is necessary to explore the philosophical underpinnings and paradigmatic expectations of this approach to give meaning to the research process which will be detailed across the following sections.

3.3. The research methodology

In the early stages of developing the research question, two interpretivist methodologies appeared to position the worldview of this researcher: grounded theory and phenomenology (Creswell, 2014).

Grounded theory is a methodology to move beyond the description of an area and look to discover a theory that would explain the process that the subjects would have experienced (Creswell, 2013). The focus seeks to unpick the elements of experience, the study of which develops theories of interrelationships between the elements, and thus enables the researcher to understand the nature and meaning of an experience for a given group at a given time. The theory is generated during the research process from the data collection (Moustakas, 1994). This research aims to identify and understand the practice experience of ENPs and how these experiences influence feelings of role proficiency. This is not the generation of a theory, rather an explanation and understanding of the meaning of the experiences of individuals.

Phenomenology seeks to describe the nature and meaning of the lived experiences of individuals of a concept or object, thus reducing the 'phenomenon' to enable an understanding of its very nature. Phenomenology is the study of the lived world as is immediately experienced by the subjects (Van Manen, 1990). The epistemological position of phenomenology is that it focuses on revealing meaning as opposed to developing a theory or arguing a point (Flood, 2010). The objectives of this research, stated earlier in this chapter, are best examined and achieved using the distinctive philosophy, theory and method of phenomenology. Phenomenology is specifically suited to the study of the lived experience (van Manen, 1990), thus aligning with the research question and objectives of this research. The methodological underpinning is a hermeneutical phenomenological approach, which was born out of the work of phenomenological scholars (Moran, 2000) from as early as the eighteenth century, with its development from psychology most commonly attributed to Edmund Husserl (Moran, 2000). Husserl's philosophy was further developed by Heidegger, the significance of which to this research will be presented in the following sections.

3.4. Phenomenology

Phenomenology is a way of doing philosophy, a practice, best understood as a way of extracting the truth of a phenomena or experience (Moran, 2000). The philosophers theorising phenomenology attempted to take an existential view of the world and how it is experienced by those viewing it or in it, rather than utilising a positivist, rationalist view (Mackey, 2004). Positivism favours a scientific approach to investigation (Jupp, 2006), and uses an approach in social enquiry that seeks knowledge only based on what the observer can perceive by their senses (Blaikie, 2007). Within phenomenology, two theoretical perspectives or approaches are seen in the literature, the difference between which is how the generation of findings or knowledge is undertaken (Flood, 2010). The two approaches are eidetic or descriptive and hermeneutic or interpretive, and they are broadly attributed to the philosophies of Husserl and Heidegger respectively.

Husserl is the psychologist who is credited with the conception of a phenomenological philosophy as a distinct method, by developing ideas on how to look at and understand the lived experience (Smith, Flowers and Larkin, 2009). His work was considered rather disorganised, abstract and theoretical, and was often criticised by his former students for this. However, despite this, he is often referred to as the founder of modern phenomenology (Moran, 2000). Phenomenology was regarded by Husserl as a science of the:

> "*essential structures of pure consciousness" (Moran, 2000. p 60).*

His philosophy focused on the experience and the perception of it, asking the individual to step out of the everyday experience and examine it, an epistemological concept he referred to as phenomenological reduction or bracketing (Dowling, 2007). He particularly suggested we turn our gaze from the object in the world and look inward at our perception of the object under investigation. Husserl sought the unbiased study of things as they appear in order to

understand the very essence of the understanding of the object under investigation as it is experienced in the consciousness of those experiencing it (Dowling, 2007). He argued that experience or consciousness is always conscious *of* something. He used the term intentionality to define the relationship between the process occurring in consciousness and the object of attention for that process. Intentionality suggests that there is always an object of consciousness, and that an object stays in the world (Lindseth and Norberg, 2004). That the mind is always directed towards objects, and that it is this directedness or focus that Husserl calls intentionality, and it was this knowledge of reality that we build that should start with the consciousness and awareness of the mind (Koch, 1995).

Husserl also highlighted and acknowledged the need to 'bracket' the taken-for-granted world in order to concentrate on our perception of the world, which is a key area of discussion in his work as it is often argued whether this is truly possible. Husserl referred to this transcendental concept as ‘epoché’, and this is often also referred to as phenomenological reduction. The concept of reduction is designed to eliminate all preconceived notions and ideas, which brackets the outer world and the very consciousness of the individual researcher in order to refrain from any form of judgement of the object under investigation (Dowling, 2007). That which exists outside the bracketed or ‘epoché’ world, including judgments, preconceptions and biases, is known as the natural attitude (Moustakas, 1994). In the natural attitude, we hold thoughts and knowledge judgementally and, to enter epoché, we simply refrain from this attitude, or everyday pre-judged and conceived world, in order to look at the world from differing perspectives (Dowling, 2007).

Valle and Halling (1989, p 11) state that the phenomenological reduction:

> *“reduces the world as it is considered in the natural attitude to a world of pure phenomena or, more poetically, to a pure phenomenological realm”.*

This is to have the phenomena present itself to the researcher in an as objective a way as possible in order that it can be described and understood in its terms (Dowling, 2007). It is highlighted in the literature that nurse researchers commonly drift away from the Husserlian notion that all judgements about the external world must be suspended and move towards epoché as a research method in itself (Paley, 1997). Paley (1997) suggests that many researchers restrict the bracketing to the pre-conceptions about the phenomenon under investigation or claim that bracketing involves an examination of their own beliefs about the phenomenon under investigation, as opposed to Husserl's true concept involving the bracketing of the natural attitude as a means to cancel it completely, not just on selected areas. This failure to stay true to the original intention of epoché is chiefly attributed to the use of secondary referencing of Husserl, Heidegger and other philosophers of the phenomenological tradition (Paley, 1997). This does, however, raise the concept that truly bracketing the natural attitude results in the phenomena becoming inaccessible to the researcher by using the very process that is intended to reveal it. Given the clinical background as an ENP of the researcher, and its relation to the derivation of this project, the idea of true bracketing, whether it is possible, restrictive or required, became important to consider in more detail and will be examined later in the chapter.

The ultimate aim of the reduction is to gain a description and understanding of the essence of the phenomena, or what makes a thing what it is (Dowling, 2007). Husserl intended to come face-to-face with what he called the essences or essential structures of the phenomena under investigation (Koch, 1994), without which the phenomena ceases to be (Van Manen, 1990). Moustakas (1994) goes on to suggest that following bracketing, the next stage of the research process is imaginative variation. That is looking at the phenomena from a variety of lenses designed to imaginatively approach it from varying perspectives, thus releasing the essence of the phenomena as a description of what the essential structures are. Dowling (2007)

suggests that the results of imaginative variations are then used to focus the researcher on the concrete experience itself, with a description of the construction of the phenomena. This is known as intentional analysis. Husserl considered that the lived experiences of individuals shared common features, and that in order to make knowledge of the descriptions, these common features, or universal essences, must be identified so that generalizable description is possible (Lopez and Willis, 2004). This research seeks to gain meaning and understanding of how ENP experiences in practice influence their feelings of the phenomena of proficiency. It was the intention of the researcher to move beyond a description of the essences of proficiency towards an interpretation of how practice experiences influence the phenomena of proficiency. This warrants a different approach to that of Husserl.

Heidegger, a former student of Husserl, argued that Husserl was concerned with what can be classified as individual psychological processes, like perception and awareness. However, Heidegger was concerned with existence itself, particularly the practical activities and relationships in which we are caught up, and through which the world appears to us and is made meaningful. The work of Martin Heidegger also took a direction change, leaning towards a hermeneutical emphasis on phenomenology (Heidegger, 1962). His approach perceived that human beings can be conceived as 'thrown into' a world of objects, relationships and language. It also argued that our being-in-the-world is always perspectival, temporal, and 'in-relation-to' something. Consequently, the interpretation of people's meaning-making activities is central to phenomenological inquiry in psychology (Smith, Flowers and Larkin, 2009).

The difference between Heidegger, who thought the mind-body (daesin) co-existed, and Husserl, who thought they were separate as a mind and body split, is commonly known as Cartesian duality. This is the being-in-the-world that Heidgegger discusses. He sees the person as a self-interpreting being (Langdridge, 2007) and is, thus, concerned with existential

ontology (what does it mean to be a person?) rather than epistemology of knowing (how do we know what we know?).

Merleau-Ponty shared much of Husserl's and Heidegger's view of our worldly being, and further conceived the body as our means of communicating with the world, not as an object within it (Smith, Flowers and Larkin, 2009). He talks about the embodied nature of our relationship with the world, seeing the other (object) as a series of displays or a piece of behaviour that doesn't have the same meaning to the self as to the other, and is not that other (Lewis and Staehler, 2010). His position presented the sense of self as looking at the world rather than being absorbed into it. He saw our body as the means of communicating with the world, or the meeting point between the self and the world. He expressed the concept that we can never entirely share the experience of the other, as that belongs to their embodied self, or its relationship with the world, thus opposing Heidegger's emphasis on our existence as an object in the world (Gallagher, 2012). Thus, the lived experience of being a body in the world cannot be entirely captured or absorbed, but must not be ignored or overlooked, which was part of the tremendous challenge and method in this research. That being to seek to best extract true values and meanings of the lived experience, beyond the essence that Husserl sought. It is key for researchers in this philosophical position that the body shapes the fundamental character of our knowing of the world, and that the physical and perceptual (practical and relation) affordances of the body are more important than the abstract or logical ones. This development, beyond essences and descriptions of phenomena, through the world revealing itself to us is the approach taken in this study. As a result, it was hoped to land at a position of reflexivity presented by the self looking at the world, meeting with it, and the perception of the behaviours of the self and the other in relation to the object.

3.5. Bracketing

Epoché, or bracketing, has been mentioned in this chapter. However, given the previous role of the researcher (Appendix ii) it is important to address how bracketing is applied to this research. As mentioned, Husserl acknowledged the need to 'bracket' the taken-for-granted world in order to concentrate on our perception of the world, which is a key area of discussion in his work as it is often argued whether this is truly possible. Husserl referred to this transcendental concept as ‘epoché’, which is often also referred to as phenomenological reduction. Husserl referred to the natural attitude where all judgements and pre-conceptions that exist in the outside world are to be ‘bracketed’ to avoid bias or application to the phenomenological descriptions to be investigated. Crotty (1998) describes it as a suspension of belief, the laying aside, or a transcendental state where the researcher suspends belief of all previous natural attitude world-based knowledge, experience and thought. The intention is to become as open as possible to the object, and allow the object to reveal itself as it presents to the consciousness of that which is experiencing it. The ultimate concept is potentially problematic as, in order to truly bracket our natural attitude, we must suspend belief in all things that intervene between consciousness and our own experiences. Such barriers include history and language, as they would obstruct our view of the object (Lewis and Staehler, 2010). This then would lead us to a state where we would be unable to see the object without placing a barrier of some sort between the object and the consciousness of it, and thus remove or affect the true epoché.

The existential phenomenologist viewpoint differs from Husserl in how this process of bracketing is operationalised by the researcher. It should be said that Heidegger rejected the ‘existential’ tag that is often associated with his work, however that is beyond the scope of this study. Heidegger sought the meaning of being through being itself, which opposes the ontology of Husserl. It also represents a position which sought to get back to the things

themselves, creating a looking in upon the object as a free-floating transcendental concept, rather than from the thing itself (Crotty, 1998). This led Heidegger to position his ontology thus:

> *'…let that which shows itself be seen from itself in the very way in which it shows itself from itself' (Heidegger, 1962. Page 58.)*

Heidegger was clear that, from his perspective, epoché cannot occur truly because of the barrier that trying to bracket actually creates. Rather the object itself has a fore structure which cannot be escaped, and shouldn't be, as without it we cannot structure a research question (Parsons, 2010). This fore structure, or pre-understanding, is not necessarily clear to the object but certainly forms the underpinning of how humans make meanings. The pre-understandings of the researcher also exist, in order to form the research query. However, unlike Husserl, Heidegger clearly asserted that it is not possible to separate ourselves from our pre-conceptions, but rather we should be aware of them, guarding against their influence upon the interpretations of the lived experience under examination (Parsons, 2010; Horrihan-Kelly et al, 2016). This forms the basis of the hermeneutic circle and the concept of reflexivity, both of which will be discussed later in the chapter.

3.6. Hermeneutics and phenomenology

Hermeneutic phenomenology shifts the commitment to examine phenomena from an interpretive, rather than descriptive, standpoint focusing on the contextual analysis of the data, rather than descriptions of it. Finlay (2011) describes that the aim of hermeneutic phenomenology is

> *'…to evoke lived experience through the explicit involvement of interpretation… thematised through language and understood …through a variety of lenses – philosophical, theoretical, literary and reflexive.' (Finlay, 2011. p110).*

Hermeneutics is concerned with the theory and art of interpretation and originated in the exegesis of biblical texts to provide a firm foundation of their meaning (Palmer, 1969). It is

> *'...the system by which the deeper significance is revealed beneath the manifest content [of the text]' (Palmer, 1969, page 44).*

Thus, this approach represents the interpretation of text to extract meaning of the phenomena under investigation. This research seeks to gain not simply descriptive accounts of the phenomena of proficiency, as would be suggested by Husserl, but the extraction of understanding and meaning, or an examination of the meanings of the experiences of the ENP, hidden or stated. The data was extracted initially by interview and recorded as text, so the interview becomes data as text. Heidegger brings together phenomenological approaches with interpretation, or hermeneutics, which concerns itself with the methods and purposes of interpretation itself, specifically seeking to uncover the intentions or original meanings of an author of the written word. This has subsequently been developed to include the spoken word.

Schleiermacher was amongst the first to write of hermeneutics in a systematic fashion, describing interpretation as involving grammatical and psychological interpretation (Smith, Flowers and Larkin, 2009), and separating the sphere of language from the sphere of thought (Palmer, 1969). The grammatical meaning referred to the exact meaning and objectivity of the text derived from the laws of language, while the psychological meaning is derived from the subjectivity of the individual interpreting the text (Palmer, 1969). It was Schleiermacher's intention to recover original psychological experiences of the past life of an object through the text world used to describe the experience of the object (Moran, 2000). It was from the work of Schleiermacher that general hermeneutics emerged, and their principles often serve as the foundation for text interpretation of all kinds (Palmer, 1969). Until this point,

hermeneutics had been very much a disciplinary concept, used differently in each area, such as law or biblical exegesis. Hermeneutics emerged from this period as a coherent science, and an art, which described the required conditions for understanding all dialogue as the study of understanding itself (Palmer, 1969).

Dilthey introduced a call for historical understanding to interpret the expression of human life in what became known as *Geisteswissenschaften*, defined as the need for all disciplines to include expressions of human life, such as gesture, actions, art as well as literature and so on (Palmer, 1969). Dilthey's view was to attempt to get inside the mind of the other, or that which is expressing human life, whilst still treating the other as the other, and expressing the historical lived experience or the way which life is lived historically. Dilthey was clear that hermeneutic approaches should not seek to reduce the other to what it is within one's own experience, i.e. treating the other and their experience with true and complete objectivity from within themselves (Moran, 2000).

Heidegger sought to fuse the work of Dilthey's hermeneutic approaches with the descriptive phenomenology of Husserl, for whom Heidegger worked as an assistant and regularly communicated with in his early career (Moran, 2000). A distance emerged between the two philosophers' view of human experience and existence. Heidegger's hermeneutic views phenomenology as the interpretation of phenomenon, and an interpretive activity (Smith, Flowers and Larkin, 2009). He considered the appearance of the phenomena presenting itself to us as entering a new state or being present as opposed to not present. The phenomena or object will have many meanings and be visible (which may be deceptive) or hidden. So what the thing is on the surface as it shows itself, and what is behind it as it emerges, may be different. The primary aim remains to examine the thing itself, and to make sense of or analyse the thing as it appears to show itself to us. He also argues that bracketing is not entirely possible because of forethought or fore conception. The analyst brings fore

conception to the encounter and cannot help but look at the experience in the light of their own experience, which is of particular relevance to this research. Fore structure is in danger of presenting an obstruction to interpretation. Priority should be given to the new object, not the preconceptions of the analyst, and we may only know what preconceptions are once the interpretation is underway (Smith, Flowers and Larkin, 2009). Each person is a location in which a language forms in an individual manner; their discourse can only be understood by the totality of meaning of language and its relationship to other experiences. Interpretation is seen as a craft or art, rather than mechanical rules. Part of the process is to understand the writer as well as the text, and perhaps therefore the researcher may end up understanding the writer more than they understand themselves:

> *'when we interpret the meaning of something we actually interpret an interpretation' (Gadamer, 1986, page 68).*

Gadamer placed an emphasis on history and fore structure in a departure from previous phenomenological thinkers. He postulated that the thing under examination can influence the interpretation which, in turn, influences the fore structure. Subsequently, this also influences the fore structure, emphasising the importance of history and its effect on interpretation (Smith, Flowers and Larkin, 2009). This cyclical arrangement gives rise to the concept of the hermeneutic circle, which will be discussed later in the chapter (Moran, 2000). He considered that one may only fully know what, in this instance, preconceptions of the researcher are once the interpretation is underway. Thus, he was sceptical of the interpreter knowing the author better than they know themselves, whilst claiming the author does not have interpretive authority over the meaning of the text. He declared there is a distinction between understanding the text and understanding the person, the former being the priority. Gadamer also thought that a historical gap prevents the recreation of the intention of the text, as the more time, the more problematic this becomes, and the intention should be to learn from it as

opposed to relive it (Gadamer, 2004). A commonly highlighted criticism of hermeneutic phenomenological philosophy and methodological approach is that it has never been fully made clear, how meaning is distilled from text, how do we get from this, text, to that, meaning (Paley, 2017). Paley (2017) goes further still, suggesting that the operationalisation of how meaning is constructed as a concept, has never been fully explored. Neither is there offered an explanation of what is being sought when seeking the concept of meaning, how is it uncovered or what sort of knowledge it provides. Paley (2017) goes a fair distance towards to bridging this gap by providing an analysis of meaning in his 2017 publication.

The trustworthiness of the results of qualitative research is often questioned and is central to the application of its recommendations and their rigour. Researcher bias is a real danger in qualitative research undertaken in the interpretive paradigm, given that the researcher is often both data collector and data analysist. Reflexivity and transparency of insider researcher positions, to be discussed in sections 3.8 and 4.7, go a considerable distance to addressing this potential by placing it front and centre to the analytical and methodological underpinnings of this study. Member checking should be considered as part of this rigour, that is a return of an interview or analysed data to the participants for validation of results (Birt et al, 2016). Birt et al (2016) highlight the differing processes of member checking across studies and the differing claims about validity that are made as a consequence alongside the common lack of rationale for which method is used. McConnell-Henry, Chapman and Francis (2011) pursue the argument that member checking is in fact incompatible with a hermeneutical phenomenological approach. The desire of participants to say the right thing known as halo effect, discussed in section 2.5, has a significant influence. When researchers return to participants for validation checks, the potential exists to guide the participant in the direction the researcher desires, making the process deviate so far from the underpinning philosophy of hermeneutic phenomenology so as to make the process

redundant. Phenomenology is not underpinned by the positivist need for correct answers as discussed earlier in this chapter, and clarification of the phenomena during the interview as will be discussed in section 4.6 (Bevan, 2014), described as co-construction by McConnell-Henry, Chapman and Francis (2011) offers consistency of methodological approach.

3.7. Hermeneutic circle

The hermeneutic circle or cycle are terms interchangeably used by scholars to assist in the explanation of how interpretation of texts within the hermeneutic field occurs (Smith, Flowers and Larkin, 2009). It represents the understanding and interpretation, or movement between the parts, of the process of interpretation by viewing the data as a whole and evolving an understanding of the parts, which in turn informs the whole. Each (whole or parts) then gives meaning to the other, in such a way as the understanding is circular (Smith, Flowers and Larkin, 2009. Ajjawi and Higgs, 2007). There has been some criticism of the circle as not representative of the process, as it appears that it either has no end or that there is no way to cease the cycle, thus leading the researcher to be caught up in the circle (Finlay, 2011). The openness of a spiral better represents the process as open at the beginning and end, with the openness being indicative of the researcher's mind as they interpret the text (McAuley, 2004). The spiral configuration is represented in figure 3-1.

(SFU, 2018)

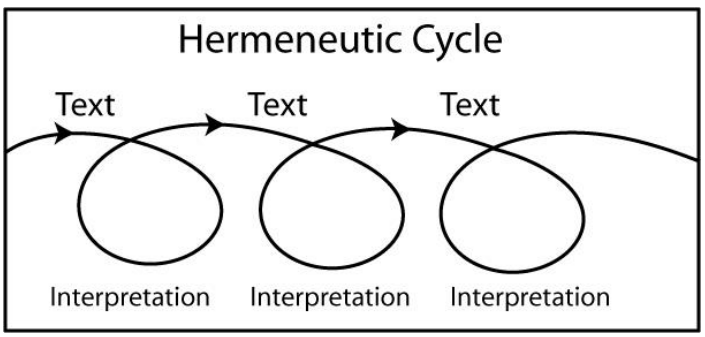

FIGURE 3-1 THE HERMENEUTIC CYCLE

3.8. Reflexivity

Reflexivity is an ongoing process and characterisation of good research practice undertaken with the intention of aiding the interpretation, translation and representation the research data (Jupp, 2006), and it is not simply a method. Nor is it a term, clearly stated by Silverman (2013), that merely refers to self-questioning of the researcher. Reflexivity is more about self-awareness, or a self-consciousness of values such as social, political or value positions and how these positions may influence the research (Bloomberg and Volpe, 2016; Murray and Holmes, 2013; Alley, Jackson and Shakya, 2015). It is a critical review of the involvement of the researcher in the research, and how this influences the research processes and outcomes (Bloomberg and Volpe, 2016).

There are similarities between reflection and reflexivity that are often confused in the literature. Reflection is characterised as a cognitive activity, whereas reflexivity is a dialogical and relational activity as a critically embodied practise, rather than an abstract one (Murray and Holmes, 2013). Reflective approaches encompass learning by reflecting on experience, such as the reflective model theorised by Schön (1983) which proposes reflection on and in action, whereas reflexive approaches embrace learning in experience. The outcome of reflection is to give order to situations. However, the practicality of reflexivity creates an unsettlement of conventional practices, which is distinct from reflection (Murray and Holmes, 2013) and, ultimately, designed to challenge thought processes relating to the conduct and effect of research.

Enosh and Ben-Ari (2016) introduce a three-dimensional approach to reflexivity as an activity for the researcher and the participants, where the research encounters themselves should be considered. It is proposed that the researcher has indirect access to and knowledge of the phenomenon under investigation and is seeking access to the direct experience of the

participant of the phenomenon through the third lens of the research encounter itself. All three of these events sit in a liminal space of the relationship that has been created with contributions from each element, resulting in the creation of new knowledge. It is the consideration and application of this situation in which reflexivity is 'done'. The critical discussions and considerations have been recorded by the author as a research diary and form a large part of the supervision relationship and discussions. The recording of a diary is well-recognised as both a personal process, and one which is essential to the ongoing development and maintenance of a reflexive stance as applied to the research and its processes (Finlay and Gough, 2003). There is support for the perspective that the journal acts as a catalyst for discussion, which leads to an additional epistemological awareness as the diary writer realizes how their own knowledge is created (Engin, 2011). Thus, the thoughtful self-awareness that reflexivity is intended to add to the ethicality of the decisions made about the research and its conduct is developed.

3.9. Conceptual framework

The conceptual framework of a study consists of the concepts, assumptions, beliefs and theories that support and inform the research study. It is the frame that encircles the study, similar to a picture frame, and assists in the justification of why and how the study is being undertaken (Casanave and Li, 2015). This is in contrast to the theoretical framework that makes clear how the concepts are related to form a model or theory as an output for the study, which will be discussed in chapter five. As such, they appear at different stages of the study, with the conceptual framework guiding the formation of the study question and dynamically developing the methodology employed, which is transformed during the study into the theoretical framework that assists in the explanation of the research question answer. Conceptual frameworks consist of personal interests, topical research and other theoretical frameworks that contribute to the focus and rationalisation of the research question (Ravitch

and Riggan, 2012). Its intention is to guide how the researcher thinks and considers the collection, analysis and interpretation of data to drive the research at its core. The formation of the framework is bedded in the literature review, found in chapter two, that outlines the conversation that has already happened relating to the topic of interest. It also gives the researcher the opportunity to consider how to add to the conversation and exposes the researcher to the potential theoretical and methodological means on which to base their question and findings (Boote and Belie, 2005).

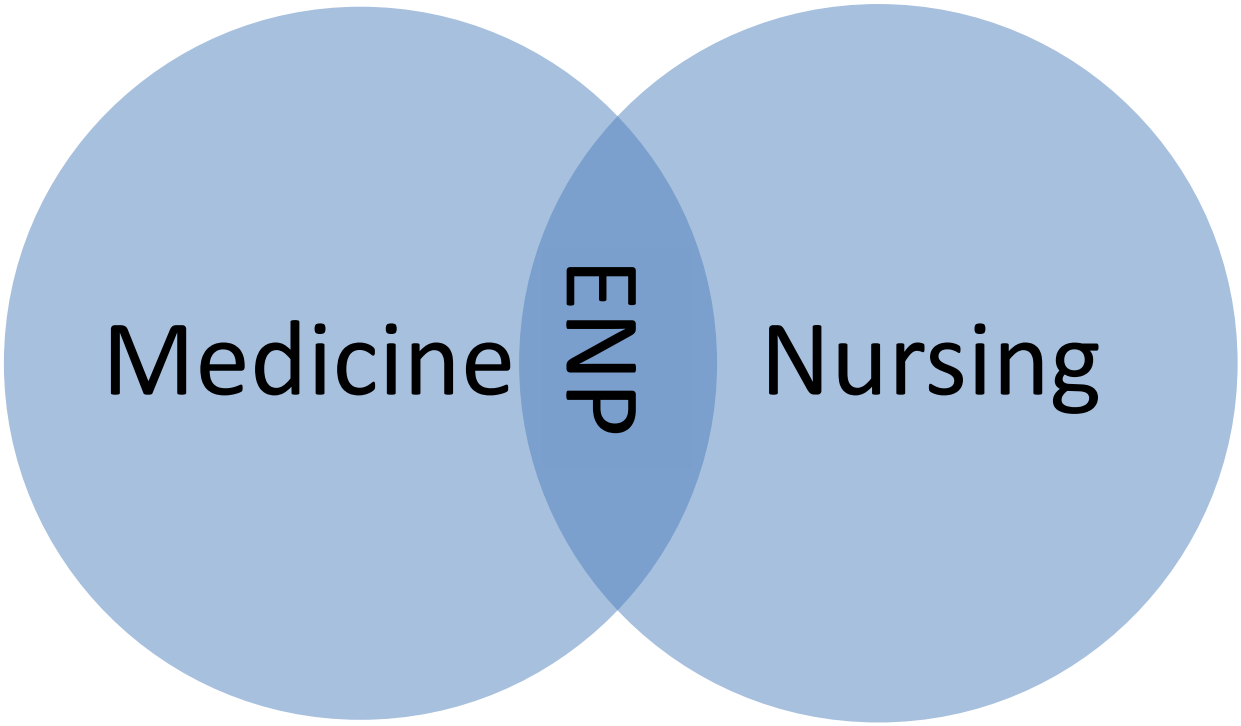

FIGURE 3-2 THE ENP ZONE

The initial process of developing the conceptual framework for this research came from the work experiences of the researcher, found in Appendix ii, where, professionally, the researcher existed in the developing ENP zone, as depicted in figure number 3-2, between the accepted roles of Doctors (medicine) and Nursing. This led the researcher to ask how it was possible to exist in this zone without losing their identity as a nurse and considered the factors

that were required to remain in the ENP zone. The framework developed further when exposed to the literature involved in the masters dissertation of the researcher (Monk, 2013). Figure number 3-3 displays a visual representation of the conceptual framework, indicating the foundations of the theoretical and organisational input into the study (Ravitch and Riggan, 2012). It is a conceptual model, informed by the literature review and formed prior to data collection, that demonstrates the perceived relationships between the components of proficiency and how those components interact with the concept of proficiency. It is not intended to be linear, nor do the size of the arrows indicate an even distribution of the influence of these components over proficiency, simply that a relationship may exist. This study will examine how these relationships inform the concept of proficiency.

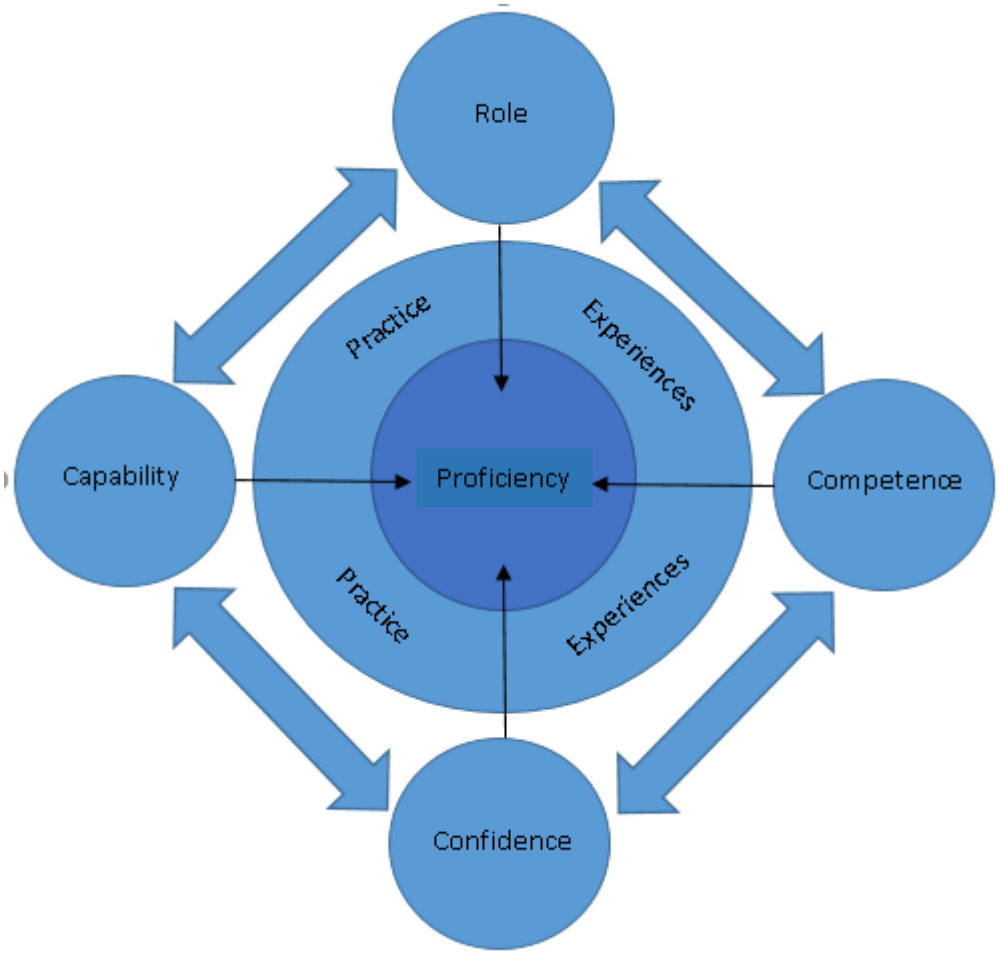

FIGURE 3-3 CONCEPTUAL FRAMEWORK

3.10. Summary

In this chapter the research question and aims have been restated, and research paradigms presented and discussed to position the worldview of the researcher with a methodology suitable to examine and answer the research question. The concepts of epistemology and ontology have been related to the interpretivist paradigms of grounded theory and phenomenology, allowing the question itself to direct the researcher towards a phenomenological underpinning. The work of Husserl was examined as addressing the phenomenon of proficiency as a lived experience from which the research should seek to extract meaning. The transcendental nature of Husserl's descriptive approach was discussed, and the concept of epoché as envisioned by Husserl found to be problematic when considered in conjunction with the researcher's clinical background. Heidegger moved the phenomenological approach towards an existential position with further input from Merleau-Ponty. Both diverged from the pure ideology of epoché presented by Husserl towards an acceptance of pre-understanding and fore structure by the researcher, encouraging an awareness and acknowledgement of these elements having a positive influence on the research. The question itself strongly lent itself to more than a descriptive account, and the work of Heidegger, fusing hermeneutics with phenomenology, allowed for understanding and interpretation of the meaning of proficiency to be extracted. The hermeneutic cycle was related to this process and reflexivity as a quality mechanism for research was examined. The development of the conceptual framework and its place was presented and outlined. This research was conducted in the hermeneutical phenomenological tradition to extract meaning and understanding from the lived experience of proficiency of ENPs in practice. The next chapter will move on to detail the methods employed to answer the research question: How do ENPs experiences in practice influence their feelings of role proficiency?

Chapter 4: Research methods

4.1. Introduction

This chapter will detail the methods and strategies employed to gather data, and the processes applied to extract meaning from the analysis of the data.

4.2. Sampling and selection

In light of the research question there was a need to sample from a small group of specialist staff. Staff self-selected based on being a UK Nursing and Midwifery Council (NMC) registrant working as a nurse practitioner (NP), as defined by the International Council of Nurses (2008), and currently practicing these skills in an emergency, urgent or unplanned care environment, such as an emergency department, urgent care or walk-in centre. The definition used was:

> *"…a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice." (ICN, 2008. p1.)*

A more recent definition of advanced clinical practice, which is the sphere in which emergency nurse practitioners (ENPs) work, as discussed in chapter two, has been operationalised since the undertaking of sampling and selection, and is focused on the workforce in England. The definition encompasses practitioners from all fields of specialism and from allied health care professions. Health Education England defines advanced clinical practice (ACP) as:

> *'…delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making.' (HEE, 2017. P8).*

It goes on to further define the level of formal education expected of an ACP as:

> *'…underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence.' (HEE, 2017.p8).*

This represents a change in position for provision of ACP as discussed in chapter two. However, it is considered that these definitions do not represent a change to the overall definition of NP as used in the study, as the core of both definitions is consistent. It is also noted that several terms are used interchangeably, such as NP and ACP, and this has been addressed in chapter two.

The sample was drawn from an NHS Trust in the North of England operating a number of minor injury units, urgent care centres and walk-in centres in the region. The units are either standalone in the community or co-located with an emergency department. These services were nurse-led and predominantly staffed by nurse practitioners meeting the ICN definition within the emergency nurse practitioner (ENP) specialism (ICN, 2008). The sample was selected to address the goal of an understanding of the phenomena of proficiency as influenced by practice experiences of ENPs. This is in line with the Heideggarian-orientated hermeneutical phenomenological underpinnings of the research, as discussed in chapter three.

Purposive sampling was used to obtain the participating population for the research (Punch, 2006). Purposive sampling allows the researcher to draw participants or cases in a targeted way, as it is likely to illustrate a feature, process or experience in which the researcher is interested (Silverman, 2013). This is as opposed to a probability or random sampling technique that would ensure that all participants would have an equal chance of selection from the population or cases available (Jupp, 2006). The research is focused on ENPs, and so

selecting from the wider population of nurses would not provide the specialist knowledge and exposure to the experience of the phenomena at the centre of this research. It is also in keeping with the methodological underpinning of the interpretive paradigm directing this research (Jupp, 2011). The sample was taken from ENPs with a range of years of experience both in wider nursing roles and as an ENP, with time of qualification as a registered nurse ranging from twelve to thirty-seven years and as an ENP from one to sixteen years, with eight female and two male participants. This is slightly over the reported gender profile of registrants according to the NMC (2019) of 89.3% female and 10.7% male. This allows for a wide range of experiences, both within the broader nursing sphere and the differences involved in ENP practice. There is also a wide range of ENP clinical experiences in practice from which to draw upon and extract data that were gathered in the digital diary on which to base the interview.

4.3. Recruitment

Following confirmed ethical approval by both University and NHS Trust ethics approval teams through the integrated research application system (IRAS), participants were approached via an email composed by the researcher and distributed by the matrons who line managed the units and departments in which the sample population practised. The recruitment email can be seen in appendix iii. The email was distributed indirectly to minimise the potential influence of insider research, and this will be discussed in section 4.7 on page 103. The thirteen NPs who responded to the initial email were contacted directly by the researcher with an introductory letter, found in appendix iv, and additional detail including participant information sheets, found in appendix v. Participants were given opportunity to discuss any questions with the researcher during the process. There were some declinations of participants, a total of three, when a realisation of the use of a digital voice

recorder (DVR) for the diary phase was discovered, and this will be detailed in the data collection section 4.5 on page 97. Some potential participants indicated that they were not keen to either record themselves or be recorded. This excluded them from the interview phase as the diary was to be used to inform the semi-structured nature of the interview discussed in section 4.6, with the researcher seeking a consistency of data collection. This is also in line with the 3-stage approach to phenomenological interviews proposed by Beven (2014) and used to guide the interview process, specifically the consistent contextualisation of experiences articulated by the participants, from which meaning is gained. The 3-stage approach is detailed further in section 4.6. Once provisional verbal consent was gained from each participant, the researcher arranged to meet the participant at their convenience and within the boundaries of obtained ethical approval. The meeting consisted of formal written consent, an example of which can be found in appendix vi, issue of the DVR and further opportunity to discuss any aspect of the research or its process. A date for collection of the DVR and, where possible, for interview at the University site was arranged at the convenience of the participant. This allowed for diary transcription and interview content planning for the researcher, as well as time management and convenience of the participant. The interviews were transcribed, having been transferred and stored, as detailed in the data management sub-section found later in this chapter. This concluded the data collection process. A diagrammatic summary of recruitment can be found below in Figure 4-1.

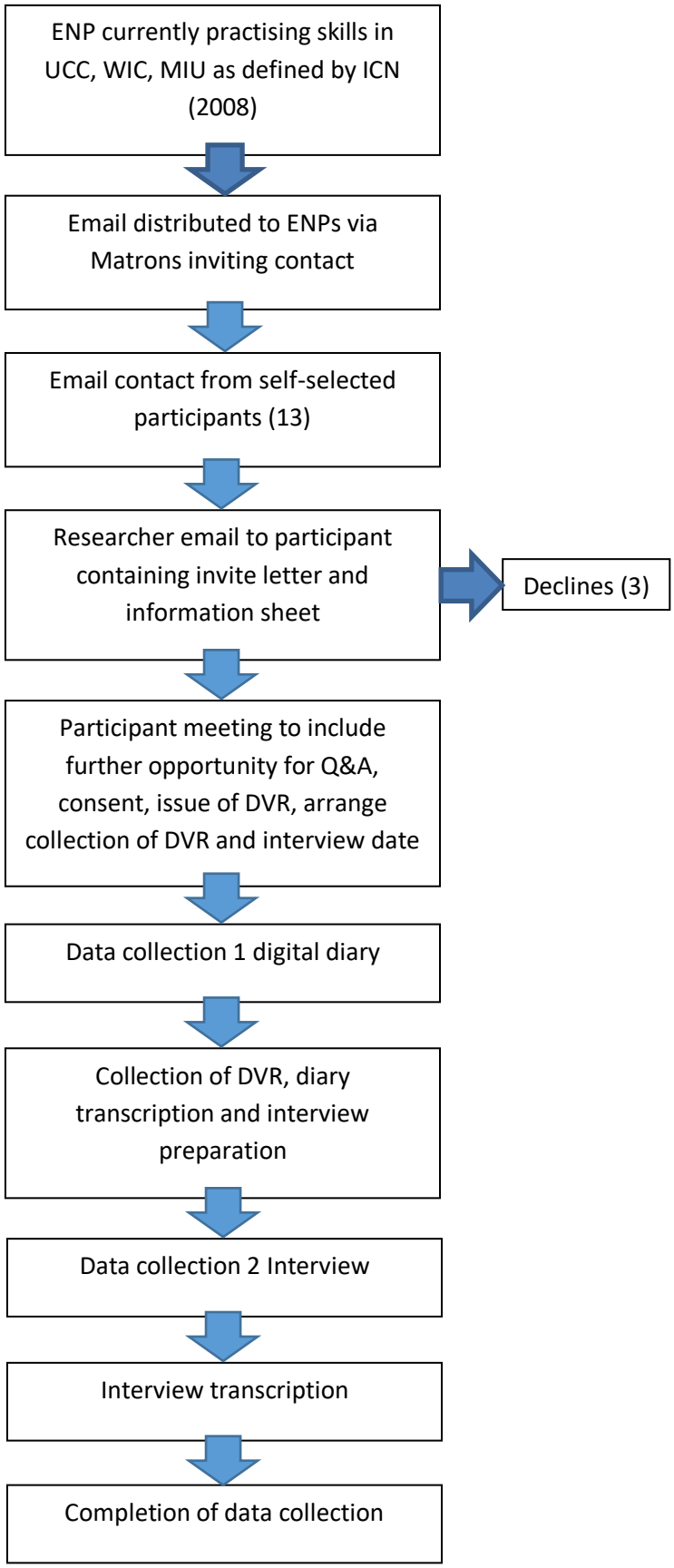

FIGURE 4-1 DATA COLLECTION PROCESS

4.4. Sample size and saturation

Denscombe (2017) presents three approaches to the calculation of sample size: statistical, pragmatic and cumulative. The statistical approach is often touted as the proper approach, however it is designed for large-scale and probability sampling techniques which are used to obtain data from large populations. The pragmatic approach is commonly associated with smaller-scale studies that find difficulty in reaching the statistical approach conditions. Market research is often pragmatic, using estimates of sample size and experience, which has limited value in well-conducted research and is associated with convenience sampling and non-probability sampling, which focus on first-to-hand participants. Cumulative samples are added to by the researcher until a point is reached where no further useful information is added to the data, and this is often referred to as saturation (Denscombe, 2017).

The concept of saturation was originally proposed by Glaser and Strauss (1967) during their work on developing grounded theory as a methodology. It has been poorly defined by other researchers, and not kept consistent to the intended use as defined by grounded theory studies (Hennink, Kaiser and Marconi, 2017). In quantitative studies, power calculations are used to determine the sample size (N) required to provide the statistical reliability and validity of the effect of interventions on whatever is being examined or tested at the study design stage. In qualitative studies, no similar standard exists and the commonly stated principle for sample sizes is that they should be of sufficient size to elucidate the aims of the study and to interview until the point of redundancy, which is until no new concepts, themes and ideas emerge (Trotter, 2012). The problem here is that in qualitative studies, the sample size can be any number, and methods for its determination vary widely and are often not transparent (Malterud, Siersman and Guassora, 2016). There is no widely accepted process for planning sample sizes and each study seems to refer to previous similar studies and their own rules of

thumb. Mason (2010) argues that qualitative researchers should pay more attention to the design of robust methods that are as secure as possible, and seek widespread agreement on how and why decisions regarding the design, sampling and analysis are made (Mason, 2010).

Information power is a model proposed by Malterud, Siersman and Guassora (2016) that seeks to address the perpetual question of what constitutes correct sample size for qualitative studies. Simply stated, information power indicates that the more information the sample holds that is relevant for the study, the fewer number of participants is required. The information power (IP) concept proposes five dimensions or items that each have an impact on the sample size. They are study aim, sample specificity, use of established theory, quality of dialogue and analysis strategy. The following discussion explains the rationale and justification for the sample size in this research relating to the concept of IP.

An information power-guided study sample size is established by considering the study aim. It is proposed that a broad study aim requires a larger sample size than a narrow aim. This is because the phenomenon under investigation, with a broader aim, would require a larger sample size to elicit the more comprehensive aims. Whereas a narrower aim, such as that of this study, will require a smaller sample size to elicit the specific aims. The narrow aim of the study refers to a very specific experience, which itself significantly limits the number of eligible participants, and contributes to an increase in information power for the sample.

The specificity of the sample carries an influence upon IP. It is proposed that participants with highly specific characteristics or knowledge relating to the phenomena under investigation will carry far greater information power than those with a sparse or non-specific characteristics or knowledge. The participants in this study are chosen purposefully as their work and experiences as an ENP are highly specific and essential to the context of the phenomena under investigation. Variation of the experience with the phenomena under

investigation should also be considered. This study is in line with this concept as participants work in services that offer varying levels of service provision from the ENP across the region, and the participants are of varying lengths from both qualification as a nurse and in service within the specialism, as detailed previously in this section.

An adequate sample size also relates to the level of the theoretical background of the study. In this study, the concepts of competence, capability, confidence and role identity are thought to contribute to feelings of role proficiency. These areas have been discussed in the literature review chapter of this study. It is a contribution or interaction of these well-researched concepts that underpin the research question. It was likely that the conclusion of the study may be grounded in these concepts, with the addition of further concepts found during the analysis of the data. It is said that smaller sample sizes can make a difference if they address and elucidate something crucial to theory, in this instance that of proficiency in ENPs.

Studies with a clear and strong dialogue between the researcher and participants require fewer participants and have greater IP than studies with ambiguous or unfocussed interviews or dialogues. The data is co-constituted between interviewer and participants, and a number of factors influence the quality of communication. The confidence of the interviewer, articulation ability of the participant and the chemistry between them are all significant. In this study, the interviewer is well known to the participants, having worked closely with them in practice over a number of years, and the concept of insider research is discussed later in this chapter (section 4.4). This provided the opportunity for a good relationship between the researcher and participants as clinical credibility and personal knowledge create an environment conducive to gathering information. The researcher is a confident, articulate character which may have provided a comfortable interaction between the parties. It is however accepted that it is possible that this may have the opposite effect. Establishment of

rapport should be swift and insider knowledge, understanding and experience of the work of the participants created dialogue founded in the experiences under investigation.

The strategy of analysis is the final item that influences the IP of this study's sample size. It was proposed that an exploratory cross-case analysis required more participants to offer sufficient information power, compared to a project aiming for in-depth analysis of discourse or narrations. This study sought to find the meaning of the phenomena of proficiency for the participants by means of the analysis of the discourse that occurred during a semi-structured interview. The 'case' in this instance is the experience of proficiency in an ENP environment.

It is seen for the previous discussions that a study such as this, with a narrow study aim, highly specific participants, supporting theory, strong interview dialogue and an in-depth analysis of discourse, requires fewer participants to achieve higher information power than the opposite position. This study fits comfortably into this concept as requiring fewer participants than other studies by its nature and the specificity of the area under investigation. It was still not possible to derive N however, although the model does give rationale firmly rooted in the research itself to justify a perceived smaller sample size. The researcher has used the model to shift focus from the achievement of a seemingly random number of participants, and using a multi-focus model, to establish the information power of the sample. However, it is also accepted that whilst linked to a different methodology, the concept of saturation still applies with a rationale that this will be achieved with a smaller number of participants than perhaps a larger, less-focussed study may achieve.

4.5. Data collection

Data was collected in two phases, inspired by the work of Bedwell, McGowan and Lavender (2015). Phase one was a digital diary and phase two a semi-structured interview. The first phase consisted of a digital diary that was used to collect data regarding the thoughts, feelings

and examples of how the ENP considers their proficiency during a working day. An example transcript can be found in appendix vii (Bedwell, McGowan and Lavender, 2012). A digital handheld recording device was loaned to the participant for up to 10 working days before the interview, which departs from the written diaries used in Bedwell, McGowan and Lavender, (2012). Diaries have been considered a useful and insightful information source (Cassell and Symon, 2004). There are a number of strengths relating to this data collection method, including the capture of thoughts and feelings, especially on intimate or challenging situations, in an accurate and contemporaneous way (Bedwell, McGowan and Lavender, 2012). These thoughts and feelings are fresh when recorded and will not have been influenced by the researcher, and thus intrusiveness is minimised (Morrell-Scott, 2018). The diary can assist in the provision of access to the world in which the participant exists, and their interpretations of that world (Nicholl, 2010). It is also useful as a device to assist with the recall of significant events when used in partnership with other data collection methods (Verbrugge, 1980), including interview, which is the second phase of data collection in this project (Zimmerman and Wieder, 1977).

It is also maintained that diaries can be a valuable data collection method supportive in the validation of interview data (Williams, 2001). Verbrugge (1980) postulated that the purpose of a diary was not only to collect data, but to focus the mind of the participant on the phenomena under investigation prior to the interview that follows. The portable and discrete nature of the voice recording devices gives direct and timely access to the experiences of the participants as close to the experiences of and influences upon feelings of role proficiency as possible, not delayed or filtered by time or location and allowing the participant to focus on the present in their own terms discussing experiences they determined were of proficiency. It also allowed a development of how participants considered proficiency as the diary progressed. This is consistent with the methodology of this study discussed in chapter 3, and

also overlaps with the work of Bevan (2014), which informs the interview process in light of his work on the interview method. Bevan (2014) discussed the need in an interview to contextualise the participant and their thoughts and experiences of the phenomena, which the digital diary supports. Such reflection should thus be given from within the world in which the phenomena is experienced, which is consistent with the perspective of Verbrugge (1980). Digital diaries have provided high levels of compliance when compared to written diaries by allowing entries to be completed either at the time of the experience or shortly afterwards, thus allowing an immediate outlet and record of rich and timely experience (Kajander et al, 2007). The use of digitally recorded diaries is a significant methodological strength of this study, associated with the methodological underpinnings discussed in chapter 3, enabling access to the participants' experience of the phenomenon of proficiency itself at the time it is experienced.

Common difficulties with this approach include failure of participants to complete the diary, the inclusion of irrelevant data by participants and the cost of analysis (Bedwell, McGowan and Lavender, 2012). Relating to DVR, issues with device failure, the inability of the user to operate or issues of location are also considered. In this study, no device failures, user operation errors or issues with location were reported. All participants completed the diary and costs of transcriptions were minimised, as the researcher undertook the process in order to absorb and understand the data, details of which will be further discussed in the data analysis section of this chapter. Content issues were managed in the meeting for consent and Q&A detailed in Figure 4-1, alongside the participant information sheet found in appendix v. Participants were keen to be told what to record, which is a common issue with solicited diaries where participants are asked to create and maintain entries by a researcher, thus the researcher can have an influence on the content of the diary (Morrell-Scott, 2018). Great caution was taken to advise the participants that the content could be neither right nor wrong,

but that the focus was the participant's experiences of proficiency in practice, not criteria set by the researcher.

4.6. Interviews

Qualitative research interviews have become the most commonly used data collection method within the social sciences (King and Horrocks, 2010) and the phenomenological methodology (Bevan, 2014). Interviews are a data collection method that involve asking a series of questions of a participant, and designed to illicit a narrative or dialogue where a social or personal interaction occurs (Jupp, 2006). Interviews are best used when the aim of the research is to understand opinions, feelings, emotions or experiences by the exploration of complex and often subtle phenomena (Denscombe, 2017). Broadly speaking, the format of an interview falls into three classifications: structured, unstructured and semi-structured. Structured interviews contain tightly controlled questions in a questionnaire-type format designed to limit the responses. Unstructured interviews are the polar opposite to structured interviews, where there is a deliberate lack of structure designed to illicit the thoughts of the participant by introducing a topic or theme and the researcher adopting a non-directive role. Semi-structured interviews were used for this study, and an example of an interview guide based on the diary discussed in section 4.5 can be found in appendix viii. They are designed with a clear list of issues and questions to be explored, with the researcher keeping the focus on the conversation whilst allowing the participant the freedom to develop and explore ideas by elaborating on the points of interest (Denscombe, 2017). This was suited in this study alongside the use of diaries to inform the interview, allowing the participant to relate to their own experiences and consider the phenomena in their own terms.

Bevan (2014) suggested a 3-stage approach to phenomenological interviews that has influenced the interview process for this work. There are those who consider structure the

very opposite to the intention of the phenomenological approach. However, some structure is rather an attempt to manage the process, as opposed to tell the researcher what to ask. Three main domains are suggested in the structure of Bevan (2014): contextualisation, apprehending the phenomenon and clarifying the phenomenon. It is here where the difference between Husserlian and Heideggarian orientations are seen to be most apparent, as Bevan (2014) suggests that the researcher should abstain from the use of personal knowledge, theory or belief. This is discussed further later in this section, in the insider researcher sub-section, and in more detail in chapter three. Contextualisation refers to consideration of the context and biography, from which the experience gains meaning. In this research, this was seen both at interview and in the preceding diary and understood by the researcher with appropriate consideration of reflexivity. Apprehending the phenomena is where the researcher begins to explore the experience in detail and seeks to discover how the experience is revealed to the participant, again with the researcher remaining reflexive and being attentive to their phenomenological attitude whilst facilitating the participant in their natural attitude. Clarifying the phenomenon involves the use of elements of experience, whilst exploring the experience itself, and applying the key phenomenological process of imaginative variation. Although this is normally associated with analysis, and not used at all by some phenomenological researchers, in this case it was seen as valuable, as noted by Bevan (2014).

It should be said that the approach of this structure is founded in the Husserlian tradition of description and phenomenological reduction, designed to bracket all of the natural attitude. As a consequence, the approach is adapted from an interpretive orientation, rather than the intended descriptive orientation of Husserl, as suggested by Bevan (2014) and his interview approach. This study has moved on from that view, as discussed in chapter three, towards a Heideggarian position that suggests to bracket the taken-for-granted world entirely is not possible, Husserl referred to the natural attitude, where all judgements and pre-conceptions

that exist in the outside world are to be 'bracketed' to avoid bias or application to the phenomenological descriptions to be investigated. The intention is to become as open as possible to the object and allow it to reveal itself as it presents to the consciousness of that which is experiencing it. Heidegger is clear that, from his perspective, bracketing cannot occur truly because of the barrier that trying to bracket actually creates. Instead, the object itself has a fore structure which cannot be escaped, and shouldn't be, as without it we cannot structure a research question (Parsons, 2010). Unlike Husserl, Heidegger clearly asserted that it is not possible to separate ourselves from our pre-conceptions, but rather we should be aware of them, and guard against their influence upon the interpretations of the lived experience under examination (Parsons, 2010. Horrihan-Kelly et al, 2016). This fits well into this methodological approach, chiefly due to the perceived usefulness of the researcher's previous experience, found in Appendix ii. However, great care was taken by the researcher to be aware of their fore structure so as to not influence the object. Instead, it was used to give depth to the understanding at the analysis phase, found in the findings of chapter five. In this study, the interviewer is well known to the participants, having worked closely with them in practice over a number of years. Thus, the concept of insider research is discussed later in the next section of this chapter. This possibly provided the opportunity for a good relationship between the researcher and participants, as clinical credibility and personal knowledge create an environment conducive to gathering information.

The semi-structured interviews were undertaken with each participant at a mutually convenient time on university property, to meet ethical approval and insurance requirements (Gerrish and Lacey, 2010). This allowed the flexibility required to follow experiences raised by the participants, explore them on the participant's terms and allow the researcher to focus on maintaining proficiency discussions in line with the methodology and diary-interview method (Clough and Nutbrown, 2002). Interviews were between 30 minutes and one hour in

duration, and each participant was interviewed once. Risk was identified as minimal and participants were clearly informed of the university policy regarding on-campus risks, such as fire procedures, on arrival for the interview and were managed by the researcher. Interviews were conducted face-to-face in a period long before the impact of the COVID-19 pandemic and, consequently, no relevant restrictions were in place. Interviews were recorded digitally, transcribed verbatim and stored as detailed in the data management section, in line with both university and NHS ethical approval and data management policy.

The trustworthiness of the results of qualitative research are central to the application of its recommendations and their rigour. Researcher bias is a real danger in qualitative research given that the researcher is often both data collector and data analysist. Reflexivity and transparency of insider researcher positions as discussed in sections 3.8 and 4.7 go a considerable distance to addressing this potential by placing it front and centre.

4.7. Insider researcher

As part of the reflexive process, it is important to address the researcher's position as an insider researcher; having worked in an ENP role at one of the planned recruiting Trusts until almost 10 years ago, the strong possibility existed that a number of the participants may know the researcher in this clinical context, as well as a researcher/academic. Having been entrenched in the culture and traditions of the ENP role, a unique fore structure and understanding was accepted and found to be valuable in deriving understanding from the data (Bedwell, McGowan and Lavender, 2012). This is consistent with the hermeneutical phenomenological approach to this study. Insider researchers are in a unique position, with a special knowledge of an area and an in-depth knowledge of the complexities of the work situation (Costley, Elliot and Gibbs, 2010). Taking guidance from the Research and Ethics Committee advice note on insider research (REsC, 2011), key issues to consider were

addressed. Most important of these was coercion, which was addressed by the voluntary nature of the recruitment as the researcher no longer works at the same Trust as the participants, and the voluntary nature of participation was highlighted clearly, along with a clear statement regarding lack of consequence on any level for choosing not to take part. Clear boundaries of confidentiality were identified prior to data collection, with a clear steer from the professional code regarding issues of disclosure (NMC, 2018). Clarity was given as to the nature of data collection and its intended purposes as research, and not practice. Also, the findings do not identify either Trust or participants, which was also made clear in both supporting information and at interview.

4.8. Data management

Data generated by qualitative methods tends to be voluminous and, as such, rather intimidating to analyse. Organising and managing the data is an essential part of the analysis, particularly when at the writing-up stage of any research project in order that sources, storage and security can be ensured, and transparent processes of analysis can be traced from the source (Bloomberg and Volpe, 2016). Phase one of the data collection consisted of a digital diary, as detailed in the data collection sub-section discussed earlier in this chapter. A meeting was arranged with each participant at their convenience to seek consent, distribute the DVR and arrange an interview date on campus. Any email communications made were stored digitally in a password-protected email server accessible only to the researcher. The DVR loaned to the participants to collect this data was given with instructions for use and collected by the researcher at the convenience of the participant after 10 working days. The DVR was not internet-connected and required an upload to store the interviews. This was performed as soon as was practicable by the researcher, stored on a university cloud drive, known as the U:drive, and then deleted from the DVR to ensure no non-secure audio copy existed. The U:drive is a secure password-protected drive accessible only to the researcher,

available only via either a university computer on campus or via a virtual private network used to secure university systems when used on external computer devices. These arrangements were approved during the ethics application and met legislation for research data storage.

Each participant was assigned an anonymised participant code to allow for the tracking and removal of data should the participant wish to do so, in line with ethical approval and participant consent. These participant codes were stored digitally on the U:drive, as described previously. At the time of the initial meeting, consent was obtained using the form found in appendix vi, after a recruitment process detailed in the recruitment sub-section of this chapter and given participant information found in appendices ii-v. Consent was recorded in hard form in line with ethical approval and stored in a locked filing cabinet accessible only by the researcher in a controlled access office on campus at the university. Transcription of the diary was undertaken by the researcher prior to interview in their office using headphones to avoid identification of participants by voice.

Phase two of data collection consisted of a semi-structured interview of each participant based on the diary phase. Interviews were conducted on campus in line with the ethical approval and captured using the same DVR device. They were then transferred and stored as detailed for the diary phase. Two types of transcription were used by the researcher. The first interview was transcribed verbatim using a university-approved transcription service, adhering to appropriate guidance for such a service. However, the researcher transcribed the remaining interviews verbatim for reasons linked to the analysis method, allowing the researcher to enter the phenomenological attitude and be intimately submerged in the data at an early stage. Whilst the process of transcription is regarded by many as tedious, transcription of the interviews by the researcher is one way of data immersion, allowing familiarity and to remain consistent with the methodological underpinnings of this research

(Bloomberg and Volpe, 2016). Transcripts of interview were stored in the same way as previously discussed. NVivo software was used to manage the data analysis process, themes and strands. It also helped to ensure anonymity of participants and the material they provide with files stored as previously described under appropriate licencing arrangements in line with ethical approval.

4.9. Data analysis

The analysis of data in the phenomenological methodology is designed to extract meaning, understanding and the essence of the phenomenon under investigation, making use of statements and meaning units derived from the data (Moustakas, 1994), thus extracting what makes a thing or object what it is (Dowling, 2007). The focus on data analysis for phenomenological researchers is the attitude in which the data is analysed, the phenomenological attitude as opposed to the natural attitude, rather than an explicit method or technique (Bloomberg and Volpe, 2016). It is felt that to approach with rules and specific analytical techniques will, by their action, influence the object under investigation. The ultimate aim is to understand, or in this case interpret, the object as it is subjectively experienced by the participants. Thus it is possible to analyse it free from prior assumptions, and bracket these assumptions as described as epoché or phenomenological reduction in chapter three.

Co-construction is a term associated with knowledge creation that is concerned with developing new insights, specifically in this instance, at the intersection of research and practice, constructing knowledge or theory that has an impact in and on practice (Parsons, 2021). Parsons (2012) also discusses the concept of close to practice research that can be seen from a number of perspectives in this research. Close to practice encompasses a relationship that is alongside the object but is not the object, which is consistent with the methodological

underpinnings of this research as discussed in chapter three. The data collection method used in this research, discussed in section 4.5, the experiences of the participants as close to the experiences of the participants and influences upon feelings of role proficiency as possible, not delayed or filtered by time or location thus collecting data that is close to practice. This close to practice data collection, allows for in-practice data to be analysed to create theory that is seen at the point of practice rather than after it or separate from it. There remains a degree of separation between the object under observation and those doing the observing, this is minimised in this research in the research methods discussed in this chapter and the methodological underpinnings discussed in chapter three. In this research, the researcher adopts a stance that is necessarily reflexive based on previous clinical experiences (appendix ii) and the insider researcher position discussed in section 4.7 creating a bridge that Parsons (2021) describes as the third space, that is the space between practice and research. That is consistent with both the concept of co-construction and to the close to practice nature of the data gathered and consequent knowledge construction to be detailed in chapters five and six, and analysed as discussed in the next section, 4.9.1.

4.9.1. Methods of data analysis

A number of methods of analysis were encountered during the search for an approach that would speak to the researcher and fulfil the principle of the hermeneutic circle. As such, it was important to utilise an approach to analysis that represented the understanding and interpretation, or movement between the parts of the process of interpretation by viewing the data as a whole and evolving an understanding of the parts, which in turn informs the whole. Diagrammatic representation of the cycle in spiral form can be found in diagram 3-1. The openness of a spiral more accurately represents the researcher's vision of interpretation, that being a process which is open at the beginning and end, with the openness being indicative of the researcher's mind as they interpret the text (McAuley, 2004). Three commonly-used

approaches to analysis are those of Colaizzi (1978), Giorgi (1985) and Van Kaam (1966). However, these are based on the Husserlian philosophy, which this research is not.

There was an initial interest in a modification of the Van Kaam (1959) analysis method proposed by Moustakas (1994) that suggested a 7-stage approach including: listing and preliminary grouping, reduction and elimination, clustering and thematising the invariant constituents, final identification of the invariant constituents and themes, individual textural description, individual structural description, and construct for each research participant. This was similar to a model that combined the characteristics of descriptive and interpretive phenomenology involving 6 stages: turning to the nature of the lived experience, exploring the lived experience as we live it, reflecting on essential themes, describing the phenomenon through the art of writing and rewriting, maintaining a strong relation to the phenomenon, and balancing the research context by considering the parts and whole (Van Manen, 1990).

It is suggested by Van Manen (1990) that thematic aspects of experience can be uncovered from participants' descriptions of the experience by holistic, selective or detailed approaches. The holistic approach views the text as a whole and meanings are captured, the selective approach pulls out essential experiences as statements and the detailed approach analyses each sentence, and interpretation then occurs (Polit and Beck, 2018). It was whilst investigating the Van Manen (1990) approach with consideration of the three thematic aspects of experience that the researcher encountered a phenomenological hermeneutic research design, inspired by Ricoeur and further adjusted to empirical studies by Lindseth and Norberg (2004). Ricoeur was a French philosopher of the twentieth century, best known for combining hermeneutics and phenomenology in a similar tradition to Husserl and Gadamer. The method almost immediately allowed the researcher to see how the interpretation process could begin and gave a structure that appeared simple and yet remained close to the methodological underpinning of the research. The method is used to study the essential

meaning of the lived experience of a particular phenomenon through the interpretation of text. The data interpretation presented as findings in chapter five will be interpreted using a three-stage process described by Lindseth and Norberg (2004). The three stages are naïve reading, structural analysis and comprehensive understanding (interpreted whole).

Naïve reading involves repeated reading of the text in order to grasp the meaning of this text as a whole and included reading the text whilst listening to the interviews. This allowed the text to speak to the researcher through being open to it, by switching from a natural attitude to a phenomenological attitude as described in chapter three. A thematic structural analysis is then undertaken in order to identify themes, with the assistance of NVivo software to manage the interpretation. To capture the meaning of the lived experience, condensed descriptions of the text are formulated. The text was read and divided into meaning units, a sentence, paragraph or section of text that conveyed one meaning. The meaning units were then read and reflected upon in the context of the naïve understanding. The meaning units were then condensed into concise everyday language that conveyed the essential meaning of each meaning unit. Similar condensed meaning units (CMU) were then assembled into sub-themes and further grouped into key themes (Lindseth and Norberg, 2004). A comprehensive understanding was then achieved by summarising and reflecting on the themes in the context of the research question and the text read again, keeping the naïve understanding and validated themes in mind. Associations were then imaginatively drawn from the literature as a result of familiarity with it, allowing for a deeper and wider understanding of its meaning, and perceiving this understanding in the light of the literature. The process was long, complex and revealing, but clearly allowed the researcher to be intimately embedded in the text and experiences of the participants. A level of validation was achieved with the assistance of the experienced supervisors of this research, who reviewed original interview transcriptions in the context of the themes extracted and ensured an association to the essential meanings of

the phenomena under investigation. The experiences of the researcher, kept in check by the process of ongoing reflexivity employed in this research.

An example of the process of full text to meaning unit to condensed meaning unit to themes is seen below.

Meaning unit extracted from full text was:

> *'Well I feel proficiency is what.. proficiency is being good at your job, it's about…knowing what your role is, knowing what patients you're looking after and knowing what boundaries you've got. Erm… understanding where the process of protocols are and how they work, yer? Erm.. proficiency is a good patient journey for me, it's about walking them to discharge, making sure everything, streams and rolls quite properly and nicely. Erm.. without hopefully any mishaps or ???? from that, so proficiency and what makes me proficient is all of those things combined to me.' Line 17-22 (Participant 1).*

Condensed meaning unit became:

> *'Proficiency is being good at your job. Knowing your role, the patients you're looking after, your boundaries, the processes. A good patient journey. Those things make me proficient.'*

The theme where this condensed meaning unit lay became the meaning of role proficiency, and the comprehensive understanding was then achieved by summarising and reflecting on the themes in the context of the research question. The text was then read again, keeping the naïve understanding and validated themes in mind.

4.10. Ethical discussions

Ethical approval for this research was achieved and approved after consideration by the Northumbria University ethics committee prior to data collection. Approval was also gained from the research and development department of the NHS Trust from whom the study participants would be recruited, through IRAS. Informed consent was obtained from all

participants using the consent form found in appendix vi, and confidentiality was maintained throughout. Data was stored in line with appropriate policy as detailed in the data management sub-section of this chapter (4.8). As researchers, we have a moral obligation to conduct our research in a manner that seeks to identify and minimise any potential harm to those who participate in the study (Bloomberg and Volpe, 2016).

4.11. Summary

This research was planned with a hermeneutic phenomenological approach. The aim of this methodology, under the Heideggarian orientation, is to extract the understanding and meaning from the object, in this case an examination of the meanings of the experiences of the ENP, hidden or stated. The data collection was undertaken in two phases, inspired by the work of Bedwell, McGowan and Lavender (2012). The first phase consisted of a digital diary that enabled the participant to begin to explore their experiences of proficiency free from the influence of others. The second phase used the diary to inform a semi-structured interview and, with use of reflexivity, allowed the relationship of the researcher to benefit the data collection process. This married well with the Heideggarian approach of this research that recognises fore structures rather than ignoring them, allowing the researcher to guard against their influence during data collection and interpretation whilst facilitating understanding of the participants' experiences. The data extracted initially by interview was transcribed verbatim, so the interview becomes data as text. Interpretation was given structure using the three-stage approach of Lindseth and Norberg (2004). The method is used to study the essential meaning of the lived experience of the ENP through the interpretation of text, remaining consistent with the hermeneutical phenomenological underpinnings of this research. The findings of this interpretation are presented in chapter five.

Chapter 5: The findings

5.1. Introduction

This chapter will review the findings as articulated by the participants, organised into six themes that emerged through the data extraction, beginning with the participants' expressions of the meaning of proficiency. The descriptions of the participants will be utilised in order to remain as close to the lived experience as possible. This is in line with the methodological underpinnings of the research, discussed in chapter three, where the results of phenomenological hermeneutical investigations are about the meaning of lived experiences (Lindseth and Norberg, 2004). Each participant quote will be referenced by line in the interview transcript and participant number, in this format: line 1-3 (participant **). An example of a participant interview transcript as a reference can be found in appendix ix.

5.2. Overview

Large volumes of data are collected in this type of research, and decisions as to how to analyse this data are discussed in the research methods chapter. The data that follows was interpreted in a three-stage process, first utilising naïve reading which involved repeated reading of the text in order to grasp the meaning of the text as a whole. This allowed the text to speak to me through being open to it by switching from a natural attitude to a phenomenological attitude, as described in chapter three. A thematic structural analysis was then undertaken in order to identify themes. To capture the meaning of the lived experience, condensed descriptions of the text were formulated. The text was read and divided into meaning units, such as a sentence, paragraph or section of text that conveyed one meaning. The meaning units were then read and reflected upon in the context of the naïve understanding. The meaning units were then condensed into concise everyday language that conveyed the essential meaning of each meaning unit. Similar condensed meaning units

(CMU) were then assembled into sub-themes and further grouped into key themes (Lindseth and Norberg, 2004). A comprehensive understanding was then achieved by summarising and reflecting on the themes in the context of the research question, and reading the text again, keeping the naïve understanding and validated themes in mind. Associations were then imaginatively drawn from the literature as a result of familiarity with it, allowing for a deeper and wider understanding of its meaning, and perceiving this understanding in the light of the literature. The themes will be discussed and presented with appropriate literature to develop the findings and aid discussion in chapter six.

5.3. Chapter structure

The remainder of this chapter will be structured around the objectives of the research question. Firstly, I will address the examination and understanding of the meaning of role proficiency to ENPs. From this meaning developed the components of proficiency, which became the themes of the practice experiences of role proficiency and how these influenced feelings of role proficiency of ENPs. These themes will be presented in sections, based on their occurrence as CMUs across the interpretation of the data, as previously described, with the vast majority of CMUs falling into the themes identified. Six major themes, to which all participants contributed data, emerged from the interpretation process and are presented in tabular form below:

Theme	Title	Summary
One	The meaning of role proficiency	The meaning to the participants of proficiency in their role, leading to its definition.
Two	Relationships	Participants overwhelmingly indicated a struggle in their relationships. They also stated relating to their role from a number of perspectives, which were expressed by themselves outwardly, reflected to them by external individuals, and provided from a departmental/organisational level.
Three	Confidence	Participants indicated that confidence plays a significant role in their feelings of proficiency. An experience that affects this confidence can have either a positive or negative effect, depending on its nature. The perspective of confidence is experienced in the 'self', or in others, and contributes to their resilience and self-efficacy.
Four	Learning and knowledge	Learning and knowledge is positioned in a formal, informal or 'on the job' capacity and affects proficiency when it is revealed to the participant as applied knowledge through what the participants commonly refer to as common sense
Five	Exposure and experience	Exposure builds proficiency with a lessening influence as experience increases. Its affect is primarily experienced through the themes of confidence which grows with exposure, causing relationships to develop, and the participant reveals their learning and knowledge through its application to that which is experienced.
Six	Care	Care is a central theme that threads through proficiency in its entirety, encircling its components and themes. It provides the participants' motivation for continually seeking both positive and negative experiences of themes that construct their feelings of proficiency.

FIGURE 5-1 SUMMARY OF THEMES

5.4. Theme one: The meaning of role proficiency

The notion of proficiency has often been taken for granted (Harsch, 2017) and, in the context of nursing practice, is barely mentioned in literature or research, as highlighted in the literature review of chapter two. However, there was a commonality of participants' understandings of what it means to them and how the expression of its meaning developed

during the interview. The participants were asked what they understood by the term 'proficiency', and it was clear that they were able to articulate what proficiency meant to them with similar and consistent views presented as to its meaning throughout the interview discussion. The concept of proficiency was strongly associated by all participants with their role in its broadest sense as a job, with participant 1 providing the most concise summary of the participants' initial understanding:

> *'...proficiency is being good at your job' line 17 (Participant 1).*

This initial definition or impression of proficiency was given by the majority of participants. However, the participants began to examine what became their superficial summary of the concept of proficiency more deeply, progressing to what they perceived to be the component parts of proficiency and how they related to each other. Its meaning then became much more about how these components were applied and understood by the ENP, and how they constructed their own feelings of proficiency using these parts. This constructed a meaning that was so much more than just being good at the job, and became more about the effectiveness with which they confidently connected and understood the components to move towards feeling proficient in their role. Their understanding was then transformed into how it is experienced by the ENP.

The majority of the participants introduced the concept that proficiency is part of a process, with a broadly linear approach to its presentation and achievement. This suggests that it begins to develop before their ENP role, but that this role had to begin from a point of competence specific to the ENP role. When that had been achieved in the eyes of the ENP, the journey towards proficiency, beyond the entry point competence required, could begin:

> *'To me, proficient [sic] is a sort of, it's the next stage on from competence I personally think.' line 18 (Participant 9).*

The participants all discussed proficiency as a continuum. There was a strong and clear message that the continuum that began before their ENP role, and that it incorporated all their clinical experiences and seemingly had no end. Thus, it was seen as a lifelong process that expanded beyond the confines of their current role, but was also time focussed on that role. As the ENP moved towards proficiency, it seemed to continue to be seen in the distance, in a similar way to reaching the end of a rainbow. Whilst this should seem like a negative view, as it is something that could never be reached or unattainable, the ENPs were entirely comfortable with this position and very much saw this as a realistic outlook. They accepted that they were not going to reach the panacea of being wholly and comprehensively proficient in all areas of their practice:

> *'I don't think there ever is an end point. I think there's a point where you are [feel] proficient, but there's never an end point to developing your skills and what you know.' line 56 (Participant 9).*

Participants rarely spoke of proficiency as a whole single object. Rather they saw it as a concept existing in parts that contribute collectively to its existence. Participants highlighted particularly well how they saw the concept of proficiency as being often broken down into its components:

> *'To be proficient, it means many different things. Being competent, accountable, responsible, working within your scope of practice. Having theory, understanding, and following guidelines and protocols so that you're working within... But that comes with experience as well. You don't just become proficient overnight It's a massive learning curve.' line 52-56 (Participant 3).*

Here, the participant presented the meaning of proficiency in what they considered its constituent parts, indicating that consideration had been given to the topic, thus justifying the

diary approach. These components were consistent between the participants. This underpinning of proficiency was put quite poetically by one participant:

> *'Underpinning that [proficiency] there's a few things. There's the science behind it …and then there's the art of nursing…' line 22-24 (Participant 6).*

Here, they referred to the science as what they have been taught in the past, and all the additional qualifications and training earned and participated in contributed to refining the art of doing and performing nursing. This suggested that there are components of proficiency that are not taught, but experienced. Participant 7 referred to how they experience proficiency:

> *'Erm… by repetition, by doing, by seeing erm… when you are initially training as a NP you sort of sit and watch and try to take in lots of information, lots of knowledge that I gain by the practitioners erm… and then having them observe you as you are doing it. Again by repetition knowing what is normal. You see and awful lot of normal things and then knowing when something's not normal.' line 32-35 (Participant 7).*

There is also consistency that proficiency is not all encompassing, but can be situationally positioned by case or presentation. As such, it does not necessarily exist across the entire scope of practice of the ENP:

> *'I kind of think of it as how you've learnt to do the job and the skills that you've got and how you utilise those skills and the knowledge that you've gained and if you've got, if you're comfortable with something and you've had a lot of experience, a lot of training, you've got the knowledge and the skills, then you feel a lot happier with that area. So you feel more proficient in it. I think proficiency is a lot to do with skills, knowledge, experience and the more that you've got, the more proficient you are.' Line 28-33 (Participant 8).*

And also:

> *'You experience it by working it. What you do on a daily basis. What you see.' line 60 (Participant 5).*

The experiences of proficiency by the participants are encompassed within the definition constructed by their feelings. The ENPs felt that they have moved towards proficiency by reaching what I have termed their 'proficiency zone'. This is defined as being when they are confidently able to understand the application of their expanded knowledge, skill, experiences and relationships to unpredictable situations, with incomplete information, and remain happy that their decision offers the best available care to that patient. Proficiency is not about knowing everything, it becomes about a confidence to apply what you do know and have experienced to situations that present themselves, whether they are predictable, or even familiar, or not. Thus, they represent a pragmatic application of knowledge, skills, exposure, experience and care to a patient episode.

5.5. Theme two: Relationships

This theme is the most-commonly referred to within the majority of CMUs formed during the data extraction phase. There are a number of subthemes within it, referring primarily to perspectives of other individuals or professions with whom the ENP has a relationship in a working context. It should be made clear that any comments about the view of other individuals or professions are about what the ENP thinks the other individual or profession believes and not necessarily the opinion of the other individual or profession. That perspective has not been sought in this study. The sub-groups are practice experiences with; doctors, other nurses (qualified), peers (other ENPs), patients, work self, the role and the environment.

This theme is about how experiences or being in relationships with people or abstract entities affected feelings of proficiency. What was interesting was that the flow was not unilateral or uni-directional. There was always an understanding that another perspective existed, that of the other gazing back at the ENP in addition to the ENP gazing outwards. Furthermore, it was

not always the individual or relationship that the gaze was focussed on, but rather a role or circumstance that the individual found themselves in.

5.5.1. Relationships with the role

This sub-theme is about the perception of the role to the ENP and how it can vary significantly on a seemingly individual basis. Even within the same Trust, participants discussed the variability in their roles, driven by factors such as differences of workload or client group and being based in different units or departments. Despite this, the following quote from participant 10 demonstrates the accepted variation in the role, and captures the scale of the breadth of both condition and patient lifespan the ENP must bridge to fulfil the role, even with variation across units:

> *'You don't know absolutely what's coming in through the door. It can range from where I am, from babies under 2s so from a few weeks to, post 6 weeks I'll see and right up to 100 really and so it can be anything in between and it can be any illness or injury.' line 9-12 (Participant 10).*

There was a frustration that was linked to this role variability in a number of ways, directed at other individual ENPs who are not practicing within any given participants' perception of the role, and also directed at units who are perceived to function with a lesser degree of role, routinely vocalised by participants as being able to 'see less', a phrase that inherently is negative and had negative associations. This essentially gives rise to an unofficial hierarchy between units, with peripheral community-based units lowest in the hierarchy and those attached to or directly associated with ED at the top, thus reflecting the perception of 'see less' versus 'see more'. This is also seen in the variability of service delivery between units in the same city, with some for example seeing patients under two years of age and some not. This further gives rise to a perception that the ENP role is seen as lesser when compared to other roles, such as other nursing or doctor roles. This is noted in some of the interactions

between these roles. The perception is that both doctors and other nurses can be felt to see the ENP role as either inferior or not as important compared to their own in the case of other Nurses, or a subsidiary role to their own, the least important or significant part in the case of some Doctors, rather than a unique role. One participant offered an honest reason for this perceived hierarchy:

> *'... so we're massively more skilled than doctors were [in minor ailments] but ultimately there are, it's a minor ailment group, there's nothing in it for medicine. They can't, they don't become professors or A&E consultants on what they see in minor ailments you see.' line 528-531 (Participant 6).*

The overall impression was that the role is about pushing boundaries, doing more, and seeing more for the benefit of the patient and wider NHS. This continuum of the role is consistent with the concept discussed in the finding of the meaning of proficiency section, where proficiency was seen as a shifting and lifelong development process. This was replicated in the role, where the position was in a constant development, never really settling as a concrete definition or description. Within the ENP population, participant 6 proposed an idea that slows this progression based on individuals and their perception of the role:

> *'And its, in any environment you've got two groups, in my experience you've got the two groups of people who just draw a line somewhere and say that's not my business whereas there's people, who I include myself, that say it could be my business if I take advice from that person, or that person' line 54-57 (Participant 6).*

The participant indicated the existence of two groups: those that seem to engage in the concept that the role is ever developing and look for solutions to resolve the gaps in the themes behind proficiency, and those who want to remain in the role as is, almost resisting development and having firm boundaries of what they will or will not manage in terms of patient presentation. There was however an alternative viewpoint from within the participants' voice. While the lack of clearly defined role does allow for boundary pushing,

when an ENP pushes the boundary beyond the perceived limits it is considered to cause problems of perception or appearance to others for ENPs who are not as prepared to move beyond the perceived limit. It also is identified as a risk to the ENP pushing the boundary who, without appropriate proficiency, may pose a risk to the patient themselves. Participant 3 referred to a situation where another ENP pushed the boundary and got in a 'muddle', implying that there was the potential for risk to patients:

> *'But there's always a few without that extra training, theory, competency, assessment. Who will go off and do things anyway. And then it becomes a muddle to them because they're not really sure what direction they're going to go down if, for example, a patient... And I'm, being the cynic that I am, going to sit back and say, "That's what you get. You shouldn't have dealt with them in the first place. You knew this was going to happen.' line 377-381 (Participant 3).*

Participant 1 suggested a motivation for pushing the boundaries, that being patient care and consideration of other areas of work:

> *'When I don't really want to bother people when, it for my patient and I have to get the right answer for it or I have to confirm that this is the right pathway because... I don't know... I'll see things as a tangent, slightly out the way, erm... ill not fit into me normal protocol which is maybe the right or wrong thing, I don't know. So I can't really go to my colleagues' cos maybes they'll not see that cos he's come off his bike 30 miles 40 mph but to me that, say la vie, head to toe, have a look at him, if I'm not happy I'll bang him next door, I'll know when somebody's sick. Are they going to do anything different to me, that's the question? If they've got a 4-hour time and a trauma and got tons, I don't mind seeing those bits and bobs' line 405-412 (Participant 1).*

There was also an acceptance that a defined boundary is useful early in the ENP role as part of a controlled learning process. It was also seen as potentially useful when affected by other themes, predominately confidence, in a protective way:

> *'.... That's when boundaries, that's when I've found boundaries are useful.' Line 139-140 (Participant 6).*

5.5.2. Relationships with the work self

This sub-theme is about the participants' interactions and relationship with their self, as it exists in a work context. This is achieved in the participants by an apparent existential peering inward at the self from without. Thus, this treats the self as the phenomenon under investigation in a fashion consistent with the concept of Daesin, as detailed in the work of Heidegger in chapter three.

The work self is something that the participants considered to exist 'in them', and was focussed on the desire to be the best. This view of self consists of a number of characteristics that the participants feel are central to the role. This includes a personal awareness and understanding of their abilities, a strong sense of responsibility for their actions, honesty with the self, a need to feel safe in their work from a decision-making perspective and a strength in the recognition of weaknesses. There was a strong feeling that any relationship that attempts to challenge of these characteristics will affect the ENP profoundly, and have an impact on other themes.

There was a critical view of the self for the participants, as it was perceived as an essential process of reflection to evaluate the self regularly in order to ensure that the participants' view of the ideal self is moved towards. Each participant places high expectations upon themselves and, if they believe that their self has not achieved this expectation, even with external third-party validation such as a peer or other health care professional, it results in an examination of the self. This reflection took the form of a consideration of both the self in that situation and the perception of where expectations had not been met. This is a process that occurs many times in a day and is dependent on the view of the participants' self, which can vary significantly throughout a day depending on the interaction that has triggered the evaluation. The common expression was that the participants' often feel that their self should know more. This can be influenced by other relationships, such as with peers or doctors, and

can be negative and positive in its affect. It was acknowledged that there are anxieties associated with questioning the work self, but that these are a necessary component of how the self contributes to influencing proficiency. Participant 7 voiced the impact of being critical of the self, what the participant perceived they should have known or done, the impact on confidence and the negative view or action on the self as a result:

> *'I think sometimes for me I kind of walk away thinking, I should, I knew I should have done that, that should have been done like that or, I never thought of doing it like that. So I kind of, for me I give myself a little bit of a bashing. (I ok) but that's my self-confidence, that's not, I would say most other people probably don't do it like that.' Line 145-148 (Participant 7).*

There were also check mechanisms in place, applied by the participants to reason with the highly critical self. There was a recognition that the participant has to manage their response to their self carefully and logically as, if unchecked, the examination of the self can become counter-productive and reduce feelings of proficiency, rather than contribute to its improvement:

> *'And it's about how you manage it. Some days you manage it better than others.' Line 369 (Participant 5).*

5.5.3. Relationships with other ENPs

This sub-theme is about how the ENP views, and their perception of how they are viewed by, other ENPs relating to their feelings of proficiency. There are three areas where this is seen in the data. These are where the ENP is advisor to other ENPs, where the ENP seeks advice from ENPs and how the actions of ENPs can have an effect on the work of other ENPs.

There is a widely held viewpoint from the participants that being asked for advice from another ENP is a very positive demonstration of how others perceive you as an ENP. The result of this is that their perception is that you are proficient in the area in which they have

asked your advice. This leads to a feeling, linked to confidence, which influences perceptions of proficiency positively:

> *'It does, it builds your confidence a bit doesn't it because you go from the fledgling NP or a fledgling nurse who's not got a big knowledge base but lots of enthusiasm yer [sic]. And it comes full circle cos you used to go and ask these lovely people… advice' line 320-322 (Participant 1).*

This also indicated the participants' acceptance that, as an early career ENP, you ask for advice from those who you consider to be more experienced, although experience is not the only criteria used to determine who to seek advice from. There was also a need to trust and value the advice being sought, and that is built up over time as teambuilding occurs. Thus, this process also allows colleagues to perceive elements of proficiency, as defined in this chapter, in others to approach for advice. Seeking advice from other ENPs is not isolated to early career ENPs, as it is a practice that is used by experienced ENPs when they perceive, for whatever reason and at any given time, that they need advice from a peer to reassure them of their proficiency for the case. This is illustrated in the quote below. It is also noted that it is very rare that this advice differs from the plan the ENP had intended to employ:

> *'Well I think, I think it makes you feel more proficient if they agree with what you've said (I ok). If they agree with what you've said and their opinion is the same as yours they can reconfirm that you're on the right lines. But only if you value their opinion.' Line 361-363 (Participant 2).*

Within the relationships with role sub-section 5.5.1, earlier in section 5.5, the discussion about boundary pushing for the benefit of the role was discussed. In the context of other ENPs, the participants voiced an alternative perspective. It is noted that to push the boundaries too far, too quickly or acutely, or indeed to take on the work of the ED department, was perceived to be detrimental by many ENPs. This was particularly the case where the perception is that the ENP in question does not have the elements of proficiency to

manage the case. The ENPs perceived that working beyond your boundaries, and those of the role as perceived by the ENP, creates a problem in that it creates the expectation for future similar cases. Thus, it could force other ENPs to work outside their zone of proficiency in a forced, rather than measured, way. The implication was not that they are not able to, more that either the case is perceived to be the work or business of another department, or the ENP would need other elements of proficiency to be comfortable and safe with the case under discussion.

5.5.4. Relationships with other nurses

This sub-theme is about how the ENP both views, and their perception of how they are viewed, by other nurses. Particular consideration seemed to be given to those that have a limited understanding of the additional responsibilities that being an ENP entails, consisting predominately of qualified nurses in roles such as staff nurse or departmental-level management. In some cases, as expressed by participants 1 and 6, this was even seen as a source of conflict. For example, participant 6 referred to a patient in their diary that they had sent to the main ED from a peripheral facility as an acute surgical referral. However, the triage nurse kept them in the waiting room as an 'acute abdomen', seemingly based on the fact that they had walked into the department. Participant 6 implied that this was perhaps a cynical response given their assessment. However, when following up later, the patient was found to have been admitted to the surgeons:

> '*I recognise I'm often talking to a junior, well senior or junior staff, it doesn't really matter it's just, there's always been a slight bit of conflict at that interface. (I ok). Which is just, just seems to be the nature of the job.' line 196-198 (Participant 6).*

Participant 1 suggested that the conflict seems to be borne from the need to prove yourself as an ENP, and prove the role value of the ENP role itself:

'I think it's a bit of both, I think you feel as though er where I work in the minors part, you feel a little bit out of the way I'm sure like... so you feel as though you're constantly striving to show... I don't know... sometimes it's a nurse against nurse thing sometimes cos sometimes... nurses in the majors department I don't feel as though nurse practitioners ... not the word worthy but are... a little bit out of the way, they don't see the majors stuff so that makes them, I don't know if that makes them feel as though they're a lesser nurse and they send them down to see the minor things that query, don't really matter when they really really do matter and that's where your best practitioners are. So I think you try to prove yourself to nurses sometimes to show this is what we do.' line 124-135 (Participant)1.

There was a perception by the ENPs that other nurses see the ENP role as lesser when compared to their own, or minor as opposed to major. The ENPs were frustrated by this perception and saw both roles as equally valuable to the group of patients, separated only by their approaches due to ENPs having higher levels of direct clinical responsibility compared to other nurses:

'I think they think, well, you're not doing much around the corner anyway, so... You don't… If you… You know, you should know this...' line 529-530 (Participant 3).

5.5.5. Relationships with doctors

Relationships between the ENP and doctors from specialty and the ED have varying influence on feelings of proficiency. One example of this was given by Participant 9, who tried to refer a quinsy to a specialist doctor and was met with what they felt was an excessive amount of questions:

'if anything it made me feel more proficient... and been in and around hospital settings and junior Doctors and you know that sort of the stage that they're at. And understanding their need to question everything and their hierarchy and the fact that they've got to justify why they've taken a patient to the Reg[istrar] and you know' line 176-181(Participant 9).

The focus was on the perspective of the doctor and their perceived insecurity of the knowledge of the ENP role or of the condition. This led to an acceptance that the Doctor had

to ask the extended questions as part of their own position, as driven by how they had been instructed, their understanding of the ENP role, or lack thereof, and their own learning. It did not, however, seem to be a deliberate attempt by the Doctor to increase the ENP's frustration or be obstructive. Similar examples were seen when referring to peers and other nurses. The relationships seem to be founded on the ENPs' understanding of the role of the other, and the ENPs' perceptions of how the other views the ENP role, rather than the perceived lack of understanding of that other.

There are examples given where both positive and negative influence are seen within the relationship, and its influence varying significantly between individual doctors. A positive example can be seen where Participant 3 recounted a consultant indicating that the ENP is most likely the expert in a particular area, as they see more of the patient type or condition than the consultant:

> *'…Consultants will say, "Well, you're probably doing that more than some of the SHOs.' Line 511 (Participant 3).*

A negative influence was seen when a consultant was rather short with Participant 2 when asked for advice by phone. This is sometimes dismissive in its delivery and does not always result in advice being given. However, the initial negativity associated with this example was deflected using a similar appreciation and understanding of the position of the ED department, and the affect this may have over the consultant. This is a similar deflection or perspective used when compared to the speciality example given earlier. The ENP often has a working personal understanding of how busy the ED is and uses this as explanation for the abruptness of the consultant. Thus, the conclusion is that the problem is with the busyness of the ED, rather than the ENP, i.e., it is not personal. There does linger a perception by the ENP that many of the consultants view the ENP role as subsidiary or subservient to that of the

consultant, rather than being a unique role. This seems to be an inconsistent opinion not shared by all, where consultants concede that the ENP is more of an expert in certain presentations than they are, and a respect is felt by the ENP in these circumstances.

5.5.6. Relationships with the environment

Participants consistently referred to the advantage of a supportive team environment, citing it as advantageous to feelings of proficiency of the individual and the continuing development of the ENP:

> *'They're absolutely, like really really supportive (I ok) team' line 405-46 (Participant 9).*

Participants go on to say that working together is important in the running of the unit, particularly by getting on well with mutual respect, and this is consistent with principles of team working in the literature (Nancarrow et al, 2013):

> *'It's the best a team, the best thing about where I work is the team in itself (INT: right). Cos there's… everybody works together and… Cos everybody gets on so well together because they all respect each other.' Line 366-372 (Participant 1).*

There was consistent reference to the perceived difference that environment makes to levels of decision making. Participants see a lack of acknowledgment that decision making is different between secondary and primary care. Secondary care wards or departments tend to arrive at more of a team decision, as a result of the number of decision makers available for discussion. Whereas in primary care, the lone working or comparative solitary nature of the work results in the perception of more autonomy, and more solitary decision making. This suggestion wasn't indicating a superior decision, simply that decision making is more challenging in the more solitary environment of a primary care-based unit:

> *'You don't actually make a decision autonomously really [in secondary care], it's more of a team decision in most cases.' Line 532 (Participant 10).*

There was evidence from a number of participants that the pressure applied by the environment, specifically staffing or perceived lack thereof, numbers of patients waiting and waiting times, can have an influence on how an ENP will work. When these conditions are felt to challenge or apply pressure to the ENP, there is an undefined point where the ENP will seek to act well within their proficiency in order to reduce the pressure. Thus establishing a degree of control over the number of patients waiting or waiting time. This can be a transient process lasting a short time until the perception of control is regained. This is linked in with the subtheme of role.

> *'...yes if you get extremely busy you just go back to the boundaries (I: right) it's very easy, you just say that you're not pushing the boundaries anymore because I haven't got time and erm... you know the client group, there's too many of them, there's only two of us so let's make it easy for ourselves again. You know, you've had an RTA, go to A&E. that's all you need to do. Even though you know they've got a minor muscle sprain which you can treat in your sleep. But if you.... That's when boundaries, that's when I've found boundaries are useful. You tend to extend your boundaries a lot more if you are in a comfortable environment I would say.' Line 135-141 (Participant 6).*

A variety of different work environments raised some observations by the participants. There is a perceived undercurrent that peripheral units don't have the kudos of more centrally based units, or those who are co-located with ED units. Thus implying that there is some hierarchy of environment where peripheral units are in some way lesser. This is interesting, as central co-located units feel the same when compared to the ED. The below is an example of an ENP who once worked in the ED, moved into the ENP role in a co-located unit and now struggles to not be a part of it, perceiving that they are no longer a member of the ED team:

> *'but when you got separated you sometimes don't feel part of the team anymore sometimes.' line 127-8 (Participant 1).*

5.5.7. Relationships with patients

This sub-theme is about how the ENP feels they are perceived by the patient, and whether an acceptance of the role is seen and understood by this group. It includes the ENPs' perceptions of what the patient wants to gain from their attendance, and also of the patient understanding that the focus of the ENP's application and role is to deliver the best care from a position of knowledge.

The establishment of a good relationship with patients seeking treatment is well documented. The ENPs acknowledged this and placed value on how the patient perceives their role. There was an acceptance that patients do not, on the whole, fully understand the role of the ENP and that this can contribute to frustration for the ENP and the patient. There is a clear context associated with this frustration, linked to a patient arriving at a service with or for something that the service or the ENP cannot manage as part of their role. There is an empathy with the patient expressed in this particular situation with an acknowledgement that it is difficult for patients to identify where to go with what condition. This frustration can be directed from the patient to the ENP, and can affect feelings of proficiency, particularly when a confrontation questions the proficiency of the ENP, through no perceived fault of their own. The positive side to this is when a patient is perceived to be satisfied with their treatment, which in turn gives the ENP a positive effect on their feelings of proficiency.

The importance of clear and concise communication with patients is recognised as key, with particular attention placed on trying to help the patient understand the care that is being delivered. This is underpinned by an apparent desire to demonstrate the knowledge of the ENP relating to best practice for the complaint the patient has attended with. This skill of communication is also employed when trying to establish the ideas, concerns and expectations of the patient in the early part of the consultation. This is seen as an important element of the consultation, particularly the ENP's perception of what the patient hopes to get

from the attendance and how this relates to an overall positive consultation. This is turn feeds into the ultimate aim of the ENP, which is to build a relationship that enables the delivery of the best care to each patient. This essentially represents working to establish a relationship that ensures that the patient understands the role of the ENP, how this links to the ideas, concerns and expectations (ICE) of the patient, and how these can be married to attain the best care provision for the patient.

5.6. Theme three: Confidence

This is a theme that has a significant impact on the experience of proficiency for ENPs. There are a number of subthemes built on perspectives or the gaze of confidence in a similar fashion to theme two. It can focus outwards from the ENP, peering back towards the ENP, or gaze inwardly within the ENP themselves. The sub-groups consist of confidence of professional self, confidence of personal self, considering them to be separate entities alongside resilience and self-efficacy, confidence of others and confidence in others.

This theme is about how the effect of confidence, whether positive or negative, affects proficiency, practice and the person of the ENP. What comes through is the way confidence is managed through a resilience system that is created by each ENP in order to support self-efficacy for the benefit of the next patient or group of patients.

5.6.1. Confidence of the professional self

This sub-theme is about how the confidence of the ENP relates to their perception of their professional self, particularly both what they feel it should be and how they react to negative experiences that impact confidence in the professional self. There are two examples, both of which were repeated throughout the participant data: how complaints and compliments affect confidence in the professional self.

There is evidence that the ENPs measured how their professional self should present against other individuals. The perceived ultimate comparison, based on respect, is against the senior doctors who the ENPs perceived have more knowledge and expertise in the same areas than them. Although many of these duties sat beyond the role boundary of the ENP, they were still perceived as the yardstick to be measured against. This participant illustrated the respect that ENPs have for the medical profession:

> *'I think they have, obviously, a longer training and a more widespread training. So I think the doctors from a medical point of view should know a lot more than us. Without a doubt.' Line 849-850 (Participant 5).*

This exists against the backdrop that the ENPs are aware that they are not, and do not intend to be, senior doctors. In fact, they are a different role defined in a different fashion to the doctors, and are very comfortable with this differentiation. The ENP also compared themselves against their peers utilising a system that revolved around advice to affirm their own confidence. The ENP very much saw that, when a peer asks them for advice, it is a measure of respect for the proficiency of their own professional self by that peer. The awareness of the importance of this interaction came from the participants' knowledge of what they look for, including proficiency, in other ENPs as they seek advice.

The participants were concerned that they would be found lacking in proficiency, particularly when seeking advice from a senior doctor. There was an anxiety provoked within this process based on a lack of perceived confidence, particularly that they will be wrong or have missed something. Interestingly, this is seldom the case and, despite the anxiety, the interactions commonly served to reinforce the professional confidence of the participants.

This was seen throughout the relationships theme, however here it specifically relates to feelings of improved positive confidence. Participants felt confidence had a significant

impact and, in combination with other sub-themes in this heading, provided a foundation for the continuing and efficient practice of the ENP. The participants cited confidence as a central experience in their proficiency.

There were a number of experiences that affect the professional self negatively, particularly when focused on the concept that the ENPs were incredibly critical of their professional self. The mechanisms and solutions proposed by participants relating to this will be discussed in the resilience and self-efficacy section. Examples include a poor consultation and patients returning for further treatment. The language the ENPs used to describe these experiences is very strong, including terms such as failed, failure and mistakes. This was directed very much at the professional self of the ENP in a particularly critical way:

> *'…they're not happy with the service or the treatment that you've given. Or that your treatment has failed. And why has it failed? Has it failed because you didn't get it right in the first place, or...? Do you know what I mean? That's what you think straightaway.' Line 149-52 (Participant 5).*

Complaints have a significant negative impact on the professional self and the confidence it contributes to proficiency. This can have an effect that lasts well beyond work time, with the majority of ENPs taking elements of negativity beyond their professional self into their personal self and home life. The majority of participants spoke of the negative impact of complaints, their sudden and quite often unexpected receipt, and the lack of formal mechanism to manage them on a clinical and professional-self level. One participant had particularly strong views on a protected time out period after a particularly difficult consultation, and the need to manage and avoid impact on further patient interactions on the same day:

> *'…and it's on your mind so that can affect, that can affect your work for a long time... And there's no debriefing sessions, there's no meaningful support… but the problem*

is that you have a difficult consultation and you have to move on to the next patient within minutes.' line 380-4 (Participant 6).

Contrasting this is the significant positive impact a compliment can have on the confidence of the professional self. All participants commented that it is a comparatively rare occurrence to receive positive feedback or compliments from patients, but that their value is tremendous to the ENP. A particularly poignant example was given by a participant whereby the patient was seen by the ENP, who was concerned and escalated their treatment to an acute unit. The patient sought out the ENP to thank them personally as, according to the receiving consultant, the actions of the ENP directly saved the life of the patient. The experience was very emotional and valuable for the ENP:

'I felt so emotional because I thought like, they've taken their time out after he's been so unwell to come in and say that and I was blown away… and I was crying' line 307-310 (Participant 7).

There was an interesting response to the positivity, where the ENP was quite self-deprecating and, on a number of occasions while the recounting of the experience, used phrases such as just doing my job, didn't do anything and that they didn't do the job for the thanks. It was apparent that, despite the significance to the patient, the ENP was at pains to not over-exaggerate their involvement or the significance of it:

'it does make you feel, now quite positive about what you do. And positive that you're doing the right thing and so it all fits into making sure you are helping with your proficiency' line 329-30 (Participant 7).

This was despite the obvious value that the ENP placed on the professional self, and superimposed on a background of a job where positive feedback is seldom received and often the ENP is not certain that they are right or wrong.

5.6.2. Confidence of the personal self

This sub-theme is about how the confidence of the ENP relates to their perception of their personal self. It discusses the sort of person they perceive themselves to be in a context of existing outside the role, how much of this personal self spills into the role and, perhaps more importantly, how much confidence affected by practice experiences spills into their personal self outside the role.

Confidence in the personal self is, by definition, an individual experience, but was presented in a common fashion by the participants. There is a great deal of doubt that exists in the personal self, as the participants indicated that this drives their willingness to practice, yet is still affected by issues experienced with the professional self. It was indicated by the participants that a negative view of personal self is almost the standard amongst them as a group. The management of this self-doubt comes through a constant process of reflection, with importance placed on not allowing the personal self to dominate and affect practice. It is kept as separate as possible from the professional self, however participants outlined that this can be difficult. There is evidence that the personal self is punished for errors that the professional self makes. This punishment is felt as emotional responses, predominantly self-criticism, to the experience that the ENP perceives is worthy of this response.

These emotional responses can spill into the lives of the participants outside the role or workplace. This is despite contrary evidence suggesting that confidence in the personal self should often be more positive. The participants accepted that they experience confidence in the personal self, but that this confidence is not seen by the participant in themselves. There is a gaze from without by the participant that looks back on themselves yet does not see the confidence of the personal self in the participant. It appears to be a mismatch between what they feel, what they see of themselves and what they are told others see of them. This mismatch is managed by a system that seems to find a significant strength in being aware and

conscious of either weaknesses or deficits in the personal self. This spills into the professional self, creating a link where the personal and professional self balance each other, and provide a control for the other, depending on which is more negative at any given time.

5.6.3. Resilience and self-efficacy

This sub-theme is about how the ENP manages the experiences that negatively affect confidence, and how this process of management is conducted. It is about the systems the participants employ to preserve themselves and their effectiveness as an ENP. Bandura (1998) refers to this ability to be effective as self-efficacy, defining that it:

> *'... refers to belief's in one's capability to organise and execute the courses of action required to produce given attainment' (Bandura, 1998. P3).*

Self-efficacy is very much about what you believe you can do with what you have, as opposed to listing a series of skills. This was considered as competencies in the ENP role:

> *'Self-efficacy is concerned not with the number of skills you have, but with what you believe you can do with what you have under a variety of circumstances' (Bandura, 1998. P37).*

Participants took a position that can be perceived as either quite negative and exposing or a sign of strength and awareness. Participant 10 put it concisely:

> *'...I think you've got to be able to recognise your own weaknesses and strengths.' Line 110 (Participant 10).*

This crosses over and is seen in the relationships with both the work self sub-theme and the confidence in the personal self sub-theme. The ability to be self-aware and critical of the self in a constructive fashion is seen as an important aspect of proficiency, making a significant contribution to the development of resilience and self-efficacy. This makes self-efficacy a

personal experience, where a great self-awareness is required. This is consistent with the work of Bandura (1998) who describes self-efficacy as:

> *'Self-efficacy is concerned with judgements of personal capability.' (Bandura, 1998. P11.)*

The most consistent example of an experience given by the participants relating to confidence was complaints. This was not necessarily a complaint where wrongdoing was established on the part of the participant, as it was reported that this is a rare occurrence. The complaint can be an expressed dissatisfaction, as opposed to a formal complaint. Instead, it is focussed on the occasions where the participant experiences feelings whereby they think they should have done better or been more effective as an immediate reaction. This results in being very harsh on the self, both personal and professional, with an ultimate effect on confidence as a whole, with a subsequent effect upon feelings of proficiency:

> *'But then it only takes one that will knock your confidence. So, if a consultation goes bad and someone starts shouting at you and starts getting angry with you, because you won't treat them or you can't treat them or you have that big antibiotic for cold debate…' Line 472-474 (Participant 5).*

There was an attempt by the participants to limit the negative experiences linked to the professional self, to protect the personal self, or at least minimise its effect outside the workplace. These attempts were largely successful, becoming more so with more experience. Also, there was a real understanding of the effect these experiences could have on confidence, justifying the resilience required to manage them. Participant 3 spoke of the process and its potential effect:

> *'…I think you just develop it and keep it professional. Because otherwise you would be going home a complete wreck every night, if that was the case. Well, not every night, but… You know, if you got your confidence knocked every time, you're unsure about something, you wouldn't come in to work the next day – because why would you? You would be so… You would feel so inadequate, wouldn't you? You would*

feel… Well, you would have no confidence to do anything. I certainly wouldn't. And you would almost be, like, starting from scratch again. You would have all that confidence wiped.' Line 708-714, (Participant 3).

Such an effect was felt from these experiences that each participant appeared to have formulated a process to manage the reflective and critical process they have determined will enable them to continue to give their best to the next patient. However, this was not a formal process and had not been taught to the participants:

'Just an unwritten rule. I mean…' line 487 (Participant 5).

There was an acceptance that a formal process is in place. However, the inference was that it does not provide a swift enough resolution:

'There is a formal… In place, clinical supervision. But we tend to just do it informally.' Line 493 (Participant 5).

It seems it was been formulated individually by each participant in order to cope with the inevitability of negative experiences that test the resilience of the participant. The process incorporated several experiences or behaviours initiated not only by the participants, but by also their peers or co-workers. The most common process is what participant 5 referred to as a 'vent', or a reset to facilitate future interactions:

'But what I've found in practice is the best way to manage is to go and vent. So if you've had a patient [experience] that has upset you, don't dwell on it. Go to one of your colleagues and go, "Duh-duh-duh-duh, this has just happened, duh-duh-duh-duh." And then they'll go, "Well, you were right." Or, you know, do you feel better now, type of thing. Or, you know… They just reassure you and then you can go back and you can go back to your desk and you say, "Right, okay. Next patient.' Line 476-481, (Participant 5).

There was evidence that this process can take quite some time, depending on the magnitude of the complaint, which is entirely established by the participants:

'So you tend to be, maybe the first six months or a year after something like that, you're a little bit more guarded and then you get back to, your confidence builds up again…' Line 259-260 (Participant 2).

There was also evidence that it is not always possible to keep the feelings separate from the professional self:

'…it has a big impact. I mean some cases you'll go home and be mulling over for days, sometimes even weeks it'll keep coming up and you know, why didn't that work as well? erm… and you sort of, it just goes on and on and you're reflecting and trying to find why it didn't work. And I think that's good part of learning because you constantly do… some you just go, I wasn't going to win with that case, you know with that patient I wasn't going to win at all. And it's over and done with quickly, but I think it depends on the situation again, and what's happened on how long it takes you to process that episode, that consultation.' Line 273-279, (Participant 8).

There was also a great deal of emotional energy attached to and invested in the process, by the participants, for the good of the patient:

'I think it does take a lot of emotional energy because you've got to turn things around and think, well I've got to change this, I've got to use it as positive, I've got to move from this, if I don't move I'm, I'm going to be no good to do the patients that come and see, you've got to give yourself the kick up the backside (Interviewer ' right') and give yourself that time to go away and look at what it is, again you know talking to your peers and your colleagues.' Line 363-367 (Participant 7).

The participants were prepared to expose themselves to an experience that they expect to be negative, knowing that ultimately their fundamental goal of the best outcome for the patient will be achieved. Participant 3 spoke of experiences of seeking advice from senior medical colleagues with whom they had repetitive negative experiences and had this developed a preference to avoid them for advice. However, it was perceived as a personal issue, as opposed to a generalisation across all medical staff. The participant expressed a reluctance to engage in advice from particular staff:

'You don't want to. You know, oh God, I don't want to do that again. But you have to…' Line 555 (participant 3).

The participant was very clear as to the purpose or motivation for exposing themselves to suspected negativity:

'I won't just sit back and take it, regardless. I'll go back and get the information that I need and stand up and be an advocate for my patient. Because ultimately that's what you're doing it for, you know.' Line 568-570 (Participant 3).

5.6.4. Confidence of others

This sub-theme is about how the confidence of the participant is affected by their perceptions of the confidence other significant practitioners have in them, and how this relates to the participants' feelings of proficiency. Many examples were given as to the positive effect on confidence of having their advice sought by a colleague:

'But people come to you for advice – and you think, well, maybe I do know what I'm talking about.' Line 254-255 (Participant 3).

It was consistently voiced that this has a significant and positive effect on the confidence of the ENP:

'Right, yeah. Well, I suppose it has to, really, hasn't it? Because they are... I suppose you don't... I'm not a big-headed person, type of thing. I don't like to, you know... But I suppose you've got to have a little bit of a confidence boost if they're actually coming to you and asking... Asking your advice. Because then they value you as a proficient practitioner.' Line 772-775 (Participant 5).

There was also a frustration associated with advice giving. The situation was reported a number of times where colleagues would ask for advice from several different ENPs, either seeking what they want to hear or avoiding making the decision themselves. This was seen by the participant as a lack of confidence by the other, and a reluctance to develop:

> *'And then it's those areas that they're not confident with that they'll come and get you to say, "What do you think?" or "What do you do here?" ...they know themselves that they know what it is. I think they need… They need the reassurance. Which is great that they come to ask you. But then they go and ask three or four people, and three and four different people are going to come up with three and four different particular… You know, not necessarily the same conclusion. So it is a combination of them not being exposed to the things that… The questioning. But unless they start seeing these patients they're never going to get that confidence, that knowledge base, that experience, to deal with it.' Line 622-630 (Participant 3).*

There was also the effect this has on the patient. The participants reported that having confidence in your own practice breeds confidence in your practice from the patients themselves:

> *'I think you should come across as a confident practitioner whatever it is erm... it breeds confidence with your patient because they feel as if you know what you are talking about and... and you appear confident it just gives the patient the extra bit of reassurance you might be a new nurse practitioner and your heart is fluttering inside cos its early days in your career but, if you come across in a confident professional manner It just, eases your patient a little bit…' Line 213-218 (Participant 1).*

Another element to a building or maintaining confidence, as a result of the perceptions of others, is when feedback is given from a senior medical colleague and this results in the ENP feeling that they are, in fact, doing a good job:

> *'It does yes, because it gives you a positive, its positive feedback. You know that you're doing the job well and that somebody senior with a lot of experience knowledge and skills feels that you're doing a good job so, that does reflect positively on you and make you more confident in what you're doing' Line 397-399 (Participant 8).*

5.6.5. Confidence in others

This sub-theme is about how the confidence of the participant is affected by their perception of the confidence they have in other staff, and how this affects their own feelings of proficiency for a given case. It is largely built on the confidence they have in the advice they

receive from others, and how valuable or reliable they consider the other's advice based on their perception of the proficiency of that other.

> *'There's still a couple that I wouldn't go to. I would rather go to the consultant because... I'm not confident in what they're saying sometimes, themselves. Or they're more flippant. I don't know, there's just some you go to and some you don't.' Line 506-508 (Participant 3).*

5.7. Theme four: Learning and knowledge

There are a number of subthemes built on the participants' perception of where and how the learning and knowledge is gained and how it is applied. The subthemes are formal, informal and on-the job-learning and knowledge, their application in a format routinely referred to as 'common sense' by participants, and how this relates to learning and knowledge.

5.7.1. Formal learning and knowledge

This sub-theme is concerned with experiences that relate to formal learning and knowledge that occur mainly in a higher education setting, and how this links to the participants' feelings of proficiency. There was a clear expression by the participants that formal knowledge attainment is a fundamental expectation for an ENP and is the foundation on which their proficiency is built. It was also clear that this knowledge acquisition process begins long before the ENP role:

> *'Obviously you do have to have underlying and underpinning knowledge. And that comes, obviously, one with your [initial] training, two with extra training, when you come into this sort of role. Like... Like coming to yourselves - the university background. And then you put that into practice.' Line 62-65 (Participant 5).*

> *'I think, I think underpinning knowledge (Interviewer, right) sort of like, you know the physical facts, what is fact about the condition or that physiology or what's normal and what's not [contributes to proficiency].' Line 70-71 (Participant 10).*

The implication was also that knowledge gained in other areas has use in a new area, so that an ENP can come from an area outside emergency care and bring knowledge with them. Such knowledge cuts across traditional specialty boundaries and offers a breadth of understanding that contributes to the collective development of the group of ENPs:

> *'But having... Doing theory prior. You know, doing your theory at degree level at University, and applying everything that you learn from one area and putting it into practice in another area...' Line 222-224 (Participant 3).*

There was clear acknowledgement that knowledge is needed to be proficient. The participants referred to this formal knowledge consistently as 'textbook' knowledge, however remained clear that this is part of a learning and knowledge acquisition process, rather than an end point to it:

> *'I think that you need that knowledge, you need that textbook knowledge in order to make the clinical decisions that you make and if you haven't got that, it's a problem.' Line 638-639 (Participant 2).*

The participants referred to other ENPs who rely too heavily on this formal knowledge in a negative way, which reinforces the concept it is part of the process. The suggestion was that these other ENPs hide behind or overly rely upon this 'textbook' knowledge to make decisions that are not personalised, too standardised and not considering what is in front of them. Whereas the participants suggested that, whilst 'textbook' knowledge is a foundation, it should be built on, rather than solely relied upon:

> *'...and then some people are very textbook minded, you know where they just read things and read things. And then they'll drop names in, you know, where you, you know where [they] hasn't got years of experience you know, but you know [they] reads up a lot, [they] reads up a lot. So [they] probably, you know, [they] probably knows more about verrucas [sic] than I have hot dinners...' line 176-180 (Participant 2).*

There was also an acceptance that there is a limit to knowledge related to the role. Thus, it was seen as not possible to know everything and that part of the formal knowledge acquisition process is developing a way to recognise and discover what is not known. For example, the below is a response to the interviewer summarising a practice experience in this way:

> *'So does that mean that part of being proficient is seeking out answers to things, perhaps, you don't know? Line 370-371 (interviewer during participant 4 interview)*

Participant 4 agreed:

> *'Yeah, I always look things up. I always look things up if I don't know the answer.' Line 374 (Participant 4).*

Thus, includes the inference that the process involves the use of 'textbooks' to begin that acquisition was given as a consistent message across the participants.

5.7.2. Informal learning and knowledge

This sub-theme is concerned with learning that is not based in the formal setting of a university or other such learning establishment, and the affect this learning and knowledge has on proficiency. There are consistent references to learning that is initiated by the participants and undertaken in their own time, and this contributes to continuing professional development (CPD) activities required by the NMC revalidation processes (NMC, 2019). This was considered to be learning activity undertaken separately from normal practice:

> *'…what you want to learn, it depends on at home as well if you want to study a little bit at home if you read it's a hobby as well as a job for me too. It doesn't take over my life…' Line 34-36 (Participant 1).*

This activity was mainly reported by participants in four forms. One of these was reading up about a presentation with which they are unfamiliar:

> *'... but some of it is then self-directed. You'll pick up a textbook, you'll go online, you'll try and increase the knowledge on that area [felt less knowledgeable on] to make you feel more competent and happy in diagnostic methods.' Line 85-87 (Participant 8).*

It was also considered important to follow up cases that participants have referred to specialty in order to check their thinking, and this ensure the correct management has been followed and is correct should a similar case present:

> *'I don't know. You just store the information for the future, and think, well, that one looked… You know, I thought that that was a cardiac event. And it was, so I was right… but being right, so that you know for future occurrences.' Line 897-898 and 907 (Participant 4).*

Informal discussions between peers intended to pass on or share knowledge for the benefit of their peers was also important. This is because impacts were felt on the participants' own confidence and learning from the perspectives where the participant is delivering the learning, or indeed receiving it:

> *'And I think as you... The more you do the job, then you've got to go on and you have to then start to teach others. So you'll have new people coming in. So then you have put your... Pass your knowledge on to them. And I think by passing your knowledge on to them that increases your confidence as well.' Line 133-136 (Participant 5).*

> *'...you've done supervision with more experienced members of staff, so there's lots of different types of, way that we learn and that you gain that sort of training.' Line 78-80 (Participant 8).*

Finally, the process of reviewing patients who have returned for further treatment having been seen in the facility previously for the same condition was also important. This can be anxiety provoking, however, as the participants seem to use it as an opportunity to review their practical application of knowledge, or whether the right knowledge was used, rather than review the

knowledge itself. It was commonly found that the return was as a result of direct advice given to the patient by the participant, having applied their knowledge to that advice:

> *'But say, for example, you give somebody something for a wound and it comes back and it's not looking any better. And you think, hmm, maybe I didn't put the right thing on the wound in the first place. I should have maybe done a different... But it's all experience and it's all learning. And if you process it and think about it, and then you think, right okay, well, I've tried this method... You know, you try your method - if it doesn't work, you try something else. That's daily practice of medicine. But I suppose me as an individual, I just want to try and get it right the first time for the patient so that they don't have to come back. They're not inconvenienced.' Line 202-209 (Participant 5).*

5.7.3. Common sense and learning and knowledge

This sub-theme is concerned with what the participants seem to routinely refer to as 'common sense' or a 'gut feeling'. It is the application of a lifelong learning experience to any given clinical presentation, and how experiences of this affect feelings of proficiency. It seems to give a security of thinking and reinforces these feelings of proficiency. There is some disagreement between participants where some see that common sense can be taught and some suggesting it cannot. Participant 2 discussed that common sense comes from knowledge and what has been learned, applied as a sense:

> *'Gut feeling comes from all your knowledge, all the things that you know. I think it's just, I think its senses it's a sense of something isn't it? A sense of a, a way a person is or how they respond, or you know, or just thinking that a condition might just get worse but…' Line 547-549 (Participant 2).*

And:

> *'I think it's all to do with your own knowledge and experience and somehow, you have like a sixth sense (I ok) that there's something that could go off here, or somethings not right or you know erm…' Line 556-557 (Participant 2).*

Participant 3 also agreed:

'It's a combination of experience, confidence, prior knowledge and being able to put that together and think, well, actually, they could be a massive head injury. Or they could be an internal bleeder. So gut instinct isn't really gut instinct, it's knowing you've got all these elements of proficiency that you pull together. You know that something is not right.' Line 209-213 (Participant 3.

However, participant 1 discussed that it is something that the ENP simply has, that it is not and can not be taught in a formal way:

'… it's not just about degrees and masters, I think you can be the cleverest person in the world and not have a degree of common sense. You can be… erm… no degrees in anything and have the most common sense and be practical with its finding the ones that have got the combination of them both. The common sense wins through everything because the it's the right thing to have in any person because it makes sense and it looks like it's not right it's not right, if it looks right it is right.' Line 619-625 (Participant 1).

However, the text here and the discussion surrounding this would suggest that participant 1 meant that common sense is more than simply formally learned knowledge, but instead incorporates learning in all its forms. Participant 9 talked about common sense as developing over time, linking it to exposure:

'I think common sense is more of a… I mean everything develops as you kind of, it's just the way people work. The more you're exposed to anything and the more you know about stuff. What you would say is common sense is, is it actually common sense or is it based on skill knowledge and you know, everything you've learned up to that point gives you a better kind of… erm… what do I want to say, kind of, it just gives you that bigger arena, bigger… I don't know what word I want to use…. It's like a bigger pitch of ideas and you know things that you can pluck from, well I've seen that before and maybe…' Line 465-471 (Participant 9).

5.8. Theme five: Exposure and experience

Exposure builds proficiency with an apparent lessening influence as experience increases. Each episode of experience is filed away in an ever-increasing filing system, available for access as a similar episode is experienced. As the number of exposures to a particular

experience increases, each has a less significant influence on the overall experience of the ENP. Participant 6 referred to this filing system as a database:

> *'And once you've been doing the job for 10 years, there's this database in your head of 150, and you can't recall them all but it's just there in your head and… of each condition that you see and then you just know the alarm bells for certain groups of symptoms…' Line 304-307 (Participant 6).*

Its affect is primarily experienced in combination with the themes of confidence, which grows with exposure. It also allows relationships to develop and the participant reveals their learning and knowledge through its application to that which is experienced. Exposure is simply about how many patients are seen with any particular condition, which accumulates experience by the application of learning and knowledge to unpredictable clinical experiences. It is important to the participants' building of proficiency to be exposed to any given condition frequently, in order for it to positively affect proficiency:

> *'I would say and the other thing that makes me wholly proficient is the amount of hours you put into it. I mean if you're working full time and you're seeing, you know you're making clinical decisions a hundred times a week, well that makes you fairly confident' (Line 26-28) Participant 6.*

Repetition is a recurrent word used to describe exposure, and there was an acknowledgement that seeing conditions over and over does have a positive effect on proficiency and appears to drive experience, which ultimately builds confidence:

> *'I think you have to do a lot [see patients]. I think you have to do years of it, I think, cos every case could be different, you know you might be straight forward ankle injury but it might be some complication or you've got some other, they're on steroids so you've got to think about that.' Line 202-204 (Participant 2).*

There was also a clear acknowledgment that simply seeing lots of patients does not on its own grow proficiency. It builds a practical applicable relationship between the learning and

knowledge that has taken place and the practicalities of actually seeing, diagnosing and treating any given condition:

> *'Experience, repetition, don't know if that's the right word. Repetition doesn't make you a good ENP repetition makes you see things that you get a built up a pattern process in your head, pattern of illness, pattern of fractures, pattern of this erm…' Line 286-284 (Participant 1).*

It is the platform on which to apply these elements to work towards proficiency as a decision maker, rather than as a protocol-driven ENP, and includes experiences from other areas:

> *'…you might see 15 ankle injuries and you think the same, you document the same. And then one just, you know, there's something different about this, you know, what's different? Throw in like they're on warfarin, or throw in, you know. There are all these other tangents of the care that come in that you can only really do, when you're proficient or you understand the conditions and you've got the experience. By doing the job day in day out. And also drawing on other experiences you maybe worked somewhere else. Erm… or learning from your other work colleagues is a biggy [sic] really. You know.' Line 217-223 (Participant 2.)*

5.9. Theme six: Care

Care is a central theme that threads through proficiency in the entirety of its development. It encircles its components and themes, providing the participants with motivation for continually seeking both positive and negative experiences that construct their feelings of proficiency. This theme was implicit in all that the participants discussed, and the patient focus was seen consistently in their voice:

> *Well proficiency to me is like, erm… probably the most appropriate delivery of care you know.' (line 53) Participant 2*

It was also seen that it is not necessarily giving the patient what they want, but working with them:

'I think my ultimate goal is that i give them the best care erm… I explain to them what's wrong with them, and even if they don't get a Ax that they wanted, they walk out of the room happy…' Line 677-678 (Participant 2)

It is also about the quality of that care provision:

'because we're there for patients it's not about us, it's not about money, it's not about budgets and pay rises, it's about patients the main product at the end of the day. And if they're getting quality care, not just cause they're seen within half an hour or so, which generally happens which is great. If they're getting quality care on top of that it just makes the patient journey so much easier…' Line 108-112 (Participant 1).

One of the more moving examples of how much care means to the ENPs related to an example given by participant 7. A patient episode was recounted where the participant was unhappy with the condition of a patient, despite their clinical condition showing no abnormality via the facilities available to the participant. The patient had presented having experienced atypical self-resolved chest pain the previous day, and had been cajoled to attend by their partner. The participant transferred the patient to the linked ED after much persuasion, and considered their job had been done. Around 3 weeks later the patient returned with their partner to the workplace of participant 7 and requested to see them. It transpired that the patient had had a significant cardiac event that required emergency operative treatment. The patient had been left in no doubt by the operating team that had they not been treated, there was a high degree of likelihood that they would not have survived. The patient and their partner had attended to personally thank participant 7 for their help. The effect this had on the participant was significant, as can be seen below. It was considered the ultimate in satisfaction, knowing that the care outcome for the patient was so good having, unbeknownst to all, been potentially so bad:

'…initially when I saw him, because it was 3 weeks down the line I didn't recognise him. Took him into my room and she said, you know you made us go and if it hadn't been for you we wouldn't have gone and she said if it hadn't been for you he would

have been dead. Erm… the cardiologist said that if he hadn't been seen he would have been dead, … and the two of them were so grateful, and they were like you know, you were just amazing, and I was like I didn't do anything, I didn't do anything, I did his observations and took a history but then the only thing I did was insist that he went to A&E erm… I felt so emotional because I thought like, they've taken their time out after he's been so unwell to come in and say that and I was blown away, cause I don't do the job for people to come in and say thank you, I do the job to help, people and if, if by doing my job and by doing a good job it helps people that's enough for me erm… but the fact that they came back and I got a lovely thankyou cared and I was crying, (laughs) I was that emotional, I was a proper wreck'. Line 298-311 (Participant 7).

The most significant finding here was that the participant simply felt that they were doing their job, unaware of the impact doing this had had on the patient. The participant went on to discuss how this positive experience significantly supported their feelings of proficiency, particularly that their motivation to care yielded such positive results.

5.10. Summary

Six themes emerged from the data and have been presented in this chapter: the meaning of proficiency, relationships, confidence, learning and knowledge, exposure and experience, and care. These themes are clearly connected to the literature discussed in chapter two and develop understanding of proficiency in consistency with the research question and objectives identified in chapter one. Proficiency is considered a continuum that participants move along, conscious that the end will never be reached. They strive to enter and then remain in a zone of proficiency, where they are confidently able to understand the application of their expanded knowledge, skill, experiences and relationships to unpredictable situations, with incomplete information, and remain happy that their decision offers the best available care to that patient. Relationships exist with the role, work self, other ENPs, other nurses, doctors, the environment and patients. The complexity of experiences with these relationships can contribute positively and negatively to feelings of role proficiency. Negative experiences are not necessarily avoided, and on occasion are actively sought, particularly when driven by

the need to provide care. Confidence is a theme that is influenced by and has influence on the ENP's perception of their professional and personal self, and is influenced by others in the context of their confidence in the ENP, and the ENP's confidence in them. Resilience and self-efficacy is key in the management of confidence, and its influence on the ENP. Learning and knowledge contributes to proficiency through experiences and engagement with formal and informal learning. The result of this is common sense, and there exists some differences of opinion between the participants as to whether this is the culmination of formal and informal learning experiences, and therefore is developed, or is simply something exists in the ENP and cannot be learned. Exposure builds proficiency, with an apparent lessening influence as experience increases. Each episode of exposure is filed as experience that is drawn upon to drive decisions, with repetition of cases important to fuel experience driven by knowledge. Care threads through proficiency and its components with quality at its core. Care is the driver for increased proficiency and the ENPs' desire to remain in the zone of proficiency.

The next chapter will provide a discussion of the themes extracted from the data and relate them to the research objectives using an analytic category tool demonstrating the development and flow of the analytic categories. This enables them to be traced through the research objectives to the research question, retaining focus on the intention of this research.

Chapter 6: Discussion

6.1. Introduction

In the previous chapter of this study there was a comprehensive narrative discussion of the findings identified that had been arranged into clear themes in line with the three-stage interpretive processes discussed in chapter four (Lindseth and Norberg, 2004). The themes identified that drew together the experiences of the emergency nurse practitioners (ENPs) are proficiency, relationships, confidence, learning and knowledge, exposure and experience, and care. These findings can be connected both with the literature review of chapter two and the research question and objectives identified in chapter one. This chapter will address a discussion of the findings relating to the research objectives by analysing the themes presented in chapter five. The chapter will be organised in order to relate the discussion to the objectives of the research question below:

The purpose of this study is to answer the research question how do ENPs' experiences in practice influence their feelings of role proficiency?

The proposed research objectives are:

- To examine and understand the meaning of role proficiency to ENPs.
- To identify practice experiences that influence role proficiency.
- To identify and understand how discovered practice experiences influence ENPs' feelings of role proficiency.

Bloomberg and Volpe (2016) proposed the use of an analytic category tool designed to give a visual aid that provides the reader with a clear idea of how the analytic categories can be

explained and presented. The tool displays the development and flow of the analytic categories, tracing them to the research question. The visual is shown below as Figure 6-1.

Research Objective	Finding Theme	Analytic Outcome
To examine and understand the meaning of role proficiency to ENPs.	Proficiency (1)	Being good at the job (1)
	Exposure and experience (5)	
To identify practice experiences that influence role proficiency	Relationships (2)	Central role of confidence (2) and relationship issues (3)
	Confidence (3)	
	Learning & knowledge (4)	
To identify and understand how identified practice experiences influence ENPs feelings of role proficiency	Learning & knowledge (4)	Coping strategy (4) and the influence of care (5)
	Exposure and experience (5)	
	Care (6)	

FIGURE 6-1 ANALYTIC CATEGORY DEVELOPMENT TOOL

Each key outcome derived from the research question and the interviews, giving rise to the themes presented in chapter five, will be discussed. This is followed by a look at how the enhanced understanding this research has provided into the influence of practice experiences upon feelings of role proficiency may affect the future landscape for ENPs. The chapter will close with a conclusion, presented to summarise the discussion.

It is important to recognise the value of reflexivity both to this research and the development of the researcher in the data collection and findings leading to this discussion. The ongoing process of reflexivity that contributed and exposed the self-awareness and self-consciousness

of the values of the researcher taught the researcher a great deal about themselves. The personal approach to the research diary made a significant contribution to development and rigour of the research and formed a large part of the supervision relationship and discussions leading to additional epistemological awareness as the researcher realised how their own knowledge was created. essential to the ongoing development and maintenance of a reflexive stance as applied to the research and its processes (Finlay and Gough, 2003). The thoughtful self-awareness that reflexivity added to the ethicality of the decisions made about the research and its conduct developed as the research progressed and the researcher grew as a researcher, and perhaps beyond. As a direct result of this process of ongoing consideration and awareness of the research process combined with the educational and clinical background in which the researcher was positioned, discussed in sections 3.8 and 4.7, a positive and focus changing impact is seen and felt throughout this research.

6.2. Key outcome 1: Proficiency

Feeling good is widely accepted as a positive thing. In fact, it has become so widely accepted and intuitive that it is considered self-evident and unquestionable. This feeling good extends into the domain of work and is linked to better task performance, more prosocial behaviour (behaviours that benefit society as a whole), and more favourable job attitudes and reactions (Hu and Kaplan, 2015). Chapter five found that the concept of proficiency was strongly associated by all participants with their role, and was consistently voiced with an initial definition of:

> *'...proficiency is being good at your job' (line 17) Participant 1*

A further examination by the participants revealed a deeper perception of the component parts of proficiency, and how they related to each other. These component parts were the themes presented in the findings chapter. Its meaning became very much more about how

these components were applied and understood by the ENP, and how they constructed their own feelings of proficiency using these component parts. This constructed meaning became so much more than just being good at the job, and was more about the effectiveness with which they confidently connected and understood the components in order that they moved towards feeling proficient in their role.

The concept of regulatory mode theory goes some way towards assisting an understanding of the constant forward motion towards the goal of proficiency experienced by the participants (Kruglanski et al, 2000. Higgins, Kruglanski and Pierro, 2003. Bélanger et al, 2015). This was represented by a sense of how the motion and confidence combine. This theory, applied to these findings, allows the development of a greater understanding of the concept of proficiency as presented by the ENPs in this study. The participants revealed two components that enabled them to feel that they were being good at their job. The first was the concept of proficiency being a continuum. Moving towards proficiency as a goal was a process that, while not viewed by the participants as being possible to complete, represented an ultimate goal to get to a point of proficiency referred to in chapter five as a proficiency zone. This enabled the feeling of proficiency in the broadest number of clinical presentations seen in their role. The second component was confidence in achieving connection and understanding of the fundamental components that construct proficiency achievement, which are thematised in chapter five, particularly exposure and experience. The concept of the proficiency zone as referred to in chapter five, is strengthened by the findings of this research. It is clear that the participants seek existence in this area that has been termed the proficiency zone by this research and is represented in figure 6-2 later in section 6.2. Participants seek experiences themed in chapter five, that drive them towards and once they have reached it, keep then in the zone of proficiency despite an acknowledgement that the zone will always move forward and never a complete process.

There are two elements relating to the concept of being good at your job relevant here, and both are dependent on the context of or gaze upon proficiency. They are being good or feeling good. The word ‘being’ is often used, but its deeper meaning has two components that are often combined and referred to as ‘being’, whilst the context of its use can reveal the alternate meaning which, whilst occasionally used, appears much less often. ‘Being’ good often refers to the ENPs’ perception of how the other views their proficiency, or essentially how the ENP considers other people see their proficiency. Whereas ‘feeling’ good often refers to the ENPs’ perception of how the self views or perceives their proficiency. The confidence the ENP has in both elements contribute to overall feelings of confidence in their role. An experience that has a negative effect on the ENP’s confidence of either being or feeling good about their proficiency can have a profound effect on their actual feelings of proficiency. This will be further discussed in key outcome 2.

Regulatory mode theory conceives self-regulation of human behaviour as two distinct, and yet inter-reliable, functions that give a sense as to how proficiency is experienced by the participants; locomotion and assessment (Bélanger et al, 2015). In regulatory mode theory, locomotion refers to movement from a current state towards or away from a desirable or undesirable state, typically representing a change in state from one position to another (Higgins et al, 2003). This can be applied to the findings of this research, to assist understanding of proficiency. Participants sought to move from a state of relative proficiency in one role (staff nurse) towards a state of proficiency or operation within the proficiency zone of another role, in this case as an ENP. Locomotion is a dimension and, as such, contains a high and low variability. High locomotor tendencies would display a just-do-it behaviour, whereby movement from the current state itself is the reward, not necessarily or only as a means to arrive at the destination (Kruglanski et al, 2000; Higgins, Kruglanski and Pierro, 2003; Bélanger et al, 2015).

Meanwhile, assessment includes a measurement of the discrepancy between the current state and a desired end state, as well as a reduction of the discrepancy that is identified via the comparison of one thing to another (Higgins et al, 2003). Assessment is captured by the phrase "doing the right thing" to establish which goal is the most worthy to carry out by a critical evaluation of all of the perspectives and options (Bélanger et al, 2015). Assessment is also a dimension and has a high and low variability. High assessors tend towards an evaluation of other states, in order to judge the relative quality of those states, which leads to reflections of the type produced when stating "how am I doing?" (Higgins, Kruglanski and Pierro, 2003). In terms of feedback, a locomotor requires feedback that indicates whether a change in state has or is occurring, and an assessor requires feedback regarding whether a comparison process is in progress. Locomotion and assessment can also function as modes, independent from each other, and can receive a different functional emphasis by different people and different situations (Higgins, Kruglanski and Pierro, 2003). This can be applied in differing clinical cases, and the variances of influence of locomotion versus assessment have an impact on feelings of proficiency. There is a tension between the two positions, that in the case of proficiency serves to keep both the drive towards proficiency and the confidence in the components required to feel proficient in check with each other. There is also some interchangeability between the positions in that exposure and experience feed into both the locomotion and assessment positions. The drive towards proficiency is kept in motion by exposure and experience to each clinical presentation. The assessment of confidence in the components is also checked by the exposure and experience each clinical presentation brings. Thus, the motion towards the proficiency zone and the confidence in the components required to get there are fuelled by the exposure and experience gained from each clinical presentation. Being good at your job, or proficiency, is not about knowing everything. It is instead about having the confidence in the components that proficiency consists of and their

application to each clinical presentation. The motion of proficiency and its components are independent, yet have a collective influence over proficiency, as represented in figure 6-2. The growth of proficiency and the combination of the components as they reach the zone of proficiency is noted.

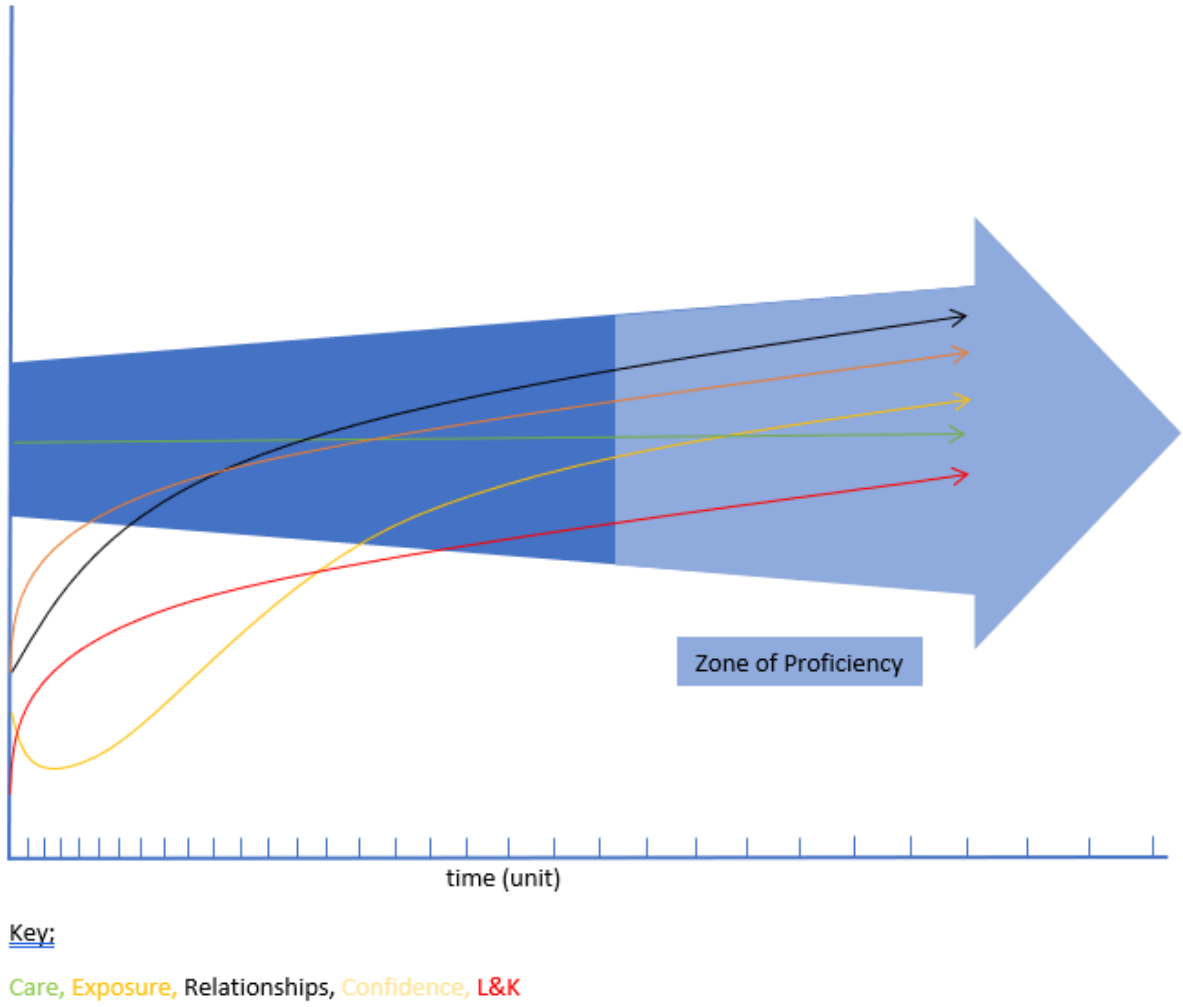

FIGURE 6-2 THE MOTION OF PROFICIENCY

The participants' experiences lent themselves to a proposed definition of what proficiency is to them and how it is experienced. The proposed definition of proficiency is:

‘Proficiency is the pragmatic and confident application of practice experiences together with relationships, learning and knowledge, exposure and experience, and care to a patient episode.’

6.3. Key outcome 2: Central role of confidence

There is little doubt in the findings that confidence was a theme of huge importance to the participants. It is a thread that hints at its presence across all the themes, and its influence can have a profound positive or negative effect on the ENP. The key outcome in the identification of the central role that confidence plays in practice experience, and its influence upon role proficiency, is the resilience system that each ENP creates in order to manage their confidence. This includes the clear end aim of allowing themselves to maintain both proficiency, and an ability to effectively apply this proficiency to seeing and treating patients. The resilience system is primarily derived by each ENP from their experiences of complaints or their self-perceived poor patient interactions. These initially have a predominantly negative influence on feelings of role proficiency, with the length that this effect lasts, and the time it takes to resolve it, seemingly based on experience, reflective abilities and the effective management of the resilience. However, if successful, it can help to bring about confidence and the self-efficacy required to benefit the next patient or group of patients.

This confidence is maintained with a delicate balance between the professional and personal self that attempts to steady both components to a level that allows the ENP to practice confidently. The steadying influence is via a developed resilience and self-efficacy which is the pivot that stabilises the two, mobile to exert influence and support on either the personal or work self as required. The professional self-recognises the need for efficacy and resilience in order to not to impact on the treatment of the next patient or group. Simultaneously, it is understood that there is a need to settle the personal self by examining how the incident came

about, and whether there was an error that will affect how the ENP treats similar episodes in the future. The system appears to ask the personal self to manage the guilt element of the negative experience, or the recognition of falling short of the ENP's perceived ideal self and the reflection on the personal self that occurs, as discussed in chapter five. This in conjunction with a check that asks the resilience system to examine interactions with other professionals that contradict or compensate for the personal self-claims, in order to balance the self-contexts. The resilience and self-efficacy of the ENP achieves this by combining the interactions with other professionals in the form of the ENP either giving or receiving advice, experiences of interaction with doctors and a near constant reflective process on the position that the personal and professional self-occupies within the work environment. This ultimately leads to a combined reflection of both of the self-contexts, which is aimed at turning the negative influence into a positive reflective exercise that informs future episodes similar to the experience that began the process. Simply put, a resilience system employed by the ENP, that is not taught, and the nuances of which are unique to each ENP, successfully balances negative experiences into a valued and useful positive learning episode designed to maintain confidence and the consistent presence of the ENP in the zone of proficiency. This balance is represented in figure 6-3 that follows.

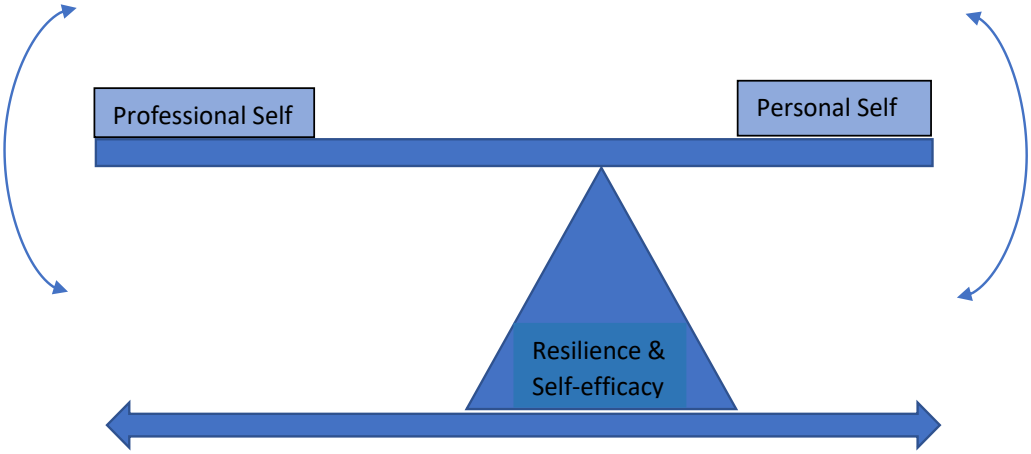

FIGURE 6-3 THE BALANCE OF CONFIDENCE

Confidence is also a key element that allows the ENP to get to the zone of proficiency in the first instance. The ENP must experience negativity in the form of either a complaint or their self-perceived poor patient interactions in order to effectively derive their resilience system. The more effectively and efficiently this system can be seen to be successful by the ENP, the more swiftly the other themes can be employed and incorporated into development to enable the ENP to get to the zone of proficiency. The more confidence they achieve in their ability to apply the system, the better the chances of moving towards, getting into or maintaining their position within the zone of proficiency. Contrasting this, the longer it takes to develop an effective resilience system, the longer it takes to get into the zone of proficiency.

6.4. Key outcome 3: Relationship issues

The relationship issues experienced by ENPs have a significant effect on feelings of proficiency. These issues are chiefly associated with an inconsistency of understanding of the role of the ENP, the expectation that the inconsistency of understanding creates regarding the role of the ENP and, paradoxically, a disagreement between ENPs as to what the role actually is in the first place.

The reality is that the role is ill-defined for the participants in this study. There is variation nationally that supports this position, with the ENP role varying by Trusts and, in this group of participants, seemingly within the same Trust. This may be put down to the way that the centres in the study area have been brought together. However, this discussion is not the focus of this research, and may indeed identify the Trust involved and compromise the ethical position of the study to discuss further. This lack of understanding of the role creates issues in the relationships with groups that should and could both assist the role development and better utilise it for the efficient care and treatment of the client group. The relationships where the role is least understood appear to be other nurses, doctors, patients and, ironically, other ENPs. This leads to an inconsistency of expectation of the role that does not meet their understanding and, when measured against their own understanding of the role, leads to feelings that either their role is undervalued or unrealistic expectations are placed upon them for the role as they perceive it.

Other nurses, by which in this context is meant non-ENP nurses, are perceived to have little understanding of the role and the responsibility that comes with it, when compared to their own role. There is a clear disparity between what is expected of the ENP by the nurse compared to what can be delivered. Where this occurs, it is an opinion held in a reductionist vein, as the role is reduced by the nurses to either a series of tasks or conditions. In such cases, the perception of the nurse is that it should just be done or seen with little understanding for the complexities and nuances that stepping into the ENP role encapsulates. It can be said in the most part that the ENP understands the role of the non-ENP nurse, whereas the non-ENP is limited in their understanding of the ENP role. This can lead to conflict between the groups, examples of which are seen in the data. One such example is seen in chapter five page 125, although the ENP rarely corrects this disparity in order to avoid the confrontation that may occur as a result.

The participants believe that there is a lack of understanding of the role from doctors, both within and external to the department where the ENPs are based. This is further compounded by the environmental factors that are felt by units considered to be community or peripherally based, creating a variation of the perception of the role by the ENP. There is a degree of confusion that this research does not offer explanation of, given that the doctors from within the department referred to here are those that were involved with the evolution and development of the role in the first place. Some of this is problematic as it is perceived that the role should be now further developed by ENPs themselves. However, it seems that medicine continues to be the only health care profession that exerts influence and direction upon other health care professions and roles, without the expectation that this influence is reciprocated. The focus of this lack of understanding is primarily directed towards two areas; a difference of perception between the two groups as to where the limits of the role are, and a difference in how ENPs acquire their knowledge. The first focus is based on the limits of the role. The inference from the data is that the ENP reaches a point where they feel that, in the interests of the patient, a more senior consultation is required. Thus, the situation is beyond the zone of proficiency of the ENP. Participant 3 described it as such:

> *'I think they think, well, you're not doing much around the corner anyway, so... You don't… If you… You know, you should know this – well, actually, I don't know everything. And there's a lot of things I don't know.' Line 529-531 (Participant 3).*

This overlaps somewhat with the final group of the ENPs themselves, which will be addressed later in this section. The participants believe that the doctor in this case expects that the ENP should just be able to complete the case in most examples, as if the ENP should just know how to do this. This links to the second area, where there is a perception that the doctor does not acknowledge that nurses tend to lean towards experiential learning in line with the theories of Kolb (2014) (Fewster-Thuente and Batteson, 2018), as this is in contrast to the

approach used in medicine. This was seen also in the findings of this research. The ENP in this instance sees the case in question as a rarity and was thus unlikely to be exposed to it often enough to become proficient. It may also be the case that further investigation is necessary, which the ENP may or may not have knowledge of, or may not have facility to execute. Doctors external to the department are perceived to have a lack an understanding of the role and its boundaries. There is acknowledgement from the ENPs that this may indeed be an issue with their own learning, as discussed in chapter five. However, it is also a reasonable conclusion to draw that it is in fact the perceived lack of understanding of the role from the specialty teams as a whole that is shared from the top down. It is not clear from the data whether there is a variation, but it would be interesting to look at this further, or indeed examine what could improve the specialty understanding of the role.

The lack of clarity and agreement on the role within the ENP group themselves is surprising. There seem to be three groups from the data: those who resist role development, those who are happy to keep the role as it is by their perception and those who want to push the boundary. These can be referred to as resistors, maintainers and innovators.

Resistors are those who resist role development or oppose it actively by placing, such as citing lack of training or support as a reason not to take on a new condition or patient group. This can be linked to environment as it appears that resistors are most likely to come from peripheral centres who perceive that there is less support for them from the main department, in terms of the hierarchy mentioned earlier in the chapter. The nuance is that this group perceive a greater risk to either themselves, the patient or both in seeing new conditions or groups of patients. These ENPs seem to be reluctant to embrace the components that move the ENP towards the zone of proficiency for new conditions or patient groups or lack the motivation to do so. This is despite voicing experiences that support the motion of proficiency, as has been applied to other clinical experiences, themselves. There is some

inference within the data that this is down to three factors. Firstly, that the role itself has moved as far as it can before becoming too much like a doctor, thus blurring the boundary too much and impacting the confidence of the ENP. Secondly, those who believe that the education and training experienced to get them to the point they are at has reached its peak, and there is perhaps reluctance to engage with a formal education process to advance this. Nurses are traditionally fearful of formal higher education, often citing that they are practical and not academic. Finally, it may just be personal factors, such as experiences that have impacted the confidence of the ENP, or perhaps personality traits that have not been captured in the data.

Maintainers are those who are quite happy with the role as they see it, including its value, usefulness and their professional ability to perform the job. These ENPs are quite happy with their proficiency and development. Maintainers continue to develop the components of proficiency to keep them in their zone of proficiency, but do not seek to develop the role itself further. This can be considered similar to the resistor group. However, the key difference here is that the maintainers do not resist development, but instead see that it is not needed as the role has reached or operates at a level that is precisely where it needs to be to provide the service to the patients. Thus, this maximises use of their proficiency to meet patient need within the context of the Trust. This group does not see itself in a negative light, but instead feels that they are doing the job that they are employed to do. There can be a difference between this group and the resistors in that maintainers have a clear perception of what the role is and see resistors as not quite matching this role.

Innovators are a group that seek to develop the role and take it beyond where they currently practice. This then moves their zone of proficiency further on, challenges the role itself and utilises the components of proficiency to see more and do more for their patients. It is well

summed up by participant 6 who referred to a particular presentation that may be outside the accepted client group by stating:

> *'.. it could be my business if I take advice from that person, or that person. I wouldn't normally say that person has to go to A&E because they need to see a doctor, I would take the next stage and chat to that doctor and see whether he would give me, or he or she would give me or enable me to treat that patient safely.' Line 57-60 (Participant 6)*

This is in contrast to the maintainer group, who would simply draw a line and send this patient either to the ED or back to their GP.

The innovator group seek to move the boundaries of the role forward, which can be in conflict with the other groups. Maintainers find it hard to justify what they consider to be unsupervised role progression, as it is perceived that this creates an expectation of the other groups to practice the role at that level. The maintainers are also concerned that the innovator goes too far and gets into trouble with the patient, by being unable to complete the care and having to refer onto other care anyway. They consider that it is a risk-taking activity that compromises the integrity and normal running of the service, and places expectations on other staff that they are not comfortable meeting. This is because they fear those expectations from staff outside the unit that this client group are now included in the unit remit, and patients will also now expect an increased level of service that the unit is not set up to provide. There is also some evidence that this extends to ENPs who have expertise in specialist areas prior to their ENP role. The maintainer perceives that the innovator is operating beyond their proficiency, whereas the innovator perceives that they are applying the components of proficiency for the benefit of the client group, thus allowing proficiency to be moved forward. Innovators seem to perceive that the role can be taken much further and seek to do so through educational developmental activities, often seeking to treat clinically challenging clients and advance the role. It is seen as a responsibility or duty to develop the

role and push themselves, rather than act as part of a hierarchy or attempt to be better than other groups.

6.5. Key outcome 4: Coping strategy

I have given this analytic outcome a great deal of thought, and initially associated this coping mechanism with its similarities to a commonly-referred-to model of grieving and loss proposed by Elisabeth Kübler-Ross (1969). In this model, the loss in this context would be reduction in the participants' feelings of role proficiency. The model proposed in 1969 was originally misunderstood as linear, through which the psychology of individuals passed as a result of some sort of loss originally associated with death and dying. The model was clarified later by the author not necessarily linear and, in fact, individuals did not have to progress through all stages, in the same order or any stages at all. The five-stage model consists of denial, anger, bargaining, depression and acceptance. It is not the intention of this key outcome to provide a critique of the work of Kübler-Ross, as that is evident in the literature. The focus instead is to seek an explanation or agreement with a process the participants were going through. The problem I encountered with this model was that if I applied it to the participants, it was something that was hung on the participants, not something that they initiated or have any control or influence of even if the loss was identified as confidence. This felt as if it contradicted the methodology of the research by imposing a structure on the experiences of the participants. The participants certainly were actively and very individually involved in their coping mechanism. However, this was formulated from their experiences and there was no set pattern for how their strategy was applied. The need for the strategy was commonly identified frequently occurring before the incident necessitating it had occurred, or as the incident was identified. It also aimed to manage the whole self, rather than components, differing from simply confidence. It was a strategy that was borne out of the experiences of the participants. This implied that there was

a process of thought and consideration at work, suggesting it was not merely passive. There was an intelligence about the strategy, or an awareness of the ENP's whole self. It was at this point I realised that the participants were showing a high degree of a concept known as emotional intelligence.

Emotional intelligence is the ability to recognise emotion in the self and others and employ emotional knowledge and reasoning to drive forward cognition and behaviour. It is the ability to monitor one's own and others' emotions, to discriminate among them, and to use the information to guide one's own thinking and actions (Mayer and Salovey, 1995; Raghubir, 2018). Emotional intelligence enables better decision making and patient management, improves relationships and positively impacts on quality of care. Individuals displaying high levels of emotional intelligence display two categories of attributes associated with emotional intelligence: personal and social. The personal element of emotional intelligence can be sub-divided into self-awareness and self-management. Self-awareness involves recognizing and understanding one's own emotions and motivations. It can be achieved by monitoring one's own state and identifying emotions, strengths, weaknesses and individual needs. Self-management involves the ability to control or redirect emotions constructively. It allows an individual to withhold judgment until enough information is gathered, and thus think before acting. The social element consists of social awareness and relationship management. Social awareness is about the ability to observe and understand the emotions, needs and concerns of others, pick up on emotional cues and the ability to see things from other people's viewpoints. Relationship management is about the ability to manage relationships with others by utilizing the emotions of one's self and of others. This facilitates the development and maintenance of good relationships, clear communication, and the ability to inspire and influence others. Examples of these attributes were in clear evidence throughout the participants' data. Thus, it was clear to suggest that having a high degree of emotional intelligence permeated through

the participants' drive and ability to become proficient, and maintain it in their role. It is something that was used by participants to help control the more volatile elements of confidence in or of the personal and professional self, as discussed in key outcome 2.

6.6. Key outcome 5: The influence of care

It should not really come as a surprise that care has a central motivating influence on feelings of proficiency for professionally registered nurses given what is known about the common and naturally caring nature of personality types within the profession. It drives the ENP to be good at their job, to seek, maintain and improve confidence, to continue to manage relationship experiences and formulate appropriate coping strategies. In fact, it is consistent with the code of conduct of the nursing profession to prioritise people, putting the interests of patients first (NMC, 2018). Care is the central thread through the motion of proficiency, as seen in Figure 6-2. It is the stabilising motivation for the other elements, the fundamental reason that the ENP is a nurse and the key driver to improve the standard, quality and level of care delivered. Care is the central motivational reason that drives the ENP towards proficiency.

The ENP does appear to use this motivation to dissociate themselves from their own feelings, and from those of the patient, to gain a clear perspective of the patient. It is on this perspective that the ENP applies their proficiency, not their own perspective. This is very similar to the underpinning phenomenological methodology of this research, in that the ENP brackets their own feelings to enable a free application of proficiency to the patient, without influence of their own feelings or position upon that application. It is as if the ENP sees their own feelings as potentially interfering with the true application of proficiency in the moment of care delivery. The feelings and experiences of the ENP can be vented elsewhere, as discussed in key outcome 4: coping strategy. The ENP uses the themes discussed in chapter

five to direct and action the best care for the patient. This can be in conflict with the patient's expected outcome however, and the ENP will accept this if the treatment is the best option.

6.7. The so what: The future landscape for ENPs

The future landscape and development for ENPs lies strongly in the HEE (2017) professional framework and the Royal College of Emergency Medicine (RCEM) credentialing process (RCEM, 2018), underpinned by the RCEM curriculum (RCEM, 2019). It will be chiefly dependant on which Trusts adopt this framework, and how they chose to use it within their departments. The variation within the role and the problems this causes are well documented, both in the literature review of chapter two and the findings of this research and will not be repeated in detail here. This curriculum, alongside the HEE framework, relies predominately on a competence development system that is evidenced in an e-portfolio and almost exclusively refers to training and education applied to clinical settings and provision. There is no mention or acknowledgement of capability, confidence of the ACP, issues with relationships or emotional intelligence. Care is referred to as '*The patient as a central focus of care*' (RCEM, 2019. P46) in the context of prioritising the patient's wishes and needs, but not in the context of its motivation and centrality for the ENP as a driving force for the elements discussed in chapter five and six. The future role and position for ENPs must incorporate the concept of proficiency as experienced and defined within this research. Simultaneously, more focus must be given to the development and relationship experiences designed to manage the key outcomes of this research, rather than the traditional focus on competency-based clinical achievement. This is particularly the case as ENPs/ACPs become more experienced as the role continues to develop at its current rapid pace. Given the political position of the NHS and the need for tens of thousands of doctors and nurses to care for the aging population, the ACP role will become integral in achieving political targets and the ability to deliver the high-quality care required by the population of the UK and across

specialties. The experiences examined in this research have implications for the appropriate employment, development, support and resilience of the ENP/ACP of the future, as well as expansion into new areas of specialism for the role as it expands.

The missing voice of the experienced ENP must be heard, addressing the gap in knowledge of what experiences they need in order to be proficient, what experiences can be avoided by better management of other factors, and what they need to learn to manage better in order to become proficient and meet the newly formed ACP role. This has an impact in how we develop ENPs to become proficient from their self-defined competent beginnings. As it stands, Trusts seem to be happy to introduce ACPs without paying enough attention to what is needed to create them from the ACP perspective, in addition to the needs of the Trust and patient. I believe this is needed as part of a wider workforce development plan across nursing and allied health professional roles. The role appears to be told that this is what is needed, even though it remains ill-defined and inconsistent. It is also told how it will be developed and implemented, rather than listening to the significant and now research-evidenced voice of the ENP on the experiences and factors required to meet the objectives of all stakeholders. Becoming an ACP is done to them rather than with them to an extent, overlooking or minimising the voice and experiences of those who came before as the forerunners of the ACP role.

6.8. Summary

The key outcomes are clearly linked to the literature surrounding role, competence, capability and confidence as presented in chapter two and developed further throughout this research, its findings and the key outcomes discussed in this chapter. The five key outcomes were derived from an analytic category tool (Bloomberg and Volpe, 2016) that traced them to the research question and aims of this research. Proficiency became very much more than feeling good at

their job, and instead was about how these components were applied and understood by the ENP, how they constructed their own feelings of proficiency, and the effectiveness with which they confidently connected and understood the components in order that they are moving towards feeling proficient in their role. Regulatory mode theory assisted the understanding of the motion of proficiency, as detailed in the findings. Locomotion helps to understand the participants' drive or motion towards proficiency in the ENP role, while assessment informs the comparison of where the ENP was and now is in terms of proficiency, as seen in Figure 6-1. The led to the definition of proficiency as the pragmatic and confident application of practice experiences together with relationships, learning and knowledge, exposure and experience, and care to a patient episode. Confidence plays a central role and is balanced by a resilience system that the ENP is not taught but is very much derived from experience. It is a balance between the personal self and professional self, with a mobile pivot of self-resilience designed to keep confidence at a point that enables the ENP to operate in their zone of proficiency (Figure 6-3).

The participants in this study experienced relationship issues that manifest as an inconsistency of understanding of the role of the ENP, the expectation that the inconsistency of understanding creates regarding the role of the ENP and, paradoxically, a disagreement between ENPs as to what the role actually is in the first place. Three groups of ENPs exist to counter this lack of clarity, as resistors, maintainers and innovators. Resistors are those who resist role development, or actively oppose it, by placing barriers to prevent development. This includes citing a lack of training or support as a reason not to take on a new condition or patient group and seeing that as a risk. Maintainers are quite happy with the role as they see it, in terms of its value, usefulness and their professional ability to perform the job. These ENPs are quite happy with their proficiency and development. Maintainers continue to develop the components of proficiency in order to keep them in their zone of proficiency, but

do not seek to develop the role itself further. This is similar to the resistor group. However, the key difference here is that the maintainers do not resist development, but instead see that it is not needed as the role has reached or operates at a level that is precisely where it needs to be to provide the service to the patients. Innovators seek to develop the role, in order to take it beyond where they currently practice and move their zone of proficiency further on. This challenges the role itself and utilises the components of proficiency to see more and do more for their patients.

An individual coping strategy derived from the experiences of each participant over time focuses on having a high degree of emotional intelligence which permeates through their drive and ability to become and maintain the proficiency of their role. This assists the ENP to manage the more volatile aspects of confidence, alongside those discussed in outcome 2. Care is the central thread through the motion of proficiency, as seen in Figure 6-2. The ENP appears to dissociate themselves from their own feelings and from those of the patient to gain a clear perspective of the patient. It is on this perspective that the ENP applies their proficiency, not their own perspective, in a similar fashion to the methodological approach of this research, discussed in chapter three. The future landscape and development for ENPs lies strongly in the HEE (2017) professional framework and the Royal College of Emergency Medicine (RCEM) credentialing process. The missing voice of the experienced ENP must be heard, addressing the gap in knowledge of what experiences they need in order to be proficient, what experiences can be avoided by better management of other factors, and what they need to learn to manage better in order to become proficient and meet the newly formed ACP role and patient need in challenging times for the NHS. The following chapter will conclude this research study and the journey taken by the researcher.

Chapter 7: Summary and Conclusion

7.1. Introduction

The purpose of this research was to explore and understand the nurse practitioners' (NPs') practice experiences, specifically focusing on emergency nurse practitioners (ENPs), and how these experiences influenced or effected their feelings of role proficiency. This was specifically focused on the position of the autonomous and clinically proficient ENP (Davis and Hase, 1999; Gardner et al, 2006(a)), and incorporating role identity, competency, capability and confidence under the term proficiency. The thesis provided a specific working definition of a NP which was suitably offered by the International Council of Nurses and was used throughout this thesis:

> *"A Nurse Practitioner….is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice." (ICN, 2008. p1.).*

The context of the ENP for this thesis required that participants were working in an emergency, urgent or unplanned care environment, such as an emergency department, urgent care or walk-in centre.

Chapter one established the research question for this study, having outlined some insight into its background and construction, as well as the experiences of the researcher that led to the research idea in the first instance. Chapter two provided a comprehensive literature review on the development of the role of the ENP and NP, and what the clinical role is constructed of, connecting to the research question and objectives. The common terms relating to ENPs found in the literature of competency, capability and confidence were reviewed to inform the researcher of the common components and expectations of an ENP. Chapter three examined the research methodology, justifying the hermeneutical

phenomenological underpinnings of the research which were designed to interpret the lived experience of the ENP to extract meaning and understanding. Chapter four detailed the methods and strategies employed to gather data and the processes applied to extract meaning from the analysis of that data. The data was then presented in chapter five in six themes: the meaning of role proficiency, relationships, confidence, learning and knowledge, exposure and experience, and care. The themes of chapter five were aligned to the research question and objectives by the use of an analytic category tool (Bloomberg and Volpe, 2016) in chapter six. This identified five key outcomes: proficiency, the central role of confidence, relationship issues, coping strategy and the influence of care. This chapter will present recommendations based on the key outcomes derived from the findings of the lived experience of ENPs discussed in chapter five and how their experiences in practice influence their feelings of role proficiency.

7.2. Revisiting the objectives

Research questions are developed from an initial idea, in this case to explore and understand the NPs' practice experiences and the impact they may have on proficiency. A research question is a specific query the researcher has and wants to resolve to tackle a research problem (Polit and Beck, 2018), and its formation drives the method and study design. A number of pertinent questions were asked of the idea that established its potential for development into research itself, guided by Gerrish and Lathlean (2015) and Bloomberg and Volpe (2016). This highlighted the object that can be researched, alongside practical considerations such as can it be conducted in the available time, and would the subject appeal to a potential supervisor or examiners.

The research question for this thesis developed through a number of iterations, with the final question for this thesis being:

'How do emergency nurse practitioners' (ENPs') experiences in practice influence their feelings of role proficiency?'

In order to approach the question, it was necessary to structure objectives for the research, that being to describe what the researcher expected to achieve by undertaking the study. Three research objectives were proposed and addressed in chapters five and six, clearly linking to the research question to allow focus and clarity of thought and direction. Thus, this allowed the researcher to systematically address the various aspects of the problem. The objectives of this study were:

- To examine and understand the meaning of role proficiency to ENPs.
- To identify practice experiences that influence role proficiency.
- To identify and understand how discovered practice experiences influence ENPs' feelings of role proficiency.

7.3. Recommendations for proficiency development in ENPs

The findings and outcomes of this study have been discussed at length in chapters five and six. It is in the final section of a thesis where the researcher presents recommendations that have been derived by the research process (Bloomberg and Volpe, 2016). These recommendations follow, arranged under the key outcomes in order to remain aligned with the analytic categories traced to the research question and objectives in figure 6-1 on page 154 of chapter six.

7.3.1. Recommendations for key outcome 1: Proficiency

The experiences and subsequent contribution of the participants in this study led to the proposal of the following definition of proficiency.

‘Proficiency is the pragmatic and confident application of practice experiences together with relationships, learning and knowledge, exposure and experience, and care to a patient episode.’

It should be noted that proficiency is not a linear notion that is achieved as such, as discussed in section 6.2. It is a dynamic notion, changeable, delicate, fragile even and not necessarily always present for every situation as the ENP would like. It is always under the influence of other factors discussed in this research and represented below in figure 7-1 that can also impinge or restrict its development or presence, the factors of which are not always under the control of the ENP as discussed in chapters five and six having first been noted in the literature review of chapter two. As discussed in 6.2 it is a concept that will continue to develop and move forward as the role and ENP themselves continue to develop.

Given that competence is mentioned on only a handful of occasions by the participants, the point is made that it is an expected component of the practitioner, and not up for debate or contention, thus considered as a given. Proficiency moves beyond competence and capability, which are concepts that are largely used, and combined under one term, in the development of advanced-level nursing and allied health roles. It is a recommendation of this research that proficiency and the drive towards the zone of proficiency for new and existing practitioners, seen in figure 6-2 on page 159, should form part of the development of ENPs, allowing them to visualise and conceptualize the place they are attempting to reach and maintain in a transparent and supportive process. This will allow advanced practitioners to have an improved understanding of the components that support this development beyond competence and capability. As a result, a model of proficiency, as derived from this research, is represented in figure 7-1 below. It is developed from the conceptual framework discussed in section 3.9 and represented in figure 3-3 found on pages 85 and 87 respectively. This model incorporates the six themes, discussed in chapters five and six, where care is

represented by the orange diamond. It surrounds, encapsulates and provides a central motivating influence over the drive towards proficiency. Themes two (section 5.5), three (section 5.6), four (section 5.7) and five (section 5.8) build together through practice experiences to reach the zone of proficiency, as discussed in section 6.2 from page 155 onwards and represented in figure 6-2 on page 159. Figure 6-2 has been incorporated into figure 7-1 to represent how emergency nurse practitioners' (ENPs') experiences in practice relating to each theme derived from this research and influence their feelings of role proficiency. There is difficulty in presenting a dynamic diagram such as this in written work. It is not intended that the diagram should be viewed as static or linear, rather dynamic and ever changing depending on the patient episode or clinical case to which the ENP is applying their proficiency. In line with this, figure 7-1 should be considered an ideal and as discussed in section 5.4 and further in section 6.2 considering the nature of proficiency as a continuum moving ever forward, the diagram is unlikely to be as balanced as it is presented. The influence exerted by each theme upon proficiency varies in magnitude in line with how the ENP feels about their proficiency. The fragility of proficiency itself can be considered as a bubble, potentially vulnerable to influence by any of the themes. The four themes represented in the blue circles should be also considered like bubbles and equally as fragile, that can become larger or smaller depending on their influence over and the impact on proficiency at any given time, as should the motion of proficiency defined in figure 6-2 and also incorporated into figure 7-1. Balances exist that protect the bubbles as discussed in chapter six including the balance of confidence (figure 6-3) and the understanding of relationship issues, lack of role definition and the concept of resistor, maintainer and innovator discussed in section 6.4. Whether this concept is used by ENPs to gain control or protection of the definition of their role has not been determined in this research and requires further research to investigate. The emotional intelligence that enables better decision making and patient

management is part of the coping strategy discussed in section 6.5. Finally, the influence of care encapsulates and protects the development of proficiency and the motivation to drive towards it, to such an extent, that it is fair to conclude that the absence of the influence of care leaves proficiency virtually unattainable for an ENP.

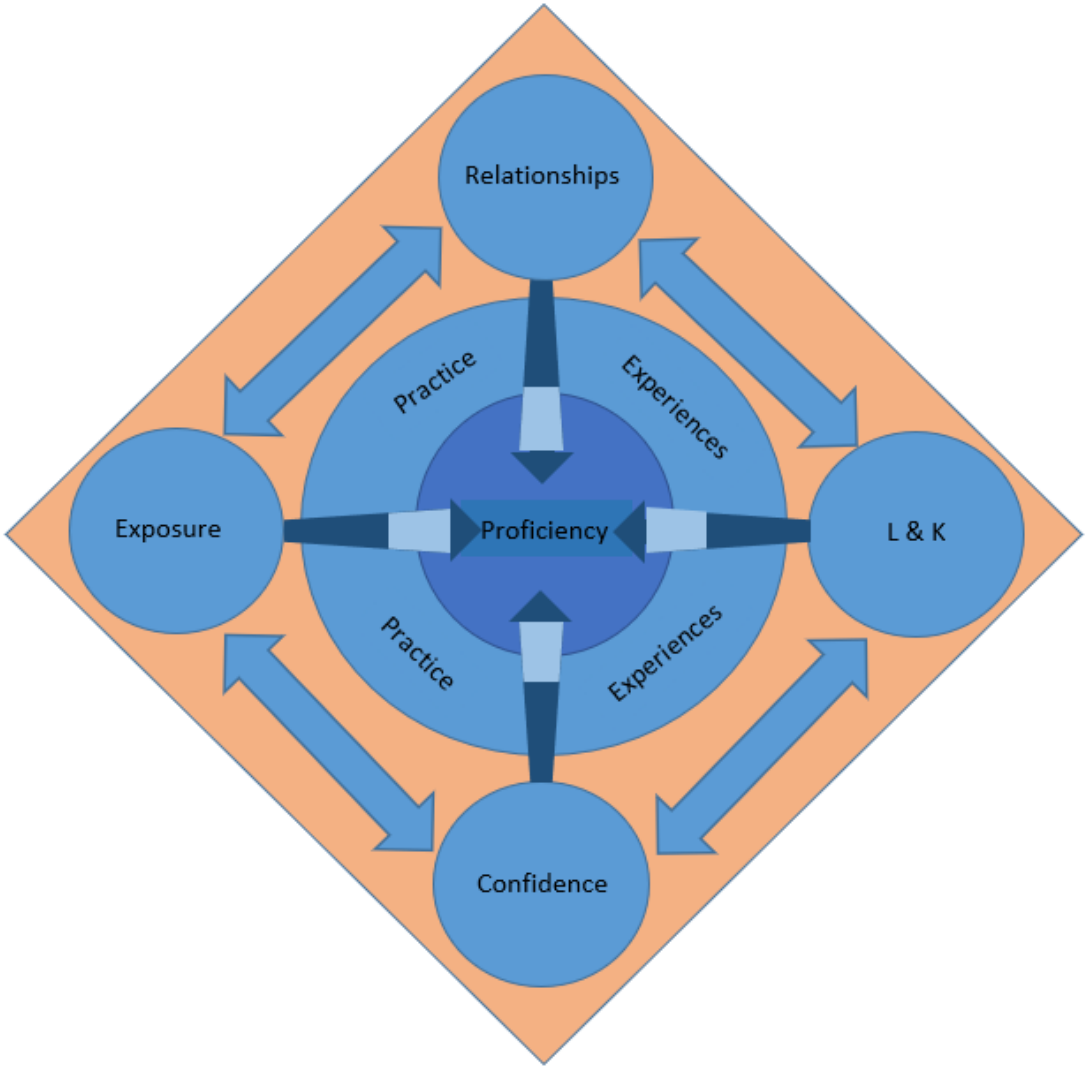

FIGURE 7-1 PROFICIENCY DEVELOPMENT IN ENPS

7.3.2. Recommendations for key outcome 2: Central role of confidence

There is little doubt of the importance and contribution that confidence makes to the development and maintenance of proficiency in ENPs. That is not to say that only

experiences that positively contribute towards confidence should be sought, rather that experiences need to be managed closely and outcomes monitored. The resilience system that each ENP creates is quite individual, but can be assisted by a further understanding of its components. It is a recommendation of this research that the role of confidence and its components, as seen in figure 6-3 on page 162, are included in ENP development to assist maintenance of both proficiency and an ability to effectively apply this proficiency to seeing and treating patients. Thus, ENPs will be allowed to either work towards or remain in their zone of proficiency. It is further recommended that additional research is carried out to determine a more focussed evidence base to establish how this resilience system is derived, its common components and how it can be applied to the balances seen in this research.

7.3.3. Recommendations for key outcome 3: Relationship issues

The relationship issues experienced by ENPs have a significant effect on feelings of proficiency. These issues chiefly are associated with an inconsistency of understanding of the role of the ENP, the expectation that the inconsistency of understanding creates regarding the role of the ENP and, paradoxically, a disagreement between ENPs as to what the role actually is in the first instance. It remains the reality that the role is ill-defined for the participants in this study, despite existing in a number of forms since the 1960s. The relationships where the role is least understood appear to be with other nurses, doctors, patients and, ironically, other ENPs. This leads to an inconsistency of expectation of the role that doesn't meet their understanding and, when measured against this understanding, subsequently results in feelings that either their role is undervalued or unrealistic expectations are placed upon them for the role as they perceive it. It is a recommendation of this research that clarity for the ENP role is provided to establish a consistent culture within organisations at a Trust level. This cultural understanding will allow for the likely demise of the resistor, provide clarity for maintainers and a flourishing and encouraging environment for innovators, as defined on

pages 165 to 167 in chapter six, to meet Trust needs. Some of this may be addressed by the development of the HEE (2017) professional framework and the Royal College of Emergency Medicine (RCEM) credentialing process (RCEM, 2018), underpinned by the RCEM curriculum (RCEM, 2019). It will be chiefly dependant on which Trusts adopt this framework and how they choose to use it within their departments. It is acknowledged that the ACP role differs from that of the ENP, and a further recommendation of this research would be to examine further the areas highlighted in relationship issues in ENPs and compare their association with the ACP role.

7.3.4. Recommendations for key outcome 4: Coping strategy

Participants created a coping strategy to manage the more volatile elements of confidence in or of the personal and professional self. The strategy involves a high degree of emotional intelligence. Individuals demonstrating high levels of emotional intelligence display two categories of attributes associated with emotional intelligence: personal and social. Having a high degree of emotional intelligence permeates through their drive and ability to become and maintain proficiency of their role, and appears advantageous to the ENP when developed. It is a recommendation of this research that ENPs are recognised both as having high levels of emotional intelligence, and the assistance this offers to their coping strategy, and that regular assessment of emotional intelligence may provide a supportive and personally informative mechanism to remain in their zone of proficiency. This may benefit ongoing differential assessment and, potentially, initial role assignment, to identify individualised areas of focus in this subject. It is further recommended that examination of the circumstances where this strategy is employed would benefit the ENP, and perhaps the ACP. It may also clarify whether a relationship with key outcome two exists, and the nature of this relationship.

7.3.5. Recommendations for key outcome 5: The influence of care

Care is a central motivating influence on feelings of proficiency and its drive towards the zone of proficiency. It drives the ENP to be good at their job, to seek, to maintain and improve confidence, to continue to manage relationship experiences and formulate appropriate coping strategies. The ENP uses this motivation to dissociate themselves from their own feelings, and from those of the patient, to gain a clear perspective of the patient. It is on this perspective that the ENP applies their proficiency, not their own perspective. It is as if the ENP sees their own feelings as potentially interfering with the true application of proficiency in the moment of care delivery. This could potentially be rather destructive for the ENP. It is a recommendation of this study that the ENP is made more aware of the influence of care throughout their development, particularly at an early stage, in order that they recognise the potential impact of dissociation from their own feelings. This would also link all key outcomes together in the drive towards the zone of proficiency.

7.3.6. Further recommendations and future research plans

It is a further recommendation of this research that, given its powerful findings, there should be an examination of comparisons made with other regions and between the ENP and ACP roles. This will embed this research in the development of advanced practitioner roles with proficiency as defined by this research, thus driving the motion, direction and delivery of the role of advanced practice roles. It is likely that the ENP role will continue in one form or another in trusts either as an independent specialist role to manage the minor injury/illness elements of urgent care or as a transition role between SN and ACP. The detail of this is likely to be left to trusts to manage. This study is limited by the number of trusts involved and by the specialty the participants worked in. The researcher is confident that the findings are transferable to other specialties with similar roles as the key findings are not obviously attributable exclusively to the ENP environment, the initial concepts from literature review

through to key outcomes are not specialty specific and relevant to all clinical areas in which an ENP type role exists. There is also the potential to be applicable to ACPs although it is conceded that further research should be undertaken to establish the accuracy of this claim given that ACPs do not only come from the Nursing profession and that the level of practice of an ACP is an advancement of clinical provision by definition.

As is often the case, answering one research question gives rise to further questions. It is the intention of this researcher to publish and implement the findings of this research in ENP and ACP education, and evaluate its impact with the intention of a wider implementation across ENP and ACP programmes nationally.

Further research will be undertaken to determine a more specific evidence base to establish how the resilience system referred to in sections 5.6.3 and 6.3 is derived by each ENP. This will include its common components and how it can be applied more widely to manage the balance of confidence (Figure 6-3), relating to the proficiency of ENPs and ACPs in practice.

Additional research questions will be derived and examined relating to how the emotional intelligence of ENPs and ACPs relates to the coping strategies discussed in section 6.5. Questions have arisen as to how this may benefit ENPs and ACPs at the outset of their training, and how ongoing assessment or awareness of it may benefit their experiences of proficiency. Further research may also be conducted into the awareness of the potential impact of the influence of care on the ENP, as discussed in sections 5.9 and 6.6.

It is important to mention the methodological contribution this research has made to the field including the co-construction of the knowledge that has been derived during this process. Section 4.5 discusses the methodological advantage of capturing the experiences of participants using a digital voice recorder as close to the experience itself. The digital voice recorder enabling direct and timely access to the experiences of the participants as close to

the experiences of and influences upon feelings of role proficiency as possible, not delayed or filtered by time or location and allowing the participant to focus on the present in their own terms, discussing experiences they determined were of proficiency. This enabled a co-construction of close to practice generated theory, underpinned firmly in the methodology discussion of chapter three and in the construction of the created knowledge seen in chapters five and six. It is a further recommendation that consideration of this methodology and data collection process is researched in more detail to appreciate its value in future research of this nature.

7.3.7. Summary

This research has explored and developed understanding of the NPs' practice experiences, specifically focusing on emergency nurse practitioners, and how these experiences influence or effect their feelings of role proficiency, specifically from the position of the autonomous and clinically proficient ENP (Davis and Hase, 1999). Role identity, competency, capability and confidence were drawn together and connected under the term proficiency. Six themes were found in the data and can be linked to the literature review of chapter two: the meaning of role proficiency, relationships, confidence, learning and knowledge, exposure and experience, and care. These findings were aligned with five key outcomes of proficiency, central role of confidence, relationship issues, coping strategy and the influence of care. These key outcomes will make a significant contribution to the development of the ENP and ACP roles. ENPs experience proficiency as a constantly developing continuum that benefits from an understanding of its components, and a further understanding of the experiences that contribute positively and negatively towards its development. ENPs should not avoid these experiences, as this research demonstrates how they build and support the ENP's journey towards proficiency and provide the ability to manage, balance and control experiences that allow the ENP to remain in their zone of proficiency.

There is little doubt that this experience had taken this researcher to places that they did not expect. However, despite, and perhaps because of, the experience they remain a passionate educator of advanced nursing roles. There continues to be a demand for these roles across specialties, and the relentless drive for care of our patients has not diminished. Many questions will continue to be asked about the role and its development, and it is with confidence that it can be said that advanced role nurses and allied health professionals will continue to deliver high quality care and treatment as the zone of proficiency moves ever onwards. The impact of advanced nursing roles during the coronavirus pandemic has made an immeasurable and invaluable contribution to the care of a population that has witnessed first-hand the dedication, commitment and expertise of the advanced nursing workforce. The regional Trust and HEI commitment that continued the provision of ACP education during the pandemic, and the increase in undergraduate nursing course applications will ensure the continuing growth of a dynamic and motivated advanced nursing workforce. The sharing, implementation and integration of the outcomes of this research are an essential component in the continuing advancement, development and safe effective delivery of the advancing level of care provided by the contemporary emergency care workforce.

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Appendix i Search Terms

Search terms examples with no of hits;

Primary	Combined with	Date	No of results
Nurs* NEAR/2 practi*	AND Competence	17/1/20	191
	Capability	17/1/20	61
	Confidence	23/1/20	265
	Role	31/1/20	973
	Proficiency	23/1/20	28
	Experience*	31/1/20	598
	Education	31/1/20	935
	Job satisfaction	31/1/20	64
Advanced NEAR/2 Practi*	AND Competenc*	7/2/20	187
	Capability	7/2/20	109
	Confidence	7/2/20	233
	Role	7/2/20	770
	Proficiency	7/2/20	47
	Experience*	7/2/20	476
	Education	7/2/20	766
Emergency NEAR/3 nurs* NEAR/1 practi*	Competence	23/1/20	12
	Capability	23/1/20	2
	Confidence	23/1/20	10
	Proficiency	13/1/20	0
Competenc*		17/1/20	4732
Capability		23/1/20	1382
Confidence		7/2/20	3666
Proficiency			

Web of Science (WOS) All databases including; SCIE, SSCI, CPCIs, ESCI.

Northumbria University search including; MEDLINE, CINAHL, Cochrane

Appendix ii Researcher CV

Work History

Director of Education (CPD) 2020 - present

Senior Lecturer in Urgent and Unplanned Care April 2011- present

A North East University

Nurse Practitioner (Band 7) Feb 2007 – March 2011

A North East Walk-in Centre

Emergency Care Practitioner (I Grade/Band 7) Sept 2005- Feb 2007

A North East Urgent Care Centre

Advanced Practitioner/ECP (I Grade/Band 7) Jan 2004-Sept 2006

A North East Urgent Care Centre and GP out of Hours service

Staff Nurse (E Grade) March 2002-Jan 2004

A North East Accident and Emergency Department

Staff Nurse (D Grade) March 2000-March 2002

A North East Accident and Emergency Department

Staff Nurse (D Grade) Sept 1999-March 2000

A North East Elective Orthopaedics Ward

Education

2013 A North East University

- MSc Academic and Professional Learning (Distinction)

2004 A Northern University

- Grad Cert Emergency Care Practice

1996-1999 A Northern University

- Advanced Diploma Nursing Studies

1993-1996 A South East University

- BSc (Hons) Health Studies with Business Studies (second class upper)

Current Studies

A North East University

- Professional Doctorate in Nursing 2015 - present

Further Qualifications

- ALS Instructor, Resuscitation Council (UK) 2021
- ALS Provider, Resuscitation Council (UK) 2019.
- Fellow of the Higher Education Academy, 2011.
- Independent Nurse Prescriber, A North East University 2005
- Emergency Care Practitioner, A North East University 2004
- ENB998 Teaching and Assessing in clinical practice, A North East University 2001
- ENB199 Accident and Emergency Nursing, A North East University 2001
- Registered Nurse PIN XXXXXXXX, A Northern University 1999

Appendix iii Recruitment email

Dear Emergency Nurse Practitioners,

I am currently looking for Emergency Nurse Practitioners (ENPs) for a study investigating the practice experiences of ENPs and how this influences and ENPs feelings of proficiency.

Briefly, the study involves keeping an audio digital diary of thoughts, feelings and examples of how you consider your proficiency during a working day for up to 10 working days. You will be provided with a loaned handheld digital device to use for this. An interview will follow of no more than 60 minutes to explore the thoughts, feelings and examples raised further.

If you are interested in taking part please contact me using the details below and I will send you further information.

This study has received approval from the Ethics committee of the Faculty of Health and Life Sciences and NUTH.

With thanks and best wishes,

Regards,

Appendix iv Recruitment invitation letter

Daniel Monk

Senior Lecturer Northumbria University

Professional Doctorate Student

Principal Investigator

Dear Colleague,

I am a student studying for a Professional Doctorate at Northumbria University and I would like to invite you to look at the information sheet enclosed regarding the research study I am undertaking at Newcastle upon Tyne Hospitals NHS Foundation Trust as part of my Doctoral studies.

I am undertaking a research project titled;

'The Influence of Practice Experiences on feelings of Role Proficiency in Emergency Nurse Practitioners': A Phenomenological Study'.

In this study, I am exploring how practice experiences influence feelings of role proficiency in Emergency Nurse Practitioners (ENPs) and would like to invite you to participate.

I would be very interested in your participation as you work in a role as a Nurse Practitioner in an emergency care environment. Inconsistencies of education for the role of ENP are widely acknowledged in the literature and it is important to improve understanding of the ENPs experience of factors in practice that influence the proficiency of the role.

It is hoped that the study, which has been approved by the research ethics committee, will provide information that will contribute to professional understanding of what influences proficiency in practice. The information sheet outlines what the study is about and why this study is important. It gives further details about the purpose of the research and what will happen if you decide to take part. Please read this when you have a spare moment. I am happy to come and talk to you in detail about

the study and what your potential involvement might mean. Please do not hesitate to contact me on 0191 215 6253 if you have any further queries.

Thank you for your time,

Daniel Monk

Principal Investigator

Please tick or fill in as appropriate	
I am happy to be contacted in relation to this study	
Name	
Contact details:	
Address	
Telephone number	
E-mail address	
Please state preferred method of contact	

<u>Preferred method of contact</u>

Appendix v Participant Information sheet

The Influence of Practice Experiences on feelings of Role Proficiency in Emergency Nurse Practitioners': A Phenomenological Study

Participant Information Sheet

You are being invited to take part in this research study. Before you decide it is important for you to read this leaflet so you understand why the study is being carried out and what it will involve.

Reading this leaflet, discussing it with others or asking any questions you might have will help you decide whether or not you would like to take part.

What is the Purpose of the Study

I have a professional interest in the development of proficiency in ENPs. It is important to discover what experiences in practice influence their feelings of proficiency. The study will record and examine these experiences, using them to guide education programmes designed to develop ENPs. I am conducting this study as part of my Professional Doctorate in Nursing at Northumbria University.

Why have I been invited?

Because you are a UK NMC registrant working as a Nurse Practitioner as defined by the International Council of Nurses in 2008 "…. a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice." (ICN, 2008. p1.). You are also practicing these skills in an emergency care environment.

Do I have to take part?

No. It is up to you whether you would like to take part in the study. I am giving you this information sheet to help you make that decision. If you do decide to take part, remember that you can stop being involved in the study whenever you choose, without telling me why. Deciding not to take part, or leaving the study at any point will not affect relationship you have either with your employer, Northumbria University or the researcher.

What will happen if I take part?

You will be asked to keep an audio digital diary of thoughts, feelings and examples of how you consider your proficiency during a working day for up to 10 working days. You will be provided with a loaned handheld digital device to use for this. An interview will follow of 30

to 60 minutes to explore the thoughts, feelings and examples raised further. This interview will be informal and will be arranged for a day and time that suits you best, it will take place at the university. With your permission I would audio-record this interview, to make sure I remember everything you talk about. Participation in both diary and interview is required for this study.

What are the possible disadvantages of taking part?

You will be asked to keep a digital audio diary during or shortly after your working day, for up to 10 working days prior to the interview. You will be asked to give up some of your time, between 30 and 60 minutes to have your interview with me. However, you are able to withdraw from the study at any point without giving a reason.

What are the possible benefits of taking part?

By taking part in the study you will be participating in research designed to build an understanding of how proficiency is experienced by ENPs, to understand the common themes experienced to achieve it and provide knowledge of these experiences in order to understand what consistent support for its development looks like and how this can be provided.

Will my taking part in this study be kept confidential and anonymous?

Yes. Your name will not be written on any of the data we collect. Your name will not be written on the recorded interviews, or on the typed up versions of your discussions from the interview, and your name will not appear in any reports or documents resulting from this study. The data collected from you in this study will be confidential. The exceptions to this are if the researcher feels that you or others may be harmed if information is not shared or information of a dangerous or unprofessional nature is disclosed. This will be reported to your department Matron.

How will my data be stored?

All paper data from your interview and your consent forms will be kept in locked storage. All electronic data; including the recordings from your interview and the typed up transcripts will be stored on the University U drive, which is password protected. All data will be stored in accordance with University guidelines and the Data Protection Act (1998).

What will happen to the results of the study?

We will share the findings from this study with:

- Yourselves as participants in this study
- Northumbria University, in the form of the Doctoral thesis
- Selected publishers of research

Who is Organising and Funding the Study?

Northumbria University are funding this study and I am carrying out this study for my Professional Doctorate in Nursing at Northumbria University.

Who has reviewed this study?

Before this study could begin, permissions were obtained from The Newcastle upon Tyne Hospitals NHS Foundation Trust and Northumbria University. The Faculty of Health and Life Sciences Research Ethics Committee at Northumbria University have also reviewed the study in order to safeguard your interests and have granted approval to conduct the study.

Contact for further information:

Researcher: Daniel Monk contact details XXXXXX

Research Supervisor: XXXXXXXX

Appendix vi Participant Consent Form

CONSENT FORM: Health Care Professionals

Research Title: The Influence of Practice Experiences on feelings of Role Proficiency in Emergency Nurse Practitioners': A Phenomenological Study

Research Aim: to build an understanding of how proficiency is experienced by ENPs to improve how it can be developed.

Researcher: Daniel Monk

	Yes (please initial)	**No (please initial)**
I have read and understand the Information Sheet and have had the opportunity to ask questions which have been answered to my satisfaction.		
I understand that I do not have to take part. If I do take part I may withdraw at any time, without giving a reason.		
I agree to keep an audio digital diary prior to the interview. I give permission to the researcher to have access to this information for analysis. (I understand that not agreeing excludes me from the study)		
I agree to participate in an unstructured narrative / interview. I understand that these will be recorded. I give permission to the researcher to have access to this information for analysis. (I understand that not agreeing excludes me from the study)		
I understand that the information I have given in this study may be used in the future as part of further work on this subject.		
I understand that my interview / narrative will be analysed, transcripts and results from the study will be anonymised and that my name and details will not appear in any printed documents**.**		
I agree to take part in this study		
I would like to receive a summary of the results of the study		

_____	_____	_____
Name of Participant	**Date**	**Signature**
_____	_____	_____

Name of Researcher	Date	Signature

Appendix vii Example of diary transcript

Extract from Participant 2 diary, number relates to diary entry number

1

Erm … I just seen a gentleman who was from, who speaks Arabic with very limited English, erm … quite an interesting one, he's complaining of sleep problems and loss of appetite over the last 2 weeks, not registered with a GP. Erm … so you know some of the dilemmas we have as NPs, we sometimes have to erm … talk to big word and interpreting service because we can't establish enough history from the patient erm … and the things that I think are important is that you try and do your assessment first, do your observations, get your history best you can and then when you get on the phone to the interpreter, then most of the basic stuff is covered and so it can sometimes make the consultation go a bit more smoother. Erm … this gentleman was very well, there was no issues really but he was just complaining of insomnia and reduced appetite, been in the country for a year, just registered with a GP erm … but then we also have to consider all the psychosocial aspects with him. Where does he live, erm … is he potentially suicidal or low in mood, so erm…? I suppose im thinking is that sometimes, you know, we think we can get away erm … without using an interpreter. On certain cases that might be true, but I think most of the time when you just hit this blank where you think, there isn't anything more, anything else I can think of then I think, really think you need to use them more than you think the interpreters. So it's just a thought, it does make me think about that much more actually and sometimes when I should have used an interpreter, I probably haven't because I've thought there wasn't anything significantly wrong with them. Erm but then, it does leave gaps in your erm … in your you know clinical erm … patient if you don't have all the facts to start with. As we become more experienced you think you know what's wrong with this person and we don't, just a thought, bye.

Appendix viii Example of interview guide

Interview guide for participant 2

What does proficiency mean to you? Can you describe proficiency?
How do you experience it, what does it consist of or what are its components?
What influence do your experience have on your feelings of proficiency?
How do experiences influence feelings of proficiency?

Context questions
Apprehending the phenomenon
Clarifying the phenomenon (Bevan, 2014)

Welcome
Explain process
Consent to record

Stock phrases;
Tell me more about that
Interesting
SHUT UP, LET THEM TALK

Start

1. Tell me about how your work as a NP
2. What do you understand by the term proficiency?
3. How do you experience it, what does it consist of or what are its components?
4. How do you feel about proficiency? Is it something you aspire to or have achieved, a kind of tangible thing? Is it something that you just have or does it need to be developed?
5. In your diary you spoke of a patient who had difficulty speaking English and you got an interpreter, how do out of the box problems like this affect proficiency?
6. You spoke of a child yo saw late on in a shift, hot unwell and you sent them to A&E for observation. You spoke of gut feeling and how they would probably be fine, but not wanting to miss something because how that makes you feel how does this affect. Proficiency feelings? How is gut feeling related to feelings of proficiency?
7. Have you missed something? How did that affect feelings of proficiency?
8. You spoke of an episode where the parent of a child was a doctor but didn't disclose, how does seeing a dr affect feelings of proficiency?
9. Asking for advice, how does this affect proficiency?
10. Complaints?
11. Colleagues?

Appendix ix Example of participant interview transcript as reference

somebody staring new, you know they're constantly reading up on everything and then panicking about everything and, o can I discharge this patient you know? Where I remember when I first started I used to be terrified of discharging patients, you know cos you're worried you know. And then when you see them in the waiting room, they come back the next day you're like… you know that feeling, its awful. And half the time its nothing, and then you don't know if you want to see them again do you because if you see them again, you know is it to do with me or are they not happy with what I've said or have they got worse and they think I've missed something. So you have all those anxieties. And I think that even as a more experienced NP you always have that. That's not… you're never going to reach a point in your career where you don't feel like that

I

So would you be worried by someone who wasn't concerned in those circumstances?

P2

Yer I would because it think that's a bot concerning. Yer, if you don't have a bit in your nature where you feel nervous and sometimes you don't feel that you practice as well as other times and its true I think you can get like that. You can be on a run where you are really doing well and other times you just don't feel like your consultations are as good. Erm… and it might be the way you feel if you're pissed off or whatever reason

I

So that's part of a drive then?

P2

Or maybe you clash with the patient you know. They come in and the attitudes there and you've got to as an experienced person. But not not even experienced actually, it's just having the right manner. You don't have to be experienced to talk to someone and calm them down. But you will see a lot more situation where Nurses are probably better because they've done more of it. But they've also made mistakes too (I yer) where they've, I mean we've all done it when we've wound the patient up and said you know, what are you doing here? And what did you come to the WIC for? You know, why did you come in with chest pain but there's no point in saying it because they are here. Its pointless, a pointless conversation, you just get their backs up, you make the consultation harder. I've done it myself. Erm… But as I get more older and experienced I don't do it now. 9Name is the same, he'll tell you that. He used to get really wound up about stuff but he's a lot more chilled, a lot more laid back now. But that maybe just, we're getting older as well.

I

What's you ultimate goal then? So in terms of the proficiency that you have, and how you use it. What's your ultimate goal with any given patient? What's your focus, what's your, the intention with each patient you see?

P2

I think my ultimate goal is that i give them the best care erm… I explain to them what's wrong with them, and even if they don't get a Ax that they wanted, they walk out of the room happy erm… the you make sure you safety net them, always safety net them. If things get worse… erm… that's it really