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*Advanced nurse practitioners'(emergency) perceptions of their role, positionality and professional identity*

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**Advanced Nurse Practitioners' (Emergency)  
Perceptions of Their Role, Positionality and  
Professional Identity**

Lisa Margaret Kerr

A thesis submitted in partial fulfilment of the requirements of  
Sheffield Hallam University  
for the degree of Doctor of Education

April 2016

### **Candidate's Declaration**

I certify that this material, which I now submit for assessment on the programme of study leading to the award of the degree of Doctor of Education, is entirely my own work. I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save, and to the extent that, such work has been cited and acknowledged within the text of my work and references.

Signed;

Student Number: 13741

Date: 25<sup>th</sup> April 2016

## Acknowledgements

To Sean, Thomas and Liam, with love

To the ten ANPs (Emergency) who kindly gave their time to share their thoughts, with hope

To Professor Ann Macaskill, my Director of Studies, whose support and guidance made my journey possible, and to Dr. Irene Garland, my former Academic Supervisor, who helped my journey start, with thanks

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## ABBREVIATIONS

<b>ABA</b>	An Bord Altranais (The Nursing Board, Ireland pre-2012)
<b>ADON</b>	Assistant Director of Nursing
<b>ANP</b>	Advanced Nurse Practitioner
<b>ANPc</b>	Advanced Nurse Practitioner Candidate
<b>CNM1</b>	Clinical Nurse Manager 1 (Junior Ward Sister)
<b>CNM2</b>	Clinical Nurse Manager 2 (Ward Sister)
<b>CNM3</b>	Clinical Nurse Manager 3 (Divisional Nurse Manager)
<b>DON</b>	Director of Nursing
<b>DoH</b>	Department of Health
<b>DoHC</b>	Department of Health and Children
<b>EDs</b>	Emergency Departments
<b>HSE</b>	Health Service Executive
<b>KPIs</b>	Key Performance Indicators
<b>MDT</b>	Multidisciplinary team
<b>NCNM</b>	National Council for the Professional Development of Nursing and Midwifery
<b>NHS</b>	National Health Service
<b>NMBI</b>	Bord Altranais agus Cnáimhseachais na hÉireann, (Nursing and Midwifery Board of Ireland post 2012)
<b>NMPDU</b>	Nursing and Midwifery Planning and Development Unit
<b>PPPGs</b>	Policies, Procedures, Protocols, Guidelines
<b>RANP</b>	Registered Advanced Nurse Practitioner
<b>RNP</b>	Registered Nurse Prescriber
<b>US</b>	United States of America

## APPENDICIES

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## ABSTRACT

Nursing theorists have reviewed the contexts and continua into which advanced nursing practice roles in emergency care have evolved and developed, yet little empirical evidence has been gleaned directly from advanced nurse practitioners' (ANP) perceptions. The nature and scope of this study is to explore ANPs' (Emergency) perceptions of their role, positionality and professional identity from an Irish perspective. A qualitative narrative approach was used to gain insight into ten ANPs' perceptions. The ANPs nursed in seven different emergency departments representing both urban and rural regions. Content analysis was applied to the narrative interviews to code and categorise the data and Bourdieu's theoretical framework was applied to this analysis. This enabled the recognition and analysis of social and health contextual factors that related to professional advanced nursing practice in Ireland.

Five key themes emerged: participants' career pathways; personal and professional transitions; role dimensions and core concepts; position within the organisation; and emergent professional identity. Each theme contained a number of categories which included: starting points and management roles; structural changes; transitions and educational challenges; multidimensional nature of practice; ANPs' communities of practice; and status and recognition. Discussion of these findings focused on: 'Habitus - the transition from nurse to ANP'; 'Field - reconstructing advanced practitioner positionality'; and 'Capital - structure and agency that influence ANPs' professional identity'.

This study identified an in-depth understanding of ANPs' experience of personal and professional transitional processes; heightened awareness of autonomy and accountability in decision making; waiting times, throughput numbers, X-ray and medication prescribing, and referral pathways as stressors; practice-based tensions regarding recognition at ADON level and communities of practice relations; and expressions of high job satisfaction in their provision of safe, timely, expert patient care. This provided a greater understanding of the ANPs' (Emergency) role, position within the organisation and emergent professional identity. These are all unique important elements that were narrated in this study by the participants. The concepts of ANPs' positionality and professional identity enable their role-fulfilment. The consequence of this is that ANPs' roles reflect the attributes of advanced practice. This is seen to confirm and add to the current contemporary body of knowledge on the national and international stage.

Recommendations for the domains of nursing, education, management and future research were drawn including: increasing awareness of ANPs' (Emergency) role and scope of practice amongst healthcare personnel; forging links between nursing academics and ANP clinicians to create appropriate course curricula for ANPs' continuing professional development; and the processes of reviewing future planning of nursing roles to include ANPs at strategic levels. Bourdieu's model provided an important theoretical framework which exposed the interrelations and interconnectedness of ANPs' habitus, field and capital. This played a major part in identifying and exploring ANPs' unique perceptions, thus contributing to the body of knowledge for the domains of nursing, education, management and research.

To conclude, this study has revealed that ANPs' (Emergency) perceptions of their role, position within the organisation and emergent professional identity are multidimensional, complex and unique within the field of healthcare practice in Ireland.

## **CHAPTER 1 INTRODUCTION TO THE STUDY**

### **1.1 Introduction**

The nature and scope of this study is to explore advanced nurse practitioners' (Emergency) perceptions of their role, positionality and professional identity. This study is set in Ireland where traditionally the role of the nurse had been governed by the religious orders, medical dominance and hierarchical nursing management. The nemesis came with the Commission of Nursing report in 1998 which championed a complete revision of the structure of Irish nursing through the removal of the traditionalist hierarchical structures and the establishment of new nursing roles. In 2001, this resulted in the formal establishment of the ANP role in Ireland mandated from the Commission's recommendations.

Through my nursing practice and, as part of my research assistant role on a national study on specialist and advanced practitioners in Ireland (Begley et al. 2010), I observed ANPs in clinical practice. Their role challenged some of my ideas about nursing theory and practice. I was interested in ANPs' scope of practice in comparison to mine and other nursing roles. I became fascinated as to how they provided, what I perceived sceptically at that time, predominantly medical tasks performed from a nursing perspective. I found it difficult to comprehend if, or how, the two approaches could be blended and so my quest began to try to understand how ANPs in this new nursing role fitted into wider social and health contexts. I perceived disparities and differences between the ANPs' role and the traditional nurses' role and this raised a number of questions for me personally and professionally. I was uncertain if it is a positive role change for emergency nursing or if it would negatively affect the discipline. This was my motivation and rationale for undertaking this study. The aim of this study is to explore ANPs' (Emergency) perceptions of their role, positionality and professional identity.

### **1.2 Research Aim and Research Questions**

The research aim for this study is to explore Advanced Nurse Practitioners' (Emergency) perceptions of their role, positionality and professional identity. The four key research questions are:

1. How do ANPs describe their reasons for becoming an ANP and their transition from their previous nursing role to becoming an ANP?
2. What are ANPs' (Emergency) perceptions of their role?
3. What are ANPs' (Emergency) perceptions of their positionality?
4. What are ANPs' (Emergency) perceptions of their professional identity?

### **1.3 Background**

In order to contextualise this study the developments of the concept/continua of advanced nursing practice and the advanced nurse practitioner from International and Irish perspectives are presented in Chapter 2. The historical and socio-political contexts are critiqued with the development of new nursing professional roles and the Irish health context is presented as this pertains to this study.

### **1.4 Literature review**

Chapter 3 presents a critique of the literature regarding ANPs and ANPs (Emergency) that were sourced from a review of national and international literature. Ninety-six papers were critically reviewed and revealed that limited qualitative research has been undertaken specifically from ANPs' (Emergency) perspectives. Where studies had been conducted, these predominantly focused on role dimensions and quantitative outcome measures (Manley 1997, Tye 1997, Lloyd Jones 2005, Griffin and Melby 2006, Begley et al. 2010). The literature review concluded that there is a paucity of methodologically robust national and international qualitative research on the advanced nurse practitioner (Emergency) practice from advanced practitioners' perceptions. This was the rationale for choosing to study this topic in this thesis and for adopting a qualitative ontological approach.

### **1.5 Research methodology**

Chapter 4 critiques the research questions and presents the philosophical assumptions that underpin this study are explored. The naturalist paradigm studies people in their natural setting and attempts to make sense of meanings people bring to their worlds (Denzin and Lincoln 2011). Therefore, a naturalistic qualitative approach of narrative enquiry suited this study because of the naturalistic focus of this study's subject matter, namely the perceptions from individuals, and of the nature of the individuals being studied, namely advanced nurse practitioners.

Bourdieu's theoretical framework is utilised to promote consideration of organisational work contexts. Individuals and social factors present in the practice environment are explored. This adds methodological justification to this study and aids in the analysis of narrative data by providing a means of highlighting subtle and tacit dimensions which are often hidden when researching practice domains. This study's ontological, epistemological and methodological approach is grounded on narrative enquiry and Bourdieu's theoretical model.

### **1.6 Research design**

Chapter 5 details the particulars of this study's research design that includes issues pertaining to: trustworthiness; the research setting; data sources and recruitment; access; and sampling. The method of data collection, including a synopsis of a narrative approach, is presented. The importance of my researcher positioning in narrative research is considered through my researcher reflexivity in reflective journaling. The ethical dimensions of using a narrative approach included consideration of: nursing research access approval and nursing research ethical board approval; consent, confidentiality and withdrawal; and data management and storage. Methods for the analysis of narrative data are presented by detailing my role in conducting the narrative interviews and in their transcription. Following a review of conceptual frameworks for data analysis, the justification for using content analysis with Bourdieu's theoretical framework are based on this study's epistemological assumptions.

### **1.7 Study findings**

The findings of the study are presented in Chapter 6. Five themes emerged from the analysis of the narrative data and this chapter presents the themes and their underpinning categories. The themes that emerged were: participants' career pathways; personal and professional transitions; role dimensions and core concepts; position within the organisation; and emergent professional identity. Each theme consisted of a number of categories. The narrative data is used to illustrate the discussions surrounding category and theme formation. Bourdieu's theoretical model was used in the analysis phase and was instrumental in exposing many of the subtleties of the practice domain highlighted in the narratives.

## **1.8 Discussion**

Chapter 7 presents discussion of the study's findings. Discussion of key themes from the findings included: 'Habitus - the transition from nurse to ANP'; 'Field - reconstructing advanced practitioner positionality'; and 'Capital - structure and agency that influence ANPs' professional identity'. This study identified an in-depth understanding of ANPs' experience of personal and professional transitional processes; heightened awareness of autonomy and accountability in decision making; waiting times, throughput numbers, medicinal and X-ray prescribing as stressors; practice-based tensions regarding recognition at ADON level and communities of practice relations; and expressions of high job satisfaction in their personal provision of client care.

## **1.9 Conclusions and recommendations**

Chapter 8 details conclusions to the study and a review of its strengths and limitations, including reflection on methodological and ethical dilemmas encountered during the study period. Recommendations for clinical practice, education, management and further research are presented with proposed dissemination of findings. This research topic is important because developing an understanding of advanced practitioners' perceptions enables greater understanding of ANPs' (Emergency) role, position and professional identity. It is hoped that the benefits from undertaking this research study will add to the body of knowledge for the domains of nursing, education, management and research. It is intended that this research study will contribute towards understanding the complex dimensions of ANPs' contemporary nursing roles, position and identity.

## CHAPTER 2 BACKGROUND

### THE CONCEPT/CONTINUA OF ADVANCED NURSING PRACTICE and the ADVANCED NURSE PRACTITIONER

To contextualise this study, this chapter presents the theoretical developments of the concept/continua of advanced nursing practice and the advanced nurse practitioner from Irish and international perspectives. The ANP (Emergency) specialism is the focus of this study and ANPs referred to in this thesis specifically relate to ANPs (Emergency).

#### **2.1 Advanced nursing practice and the advanced nurse practitioner – international perspectives**

The International Congress on Nursing (ICN) states that advanced nursing practice has been established, or is being developed, internationally in over fifty countries, however they acknowledge that defining conclusively what is meant by ‘advanced nursing practice’ remains elusive due to a lack of international standardisation (ICN 2002). There is however some commonalities of meanings of advanced nursing practice and these form the basis of the following critique.

#### **Defining advanced nursing practice and the advanced nurse practitioner**

Advanced nursing practice has formally been in existence internationally for a number of years. The US spearheaded developments in the 1960s and subsequently many European nations followed suit over the following decades including the UK (1980s), Australia (1995), New Zealand and Canada (2000), and Ireland in 2001 (Sheer and Wong 2008). Currently there are over fifty nations recorded as formally providing advanced nursing practice. However Por (2008, p 84) reveals that “defining what advanced nursing practice is, and what it might become, remains problematic” and this difficulty is echoed over time by many authors including Lorensen, Jones and Hamilton (1998), Ketefian et al. (2001), Stasa et al. (2014), and Hutchinson et al. (2014).

Gardner, Chang and Duffield (2007) undertook an interpretative qualitative examination of Australian advanced practitioners (n=9) with the aim of developing a model and analysis framework for advanced practice roles. They concluded that differences are evident in advanced practice roles, and yet as Rolfe (2014a, 2014b) critiques in his two recent discussion papers there remains debate within the literature as to defining

conclusively what these advanced practice differences are. He concludes that advanced practice does have a distinct focus and approach, and these elements enable advanced practitioners to provide nursing care that is at a higher level than generalist nursing care. In order to achieve 'higher level' care there is a requirement that nursing provision be provided by a nurse practitioner with advanced level skills and competencies.

It is suggested that the move towards advanced nursing practice was a strategic attempt to supplement the reduction in doctor numbers. O'Shea (2008) and Stanley (2011) in contrast, contend that the driving force for the ANP role was not external but emerged from inside the nursing profession motivated by the desire for professional development. In contrast, it is suggested that health service reforms were the driving influences in that advanced practitioners serve to bridge the junior doctor shortfall (Humphreys et al. 2007). This is not a popular stance amongst many nurse theorists who regard the ANP role as a nursing development and not driven by the medical model (Furlong and Smith 2005, O'Shea 2008). However, Furlong and Smith (2005) state it would be naïve to ignore the impact that macro health service policy and socio-economic forces have on nursing's structures and roles. This may be reflective of Gladwell's (2006) tipping point whereby conditions such as organisational readiness (Manley et al. 2011) and effective workplace cultures (Hardy et al. 2013) align to promote practice development.

The underpinning driving forces for advanced nursing practice continue to be debated within national and international nursing literature. Currently no definitive conclusion has been agreed. However it is recognised that advanced nursing practice requires higher level nurse practitioners. Internationally there has been, and continues to be, differing names, terms and definitions associated with advanced nursing practice and the advanced nurse practitioner. A lack of standardisation exists globally regarding: the definition of advanced practice and surrounding terminology; advanced practitioner educational requirements; and the registration and regulatory frameworks for advanced practitioners. This is because individual nations set their own nomenclature and scopes of practice. Pulcini et al. (2008) conducted an international survey of eighteen countries and identified fourteen different titles designating advanced practice roles. This variance is due to the contexts and countries where they are accredited (Sheer and Wong 2008).

The international literature suggests that the underpinning rationale for this lack of clarity stems from a continuing confusion in terminology surrounding advanced nursing roles and a lack of firm clarification of the concept of advanced nursing practice (Ingersoll, McIntosh and Williams 2000, Donnelly 2003, Furlong and Smith 2005, Booth et al. 2006, Elsom, Hapell and Manias 2006, Mantzoukas and Watkinson 2007, Gardner, Chang and Duffield 2007, Sheer and Wong 2008). In an attempt to establish a standardised definition the International Council of Nursing (ICN 2002) provided this definition of a nurse practitioner:

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 contexts and/or country in which s/he is credentialed to practice. A master's degree is recommended for entry level.

The ICN have attempted to identify key elements which define the nature of advanced practice pertinent to advanced nurse practitioners. Yet it is noted that these are not universal as country specific regulations underpin ANP practice. Advanced skills require educational preparation at an advanced level as the ICN states that formal recognition of educational programs is required to prepare nurse practitioners/advanced practice nurses roles. Course accreditation and approval with a formal system of licensure, registration, certification and credentialing are necessary. This currently has great variance across different countries.

Since its inception there have been a number of national and international empirical studies. Yet definitive definitions on what an ANP is, how an ANP should practise, and to what level the ANP should be educated have not been conclusively empirically evidenced. This lack of consensus results in a variance in ANPs' scope of practice internationally. It is suggested that this variability should be expected as structural variations occur in the context of social and healthcare systems in which ANPs practise. However, it is acknowledged that this lack of standardisation does make it difficult to compare research studies undertaken internationally (Begley et al. 2010).

## **2.2 Advanced nursing practice and the advanced nurse practitioner – Irish perspectives**

### **Ireland's social and health contexts**

The Irish health service changed in structure in January 2005 when the Health Service Executive (HSE) came into existence. The HSE is charged with managing the large

complex health services in Ireland. The Irish health service structure is unique and consists of a two tier system with both state provided public services and private provision. The private provision is predominately funded through health insurance. Various levels of fees are levied on people when they access public and private systems. Emergency care hospital services are provided in emergency departments (EDs) in twenty-eight public hospitals. In addition five private hospitals have commenced providing time-limited emergency care services.

The Irish Department of Health and Children (DoHC) published a number of significant social policy documents including Quality and Fairness – A Health System for You (2001a); Primary Care – A New Direction (2001b) and Health Service Reform Programme (2003a). These policies outlined the context of social and health service reform initiatives nationally. In addition the Organisation of Working Time Act came into force in 1997 which decreed a reduction in the number of continuous hours junior doctors could practise (Government of Ireland 1997). This law resulted in a shortfall in medical staffing levels as highlighted in the Report of the National Taskforce on Medical Staffing (DoHC 2003b). This medical shortfall still remains problematic (HSE 2012). Ireland is still to enact the full implementation of this legislation due to the continuing doctor shortfall. Nursing staffing levels are also limited due to the imposition by the HSE in 2009 of the moratorium on recruitment and promotions for nurses; this moratorium has only recently been relaxed.

Ireland has a growing population of five million people and life expectancy is increasing nationally. In particular the older population (80+ years) is increasing significantly. This increasing population size along with higher rates of morbidity result in additional demands being placed on an already budget-limited health service provision.

### **The emergency medicine speciality in Ireland**

A number of issues exist nationally in Ireland with regards to the health service provision of emergency care in hospital EDs. The current policy initiative is the Emergency Medicine Programme (EMP) (HSE 2012) and the National Programme to enhance ANP Services across Emergency Care Networks in Ireland as illustrated in 'The Guide' (HSE 2013). This policy initiative is aimed at addressing the complex legatorial and organisational issues of EDs which include:

- bed shortages nationally due to bed closures and a delay in discharge of patients from hospitals due to a lack of nursing home beds/step down provision
- budgetary and staffing constraints
- overcrowding due to low staffing levels and increasing ED presentations resulting in elongated waiting times
- prolonged waits for patients' on trolleys in the ED for hospital beds that are currently being faced in the Irish ED system

Research suggests that a number of contextual and social factors drove ANP role development nationally. Furlong and Smith (2005) identify that increased population numbers; social and health policy initiatives; service user demands; nursing and medical staff shortages; and the implementation of the working time directive for junior doctors; financial planning and resource allocation; and clinical nursing career opportunities were regarded as influential factors in ANP role development. The ANP role was showcased as the panacea to address these shortfalls. However, Begley et al. (2010) suggests that the antecedents of advanced practice in Ireland stemmed from more global international trends, changes in medical practices, third level higher education and the quest for safe clinical expertise. I suggest that it was a multiplicity of social, health and contextual elements that led significantly in 2001 to the ANP role being formalised in Ireland. The first accredited Irish ANP in 2002 was from the emergency nursing speciality.

### **The move towards advanced nursing practice in Ireland**

In 2002 the advanced nurse practitioner role was formally accredited in Ireland by the National Council for the Professional Development of Nursing and Midwifery (NCNM) and An Bord Altranais (NCNM 2001, Small 2010, Thompson and Meskell 2012). Irish nursing is structured on a multileveled system whereby different grades of nurses fulfil specific roles and functions. These specific roles and functions are based on nurses' level of skill and competency. The latest 2014 statistics from the Nursing and Midwifery Board of Ireland (NMBI) state that in Ireland there were 193 posts accredited with 146 ANPs on the active register (five RANPs are currently on a leave of absence) (NMBI 2014a). The total number of registered nurses across all disciplines was 94, 604 therefore RANPs represent 0.15% of the total registrant population. This is a small yet significant percentage and one that is increasing in number annually in

response to social and contextual need. ANPs work in various nursing domains that span the four disciplines of general, children's, intellectual disability, and psychiatric nursing. The ANP (Emergency) is a registered distinct specialism.

In order to comply with the Nurses Act legislation (Government of Ireland 2011), the requirements and standards for advanced nursing practice in Ireland are currently being reviewed by a working group on advanced practice (NMBI 2014a) and in September – October 2015 the draft Standards and Requirements underwent public consultation (NMBI 2015b). The Nurses Act (1985) has recently been amended in statute to the Nurses Act (2011) in order to incorporate legal standing to the division of Registered Advanced Nurse Practitioner (RANP) by the Nursing and Midwifery Board of Ireland (Government of Ireland 2011a). The registration framework has been in place since 2002 but was formalised by statute in 2011. Strict regulatory frameworks and controls over ANP practice are now grounded in statute.

The structures and processes for advanced practice serve as a mechanism for professional regulation and the term Advanced Nurse Practitioner is a legally protected title as illustrated by Ingram (2014). Having a protected title ensures that only RANPs are able to go by this title and generalist nurses can not claim to be ANP unless they are a RANP. This is significant to the acknowledgment of ANPs' standing and positioning in the healthcare domain. ANPs are also bound by a number of further guidelines and protocols including: the Code of Conduct and Ethics for Nurses and Midwives (NMBI 2014b); the Scope of Practice Framework (An Bord Altranais 2000, NMBI 2014c); and specifically the ANP framework (NCNM 2008a). These documents further define the ethical and practice boundaries of advanced nursing practice.

A series of frameworks for ANPs were devised under the auspices of the National Council for the Professional Development of Nursing and Midwifery (NCNM 2001, 2003, 2004, 2005a, 2008a, 2008c). These sequential documents detail the progress and refinements that have evolved for advanced practitioners and their core concepts since its inception in 2001 due to contemporary changes in socio-health policy, business aspects, outcomes evaluations, organisational restructuring and statutory developments both nationally and internationally (Hamric et al. 2014). The NCNM (2008a) require ANPs to fulfil certain educational and practice requirements in order to be eligible for registration as an ANP. These requirements are that: ANPs must be a registered nurse or

midwife on the Nursing and Midwifery Board of Ireland live register; be registered on the division of register for which an ANP application is being made; and have master's degree level education (or higher) in nursing/midwifery or an area relevant to their specialist field of practice. This educational preparation must include a substantial clinical modular component pertaining to the relevant area of specialist practice. The applicant must have extensive experience in the relevant specialist area with at least seven years post-registration experience including five years in the chosen area of specialist practice.

This is the current ANP framework in Ireland (Woodward, Webb and Prowse. 2005, NCNM 2008a). However consensus of educational and practice requirements internationally is not universal as illustrated in Pulcini et al.'s (2010) international survey on advanced practice nursing education, practice and regulation. Individual nations set their own parameters. For example, in the US a master's degree level education is mandatory for all advanced practitioners and they are currently moving towards doctoral level as prerequisite. In England however, a master's level degree is not at present mandatory for advanced practitioners although this criterion is presently under review. Interestingly it is a mandatory requirement in Wales (NHS 2010).

The Report of the Commission on Nursing (Government of Ireland 1998) provided the catalyst for many changes in the structure of nursing in Ireland as:

Its recommendations sought to provide a secure basis for further professional development of nursing in the context of anticipated changes in health services, their organisation and delivery. (Dwyer and Taaffe 1998, p242)

The Commission's terms of reference included recruitment and retention into nursing; pre-registration education; continuing professional development; management; community nursing; specialisation and advanced practice. The underpinning reason given by the Commission for advanced practice role development was that it provided for a clinical career trajectory for experienced practice-based nurses. This was intended to enable progression and promotion opportunities for nurses in clinical arenas. Prior to this role formation, experienced nurses had moved from clinical areas into the fields of nurse management and education to seek career development. This resulted in a reduction in the number of experienced frontline nurses. Depletion of experienced frontline nurses was regarded as impacting negatively on the provision of safe quality patient care. 'Frontline nurses' refers to nurses practicing at ward level in the provision

of direct clinical nursing care. The ANP role was devised by the Commission as a strategic practice development initiative to address this deficit by providing the opportunity of a clinical career pathway on a par with nursing management and nurse education.

The Commission recommends that the Minister also provides for a grade of advanced nurse or midwife practitioner equivalent to middle nursing and midwifery management level. (Government of Ireland 1998, p13)

This was aimed at incentivising expert nurses to remain on the frontline; with the ANP position being regarded as at the upper echelon of an expert clinical nursing career trajectory. It could be debated that, if the ANP position is regarded as the highest expert clinical role, are ANPs content to remain in this specialism and post ad infinitum? In addition, ANPs practise within their specific specialism and in an accredited post. Transfer to other areas of practice is limited unless the ANP satisfies NMBI registration criteria for both the post and the speciality. This impacts upon ANPs' career progression and transferability options (NMBI 2014a).

Interestingly the NMBI (2015) statistical data confirms that ANP retention rates are favourable, currently only two RANPs have resigned/retired and a further two have moved to non-ANP posts. It would have been valuable to ascertain if they had resigned but unfortunately the NMBI do not specify. This implies that the majority of ANPs are satisfied to remain in their ANP roles within their chosen specialist practice domains; a fact that may be not surprising as they were familiar with the practice area having worked for five years in the speciality before opting for ANP candidacy in that field. In conjunction with this data, it would be advantageous to monitor and review ANP candidates' completion statistics and exit reasoning, as both sets of statistics could inform service recruitment and retention practices.

In Ireland, additional clinical roles of Clinical Nurse Specialist (CNS), physicians' assistants and Emergency Nurse Practitioner were also being developed during this restructuring period. The CNS role is regarded as a specialist nursing role but does not have the advanced practice status synonymous with the ANP. The development of the physicians' assistant role (Okereke 2011) commenced piloting in Ireland in September 2015. It is a role that has been established in the US for a number of years and is intended to provide a supportive role to medics in practice. It is not a nursing role but a clinical one that has overlap with some ANPs' roles such as patient assessment. Notably

the physicians' assistant pilot study does not involve the EDs in Ireland as a pilot site. It will be of interest to review this pilot study and the possible consequences of this role on and for ANPs' future development.

The Emergency Nurse Practitioner (ENP) is a role that exists in some countries and therefore is considered in this synopsis. The ENP role was established temporarily in Ireland in 1996 and acted as a fore-runner to ANP role development (Small 2010). This role does not now exist in Ireland and has been superseded by the ANP (Emergency) role.

### **2.3 The Advanced Nurse Practitioner (Emergency)**

As mentioned previously, a defining aspect of advanced practice is specialism, and the development of advanced practice roles in the speciality of emergency care have evolved alongside developments in practitioner roles nationally and internationally. Emergency nursing is defined as the provision of immediate nursing care and intervention to adults and children who have undiagnosed, undifferentiated healthcare needs arising from social, psychological, physical and cultural factors (HSE 2012). In conjunction with the empirical literature on ANPs in general, authors have specifically researched the ANP (Emergency) specialism, notably Tye and Ross (2000), Mick and Ackerman (2000), Charters et al. (2005), Martin and Considine (2005), Griffin and Melby (2006), McGee and Kaplan (2007), Lee, Jennings and Bailey (2007), Currie and Crouch (2008), Wilson, Cameron and Jennings (2008), Small (2010), Melby, Gillespie and Martin (2010) and McDaid et al. (2015).

The development of the advanced practice role in emergency nursing in Ireland was spearheaded in 1996 when a pilot project implementing the emergency nurse practitioner (ENP) role was undertaken (Small 2010). This pilot evaluated positively and the first ENP post in Ireland was established. This ENP role was not classified as an 'advanced' nurse practitioner role until An Bord Altranais established the advanced nurse practitioner role nationally in 2001. Thompson and Meskell's (2012) audit identified that the first accredited ANP post in Ireland was the ANP (Emergency) in 2002. As of October 2015, the ANP (Emergency) division has the largest cohort of ANPs practicing in hospitals in Ireland with 88 registered ANPs (Emergency)

representing 61% of the total ANP population (NMBI 2015a). The specialism of ANP (Emergency) will be discussed in detail in the following sections.

Emergency Departments provide twenty-four hours a day, seven days a week care for all patients who present with undifferentiated and undiagnosed emergency and urgent care needs. The National Emergency Medicine Programme Plan states that “the most important component of Emergency Medicine work is the prioritised evaluation and treatment of patients with time-critical healthcare needs” (HSE 2012, p30). Annually the assessment and treatment of 1.2 million patient attendances across twenty-eight EDs is provided by emergency medicine teams in Ireland (McDaid et al. 2015). ANPs (Emergency) are regarded by the HSE as important members of these teams (HSE 2013). The client portfolio of each ANP is dependent on the Emergency Department in which they work. For example, some ANPs care solely for adults and some ANPs care for both adults and children if their particular hospital provides paediatric services. In addition a small number of ANPs care for children only if they practise in a stand-alone paediatric hospital.

ANPs follow day duty shift patterns and cover a seven day week duty roster. In Ireland they currently do not work night-duty rotations as their cohort present mainly during the day shift period. However a number of patients from ANPs’ cohort do present at night but these cases may be compounded by substance usage (alcohol/drug) and assessment of patients with substance misuse falls outside ANPs’ scope of practice and case management remit. There are also fiscal implications if ANPs work premium-rate night duty hours as these would need to be offset by productivity which may not be possible throughout the full night period. However, in some jurisdictions night-duty is part of ANPs’ practice. It will be interesting to see if in the future, in response to socially-driven service need, this issue will be revised.

The Emergency Medicine Programme workforce survey (HSE 2012, p239) states that 3.1% of nursing personnel in emergency departments are ANPs and there is general acceptance that the development of ANP roles, across the whole emergency care system, are key to delivering practice development improvements in access to safe quality care.

The development of ANP posts is expected to continue in line with the models of hospital/types of units. The numbers of ANPs required to deliver services within Emergency Care Units will form part of the strategic plan for the future.

Current problems in emergency care relate to environmental and staffing issues. Emergency departments are often overcrowded because patients awaiting hospital admission are cared for in EDs' clinical areas for prolonged periods of time. This overcrowding is compounded by a lack of hospital admission beds, bed closures and poor staffing levels (INMO 2014a). The ED is designed for the short term management of emergency department patients and not patients requiring long-term care. Implementation of the core components of emergency medicine practice is essential for quality improvement as this informs the development of explicit service goals and appropriate allocation of resources. The National Emergency Care System, of which the ANP Capacity Building Strategy is a part, aims to achieve the best possible outcomes for patients and communities and this requires a collaborative and congruent approach.

... across potential boundaries, be they geographical, political or those traditionally existing between medical specialties, healthcare professions and within health care systems... (HSE 2012, p56)

In order to meet the patient care needs of the communities they serve, emergency departments require efficient, effective and sustainable operational governance structures. Current key organisational factors being focused on at strategic policy level include: access, resource allocation, organisational readiness and workforce planning, waiting times and patient satisfaction. It is into this organisational milieu, and subsequent inherent pressures, that ANPs' (Emergency) practise.

This background synopsis on the relationship between the major themes and concepts of advanced practice and advanced nurse practitioners reveals critical gaps and disagreement between ANPs' role, positionality and professional identity. Given the pivotal role that ANPs' play in the field of healthcare, an appreciation of these concepts are important to examine in order to establish an in-depth understanding of the nature of advanced practice and of ANPs. This justifies the need to investigate this topic further in the following literature review chapter.

## **2.4 Conclusion**

This chapter explored the development of the concept/continua of advanced nursing practice and the advanced nurse practitioner internationally, and specifically within an

Irish context. This critique revealed that debate in the contemporary literature surrounds the concepts of advanced nursing practice and advanced nurse practitioners and a lack of standardisation causes difficulty in drawing conclusive international comparisons. However the development of advanced nurse practitioner roles has led to changes in the nursing profession and in the field of healthcare.

The ANP role is a contemporary, immature role in the Irish healthcare system having been established only fifteen years ago in 2001. Within the specialist domain of emergency nursing, ANPs care for their clients' full episode of care for those whose conditions are undifferentiated and undiagnosed. This is unique and significant to the discipline of emergency advanced practice, as in other ANP disciplines patients attendance is planned with a differential diagnosis already made (Small 2010). The nature of advanced practice in emergency nursing is complex. In order to understand the role, positionality and professional identity of ANPs, analysis of these concepts are critiqued in the following chapter.

## **CHAPTER 3            LITERATURE REVIEW**

### **3.1    Introduction**

This chapter presents a critique of the empirical studies that explore an ANP's role, positionality and professional identity. A clear literature review strategy and a standard format was utilised, guided by the single review aim of exploring Advanced Nurse Practitioners' (Emergency) perceptions of their role, positionality and professional identity. This enabled critical appraisal of the main conceptual dimensions of these three key concepts

### **3.2    Literature review strategy utilising Hart's critical analytical criteria**

It is important to situate this empirical study within the wider professional context based on the literature and theories of professional roles, positioning and identity to ensure this study's validity. In order to do this, the critical analytical techniques outlined by Hart (1998 and 2001) as illustrated in Appendix B were utilised. Utilising Hart's systematic set of procedures for literature searching (2001) and literature reviewing (1998) ensured that I comprehensively and methodically searched and reviewed the literature and explored their arguments. Concept mapping enabled analytical synthesis and evaluation of arguments. The common concepts in the literature on ANPs could be identified. This enabled my research study to be grounded in, and mapped onto, the nexus of knowledge on advanced practitioners.

#### **3.2.1   Literature search strategy**

Based on Hart's (2001) literature search strategy I critically searched the various databases and search engines using key words and synonyms as illustrated in Table 1. I then appraised the literature in relation to my specific key aim and research questions.

No time limitation was set as the ANP role is contemporary and therefore data sourced would be current. Due to the confusion surrounding nomenclature various synonyms and keywords aligned to the ANP definition in Ireland were searched in order to ensure a comprehensive search. For example, the nurse consultant definition in England or advanced practice nurses in the US are not identical to the ANP in the Irish context, yet some parity exists therefore these terms were used in the search process. The Clinical Nurse Specialist (CNS) role in Ireland does not have the same criterion synonymous

with the ANP role and therefore data pertaining to the CNS role is not included in this study. Studies were included if published in English and relevant to advanced nursing practice. Exclusion criteria included literature not available on the databases in the English language and literature on the advance midwife practitioner (AMP) role. Currently only two AMPs work in the Irish healthcare system and there are a number of debates within the midwifery professions regarding the AMP role and a critique of these debates are presented in Begley et al.'s (2010) study. Exclusion of midwifery literature in this review is based upon the distinctive nature of AMPs practice. Reference lists for each report, book or chapter were also examined for any relevant literature not identified from the electronic databases.

**Table 1 Literature search strategy adapted from Hart (2001)**

Key words & literature searched	Search Engines	Databases
<p>'Advanced Nurse Practitioner' (ANP) (n=6347), 'Advanced Nurse Practitioner' + Ireland (n=25), 'advanced practice nursing' (n=33,503), 'advanced nursing practice' (n=33,503) and 'ANP' + 'emergency' (n=384) and 'accident and emergency' (n=103) 'ENP' (4345), 'nurse consultant', 'clinical nurse consultant', and 'advanced clinical nurse' (17819), ANP + Emergency Department' &amp; 'ED' (n=119) .</p> <p>Advanced nurse practitioner + Ireland/Irish/Republic of Ireland (n=25)</p> <p>Role + ANP (n=1758)</p> <p>Positionality + ANP (n=179)</p> <p>Identity + ANP (n=41)</p> <p>Transition + ANP (n=107)</p> <p>Interprofessional relationship + ANP (n=22)</p>	<p>Ovid</p> <p>EBSCO</p> <p>Emerald</p>	<p>Medline, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Applied Social Sciences Index and Abstracts (ASSIA), Cochrane Database of Systematic Reviews (CDSR), Science Direct, SCOPUS, Web of Science, Dissertation Abstracts, and Database of Abstracts of Reviews of Effects (DARES), and Excerpta Medica Database (EMBASE).Rian (Irish institutional repositories), Lenus (Irish Health Repository)</p> <p>Relevant nursing texts and professional organization websites were also accessed. The review included research data from comparable professions aligned to nursing including education and management.</p>

### 3.2.2 Identified literature

In total ninety-one papers met the criteria to be reviewed. The majority of these articles focused on ANPs from holistic perspectives and raised elements of the three concepts within the paper. A smaller number of papers explored one specific concept, for example: emergency nursing, accountability, interprofessional relationships or power. Papers from the nursing discipline represented the majority of papers sourced; however additional theoretical literature and key reference texts from the fields of education, sociology, psychology and business were also sourced.

In line with role developments, there has been an increase in empirical data since the role's inception in the 1960s. However after mapping Irish and international studies chronologically, dominance in quantitative methodologies is evident. Newhouse et al. (2011) identified in their systematic review of advanced practice outcomes that many studies predominantly focused on the quantitative impacts and outcomes that ANP services provide to the wider healthcare field. The types of evidence came from various genres representing empirical studies and theoretical papers (n=40) with qualitative, quantitative and mixed methodological empirical studies sourced. Systematic literature reviews (n=9) and practice-based articles (n=43) were represented. Thirteen papers including eight empirical studies conducted from an Irish perspective are included in this literature review.

I repeated the literature search after completion of my data collection in order to ensure that any new research and theoretical knowledge was sourced. This promoted validation of points raised in the discussion chapter. When the secondary literature search was conducted 1872 additional papers on advanced nurse practitioners had been published over the study period (2012-2016). In order to ensure currency and completeness eleven of these studies that fitted the criteria were incorporated into the literature review critique. The remaining papers did not fit the criteria and were discarded.

This chapter presents a critique of this literature on advanced nurse practitioner (Emergency) role, positionality and professional identity. The three concepts have been separated for simplicity in analysis; however through this review the enablers, attributes and consequences of the three concepts and their interrelation are explored with important gaps in the literature identified.

### **3.3 Defining the theoretical concepts of role, positionality and professional identity**

The concepts of role, positionality and professional identity are commonly studied constructs in social science. Jenkins (2008) identifies that notable theorists such as Giddens, Mead, Goffman, Schön, Foucault, and more recently Wenger, Bourdieu, McCall and Simmons, and Tajfel and Turner have theorised over the epistemic underpinnings of these complex concepts. Theoretically, definitive definitions of these concepts have not been reached. In order to contextualise the concepts of role, positionality and professional identity for this study, a methodologically eclectic working definition of each concept is presented in the following chapter and further developed throughout this study. ANPs' role, positionality and professional identity development is about being in a healthcare practice world, and increasingly about being in a multiplicity of worlds.

### **3.4 Critical review of the literature exploring ANPs' role**

Redfern (2006, p785) posits that "little empirical research on this new role has yet to be published ... most of what has been published so far has been confined to news items, anecdotal reports or non-research-based discussion papers". Coster et al. (2006) and Redfern (2008) suggest that the research on ANPs which has been undertaken has tended to focus primarily upon service structures, processes and outcomes such as performance, service-user satisfaction, waiting times, throughput numbers, and competency attainment. Ball (2003) suggests, in his paper on the origin, processes and effects of performativity in the public sector, that this stems from a move from old professionalism towards a greater emphasis on commodification and quantification.

Research suggests ANPs are increasingly subjected to quantification in their practice (Ball and Cox 2003, Begley et al. 2010, NCNM 2010a). Ball's (1999) preliminary doctoral study was developed in Ball and Cox's (2003, 2004) grounded theory studies conducted in the US, Australia, New Zealand and the U.K. They examined advanced clinical practice and the constraining and facilitating factors to legitimising advanced practitioners' power base. They found that legitimising ANPs' power was influenced by changing market forces, demographics and epidemiological population profiles, health service policy and managerial structure. Thus, boundaries between roles in service

organisations can be subject to blurring as policy driven discourses and structural reforms emerge.

Newhouse et al. (2011) conducted a systematic review of advanced nursing practice outcomes for the period 1990 – 2008. They reviewed 107 observational studies and gold standard randomised controlled trials (RCT) that were conducted in the US. They concluded that outcome measures were positive with regard to advanced nursing practice. This study's inclusion criterion was US based only and therefore whilst the results may be transferable to other jurisdictions, it could not be classified as internationally generalisable. It is acknowledged that, whatever the driving forces were, the ANP role has been established and this has direct implications for the nursing profession and the wider healthcare field (McDonnell et al. 2015). The impacts on ANPs' role, positionality and professional identity have not been researched in sufficient depth internationally, nor specifically from an Irish perspective, and it is this deficit that this research study addresses.

The fifty-three papers relevant to the concept of ANPs' role are presented in Appendix A. Reference to some studies on ANPs' positionality and ANPs' professional identity are also made, as a natural overlap occurs between the three concepts. Manley (1997), Woods (1999), Brown and Draye (2003), Ball and Cox (2003-2004), Guest et al (2004), Charters et al. (2005), Fisher, Steggall and Cox (2006), Manley and Titchen (2012) and Gardner et al. (2013) studied aspects of ANPs' roles and scope of practice in nursing on the international stage. In addition, a smaller number of studies specifically investigated the dimensions of advanced nurse practitioners' roles in emergency nursing. These included Tye and Ross (2000), Byrne et al. (2000), Griffin and Melby (2006) and Norris and Melby (2006), Considine et al. (2006), Currie et al. (2007), Fotheringham, Dickie and Cooper (2011), Hoskins (2011b), Kennedy et al. (2011) and McConnell, Slevin and McIlfratrick (2012). A small number of empirical studies were undertaken in Ireland, notably, Small (1999), Smith (2003), Furlong and Smith (2005), NCNM (2005a), Conlon et al. (2009), Begley et al. (2010), Thompson and Meskell (2012), and more recently Elliott et al. (2014), Higgins et al. (2014), McDonnell et al. (2015) and O'Keeffe et al. (2015).

In order to delineate advanced practice from generalist practice, ANPs are said to possess a protected title. In Ireland the ANP title is protected in statute and is a

recognised registered discipline by the NMBI. As introduced in Chapter 2, ANPs are regarded as possessing specific key attributes that enable them to provide care at an advanced level. These key attributes, their enablers and consequences to/on ANPs' role fulfilment in practice forms the basis of the following critique.

### **3.4.1 ANPs' role - attributes and enabling factors**

From an Irish context, the NCNM (2008a, p5) state that ANPs' roles and attributes are:

- promoting wellness, offering healthcare interventions and advocating healthy lifestyle choices for patients/clients, their families and carers in a wide variety of settings in collaboration with other healthcare professionals, according to agreed scope of practice guidelines.
- utilising advanced clinical nursing knowledge and critical thinking skills to independently provide optimum patient/client care through caseload management of acute and/or chronic illness.
- be grounded in the theory and practice of nursing and incorporates nursing and other related research, management and leadership theories and skills in order to encourage a collegiate, multidisciplinary approach to quality patient/client care.
- be autonomous, experienced practitioners who are competent, accountable and responsible for their own practice.
- highly experienced in clinical practice and are educated to master's degree level (or higher).

The ANP role is defined in Ireland as possessing the four core concepts of: autonomy in clinical practice; expert practice; professional and clinical leadership; and research. These are analogous to, but not identical to, the 'four pillars' of expert practice, education, leadership and research that Guest et al.'s (2004) study describes of nurse consultants in the UK. The criteria needed in order to be registered as an ANP is presented in the Framework for the Establishment of Advanced Nurse Practitioner Posts (NCNM 2008a, p11) as illustrated below:

1. Be a registered nurse or midwife on An Bord Altranais' live register
2. Be registered in the division of An Bord Altranais' live register for which the application is being made or, in recognition of services which span several patient/client groups and/or registrations, provide evidence of validated competencies relevant to the context of practice
3. Be educated to master's degree level (or higher). The postgraduate programme must be in nursing/midwifery or an area which reflects the

specialist field of practice (educational preparation must include a substantial clinical modular component(s) pertaining to the relevant area of specialist practice)

4. Have a minimum of 7 years post-registration experience, which will include 5 years experience in the chosen area of specialist practice
5. Have substantive hours at supervised advanced practice level
6. Have the competence to exercise higher levels of judgement, discretion and decision making in the clinical area above that expected of the nurse/midwife working at primary practice level or of the clinical nurse/midwife specialist
7. Demonstrate competencies relevant to context of practice
8. Provide evidence of continuing professional development.

Manley's (1997) emancipatory action research study significantly added to the body of knowledge on advanced practice through the development of a conceptual framework for advanced practice and the operationalisation of advanced practice nursing roles. She developed understanding of advanced practitioners key attributes and organisational contexts (Manley 1997). In addition, Lloyd Jones (2005), Woodward et al. (2005), Humphreys et al. (2007), Mantzoukas and Watkinson (2007), Spross and Lawson (2009), Begley et al. (2010), Callander and Schofield (2011), Hoskins (2011b), Kennedy et al. (2011) describe ANPs key characteristics through their respective systematic reviews and meta-synthesis. These literature studies concur with the NCNM (2008) definition and collectively summarise advanced nurse practitioner generic features and key attributes as including:

- critical thinking, analysis and inquiry that integrates research, education, practice and management
- expert dynamic practice and recognized advanced clinical competencies from a strong nursing foundation
- direct clinical care, triage and allocation of priority for care, and responsibility for independent case management
- pioneering strong professional leadership and clinical leadership – advocate, collaborator and transformational leader
- researcher proficiency and ethical decision making
- possesses a high degree of professional efficacy supported by significant autonomy and accountable independent practice

- educator with consultancy, coaching, mentoring and guidance skills - empowering other nurses/allied health professions to develop care practices and role modelling
- advanced health assessment skills, decision-making skills and diagnostic reasoning skills. rapid patient assessment and assimilation of information often beyond the presenting problem with intervention based on the assessment
- on-going evaluation; and discharge or referral to other sources of care undertaken independently by the ANP

Advanced practice skills had previously been the remit of doctors. The assimilation of medical skills by advanced practitioners has been debated in medical and nursing circles and polarised views remain in the literature as to the appropriateness and efficacy of advanced practitioners' role developments. Concerns were identified in Carryer et al.'s (2007) interpretative study on Australian and New Zealander nurse practitioners (n=15). They found that potential problems occurred with the blending and blurring of role boundaries as ANPs assume role extensions at the nurse-medicine interface. Role extensions are decided and regulated locally and nationally. This results internationally in a lack of standardisation and transferability of advanced practice roles. However some commonalities in advanced practice attributes are seen internationally. For example, Lockwood and Fealy's (2008) quantitative research identifies that medicinal prescribing is a commonly observed advanced practice role extension in a number of countries.

Building on from the seminal work of Hamric (1996) and Manley (1997), Humphreys et al. (2007) studied the nurse, midwife and allied health consultant roles in the UK. These consultant roles had been developed from the modernisation agenda of the health services in the UK. Humphreys et al. (2007) concluded that difficulty is seen in differentiating between the consultants' key functions as they are interrelated but not mutually exclusive. This difficulty in differentiation is an important factor because it results in a lack of clarity and as a consequence can cause confusion over practitioner's roles. Redfern's (2008, p1253) commentary paper positively acknowledges Humphreys et al.'s unique contribution to knowledge on advanced practice, whilst she also acknowledges that "more impact and outcome studies are needed". In Ireland the NCNM (2001) attempted to overcome this lack of clarity by defining ANPs' attributes

through the four core concepts of 'autonomy in clinical practice', 'expert practice', 'professional and clinical leadership' and 'research'.

A preliminary evaluative study of the role of the ANP in Ireland reviewed the implementation of the ANP role through the role fulfilment of these four core concepts (NCNM 2005). Influencing factors, impacts and benefits of the role were also assessed by the study. The findings revealed that the role evaluated positively and that ANPs were able to use their clinical expertise in delivering care to patients as they spent most of their time in clinical practice with direct patient contact. Time constraints were seen as impeding the clinical leadership and research aspects of the role. In addition, restrictions governing prescribing of medications and requesting of X-rays was regarded in some instances as restricting their autonomy. However these findings need to be taken into context as this study used a small-scale mixed methodology approach (n=25) and was conducted at a very immature time in advanced practitioner role development.

In 2010, Begley et al. replicated and extended this preliminary study by conducting a large scale evaluative study on specialist clinician and advanced practitioner roles in Ireland. This was valuable in enabling an, albeit limited, longitudinal perspective. Begley et al.'s (2010) large scale three phase multi-method national study consisting of: Phase one: Literature review, Delphi survey, Focus groups, Validation survey and Evaluative survey, Phase two: Observations, Documentary analysis, Interviews, Surveys, and Economic evaluation, and Phase three: Interviews with policy makers and interpretation and integration of multiple datasets using a structure-process-outcome model of evaluation. This study's findings revealed positivity towards the ANP role from service users, medics and MDTs. They also state that the outcome measures and consequences of advanced practice include increased patient satisfaction and reduced waiting times for ambulatory care patients in EDs. Whilst Begley et al.'s study did include advanced practitioner focus groups, the gathering of further data from ANPs' perspectives would have added robustness to the evaluation study. However it is acknowledged that this was not the sole aim of the study.

Coster et al.'s (2006) evaluative study of nurse consultants in England affirms Humphreys et al.'s (2007) findings that difficulties exist in evaluating complex roles. Their triangulated multi-method approach used data collection methods that included surveys (n=419), focus groups (n=22), and telephone interviews with nurse consultants

(n=32). Their evaluation discovered that the positive impacts of the consultant role on practice confirms Guest et al.'s (2004) findings and echoes Begley et al.'s study (2010). In order to analyse ANPs' complex roles, their enablers, attributes and consequences, the literature based on the NCNM (2008a) four core concepts will be critiqued in the following sections.

#### **3.4.1.1 Autonomy in clinical practice**

ANPs' demonstration of autonomy in clinical practice is regarded as a key enabler in the fulfilment of the distinctive attributes of advanced practice. Callaghan's (2008) systematic literature review identifies that ANPs' possession of a high degree of professional autonomy is achieved through being accountable and responsible for advanced levels of decision making in their case management of a specific patient cohort. Importantly the distinction is made in Tye and Ross's (2000) study, that it is the level of decision making and responsibility rather than the nature or difficulty of the task undertaken which distinguishes ANPs' practice as at a higher level. Tye and Ross's findings were echoed in Currie and Crouch's (2008) qualitative study that explored emergency care doctors and nurses perceptions of their respective roles. They found that in order to enable clinical role development, higher level decision-making and scope of practice required clarification.

Fisher, Steggall and Cox's (2006) findings from their grounded theory study contrasts with Tye and Ross's (2000) regarding the promotion of local consistency in practice rather than universal standardisation. This however was a small scale study with a limited sample size of nurse practitioners (n=3) and consultant doctors (n=2) and therefore additional data is required to enable validation of Fisher, Steggall and Cox's findings. Small's (1999) research study identified that approximately thirty clinical presentations are assigned to ANPs' (Emergency) clinical caseload and scope of practice in Ireland, and this figure is increasing as she notes in a secondary paper in 2010. Distinctive attributes in emergency nursing include that ANPs (Emergency) provide advanced practice nursing care for patients whose attendance is unplanned; whose conditions are undifferentiated and undiagnosed; and for the patients' full episode of care. In order for ANPs to provide this nursing care, a number of key enabling factors are required, chiefly having the autonomy to conduct comprehensive

health assessments in practice. This thereby enables the demonstration of expert skills in clinical decision making, diagnosis, management and treatment.

The NCNM (2008c) states that the attributes of knowledge and experience used by ANPs continuously informs decision-making through a collaboratively agreed scope of practice framework. Being a 'knowledgeable doer' and increasing professional effectiveness, as Schön (1983) theorises, involves the attributes of critical thinking, critical analysis and critical inquiry. Possession of these key attributes enables ANPs to practise their roles as skilled assessors, diagnosticians, decision makers and expert treatment givers. Fundamental to the fulfilment of advanced roles is the exercise of autonomy and authority to refer clients to other professionals and to independently admit, treat and discharge their caseload of patients (Manley 2000a and 2000b, Furlong and Smith 2005, Coster et al. 2006).

Hoskins' (2011b) systematic literature review acknowledges that these attributes are regarded as higher level competencies indicative of advanced nursing practice and are central to enabling ANPs to perform at an advanced level. ANPs are accorded certain rights as prerequisite to enabling and enhancing their role fulfilment. These key role extensions, referred to by Carryer et al. (2007) as legislated privileges, enable ANPs to practise at advanced levels. These privileges are summarised in the literature as:

- the right to make differential diagnoses
- authority to prescribe medication, medicinal ionising radiation, request pathology tests and independently treat clients
- organisational and management authority to implement changes to services
- the authority to case manage and collaboratively refer clients to other professionals
- the authority to admit and discharge patients
- the authority to certify specific certificates

MacLellan (2007) and Laperrière (2008) identified that an increase in clinical autonomy is required for effective performance of advanced practice roles. Accountability is also an integral concept in advanced practice. Higher levels of autonomy brings to the fore heightened clinical and professional accountability as Roberts and Vasquez (2004) revealed in their literature review. ANPs' role developments are indicative of this higher level practice. Carryer et al. (2007) found that the consequences of enabling advanced

practitioners to exercise these privileges results in a reduction in fragmentation of care, improved patient convenience and timely access to services benefiting patient care. Manley (1997) adds that the exercise of organisational authority by higher level practitioners enables the development and empowerment of staff, the development of nursing practice and consequentially the development of a transformational culture leading to quality care provision.

ANPs' extended rights are however exercised under defined individual organisational and national PPPGs and specified scopes of practice frameworks which are enforced and monitored through clinical governance structures. This presents an interesting dichotomy where ANPs have autonomy in practice and yet, simultaneously and conversely, organisational bureaucratic rules and regulations define their practice. Guest et al.'s (2004) evaluative study explored this aspect and they found that ANPs often practise within a narrow focus of a specific client caseload and act within strictly defined protocols. This could be perceived as limiting and restricting advanced practitioners' clinical criticality in decision making. To counter this assertion I would purport that it is more pertinent to judge the exercise of autonomy as in how the ANPs apply and enact their PPPGs, rather than them being constrained and rule-bound by them.

Analogous to this is the perceived comparative freedom in clinical decision-making that medical doctors demonstrate when undertaking the same practices. This significant historical disparity in clinical governance between the professions of nursing and medicine is demonstrated by ANPs' enablers and/or barriers to practise. Recognising cultural and organisational constraints and facilitators to autonomous practice has important implications to the promotion of expert practice and the practice development of immature professional roles, such as the ANP role in Ireland.

#### **3.4.1.2 Expert practice**

Nursing knowledge and expert practice has been the subject of many debates within nursing and social sciences as illustrated by Benner (1984) and Fairley and Closs (2006). The core concept of expert practice is defined as the demonstration of practical and theoretical knowledge with critical thinking skills. A distinctive feature of the expert practitioner in Ireland is that they are educated at master's degree level (or

higher) in a programme relevant to their area of specialist practice which encompasses a major clinical component. This enables ANPs to assimilate a wide range of knowledge and understanding which they apply in clinical practice. Benner's taxonomy positions expert level practice as the fifth phase in her stage theory; expert status is regarded as the pinnacle competency level obtainable. Benner (1984) suggests that an expert practitioner moves from rule-governed behaviour to intuitive, holistic and contextually determined behaviour.

Benner's work has been accorded worldwide acclaim. However a number of studies have conflicting findings, questioning if competence is indeed a linear escalating process. It is also suggested that the application of notions of 'competency' is reductionist, incongruent and contradictory to the concept of advanced practice (Manley 1997, Lakeman 2000, Stronach et al. 2002, Currie et al. 2007). The imposition of rigid 'competencies' on advanced nurse practitioners is ideologically mismatched as professional knowledge opposes standardisation, rationalisation and commodification (Freidson 2001). Yet competency frameworks in the form of key performance indicators (KPIs) (NCNM 2010a) and Draft Standards and Requirements for Advanced Practice currently awaiting ratification by the NMBI (2015b) are realised in practice. ANPs' adherence to clinical care guidelines is normative, whereas Benner, Tanner and Chesla (2009) contend that clinical guidelines de-contextualise and constrain thinking. This is similar to the imposition of PPPGs as discussed in the previous section. It could be argued that it is in how advanced practitioners implement clinical guidelines that demonstrates their higher level ability for contextual sensitivity and situational thinking, as opposed to being restrictive.

A number of key referral rights are accorded to ANPs because of their expert practitioner status. These include the right to diagnose, treat, refer, admit and discharge for the full episode of care. ANPs are regarded as being diagnosticians who demonstrate advanced health assessment skills, decision-making skills and diagnostic reasoning skills. These skills enable rapid patient assessment and assimilation of information often beyond the presenting problem. This is pronounced in emergency nursing where patients attend with undiagnosed and undifferentiated conditions. Small (1999) researched the case presentations in one large urban hospital ED over a period of one

year and found that a mirage of case presentations were seen safely, appropriately diagnosed and treated by ANPs.

ANPs' ionising radiation and medication prescriptive authority are regarded as important attributes in the fulfilment of their expert role and is particularly central to the ANPs' (Emergency) practise as their case management involves adult and paediatric trauma (Martin and Considine 2005, Considine et al. 2006, HSE 2009, Callander and Schofield 2011, NMBI 2012). Thompson and Meskell's (2012) retrospective comparative audit evaluated ANP (Emergency) outcomes of care. This was conducted in a general hospital in Ireland and identified that medicinal ionising radiation prescriptive authority is regarded as central to the performance of their unique diagnostic role and enables advanced practice to be realised. This is significant as in recent years (2012-2014) in Ireland, there had been a dispute over ANPs' rights to prescribe paediatric X-rays. The radiography body questioned the validity of the theoretical instruction that the ANPs had undertaken on the basis of it being generic and non-paediatric specific. A number of ANPs were impeded by the HSE from prescribing paediatric X-rays until a paediatric specific component was amended in their course curriculum (NMBI 2012). This impediment has now been rectified by placing a paediatric add-on component to the theoretical module, thus enabling the resumption of ANPs' prescriptive authority for paediatric X-rays nationally. The ANPs are now enabled to fulfil this important advanced practice role.

Thompson and Meskell's (2012) audit found positive evaluations of outcomes of care regarding radiological investigations, administration of analgesia and EDs waiting times for their clients. This is affirmed by Clancy's (2011) quantitative survey on medicinal prescribing. She surveyed a systematic random sample of ED nurses (n=337) and found that there was overall positive support towards nurses' role expansion into nurse prescribing. The literature suggests that the consequences of advanced practitioners enacting these developing roles enables hospitals to reach the national targets for speedy and timely access to healthcare and pain management; to reduce patient return rates to emergency departments; to promote cost effectiveness, and to promote safety by ensuring appropriate referrals pathways for their patients. I contend that this presents a convincing *raison d'être*, and yet interestingly elements of MDT professional antagonism appear to have impacted on the smooth assimilation of these

extended roles. This demonstrates how the authority for ANPs to practice as experts can be supported or negated by individuals' organisational culture and contexts. These organisational facilitators and barriers are explored in detail later in the chapter.

### **3.4.1.3 Professional and clinical leadership**

ANPs' professional and clinical leadership, as defined by the NCNM (2008c), identifies that the qualities of being pioneers and clinical leaders are key ANP attributes to enable the initiation and implementation of healthcare changes in response to patient and service needs. ANPs' role developments furnish vision and commitment to develop innovative practice provisions collaboratively with other healthcare professionals. Daly and Carnwell (2003) identify that 'role development' is synonymous with role extension and role expansion, and is more appropriate terminology in the advanced practice context. This is acknowledged in the Strategic Framework for Role Expansion of Nurses and Midwives: Promoting Quality Patient Care (DoHC 2011, p20) where both concepts of role extension and role expansion are described as supporting the practice development of nursing.

Mantzoukas and Watkinson (2007) observe that fragmentation of nursing care can result from role extension if a blurring of roles emerges. This is validated in Harmer's (2010) paper. Arslanian-Engoren et al. (2005) also adds that the focus on role extension raises concerns that a medical rather than a nursing focus gains dominance in ANP practice. Brown and Draye (2003, p393) report that nurse practitioners are frustrated that others focus on the medical components of their role rather than on their "blending of nursing and medicine". In Fisher, Steggall and Cox's (2006) study one consultant commented that the NP role was quasi-medical. The issue of ANPs' roles replacing or supporting doctors is discussed by Bryant-Lukosius et al. (2004). They argue in their paper that "the nursing components of the roles may become less valued and visible" (p524) if the primary focus of advanced practice roles are not defined in relation to health needs. The resultant effect is that ANP practices would be vulnerable to mirroring the logical positivist paradigm and perspective of medicine.

Hughes (2003) criticises comparing advanced practitioners with medical doctors as she argues that comparing ANPs with doctors fails to explicate the complexity of care delivered by nurses in such roles. Bryant-Lukosius et al. (2004) acknowledge that it is

particularly difficult to illuminate the often hidden qualities of caring and compassion, and to quantify the relevance that a nursing paradigmatic approach brings to the client experience. Ingersoll, McIntosh and Williams's (2000) research on nurse sensitive outcomes of advanced practice illustrates the importance communication for clients in their perception of being well cared for and to the development of a sense of trust in their nurse.

ANPs' role developments of educating, coaching and guiding through role-modelling, mentoring, sharing and facilitating the exchange of knowledge both in the classroom, the clinical area are leadership attributes accorded to ANPs. Higgins et al.'s (2014) study on advanced practitioners' enactment of leadership qualities presents a secondary analysis from the SCAPE study. Data from twenty-three case studies were analysed and four mediating factors were found to influence practitioners' abilities to perform their leadership attributes, notably (i) the presence of a framework for professional development, (ii) opportunities to act as leaders, (iii) mechanisms for sustaining leadership and (iv) personal attributes of the practitioners.

Higgins et al. (2014, p894) suggest that nursing and midwifery managers "have a key role in supporting leadership potential of advanced practitioners" through countering professional isolation by encouraging networking and expanding opportunities for practitioners to influence policies. The actual number of ANPs in this study was limited as the case study number of twenty-three also included clinical specialist nurses. However, it does raise some pertinent points as Ireland's current health policy framework proposes further expansion of advanced practitioners' leadership potential in order to promote the delivery of safe, quality care provision (DoHC 2011). The consequences of ANPs' practice development results in the professional development of nursing nationally and internationally, with subsequent nursing representations at strategic levels.

#### **3.4.1.4 Research**

The literature on advanced practitioners' research acumen is limited. Significantly however the NCNM classifies research as one of the ANPs' four core concepts. The NCNM (2008a) classify ANPs' research proficiency and ethical decision-making as enabling them to provide the best evidence-based practice in meeting both patient and

service need. ANPs are required to engage in nursing research in order to contribute to quality-assured patient care through the following: advancing nursing and health knowledge; informing policy and practice development; and implementing and evaluating healthcare practices. Application of evidence-based practice, audit and research informs practice which contributes to the professional body of nursing knowledge both nationally and internationally (NCNM 2008a).

Begley et al.'s (2010) study acknowledges that ANPs' research prowess was limited by time constraints due to pressing clinical work commitments. This was judged as impinging on their capacity to fulfil this core competency. Organisationally, protected time structures for research and audit are not generally universally applicable within Irish healthcare systems as identified by Begley et al. (2014). A reticence to actively engage in research may also stem from a lack of confidence regarding their research skills competence, both perceived and actual. Interestingly, after success at MSc level which requires a substantial research thesis, there appears to be limited evidence of further research studies or doctoral studies amongst ANPs currently in Ireland. A lack of research activity represents limitations for the further development of nursing's knowledge from an Irish context. A practice development strategy of targeting registered advanced practitioners through the promotion of PhD and professional doctoral study may assist in addressing some limitations by optimising ANPs' research potential.

It is not solely the conduct of research that defines this core concept as a broader spectrum of researcher attributes includes consultancy, teaching, leading a research culture through evidence-based PPPGs, journal clubs and audit. Begley et al.'s (2014) study on advanced practice highlights the views held by policy makers that advanced practice roles have a positive impact on guideline development in Ireland. Gerrish et al. (2012) in their study on the contribution of nurses in advanced practice roles acknowledge that advanced practitioners empower front-line staff to deliver evidence-based care. The attributes of advanced practitioners acting as research educators and role models enables support scaffolding to frontline nurses. This support scaffolding acts as an effective mechanism by advanced practitioners to promote frontline nurses' research proficiency. The success and outcomes of this support scaffolding and liaisons will be valuable to assess and audit in the coming years.

One method currently being employed in many Irish healthcare organisations is promoting collaborative research whereby ANPs are facilitated by their organisation to work in partnership with academics with the aim of producing quality healthcare research. I would contend that more than clinician-academic partnerships are required to promote ANPs' research productivity. Engaging in research requires significant investment in time, effort, management support, motivation, and finance from ANPs who in many instances carry a demanding clinical caseload alongside a significant educational portfolio.

To conclude, this critical review of the literature pertaining to the ANP role identified the key attributes and behaviours expected from ANPs by virtue of their role. Many theorists, including Berger and Luckman (1966), Searle (1995) and Bourdieu (1990) considered role and role development by looking at how social actors construct and learn how to act in their roles. As discussed earlier in this chapter, ANPs' roles are intended to reflect the attributes of advanced practice that is influenced by and in turn influences ANPs' positionality. The concept of advanced practitioner positionality is critiqued in the following section.

### **3.5 Critical review of the literature on ANPs' positionality**

Positionality is defined as a person's "location within shifting networks of relationships that can be analyzed and changed" (Maher and Tetreault 1994, p.164). Bourdieu (1990) proposes that positionality is the relational place or value one has that influences and is influenced by varying social, political, historical, educational, and economical contexts and their possession of capital. Bourdieu gives insight into an agent's positionality through the analysis of his key concepts. His conceptual framework enables insight into agents' positionality in the practice field through exploring the relational perspectives of practice, structures and social relations (Maton 2003). According to Bourdieu, an agent's practice is determined both by rational decisions and embodied dispositions of habitus. Bourdieu theorises that it is problematic to see individuals as separate from the situation in which they work. This is echoed in Hodkinson and Hodkinson's (2004) empirical research on communities of practice. Twenty-four papers relevant to the concept of positionality are illustrated in Appendix A and form the basis of the following literature review critique.

### **3.5.1 ANPs' positionality - attributes and enabling factors**

A country's healthcare system is the product of political, sociological, economic, cultural, and demographic trends. An example of cultural impact is provided in Barton and Mashlan's research (2011). They collected the opinions of thirty-eight professional and non-professional personnel in compiling a service review of an advanced nurse practitioner-led rehabilitation service in an acute hospital in Wales. They found that organisational cultural traditions impinged on service provision and they recommended that senior management act upon constraining factors to enable a developmental infrastructure to enhance service provision. This was also considered by Stevenson, Ryan and Masterson (2011) in their qualitative study on nurse and allied health professional consultants perceptions and experiences of their role. They conducted interviews and focus groups on non-medical consultants and stakeholder participants (n=15) and found that four themes emerged: role interpretation, role implementation, role impacts and challenges. A lack of organisational support was found to be a key challenge to the establishment of advanced practice roles. This is further explored by Stanley (2011) who contends that role developments, such as the advanced practitioner role, are now part of the organisational infrastructure in many contemporary healthcare systems. Appreciation of economic and political forces, that influence the structure and function of health care delivery systems, enables the nursing profession to decide how, and where, it is positioned in the emerging delivery system.

Stronach et al.'s (2002, p109) paper discusses the politics of professionalism regarding teacher and nurse identities. They comment that the nurse is "located in a complicated nexus between policy, ideology and practice; stressing the local, situated and indeterminable nature of professional practice". It is debated amongst theorists whether the person creates the world around them or whether social structures determine the characteristics and actions of people. The polemic nature of these positions is well documented. For example, the ethno-methodological paradigm purports the existence of social structure as a construct (Schutz 1972). In contrast, Functionalists like Durkheim and Marx from the Frankfurt School argue that individuals are only the bearers of social relations and therefore social relations, not individuals, are the proper objects of analysis (Crotty 1998).

However, Berger and Luckmann (1966) present an alternative position. They argue that there is a dialectical process in which the meanings given by individuals to their worlds become embedded into social structures. Coldron and Smith (1999) highlight the relevance of social constructs and institutional practices. Moreover Giddens (1993) adds the notion that a 'duality of structure' exists, and that structure is both the medium and the outcome of actions. Actions are thus conversely organised by structures. Theoretically his concept attempts to overcome the division between agency and structure. In order to affirm or negate this duality, it is pertinent to evaluate specifically the complex interrelationship between ANPs and the structures of both nursing and the healthcare field.

#### **3.5.1.1 Organisational influences**

Hunt (1999), Wilson and Bunnell (2007), Fullbrook (2008), and Drennan and Goodman (2011) confirm that the complexities of operationalising new practice roles in general, and specifically advanced practice roles, are subject to the nature of the organisation into which they relate. Furthermore, Currie, Finn and Martin's research (2008) states that professional institutions sustain professional hierarchies and power differentials. Therefore when new roles are formed in organisations, problems can arise with boundary spanning as changing patterns of work in professional organisations emerge. The field of nursing is influenced by many structural elements including: hierarchies, managerial orthodoxy; markets and policies; clinical governance structures; communities of practice; and cultural factors from the professions of both nursing and medicine (Hall 2005, Coster et al. 2006, Baxter and Brumfitt 2008, Hoskins 2011a, Manley, Crisp and Moss, 2011, Hardy et al. 2013). An amalgamation of these elements constitutes the complex organisational context within which ANPs practise.

A compounding organisational element, highlighted in Redfern's (2008) commentary paper, is the diversification of clinical specialities in which ANPs practise. This diversity renders transferability and comparisons problematic within and across studies. The influences that clinical specialisms have on specific outcomes require consideration as the concepts of individual structure and agency are significant, for as Bourdieu (1977) highlights they are intertwined. This confirms the need for empirical studies that focus upon one specific specialism of advanced practice. This is the underpinning

rational for opting to study one specialism, that of advanced nursing practice in emergency care, in this study.

Woodward, Webb and Prowse (2005, 2006) studied nurse consultants' characteristics, achievements and organisational influences through in-depth interviewing of ten nurse consultants. This study concluded that support systems had an important effect on practitioners' role achievements and role integration. The culture and structure of the healthcare organisation powerfully influenced participants' positionality. Woodward, Webb and Prowse's (2005, 2006) studies built on Guest et al.'s (2004) evaluation study, however their sample size was limited in location and number and thus additional research is needed to validate their findings. The study conducted by Kouzes and Mico (1979) identified that human service organisations are found to have distinct norms, identities and practices and they define the organisational context in terms of "domains of policy, management and service" (Kouzes and Mico 1979, p449).

Theoretically, organisational analysis brings to the fore organisational complexities (Burrell and Morgan 1979). In applying Kouzes and Mico's (1979) domain analysis to the ANP context it is apparent that ANPs are positioned in complex healthcare organisations where ANPs' norms, identities and practices differ from other members of the organisation as they occupy unique policy, management and service paradigmatic positions. If an organisational culture enables the ANP to have autonomy and management authority to implement changes to services, they can then influence the organisational contexts by acting as effective change agents. Supportive structures are regarded as fundamental to enablement and empowerment of ANPs to act from a position of authority and clinical credibility (Gerrish et al. 2012). As a consequence without key support scaffolding at organisational level ANPs will not be enabled or empowered to practise at advanced levels.

Hardy et al.'s (2013, p1103) research provides insight on the potential that transformational practice development has in enabling advanced level practitioners to engage collaboratively with transformational change within organisations. In addition, Wenger (1999) posits that positive interprofessional and intraprofessional relationships within communities of practice are required to enable effective role transitioning. Kennedy et al.'s (2011, p 19) systematic literature review examining the impact of nurse consultant roles in adult healthcare settings throughout the UK, concurs with Wenger

(1998) that when establishing new posts areas of potential difficulty, such as staff conflict, should be considered. This is important because understanding potential practice-based issues, at both macro and micro healthcare systems levels, would inform appropriation of training support and practice development methodologies for nurses in ANP roles (McCormack, Manley and Titchen, 2013).

Manley et al. (2011, p1) identified that “the culture of the healthcare workplace is influential in delivering care that is person-centred, clinically effective and continually improving in response to a changing context”. Rischel, Larsen and Jackson’s exploratory study (2008) adds that the social world of nursing is situational and based upon the relations of agents within the field. They undertook twelve structured non-participant observations of nurses’ competence in admission assessments. They theorise that the practice of nurses depends on their habitus and positions in social space and they could not verify Benner’s developmental model empirically. Due to the specialist nature of their roles ANPs’ habitus and position is unique from other agents and other fields. Tye and Ross’s (2000) case study research evaluated the emergency nurse practitioner role and found that the operational configuration of ANP roles means they often practise in isolation within the defined specialism of emergency care. This distinctive nature of their practice means ANPs inhabit a unique position within the healthcare field, resulting in ANPs’ positionality being neither aligned to a generalist nurse nor a medical doctor.

Bourdieu (1990) theorises that the possession of various forms of capital influence an agent’s positioning within their field, and hence within their social world. He theorises that the possession of capital, in its various social, cultural and economic forms, are important elements in locating where and how the ANP is positioned. Rischel, Larsen and Jackson (2008, p514) emphasise that nurses’ symbolic capital is distinct from doctors as “in the field of medicine the institutional form of cultural capital, including acknowledgement of the academic scientific discipline, is dominant”. Significantly, ANPs’ boundaries span both the fields of nursing and medicine in their practice and thus are exposed to the hierarchical legacy of the dominance of medicine’s cultural capital (Currie, Finn and Martin 2010, ter Maten-Speksnijder et al. 2014). The distribution of capital in nursing and medicine has significance on the positionality of the ANP role in the field of healthcare which in turn impacts upon ANP identity. ANPs’

capital is different to that of a doctor and a generalist nurse, and this is reflected in their altered power base and altered position in the field.

ANPs are positioned at Assistant Director of Nursing (ADON) grade; classified as a senior nursing grade. This is reflected economically through being positioned on the higher level nursing pay scales on a par with ADONs, with a starting salary of €54,870 with increments up to a maximum of €65,066 (INMO 2014b). ANPs' salaries are comparable with a junior doctor, but ANPs are disadvantaged by less incremental potential. The difference in higher ANP and lower newly qualified nurse pay scale (starting salary of €27,211) reflects the difference in scope of practice and status, a point which again places the ANP in a uniquely precarious position. The economic analysis undertaken as part of the SCAPE study states that cost implications for employing ANPs versus medics in Ireland was cost neutral (Begley et al. 2010). While additional costs were associated with higher salaries paid to ANPs these were offset by an increase in productivity and economies of scale. Further research on cost implications for admission/re-admission rates; chronic disease management; and ANP practices are required in order to confirm ANP economic viability.

Stanley (2011) contends that the position of advanced practitioners within an organization has been influenced by a number of professional internal and external factors. ANPs' higher levels of autonomy, accountability and independent decision-making serve to legitimize ANPs' positionality as professional and clinical leaders within nursing's hierarchy. This positionality is important to enable ANPs to potentiate change and to practice at a higher level. Research suggests that once collegiality is experienced, problems between or among groups diminish and this results in a mutual acceptance of roles within healthcare communities of practice and reduces professional isolation (Currie and Couch 2008, Melby, Gillespie and Martin 2010, Maylone et al. 2010, Higgins et al. 2014). I would contend that it is not always a conscious universal mutual acceptance but may reflect more acquiescence to organisational order. In order to explore ANPs' inter and intraprofessional relations their communities of practice will be critiqued in the following sections.

### **3.5.2 ANPs' communities of practice**

My literature search revealed a small number of generalist data pertaining to nurse-doctors interprofessional relations. Some of this may be transferable but, as discussed in the previous sections, the change in ANPs' role and position results in altered unique relational dynamics and power differentials within the healthcare field. However, only a small number of empirical studies consider specifically ANP-medical doctors interprofessional relations; ANP-nurse intraprofessional relations and ANP-MDT professional relationships.

#### **3.5.2.1 ANPs and medical doctors**

Social theorists, including notably Etzioni (1969) and Freidson (2001) have studied the differences in status between the professions of nursing and medicine. Their theories confirm that dominance by the medical profession over the nursing profession has been normative. In the contemporary structure of healthcare in Ireland, the superior status and dominance by medicine is still evident, albeit with less overt direct power. This was identified in Tye and Ross's (2000) study that revealed changing shifts in power, authority and control are occurring within the healthcare field into which the ANP role is developing. This may be one of the key reasons why the ANP role has been permitted to develop at all, for as Carrier and Kendall (1995) found, doctors were relinquishing exclusive claims to some dimensions of practice and were willing to work collaboratively with nurses. Interestingly, the choices of which dimensions of practice are shared remains tightly controlled by medics. I would question if this willingness stemmed from a genuine desire for shared practice or originated and was motivated by socioeconomic demands and organisational service needs.

Lloyd Jones (2005) and Coster et al. (2006) identify that there is a lack of empirical evidence to corroborate the assertion that wide acceptance of ANP roles is the norm, especially as empirical evidence is limited. Tye and Ross's (2000) case study suggests that opposition to establishing these roles stemmed from concerns by a number of medics that relinquishing aspects of their case loads and skills set to ANPs would diminish their professional status. Tye and Ross (2000, p1095) caution that:

Thus, while supportive of the [ANP] role at its current stage of development, the medical staff appear to have some reservations about where future boundaries should be drawn.

Indeed, an additional difficulty to ANP positionality is the reported opposition from some members of organised medicine to the role nationally and internationally (Plager and Conger 2007). In Sweden, Lindblad et al. (2010) report some opposition from General Practitioners (GPs) to the new role of ANPs in primary care. This opposition is also seen with regard to prescribing roles in the US. The literature cites that some doctors are reluctant to “accept that nurses should be allowed to undertake certain advanced skills” (Norris and Melby 2006, p260). Some resistance by doctors to the nurse practitioner role also occurred in New Zealand, but O’Connor’s (2008, p.13) view more recently is that doctors have “mellowed” to the ANP role.

Similarly, in Ireland, Griffin and Melby (2006) reported reticence from some medics in their quantitative research study. They conducted a survey into attitudes of nurses and doctors towards developing an advanced practitioner service in emergency care and found that General Practitioners (GP) are less positive than emergency doctors towards the development of advanced nursing practice roles in emergency nursing. They attribute this to be because GPs have a poorer understanding of advanced practice. In Lloyd Jones’s (2005) systematic literature review cites a reason for this reticence includes concerns by GPs that the ANP role would result in a diminution of medical power, status and control. In contrast, Begley et al.’s (2010, p305) study in Ireland reported “unanimous support from consultants and senior doctors in the advanced practitioner post-holding sites”. They asserted that the medical profession had a positive view of ANPs. I would recommend that further data is required to substantiate this assertion.

Baumann et al. (1998, p1042) highlight that the ANP role is complementary aiming to distill the best of nursing with the best of medicine, as they contend that advanced nursing practice “places the emphasis on the individual needs of the patient, rather than what should be done by doctors as opposed to nurses”. The dichotomy between the concepts of a positivist medical model versus a holistic nursing model, especially within the context of advanced practice, has been widely debated in national and international literature (Smith 2003, Guest et al. 2004). The current ethos within nursing and medicine is on promotion of interdisciplinary shared learning in higher education and integrated care planning in the clinical area. However, Callaghan (2008) questions if these contemporary changes in the practices and education of nurses and doctors reflect

a deeper more complex reality than that which has previously been simplistically portrayed. Indeed, these changes have implications for the future development of professional socialisation and nurse-doctor interprofessional relationships.

Callaghan (2008) identifies that tensions remain surrounding the interdisciplinary relationship, a notion to which Smith (2003) and Woodward, Webb and Prowse (2005) concur. In Woodward, Webb and Prowse's (2005) UK-based study, ten nurse consultants described their working relationships with medical colleagues as mixed. Some respondents described positive support from medics whereas others found the relationship more challenging. Professional antagonism is quoted as a possible undercurrent generated from a lack of collegial understanding of the advanced practice role. The small sample size of this study limits generalisation, however the feelings of professional antagonism experienced by the nurse consultants are important to acknowledge. There are many subjective anecdotal debates into nurse-doctor relationships, but there are limited empirical research studies generally and these are specifically scant regarding ANP-doctor interprofessional relations (Carrier and Kendall 1995, Corley 1998, Blue and Fitzgerald 2002). Schadewaldt et al. (2014) reflect that recent definitions of collaboration describe it as being based on communication, shared decision-making and the respect and equality of team members. However, research demonstrates a tension between this theoretical ideal and how collaboration between nurse practitioners and medical practitioners occurs in practice. Different cultural norms and socialisation processes of the two professions influence these collaborative practices.

Contemporary changes, such as the ANP role, are regarded as promoting changes to professional interactions that result in a power balancing in nurse-doctor relations (Fitzgerald and Teal 2004). In addition, Pullon (2008) adds that while effective interpersonal relationships between nurses and doctors can exist, this is not always universal.

### **Clinical governance**

Brown and Draye (2003, p393) highlight in their descriptive study that ANPs sought to create:

a new kind of collegiality with physicians that facilitated peer level consultation, with shared information and responsibility, and collaborative clinical decision making.

This is realised in the clinical area with ANPs having unique clinical governance structures and mechanisms. Notably ANP's reporting relationships and supervision for their clinical practice is with their medical consultant, and not their director of nursing. This is a departure from the normative lines of reporting relationships within traditional nursing. The dynamics of these new relationships have implications for interprofessional relations especially when cognisance is taken of the legacy of medical dominance over nursing. Barton (2006b) notes that there is limited empirical research into this mentorship aspect. He conducted a small ethnographic study researching ANP mentoring and he found that conflicting experiences were seen in the previously unexplored ambiguous relationship between ANPs and medical mentors. However the NCNM (2008a) emphasise the importance of ANPs having established lines of direct clinical assessment of competence by their medical colleagues in order to ensure clinical supervision and clinical governance.

In operationalising the ANP role, the NCNM (2001) set additional unique conditions requiring accreditation of the person and accreditation of the site. In addition, ANPs currently must apply for reaccreditation every five years. These two factors are significant to the ANP role and significantly add a layering of clinical governance not experienced by any comparable nursing or medical roles. Site accreditation is intended to ensure organisational readiness as organisations that are appropriately prepared, committed and supportive of practice development in their organisation have improved innovative success (Manley et al. 2011). To gain accreditation certain conditions were required to be put in place and documentation submitted. Ingram (2014) outlines the key aspects of the accreditation and registration process in detail in her opinion article and highlights their multi-factorial nature. This accreditation process was intended to promote the involvement of key stakeholders locally, including medical consultants, as this was regarded as central to successful advanced practitioner role development at individual hospital level. The second condition was that five years following registration ANPs are required to apply for reaccreditation by demonstrating their competency attainment through the fulfilment of the ANP four core concepts. This is also a unique formalised element to ANP practice, although evidencing and measuring nurse competency attainment is becoming normative across the nursing profession.

Brown and Draye's (2003) descriptive study of nurse practitioners (n=50) in the US, question if mentoring by doctors threatens the autonomous nature of advanced nursing practice and the potentially negative implications of restricting autonomy. However they found that creating new working relationships based on collegiality enabled an effective collaborative working model in practice which resulted in closer professional working relations between medics and ANPs. Callaghan (2008, p210) terms this collaboration as "the synergistic way forward". Collaborative practice is said to provide a solution to many of the rigid hierarchical traditions of nursing and medicine, as individuals involved in collaboration act by power-sharing based on knowledge and expertise, as opposed to role and function (Henneman, Lee and Cohen 1995, Manley 1997).

Educationally the current emergence of interdisciplinary approaches to blended learning by the professions of nursing and medicine is illustrated by Mitchell et al. (2013). They propose that understanding the complex affective, behavioural and cognitive dynamics in interprofessional teams assists in promoting the development of shared group identity and, as Manley et al. (2011) explored, the emergence of effective workplace cultures. Whilst this appears ideal, I suggest that it would be naïve to consider that the adversarial legacy of division between nurses and medics can be eradicated totally and completely, but there does appear to be a move towards an acceptance of the mutuality of nursing and medical practice.

### **3.5.2.2 ANPs and frontline nurses, clinical nurse managers and ADONs**

Bourdieu (1998) theorises that the possession of social, cultural, and economic capital reflected through their symbolic capital is important in legitimising where and how the agent is positioned. Significantly ANPs' capital is distinct from generalist nurses as reflected in ANPs' practice; position; education level; grade; remuneration; and registration (An Bord Altranais 2010a; INMO 2014b, NMBI 2015a).

ANPs practise autonomously in the clinical field; however they are part of a wider emergency team which includes nurses of different grades and roles. Frontline nurses, clinical nurse managers (CNM1, CNM2 and CNM3), assistant directors of nursing (ADON), and a director of nursing (DON) are part of this network. Advanced practitioners are situated at the same nursing grade and seniority level as ADONs.

ANPs report to the DON for nursing governance, and as mentioned in the previous section, their clinical governance is with the medical consultant. This bipartite governance structure places ANPs in a unique position and this, it is suggested, may lead to a lack of understanding of advanced practice roles and positionality by other nursing grades within the healthcare field.

A point alluded to in Brown and Draye's (2003, p394) study is that some of the nurse practitioners interviewed recounted they had been accused, by some nursing colleagues, of "no longer being nurses". The nurse practitioners regarded this as a negative assertion as they did not want to be thought of as doctors and vehemently aligned themselves, and their identity, to being nurses. However many nurse colleagues, and also patients/clients, reportedly judge ANPs as aligned more to a doctor than a nurse (Lloyd Jones 2005). He also found that negative attitudes towards advanced nurse practitioners from other frontline nursing staff were experienced and were attributed to feelings of uncertainty over ANPs' roles and identity.

Woodward, Webb and Prowse's (2006, p274) study identifies that professional nurse to nurse antagonism is a reality for some practitioners as illustrated by one nurse consultant's stark comment that her experience of working with other nursing colleagues was comparable to "swimming with sharks". They attributed this to a lack of understanding of the advanced practice role. This tension is also explored by Bryant-Lukosius et al. (2004) who note that ANPs expend considerable effort overcoming role conflicts and resistance from nurses in the clinical areas. Interestingly little has been written in the national and international nursing literature on this aspect specifically and this research study aims to enable insight into relationships between ANPs and frontline nurses within the clinical field.

### **3.5.2.3 ANPs and the multidisciplinary team**

ANPs' communities of practice are compiled of many aligned healthcare practitioners, including occupational therapists, physiotherapists, social workers, and radiographers. Hall (2005) acknowledges that complex phenomenon of interprofessional working in healthcare presents a mirage of educational, systemic and personal issues. Baxter and Brumfitt's (2008) case studies found that professional differences in interprofessional working emerged as a significant theme. Professional knowledge is a complex concept

with professional difference impacting upon practitioners' interprofessional working. Little research has been conducted specifically on advanced practitioners' interprofessional team-working with their multidisciplinary colleagues, however some insight has been gleaned, building on the studies of Norris and Melby (2006) and Griffin and Melby (2006), by Melby, Gillespie and Martin (2010).

Melby, Gillespie and Martin (2010) undertook a mixed-method triangulated approach to exploring the views of health professionals of emergency nurse practitioners in one acute trust in the UK. The study was methodologically limited though it did add to the understanding of MDT interprofessional working. A questionnaire survey was distributed to 505 staff and only 144 responded, yielding a poor response rate of 28.5%. The demographics identified that the majority of respondents were nurses (n=100) and doctors (n=27). Some MDT members responded namely pharmacists (n=5) and radiographers (n=12). Significantly no physiotherapists, social workers or occupational therapists were included in the sample population. This compromised the validity of the findings as these MDT members are key referral practitioners for ANPs, as previously identified. A point of critique is that surveys were given to all 17 radiology and radiography staff and 12 were returned giving an uneven representation with a 70% response rate for this discipline. The study is not generalisable though it did find that health professionals were generally supportive of an emergency nurse practitioner service. However concerns were raised in relation to acceptance by MDT and "the potential for role conflict within and between different MDT members were indicated as considerable challenges to service providers" (Melby, Gillespie and Martin 2010, p240).

Hoskins (2011a) in her literature review on interprofessional working identifies that a great deal of progress is needed in order to fully augment interprofessional practice. She concludes that the nurse practitioner role is seen as moving from role substitution to maturing and evolving into interprofessional working. She does however highlight that there is a need for greater robust research on the topic of the emerging non-medical roles such as the advanced practitioner role in emergency care. I recommend that further research on the MDT community and their attitudes towards ANPs is required as this is an important dimension to consider when reviewing ANPs' positionality within the healthcare domain. This study intends to explore this under-researched element. In summary, this critical appraisal of ANPs' positionality has identified that being

appointed an ANP results in an alteration of their positioning within the healthcare field. The positionality experienced by ANPs is influenced by, and in turn influences, the establishment of their professional identity.

### **3.6 Critical review of the literature on ANPs' professional identity**

Fagermoen (1997) defines the theoretical concept of professional identity as one's professional self-concept based on attributes, beliefs, values, motives, and experiences. According to Jenkins (2008) professional identity involves an individual's experiences and feelings of oneself, for example, a person's experience of being a nurse (self-concept), and others' image of that person as a nurse (social image). This concept forms part of workplace cultures where group interactions, and how people compare and distinguish themselves with other professional groups, emerge. Bourdieu (1990) theorises that the influence of the structural features of the social world plays an important role in identity formation.

Professional identity is formed as a component of a person's overall identity relative to their position in society, interpersonal relations and interpretations of their experiences (Fagermoen 1997, Hall 2005). Johnson et al. (2012) contend that professional identity is a term that is often written about in nursing literature, and yet little empirical evidence exists with regards the formation of ANP identities. In their discussion paper, ten Hoeve, Jansen and Roodbol (2013) explain that nurses derive their professional identity attributes from: their work environment and work values; education and career choice; and social and cultural values. Manley et al.'s (2011, p2) research into effective workplace cultures acknowledges the complexity of the healthcare practice setting with "the social contexts that influence the way people behave and the social norms that are accepted and expected". Appendix A illustrates fourteen studies relating to the concept of ANPs' professional identity.

#### **3.6.1 ANPs' professional identity – attributes and enabling factors**

Professional identities are said to be developmental throughout practitioners' nursing careers. Woods' (1999) research recognised that the socially constructed context and conditions of expert nursing roles, and transitional phases, are influenced by past experiences, education and practitioners' interpretation of their role.

### **3.6.1.1 “The fish in water or the fish out of water” Role transitioning – becoming and being an ANP**

It is acknowledged that nurses undergo a series of transitional phases in their journeys from nurse to becoming an ANP. Initially, a transition from nurse to an ANP candidate takes place. A second transitional stage is said to occur following successful course completion when the ANP candidate moves to being a registered ANP. Bourdieu (1990) theorises that personal and professional transitions are individualistic processes. However learning the artistry and craft of a new workplace role involves the experience of situational, personal, professional and cultural change. A change in occupation or role is an example of a transitory experience; these transitions involve alterations in a person’s sense of self. Bourdieu’s theory of habitus is regarded as internalised histories and experiences that work to generate and organise practice, and in turn enable individuals to cope with unforeseen and ever changing situations (Maton 2008). Bourdieu (1990) says that it is in how an individual practitioner reconciles their concepts of habitus, field and capital internally that determines their experiences of harmony or disharmony in situations of transition. This he likened to “the fish in water or the fish out of water” experience (Bourdieu 1990, p108).

#### **Transitional passage**

The nurse to ANP transitional passage is analysed in Woods’ (1999) longitudinal case study research conducted over a two year period. He explored the personal and practice development of the ANP during their transitioning into the advanced practice role. He used multi-method data collection from ANPs (n=5) who worked in different nursing specialities. Relevant to this study, one ANP was from the emergency nursing discipline. The ANPs’ colleagues including nurses, managers, junior doctors and a university lecturer were interviewed. His research discovered that three discrete stages mark the transitional processes an agent transcends when journeying from experienced nurse to nurse practitioner.

The first stage represents a state of “idealism of reconstruction” with the ANP and organisational personnel viewing the ANP role development as a nemesis for their healthcare service. However, idealism is viewed with scepticism when conflict is experienced between the expectations and reality as seen in Woods’ (1999) second stage: “organisational governance”. Structure and situational demands can be regarded

as significant socialising agents for the developing new role. The complexity of educating advanced level practitioners within healthcare workplace environments is considered by Hardy et al. (2013). Analysis of their case studies found that ANPs discovered, in contrast to their initial optimism, that their orientation, goal, and delivery of their role are controlled by key stakeholders within their organisation. In the healthcare field, key stakeholders are regarded as medical personnel and managers. Emergence of professional-bureaucratic conflict can implode on initial idealism and can manifest as conflicting and challenging experiences. The third stage “resolution” emerges towards the end of the second year in post and is regarded by Woods (1999, p126) as a period of “reluctant acquiescence and acceptance on the part of the advanced practitioner”. This stage signals a levelling where ANPs accept organisationally imposed role limitations and begin to work within the pre-negotiated parameters of their role.

His findings concluded that “the transitional process appears to require the practitioner to ‘reconstruct’ their practice and professional frame of reference” (Woods, p122). Influenced by a multiplicity of factors ANPs reconstruct their professional self in order to flourish as higher level advanced nurse practitioners. Woods’ research is significant as it gives some insight into an under-researched aspect of advanced practice. However a point of critique is that limitations of sample size (n=5) and variance of speciality (n=5) impedes the synthesis of understanding from within and between case comparisons. In order to validate his stage theory it would have been valuable to look further into the many situational variables which influence individual ANPs’ social and practice experiences of role transition.

Johnson et al.’s (2012) theoretical critique concurs that there is a need for additional studies on student-to-graduate identity development and on the theoretical concepts that underlie professional identity. This, they contend will reveal the potential to enhance nursing career support and improve workforce policies. I contend that further transitional levels emerge as the person and the role evolve and that points exist beyond reaching Woods’s (1999) resolution or achieving Benner’s (1984) expert status. This is a significant aspect which requires further research as transitional elements and a reconstruction of one’s professional identity have implications for ANPs’ personal, professional and practice development.

Aspects of Woods' contingent nature of advanced nursing practice are reminiscent of Benner's seminal work 'From Novice to Expert' (1984). Her descriptive study applied the Dreyfus and Dreyfus model of skills acquisition to the nursing context. She observed and interviewed sixty-seven nursing participants across six different hospitals in the US. Her findings stated that nurses progress through five stages of skills acquisition: from novice, advanced beginner, competent, proficient, to expert. Interestingly advanced practitioners are regarded as 'expert' and yet due to the difference in their competencies to generalist nurses it could be suggested that new layers could be added to Benner's model, namely that of 'novice expert', 'advanced beginner expert' and so forth. Further longitudinal research would be pertinent to investigate this theory regarding ANPs learning trajectories.

The ANP role represents a new role and a new person in that role, yet it has been developed and exists as part of an established institution. These three variables are influential in the contingent nature of ANP role transition as Barton's (2007) qualitative ethnographic study on 'student nurse practitioner – a rite of passage?' explored. He researched ten student nurse practitioners over a two year programme in the UK and eleven of their medical/academic mentors. Data was collected through semi-structured interviews and field notes and revealed that student nurse practitioners revealed a complex three stage composite of social, cultural and professions comparable to Van Gennep's model of social interaction. Role theory and theories of socialisation provide some underpinning theoretical reasoning as to why transitional processes are influenced by a person's structure and agency.

Ten Hoeve, Jansen and Rodbol (2013) and Johnson et al. (2012) concur that the manner in which nurses are primarily socialised into the culture and norms of their role is promoted through the formal and informal educational contexts that they encounter. ANP candidacy course design incorporates clinical placements integrated with university-based theoretical lectures (Benner, Tanner and Chesla 2009). Experiential learning placements are regarded as actively supporting professional identity development through promotion of role modelling and mentorship for ANP candidates by registered ANPs. This forms the modus operandi by which ANP candidates learn their artistry, craft, knowledge and skills. The learning of implicit and tacit knowledge of how to act and behave as an ANP, and gain a sense of what it means to be an ANP in

a professional sense is important. The collective awareness of values, practices and purposes inherent in the ANP role can then be realised and replicated as ANP candidates' transition and flourish as registered ANPs.

### **3.6.1.2 Professional self-concept**

Johnson et al.'s (2012) conceptual analysis claims that the theoretical concepts underpinning professional identity are linked with overall professional self-concept. The theoretical concepts of agency and identity are extensive. A number of paradigms have been critiqued in previous sections of this literature review, thereby reflecting the inter-linkage of structure and agency that Bourdieu and Wacquant (1992) theorise. Application of Bourdieu's relational analysis of habitus, field and capital serves to illuminate a number of the key elements with regards to ANPs' role, position and identity (Bourdieu 1990). Significantly, Brown and Draye (2003, p394) found that rather than being seen to represent clinical nursing expertise, advanced nurse practitioners reported being told that they were "no longer being nurses". This may have implications for the ANP regarding their perceptions of how other clinicians view them, and in turn may be internalised to alter how they then view themselves.

Ten Hoeve, Jansen and Roodbol's (2013) discussion paper emphasises the impact that other people's perceptions have for nurses in their professional identity formation. Negative perceptions are reported to manifest in a lowering of a nurse's self-concept whereas positive perceptions add to heightened a nurse's self-concept. Research by Coldron and Smith's (1999, p711) into teacher identity adds to this theory:

Identity as a teacher is partly given and partly achieved by active location in social space. Social space is an array of possible relations that one person can have to others. Some of these relations are conferred by inherited social structures and categorisations and some are chosen or created by the individual.

As previously illustrated in Chapter 2, the literature identifies that ANPs have a unique agency and identity, and as ANPs' self-concept and social image are developing their professional identity is evolving. I would contend that it is because of their uniqueness that ANPs appear to have formed their collective identity as a unified homogeneous group.

It is questionable if a comprehensive empirical role evaluation can be robust if it is carried out irrespective of studying personal qualities of individual ANPs. This point is

noted by Tye and Ross (2000, p1095) who highlight that their study on ANPs “reinforces a basic, yet frequently ignored, premise that any role is inevitably a reflection of the individual assuming the parameters and responsibilities of that role.” As highlighted previously, Mantzoukas and Watkinson (2007) and Spross (2014) suggest some key generic advanced practitioner attributes. However, theories of identity struggle to balance the social construction of identity with individual agency. If and how personal attributes can be isolated in relation to professional identity are debated concepts within the social sciences (Hacking 2007, Mackey 2007). Currie, Finn and Martin’s (2010, p954) study notes that tensions between individual and collective identity constructions exist and that “this is a broadly neglected area in the debates of changing roles of health professions”. Stronach et al. (2002, p121) add that this provides an epistemological deconstruction of professional identities where the plurality of identities is critically evaluated and that “professionals walk the tightrope of an uncertain being”. I suggest that the agency and identity that ANPs experience is synonymous with this portrayal.

### **3.6.1.3 Professional boundary spanning**

Collective and individual constructions of agency and identity are of particular importance to ANPs whose roles “boundary span” the professions of medicine and nursing, and whose unique positionality renders them vulnerable to interprofessional institutional structures and “relational identities” (Currie, Finn and Martin 2010, p955). It is acknowledged that this is due to the unique multifaceted nature of ANPs’ roles and specialist practice arenas. Institutionalised relationships of status and recognition are important concepts for ANPs’ positioning across medical and nursing fields. This phenomenon is discussed by MacDonald and Ritzer (1988), Dwyer and Taaffe (1998) and McCarthy (2000) in their explorations of historical and contemporary power discourses between the two professions. The ANP is on the frontline as changing relationships are developing and evolving. Ponte et al. (2007) acknowledge that the duality of working alongside and with medics, who undertake the same patient portfolio but who practise within different parameters is a significant challenge. In addition, working with frontline nurses who practise at Benner’s (1984) non-expert stages is also significant.

### 3.7 Summary and Conclusion

In summary, this critical literature review has identified that the theoretical concepts of role, positionality and professional identity are multifaceted and that the relationship between each concept is unique to ANPs in the healthcare field. A critique of empirical studies on the advanced nurse practitioner role, positionality and professional identity in emergency care identified limitations of empirical evidence methodologically from both Irish and international literature. This review concluded that there remains a notable lack of empirical evidence from ANPs' perceptions. Research predominately focused on quantitative outcome measures such as patient satisfaction; through-put numbers; referrals made; readmission rates; and costing. As a result of this critical analysis of the literature I intend to study the under-researched concepts of role, positionality and professional identity from ANPs' perceptions.

In conclusion this critique has provided balanced judgements about the current state of knowledge. The gaps in knowledge identified in this literature review are:

- limited qualitative data internationally and from Ireland on the advanced nurse practitioner role
- deficit in contextual data from Ireland on ANPs in general and specifically on ANPs (Emergency)
- dearth of empirical data from ANPs'(Emergency) perceptions of their role, positionality and professional identity
- limited research on elements of the transitional experiences from nurse to ANPc, from ANPc to RANP, and beyond registration as an ANP

This lack of robust empirical research from qualitative methodologies is significant, as in order to provide a comprehensive portrayal of advanced nursing practice roles both qualitative and quantitative paradigmatic approaches are required. My research project arose from this literature review as a deficit in qualitative introspective research was identified. This study aims to address this deficit through exploring the perceptions of ANPs (Emergency) regarding their role, positionality and professional identity by addressing the following four key research questions:

1. How do ANPs describe their reasons for becoming an ANP and their transition from their previous nursing role to becoming an ANP?
2. What are ANPs' (Emergency) perceptions of their role?

3. What are ANPs' (Emergency) perceptions of their positionality?
4. What are ANPs' (Emergency) perceptions of their professional identity?

In order to address these questions it is important to theoretically frame this study, therefore the following chapter presents a critical review of the methodological thinking underpinning this study's philosophical assumptions.

## CHAPTER 4 RESEARCH METHODOLOGY

### 4.1 Introduction

This chapter presents the methodological reasoning and underpinning philosophical assumptions of this study. Guba and Lincoln (1994, p105) state that:

Questions of method are secondary to questions of paradigm, which we define as the basic belief system or world view that guides the investigator, not only in choices of method but in ontologically and epistemologically fundamental ways.

Bourdieu's theory of practice has been used as a theoretical framework in a variety of research domains, including the nursing paradigm. As Bourdieu does not prescribe the use of any one methodological approach (Rhynas 2005), I am proposing to apply Bourdieu's model (1990) within a narrative methodology as an appropriate theoretical frame for researching ANPs' perceptions of their role, positionality and professional identity. Paradigmatic justification for this proposal is presented in the following sections.

### 4.2 Qualitative research – ontological and epistemological considerations

Variations in theoretical thinking are founded upon differing ontological and epistemological positions on the study of the nature of being and the nature of knowledge (Grix 2002). A move to increase flexibility and move away from past rigidity of theoretical approaches has seen an emergence of developments in theoretical and methodological positions (Crotty 1998). It may be that one methodology is appropriate or perhaps a methodological 'bricoleur' approach may serve as the best approach to answer the research question. In recent years, methodologically pluralistic approaches have been utilised in healthcare research as a means of capturing the full complexities inherent within the healthcare setting. If Guba and Lincoln's (1994) position is accepted, the basic belief system or world view that guides this research needs to be explained. It is essential that my beliefs on the nature of reality (ontology) and how knowledge is obtained (epistemology) are presented, as it is on this basis that my methodology is grounded.

A constructivist approach states that knowledge of the world is mediated by cognitive structures resulting from the mind-environment interaction (Teddie and Tashakkori 2009). This infers ontologically that reality is both individually and socially constructed.

Epistemology is the way in which we understand and explain “how we know what we know” (Crotty 1998, p8), and methodology is how we go about uncovering that knowledge (Grix 2002). In the quest to find the best theoretical fit for this study I reviewed various approaches including ethnomethodology, phenomenology and narrative. I decided against using ethnomethodological and phenomenological approaches because they did not provide ontologically the insights that this research sought. A narrative approach in naturalistic inquiry is grounded on assumptions that attempt to enable insight into people’s realities and this approach would enable insight into ANPs’ perceptions.

One advantage of using a narrative approach over other approaches is that a narrative approach is effective in enabling participants to story-tell their experiences and transitions as a life story (Nairn 2004, Taylor 2011). This eases disclosure as participants sequentially recall and narrate their life experiences. This presumption and the rationale underpinning why a narrative approach was chosen for this study will be further presented and analysed in this chapter.

An appropriate theoretical framework was required to ontologically and epistemologically frame this narrative methodological approach (Craib 1992). I considered a number of theoretical frameworks including Benner (1984), Habermas (1984) and Bourdieu (1990). Benner’s framework did present an interesting overview of the process of nurses’ experiential learning but I did not judge it to be comprehensive in dealing with this study’s tripartite focus of role, positionality and identity. I do however draw on some of Benner’s theorem when looking at novice to expert transitional stages. Habermas (1984) provides critically renowned theories on power, legitimacy and communication. However I felt that a broader theoretical framework was required to underpin this study’s epistemological quest. I favoured Bourdieu’s key concepts as the appropriate theoretical framework for this study because his ‘thinking tools’ of habitus, field and capital provide a comprehensive base upon which to investigate role, positionality and identity in the practice domain of ANPs (Emergency). This will be expanded on further in the following sections.

Based on these ontological and epistemological positions and underpinning rationale, methodologically combining Bourdieu’s theory and a narrative approach appeared to be

appropriate with my thinking and the research focus of this study. The following paragraphs present the underpinning rationale for this bricolage approach.

### **4.3 Bourdieu's theoretical framework: ontological and epistemological assumptions**

Bourdieu's theory of practice details relational perspectives between practice, structure and social relations (Bourdieu 1990). He uses the term 'agent' to describe a person's practice that is determined by both rational decisions and by embodied dispositions of habitus. He developed a highly specialised series of concepts that he termed his 'thinking tools'. The key concepts of habitus, field and capital are tools aimed at uncovering some of the nuances realised in the social world. These key concepts are portrayed as interconnected entities that make up the structure and conditions of the social world. This approach appears appropriate to the complexities this study intends to explore. In order to provide methodological justification illustrating how Bourdieu's thinking tools provide the appropriate theoretical frame for this research study it is pertinent at this stage to explore these concepts in greater depth.

#### **4.3.1 The theory and logic of practice**

Bourdieu's aim in developing a theory of practice was to provide theoretical perspectives for: the practical logic of everyday action, and the objective structures within which practice takes place (Bourdieu 1990). This theory is presented through the series of key concepts: habitus, capital and field. These form the foundation for his theory and logic of practice.

##### **4.3.1.1 The "feel for the game" - Bourdieu's key concepts of habitus, field and capital**

The concept of habitus promotes the understanding of societies, their practices and their structures. Bourdieu (1990) claims a person's habitus is structured by their past and present circumstances, and in turn, their habitus structures present and future practices. Structure is comprised of a "system of dispositions which generate perceptions, appreciations and practices" (Bourdieu 1990, p53). Maton (2008) identifies that 'structure' in Bourdieuan terms refers to a systematic ordering rather than random occurrences. Past and present circumstances of family upbringing and education, for example, influence an agent's present and future practices. Dispositions bring together

tendencies that refer to ways of being grounded upon a person's conditions of existence. These dispositions generate practices, beliefs, perceptions and feelings in relation to their own structure. It has been argued that this reflects the concept of 'socialisation', although habitus is seen to move beyond the socialisation theory by focusing upon internal and unconscious dispositions. Bourdieu attempts to explore the "embodied lens through which agents understand and interpret the social world and relations" (Rischel, Larsen and Jackson 2008, p154).

Habitus is the historical and sociocultural background; embodied norms, values and dispositions through which agents understand and interpret the social world and its relations. Bourdieu and Wacquant (1992, p126) explain that habitus should be understood as "a socialised subjectivity". Habitus, comprising internalised history and experiences, works as a structure which generates and organises practices. This enables humans to deal with unforeseen changing situations. Rischel, Larsen and Jackson (2008, p514) state that "the practice of a nurse is situational and depends on habitus and positions in the social space". Habitus represents the embodied reality of the ANP world influenced by history, tradition, customs and principles that are often not explicit. This is what differentiates ANPs' habitus from other nurses' habitus. Jenkins (2002) emphasises the point that habitus is not learned but formed.

There have been a number of studies operationalising the concept of habitus within social science research (Grenfell 1996, Nash 1999, Reay 2004). Reay (2004) details a number of educational researchers' studies applying the concept of habitus as a means of exploring its empirical utility in the real world. Grenfell (1996) and Reay (2004) concur that the concept of habitus can be adapted within a real world scenario. This adaptability permits researchers the space and freedom to explore new theories developing from their empirical data without methodological constraints. One critique of Bourdieu's concept of habitus is that it limits an individual to only reproduce what they know. Habitus has been critiqued as being deterministic, however Reay (2004, p434-435) challenges this and argues that:

While habitus reflects the social position in which it was constructed, it also carries within it the genesis of new creative responses that are capable of transcending the social conditions in which it was produced.

The social world is explained by the concept of field where numerous fields exist in parallel, each having a particular logic of practice. Through the study of field, rather than individuals, patterns of behaviour can be identified. Within the ANPs' complex field, multiple personnel and structures interplay. Relationships and interactions between the ANP, as the agent, and the multiplicity of other actors and structures are dynamic. This has the potential to transcend the nature and direction of ANPs' field.

The dispositions of habitus are based on levels of capital. The concept of capital is defined as representing the power a person has by virtue of their social, economic, cultural and symbolic wealth (Lynam et al. 2007). It is through the exchange and/or use of capital that reconfiguration of the field takes place (Bourdieu 1998). Capital can be used or exchanged in order to improve an agent's position within the field (Bourdieu 1998). In the field of healthcare, medicine has a legacy of higher cultural capital, historically from the dominance of their academic scientific paradigm. The ANP is a relatively new contemporary role within healthcare, and the dynamics of the various forms of ANPs' capital are evolving. Applying Bourdieu's concepts could provide a means by which important elements of ANPs' habitus, field and capital are realised. Uncovering the perceived effects that these concepts have, on and for, ANPs in the wider healthcare field may help to expose the inner realities of their practice.

Bourdieu (1977) critiques that the individual retains subjectivity as reflected in their practice. The processes of their conceptualisations may not however be explicit. As an advocate of field work, as illustrated in his extensive research with the Kayabal tribe, he was critical of research methods that rely solely on participants' accounts. This seems to stem from the conditions of the narrative rather than the veracity of what is being articulated. He comments that it is the interviewer's responsibility to offer:

the respondent an absolutely exceptional situation for communication, freed from the usual constraints (particularly of time) that weigh on most everyday interchanges, and opening up alternatives which prompt or authorize the articulation of worries, needs or wishes discovered through this very articulation, the researcher helps create the conditions for an extra-ordinary discourse, which might never have been spoken, but which was already there, merely awaiting the conditions of its actualization. (Bourdieu 1990, p614)

Therefore, through the use of appropriate narrative discourses, exploration of Bourdieu's concept of habitus, field and capital would allow relationships between the ANP, individuals and structures to be spoken (Rhynas 2005). This will serve to

illuminate the unique concepts of ANPs' practice. It is proposed that the use of narrative discourse may also enable their conceptualisations to become more explicit. The narrative paradigm will be critiqued in the following paragraphs.

#### **4.4 Narrative paradigm**

As introduced earlier in this chapter, to explore ANPs' role, positionality and professional identity it is proposed that this study is grounded methodologically upon a narrative paradigmatic approach. A narrative approach is advantageous over other approaches because it is effective in enabling participants to story-tell their experiences and transitions through narrating their life story (Taylor 2011). This promotes disclosure as participants' sequentially narrate their life experiences. The utilisation of a narrative approach has been debated by social science theorists, and these will be explored within the following sections.

##### **4.4.1 Different epistemological claims - definitions of narrative in social research**

There has been debate on the application of the narrative paradigm as a methodology by Melia (1982), Sandelowski (1991), and more recently by Holstein and Gubrium (2005) and Smith and Sparkes (2008). They provide a comprehensive review of the scholastic debates of narrative methodological approaches. They contend that while there are differences in narrative methodologies, the main centre of agreement is that people's identities are shaped by the larger sociocultural matrix of a person being in the world. In addition, Bruner (1991) argues that narrative discourses enable people to think and know how to act in society and carry out relationships. This represents an important function of social identity for the person and for society. The ability of narrative to "capture nuances, indeterminacy and interconnectedness in ways that defy formalistic expression and expand the possibilities for interpretation and understanding" is acknowledged by Doyle and Carter (2003, p130). This reiterates the previously discussed Bourdieuan philosophy of enabling the unspoken to be spoken.

Tierney (1998) identifies that multiple definitions surround the concept of narrative that highlight various defining elements. Elliott (2005, p3) proposes that:

A narrative can be understood to organise a sequence of events into a whole so that the significance of each event can be understood through its relation to that whole. In this way narrative conveys the meaning of events.

An individual person presents a biographical personal view of their experiences as they perceive them. This is said to represent a culturally produced account whilst at the same time being an interpretive document as chronicling and sequencing occurs. This enables an exploration of temporality and causality. It is stated that narrative methodology is founded upon the belief that clear sequentially-ordered discourses will connect events and meanings for a defined group. This is regarded as enabling insight into the world and/or people's experiences of the world (Hinchman and Hinchman 1997). Bourdieu's (1990) theory of habitus and field concurs with this position.

#### **4.4.2 The characteristics of narrative research – exploration of role, positionality and identity**

Plummer (1983), Watson and Watson-Franke (1985) and Silverman (2001) define narrative methodology as aiming to gather an authentic understanding of people's lives derived from the stories of the people living their lives. Marshall and Rossman (2011) identify that narrative inquiry is of particular benefit in studying aspects of acculturation and socialisation in institutions and professions. In order to explore ANPs' (Emergency) perceptions of their role, positionality and professional identity it is pertinent to purview their worlds and their culture as they narrate them. Narrative research asks questions such as:

Who are you? What are you? Why are you? Why do you think, believe, do, and make sense of the world and the things that happen to you, as you do? Why have these particular things happened to you? Why has your life taken the course that it has? Where is it likely to go? (Goodson and Sikes 2001, p1)

Social theorists present varied definitions of professional identity which include considerations of cultural, social, political and economic contexts into which a person's life story exists. Benton and Craib (2001, p183) state that:

The idea that human beings are story-telling animals and make sense of their lives in narrative form has long been present in interpretative traditions.

In order to make theoretical sense of a person's life story, it is the individual's perspectives that require exploration. This appears to be the basis of the narrative paradigm. In order to validate this thinking the following sections seek to critically analyse narrative methodological and theoretical foundations, its strengths and possible weaknesses, and ways in which potential problems might be resolved.

According to Goodson and Sikes (2001, p1) “individuals talk about and story their experiences and perceptions of the social contexts they inhabit”. Narrative research is more than the simple collection of stories about individuals’ lives. It is interested in the ways in which people ‘story’ or narrate their lives. The aim is to understand those stories against the background of wider socio-political and historical contexts and processes. Dhunpath (2000) identifies that one of the most enduring critiques against narrative research revolves around the epistemological significance of narrative discourse. Bolton (2006 p203) proposes that underpinning narrative is the assumption that “stories are prime human ways of understanding, communicating and remembering” and that those living within their world are best placed to be able to elucidate these nuances and interconnectedness. However, how a person can know these nuances and interconnections is questioned. The closeness to their worlds may render them lacking insight as they may be unaware of the ‘otherness’ (Delamont 2002).

It is questioned that if a person does not know they are there, how can they identify it? The assumption that the individual in their own world is able to objectify their subjective habitus is fraught with uncertainty. It can also be questioned how an outsider can be sensitive to and have insight into a person’s nuances, indeterminacy and interconnectedness. Bourdieu (1990) has considered this assertion within his theory and has devised a ‘logic of practice’ which goes some way towards promoting objectification of the subjective habitus. This assumption has, and continues to be, the subject of debate within social sciences (Robbins, 2008). No definitive answer can be made as to who is the best positioned to elicit the fullest insight into a person’s world. A narrative approach attempts to address this potential weakness by bringing the narrator and researcher together in an attempt to explore the multiple layers of a person’s life-world. This is the intention within this research study.

#### **4.4.3 Narrative methodological foundations – narrative interviewing, interpreting people’s stories and narrative analysis of content and form**

If it is accepted that a person’s life-world can be explored either from the person within their world alone or with a researcher, the next issue is how life-worlds can be explored and communicated to promote understanding. There are a number of critiques of if and how these nuances, indeterminacy and interconnectedness can emerge through narrative. It has been suggested that the act of constructing and presenting a narrative to

produce a life story can decolonize the narrator and that through raising awareness people can change from their sub-conscious patterns. A raised consciousness may alter a person's perceptions and thus their narrative. This may result in a narration which does not reflect their reality. Nevertheless theorists would contest that it is the person's own version of their reality that should be accepted as valid. In fact by making individuals more consciously aware of the social and ideological roots of their self-understanding, the narrators are able to alter, reject, or make more secure their tentative views of the world (Dhunpath 2000).

Pamphilon (1999) presents a framework which encourages the examination of narrative from different perspectives, recognizing that no one perspective alone can reveal their full complexity. The framework identifies the socio-historical dimension by exploring collective meanings as they relate to individual experience. Revelation of personal levels of values, interpretations and positioning are also identified. The framework identifies what Pamphilon terms the 'micro-zoom' level. This focuses on the subtleties of the telling whilst examining emotions and voice. The 'interactional-zoom' however, recognizes narratives as a product of the relationship between narrator and researcher. Each level of analysis of the life history's multiple perspectives enables differing, complementary, and even contradictory data to emerge. Pamphilon's model proposes to enable the researcher to acknowledge and productively hold in tension both individual and collective meanings within narratives. Potential concerns for misinterpretation by the interviewer and interviewee have been identified by Gubrium and Holstein (2002).

Interpretation of narrative has raised a number of concerns within social sciences. Bruner (1991, p33) states that:

The very shape of our lives – the rough and perpetually changing draft of our autobiography that we carry in our minds – is understandable to ourselves and to others only by virtue of those cultural systems of interpretation.

This appears to suggest that the meanings readers derive from a text are shaped by the discourse communities to which they belong (Denzin and Lincoln 2000). If this is accepted, meanings could be open to different interpretations or interpretations at different levels, especially if the reader is not a part of the discourse community. The potential for words to have differing meanings between cultural systems questions how knowledge can ever be gained from world-views which differ from our own. The researcher is required to ensure contextual commentary on issues of time and space are

made. Failing to provide context, means that narratives are uncoupled from the conditions of their social construction, and thus lose meaning (Goodson and Sikes 2001).

One concern identified in the literature is that the researcher is external to the discourse and may be exposed to the same concern of being unable to interpret and understand the narratives accurately (Walker 2007). How can the researcher see the nuances if they do not know what the nuances are? One method is to ensure accuracy in data analysis. The approach used in this study is content analysis which attempts to ensure all nuances are exposed. In addition, an approach used by social scientists aimed at ensuring authenticity is to return to the narrators in an attempt to clarify those cultural systems of interpretation. When a person shares their narrative with a researcher they tell a story of the real people and events in their life. In differing ways, for both the researcher and the narrator, these real people become symbolic characters representing larger constructs. It is inevitable that interpretation will have variation between one person and another.

I am not an ANP but I am a nurse and by virtue have some insight into the ANP professional world. I have some familiarity with the study area, but not the over-familiarity that Delamont (2002) contends can be problematic for a researcher. A researcher being over-familiar with the study area is said to render them too close to actually see the reality. She suggests returning to the narrator and asking them to act as an interpreter to assist in reducing potential researcher influence and over-familiarity. Tierney (1998) emphasises the importance placed upon the interactions between the researcher and the researched. The interviewer and interviewee relationship is interconnected and does not reflect the removed interviewer as evident within a realist approach (Silverman 2001). Traditional realists view with scepticism the interconnected interviewer-interviewee relationship as lacking impartiality, being open to bias and inaccuracies, and ultimately being unscientific. It is acknowledged that within all research, there is to some extent, contamination by the values of the researcher. Although acknowledging possible researcher interconnection may to some extent promote communication and may prevent inaccuracies (Bryman 1988).

#### 4.4.4 The nature of objectivity and subjectivity - meaning and reality

Methods of collecting data by oral or written narratives have individual strengths and weaknesses. There has been much debate on linguistics amongst social scientists (Habermas 1984, Norris 1997, Archer et al. 1998). Norris (1997, p133) cites Wittgenstein's (1961) phrase that "the limits of my language mean the limits of my world". This quote identifies an important concept related to the narrative paradigm, for if Wittgenstein's assertion is to be considered then an individual person's self-account may be limited linguistically. The person may not have the lexicon to explain what they are experiencing (Norris 1997). The use of specialist language and dialect within the person's life world may also have implications when deciding upon a narrative approach. If a person can not either verbally or in narrative form describe their worlds then their narrative may be limited and important elements may remain unexplored.

The intricacies of memory and history are explored by Tierney (1998). He states that an "inevitable tension between myth and fact" exists when considering narrative (Tierney 1998, p538). Silverman (2001) discusses the tensions that exist between reality and representation in narrative histories. He acknowledges that what is important in narrative research is the process through which the narratives depict 'reality' rather than whether such narratives contain true or false statements. Indeed, narratives are said to represent a process of reconstructing rather than simply resurrecting the past (Pamphilon 1999). This is a much debated position as illustrated in the epistemic debates of narrative research as discussed by Dhunpath (2000).

Alternatively it appears logical that what the person chooses to remember are the important elements of their world to them and as such these elements have relevance and are therefore representative. Whether they are true or not is irrelevant as they are the reality to the person narrating them. Conversely, there is a school of thought which would negate this assertion. They would purport that factual truth is essential if the research is to have any credence (Crotty 1998). If this stance is accepted, the robustness of narrative as a methodology can be questioned. Theorists contest however, that if through people's narratives commonalities emerge and are connected to the broader social and historical context, this is said to be representative of the narrator's reality. This representativeness is what matters whether truth or falsity exists. Hill Bailey

(1997) acknowledges that the goal of interpretative inquiry is to understand meaning not truth.

In his theory of practice, objectivity and subjectivity are used to create a theory that represents the practices and experiences of a social group. Recognition of subjective and objective thinking may lend itself to inconsistencies, as actions of social groups cannot be explained simply as an 'aggregate' of individual behaviours but are influenced by cultures, structures, and traditions. The value of applying this theorising to the ANP would enable recognition of their complexity and seek to expose the often unrecognised nuances of their role, positionality and identity.

Having reviewed the concept of ANPs' role, positionality and professional identity from a philosophical perspective, a summary of the methodological underpinning of this study is presented in the following section.

#### **4.5 Positioning my methodology in the research domain – Contextualising Bourdieu, the narrative approach and researching ANPs' role, positionality and professional identity**

Bourdieu (1990) presents an insightful theory on exploring professional practice that adds to other conceptual frameworks presented by theorists such as Benner (1984) and Habermas (1984). Rhynas (2005) argues Bourdieu's concepts are suitable for nursing research but are rarely used in the discipline. Bourdieu's theoretical framework has been utilised within areas including social care, epidemiology, public health and educational research. Rischel, Larsen and Jackson (2008) acknowledge that applying Bourdieuan concepts for the purpose of exploring the practice of nursing is an important development in nursing research.

Grenfell and James (1998) acknowledge Bourdieu's theory can be applied to researching experiences of social groups. Therefore, in order to study the ANPs' role, positionality and identity, application of Bourdieu's philosophical framework may prove insightful. The direct interaction of habitus, capital and field influences the context in which practice takes place and is given meaning. This theory of practice would give nurse researchers a powerful conceptual tool for describing practice. Using dynamic and relational concepts enables exploration of the distinct location of ANPs' position in the field of healthcare. Bourdieu's thinking stresses the situated, embodied

and practical nature of both conscious and subconscious social action. This allows structures in healthcare to be considered along with individual responses to those structures. This requires a relational and reflexive form of research in order to properly frame the social logic of any given practice.

#### **4.5.1 Findings from the pilot study**

A pilot study was undertaken to assess the 'fit' of my underpinning philosophical assumptions and chosen methodology with the research question. This was to achieve an evaluation from methodological, technical, ethical, and personal perspectives. It seemed appropriate at this pilot stage to formulise a single narrative question asking the participants to self report on their perceptions of their role. This was to be one of the key concepts which I intended to explore at the main thesis stage. Two ANPs were narrative-interviewed between December 2011 and February 2012. The ANPs were chosen on an opportunistic basis through a contact which I had formed during my research assistant role with the SCAPE study. Both of the interviewees were not known to me personally or professionally and both worked together on the same ANP team in the same ED.

The rationale for these decisions emanated from the following:

- I was concerned that the participants may say little or may lose focus. I felt by undertaking these two interviews would enable me to see if the approach did 'fit' and would yield the aspired to depth of verbatim data.
- It was important to see if any issues or problems arose so that any potential issues could be pre-empted and strategies put in place to deal with them.
- Using a qualitative narrative approach from a small sample population meant that two interviews should be reflective of the wider population and hence affirm the possible variety of responses. Naturally the process is to uncover those tacit dimensions and the pilot was intended to illuminate some of those individual and collective journeys and experiences. This is why I chose to select two ANPs from the same ED.

#### **Interviews with Aoibhe (December 2011) and Dearbhla (February 2012)**

These interviews were very detailed, with both participants speaking at length (approximately 45 minutes each). The clinical examples that punctuated their prose

were bountiful and insightful. I was pleasantly surprised by the ‘caring’ which was strongly portrayed. It was not that I had assumed they did not care but I was interested in how their compassion permeated all their reflections. My concerns that the narratives would be stilted were dissipated as Aoibhe and Dearbhla’s thoughts and experiences flowed throughout the interviews. The key concepts addressed by the participants mutually were ANP positionality in the multidisciplinary team, ANPs’ nursing identity and the concept of ANPs’ clinical nursing roles. These concepts had permeated my literature review critique in module three of this programme and these were expressed during the pilot interviews. This affirmed both the appropriateness of the concepts to be studied and the approach to be taken in this thesis.

### **Summary of pilot stage**

The pilot study was beneficial in enabling clarification of a number of aspects of the study. The interviews confirmed that my opening narrative question was sufficient to allow text-rich data to be narrated. I was able to confirm the value in focusing on one specialism, the ANP (Emergency), as opposed to ANPs in general. The collective experiences Aoibhe and Dearbhla expressed, for example regarding their intra and interprofessional relationships, had similarities of perceptions. The interviews also contained some contrasting views which reflected individual journeys and contextual perceptions. The pilot stage was successful in achieving its intended aims and objectives and allowed me to undertake further refinement of the research design for this thesis study through: (1) confirming the appropriateness and validity of sampling from the ANP (Emergency) population, (2) widening the key concept of role to include positionality and identity and (3) gaining reassurance that the narrative methodological approach and narrative questioning would glean rich and varied narrations. This refinement improved the cohesiveness and quality of this study.

### **4.6 Conclusion**

This chapter has presented the philosophical underpinnings of naturalistic inquiry as the appropriate philosophical basis for this study in order to address the study’s research questions. Ontologically and epistemologically Bourdieu’s theoretical framework with a qualitative narrative methodology is to be utilised to glean an understanding of ANPs’ perceptions of their role, positionality, and professional identity. In order to illustrate how this was applied the following chapter presents this study’s research design.

## CHAPTER 5 RESEARCH DESIGN

### 5.1 Introduction

The research design of this study is presented in the following chapter in order to illustrate the 'fit' between my research methodology, research questions and research design. This study's aim was to explore the perceptions of ANPs (Emergency) regarding their role, positionality and professional identity. Using a narrative methodological approach the following four key research questions were addressed:

1. How do ANPs describe their reasons for becoming an ANP and their transition from their previous nursing role to becoming an ANP?
2. What are ANPs' (Emergency) perceptions of their role?
3. What are ANPs' (Emergency) perceptions of their positionality?
4. What are ANPs' (Emergency) perceptions of their professional identity?

Critical in qualitative research is the assessment of worth, as it is through consideration of the 'fit' between the research methodology and the research methods that this worth can be assessed (Carr 1994, Benton and Craib 2001, Tashakkori and Teddie 2003, Bryman 2004, Flick 2007). The research method makes explicit researchers' decisions regarding the research design for collecting and analysing data and for reporting of research findings. These decisions are presented in the following sections.

### 5.2 Trustworthiness

In order to assess issues of trustworthiness, Elliott, Fischer and Rennie's (1999) validity criteria was used as a framework for assuring quality in this study as illustrated in Appendix N. This framework has seven guideline criteria for ensuring rigor in qualitative research. These are: (i) owning one's perspectives; (ii) situating the sample; (iii) grounding in examples; (iv) providing credibility checks; (v) coherence; (vi) accomplishing general versus specific research tasks; and (vii) resonating with readers. Each criterion was addressed in this study through the evidence detailed in the following chapters and summarily presented in Appendix N.

Reflexivity on my perspectives involved situating my sample by describing the participants. I used examples from the narrative data to evidence analysis and interpretation. I provided credibility checks by seeking confirmation of themes from participants in order to maintain coherence in the telling of the participants' stories.

Accomplishing the specific focus of this study is illustrated in the study's aims and objectives and it is intended that the reader will develop a greater understanding of ANPs' (Emergency) perceptions of their role, positionality and professional identity. Serving to strengthen the trustworthiness of this study, Elliott, Fischer and Rennie's (1999) criteria is revisited later in the study to enable additional examples of how each criterion was addressed (Appendix N).

The concept of reliability relates to the dependability that an instrument measures the intended attribute thus giving confidence in data collection. Long and Johnson (2000) acknowledge that in interpretative research, reliability is unlikely to be a demonstrable strength of the research. However, Guba and Lincoln (1994) suggest that dependability in the stability of data and procedures is more closely aligned in the qualitative paradigm. Sandelowski (1986, 1993) highlights that in the persistent search for rigour in qualitative research, issues are raised such as rigidity and uncompromising harshness. She contends that "rigour is less about adherence to the letter of rules and procedures than it is about fidelity to the spirit of qualitative work" (Sandelowski 1993, p2). Reality within the interpretative paradigm is assumed to be multiple and constructed rather than singular and tangible.

A point of debate within narrative research is the issue of replication. Marshall and Rossman (2011) contend that narrative inquiry approaches can be difficult to replicate. Sandelowski (1993, p3) acknowledges this but states that the nature of narrative data is inherently revisionist and that:

Repeatability is not an essential (or necessary, or sufficient) property of the things themselves (whether the thing is qualitative research or the qualitative interview).

Replication is a difficult concept in research as each individual researcher will have differences in their philosophical and theoretical approaches. Inevitably this may result in different outcomes. The uniqueness of this piece of research is achieved by being true to the meanings derived from the narratives at the time that they were given to me.

### **5.3 Research setting**

Ten ANPs from hospital emergency departments representing both rural and urban locations in Ireland participated in the study. Three health board areas were represented with a total of seven individual hospitals.

## **5.4 Study participants**

Mason (2002) proposes that the researcher is required to consider a number of points when selecting and evaluating potential data sources. She comments that sources must possess the potential to generate knowledge.

How well does the use of these data sources match the ontological perspective on what constitutes the social world, and the epistemological perspective on how knowledge about that world can be produced? (Mason 2002, p53)

The participants of this study were ten ANPs (Emergency). The analysis of commonalities within and between participants was possible as all participants were sampled from the same nursing specialism. This gave rise to the exploration of similarities and differences in experiences, language and culture.

### **5.4.1 Participant recruitment**

In order to ensure clear objectivity and equality, I contacted the NMBI to request a listing of all ANPs (Emergency) registered. However, no contact listing was made available. I had developed links with an ANP from the pilot study and she agreed to act as a gatekeeper for this study. In order to invite participants to be part of this study I composed a letter of introduction to the study (Appendix E) and an expression of interest reply form (Appendix F). To address the issue of potential bias and the need for confidentiality, the letter of introduction to the study and the expression of interest reply form were emailed to ANPs (Emergency) via the gatekeeper. I was not in direct contact with potential participants until such time as they chose to self-select by returning the expression of interest form via post/email or by telephoning me directly. Five participants responded to this request.

In addition, I sent information letters and expression of interest forms with self-addressed envelopes to various Emergency Departments asking for recruits. Six ANPs responded positively to this request. However one ANP did not reply when requested to arrange a meeting. I also contacted the Irish Association of Advanced Nurse/Midwife Practitioners (IAANMP) group via the chairperson. The IAANMP is a networking group established for ANPs in Ireland. The chairperson agreed to present my introductory letter and expression of interest form to their Annual General Meeting.

This enabled self-selection and ensured a wider audience was made aware of this study. Interestingly and disappointingly, I did not receive any replies from this request.

The sampling approach in this study was achieved through networking. This approach ensured appropriate sample selection and access. As mentioned previously, the ED in which the ANP practises determines whether they care for adults and children, adults only, or children only and as this study sought to research ANPs' perceptions, I chose not to distinguish between their client portfolios during sampling. Being inclusive was aimed at enriching the data gathered by reflecting the true reality of ANPs' practice worlds.

#### **5.4.2 Access**

Pitts and Miller-Day (2007) acknowledge the significance of developing a trusting rapport between the researcher and potential participants in order to secure access and enhance the success of the research. They contend that rapport building can be promoted through forming authentic communication channels with participants. Once I received a returned expression of interest form, I telephoned the ANPs and discussed the details of the study. I explained that I would contact them again once I had been granted access and ethics approval from their hospital and DON. A time was then to be arranged to meet for the narrative interview at a location convenient to them.

In Ireland, there are additional requirements that research undertaken with nurses requires Research Ethics Committee (REC) and Nursing Research Access Committee (NRAC) approval from participants' individual hospitals. I received approval from all five RECs and NRACs to which I applied. In addition, I was required to write to the relevant Directors of Nursing seeking access to the ANPs (Appendix C). These were all responded to positively which allowed me direct access to the ANPs. At present there is no standardisation, so submitting individual applications is a very time consuming and repetitive process. There are plans to develop a generic application form which will lessen this repetitive process.

#### **5.4.3 Sampling**

Purposive sampling of ANPs (Emergency) was based on the value of the information that could be gleaned from them. Naturalistic inquiry relates to the context and not to

statistical considerations as Teddie and Tashakkori (2009) comment that sampling involves selecting units that maximises the researcher's ability to answer the research question. Units in this context refer to knowledgeable people, groups, artefacts and settings. These units are then the foci for data collection. The potential for bias with purposive sampling is raised in the literature by Denzin and Lincoln (1994) and Politt and Beck (2014).

However Richie, Lewis and Elam (2003) acknowledge that purposive sampling is based on deliberate criteria for selection and should not have bias in the nature of choices made. It is important to consider the possibility of bias within the research methods so that strategies can be incorporated to lessen the influence of bias within the research design. Flick (2006) states that it is essential that the researcher explicitly identifies biases, values and personal interests with the research topic and/or processes. This is in agreement with Patton (2002) who acknowledges that criteria for judging quality and credibility include the discussion and acknowledgement of subjective biases. I did not know any of the participants personally nor did I have any personal bias towards or against the research topic.

Currently there are eighty-eight ANP (Emergency) registered with NMBI (NMBI 2015a). My original sample size was fifteen from this target population. This was a significant sample population for a qualitative study. The rationale for the number of respondents was that fifteen recounts would provide sufficient narrative data for purposeful thematic analysis and evaluation. Baker and Edwards (2012) add that sampling should be determined by the focus of the research question, aims and objectives and led by quality and not by numbers. This concurs with Mason (2002) who states, that in qualitative research, the guiding principle should be the concept of saturation.

#### **5.4.4 Study participants' demographical profile**

The ten ANPs varied in relation to length of time in their ANP post as illustrated in tabular form below. A nurse is aged twenty-two at minimum after initial nurse registration. The NMBI requires that ANPs have a minimum of seven years post-registration experience and have completed their master's education candidacy period in order to register as an ANP. This means that the earliest age at which a nurse is in a

position to become an ANP is 29. Participants' gender was mixed. The wider nurse population has a significantly larger ratio of female registrants to male registrants. I have opted not to include participants' gender differentials in this demographic profile as the small number of male ANPs means a potential risk that identification could be made.

**Table 2: Participants' demographic profile**

	<b>Number of Participants</b>
<b>Advanced Nurse Practitioner (Emergency)</b>	10
<b>Age profile</b>	
29-35 years	2
36- 40years	3
40 years +	5
<b>Length of time since qualification</b>	
10 - 20years	5
20 years +	5
<b>Length of time in ANP post</b> (maximum length since ABA registration in Ireland in 2016 is 14 years)	
0-9years	6
10 years +	4
<b>Professional Qualifications</b>	
Registered General Nurse*	10
Specialist Qualifications in Emergency Nursing	10
<b>Post Registration Educational Qualifications</b>	
Post Graduate Diploma	2
MSc in Nursing	10
PhD/Professional Doctorate	0
<b>Hospitals locations where participants practised</b>	
Large City Hospital	6
Smaller City/Town based Hospital	4
Previously practised in an ED outside of Ireland	5

(\*some participants also held dual qualifications)

The types and locations of hospitals in which participants practised were varied. Six worked in large city centre emergency departments with large urban populations, and four were based in more rural locations in smaller cities/towns. Each ANP's patient cohort revealed many local and national social issues. As mentioned previously some emergency departments provide care in the public system and some in the private sector. However in this study, all participants worked in public hospitals. ANPs from the private sector were not excluded from sampling; but they did not choose to self-select during sampling. In this study, the participants' patient cohorts included both adults and children. All ANPs worked twelve hour day shift patterns that included

weekend duty. No ANP worked night duty shifts. One ANP was employed on part-time hours and nine worked full-time hours. Two ANPs were solo practitioners, although both were mentoring ANP candidates at the time of the interviews; the remaining eight worked as part of a team of ANPs. The teams ranged in numbers from two ANPs to six ANPs.

Ten respondents were deemed adequate to provide enough data to achieve the desired saturation. This study has a well-defined research question addressing a very specific area and context, and for this reason saturation should be achievable with ten respondents. Had this not been the case I would have tried to recruit more participants. It is suggested that the guiding principle of research is aimed at achieving saturation. Mason (2010, article 8) contends that saturation can be a contentious issue, and when questioning how saturation is achievable, he suggests that:

The point of saturation is, as noted here, a rather difficult point to identify and of course a rather elastic notion. New data (especially if theoretically sampled) will always add something new, but there are diminishing returns, and the cut off between adding to emerging findings and not adding, might be considered inevitably arbitrary.

I appeared to reach this point during my ninth narration and then in order to ensure my research was defensible I conducted a further interview to test my findings and confirm the theory that I had gleaned from participants' narrations.

## **5.5 Data Collection**

In line with the narrative paradigm the collection of data in this study was through narrative interviewing and narrative questioning. This methodological approach is discussed in the following paragraphs.

### **5.5.1 Narrative interviewing**

Mishler's (1986) influential work provides great insight into the importance of narrative interviewing. He emphasises that the researcher's role is to listen and not to suppress narrators' storytelling. Marshall and Rossman (2011, p168) distinguish some strengths and challenges in using narrative inquiry as a primary data collection method and contend that narrative inquiry:

fosters face-to-face interactions with participants and is useful for uncovering participants' perspectives ... including describing complex interactions and facilitates discovery of nuances in culture.

The narrative interview seeks rich descriptions of people as they exist and unfold in their natural worlds. Emphasis is on understanding the production of the narrator's social world (Elliott, 2005). Marshall and Rossman (2011, p153) acknowledge that "narrative inquiry assumes that people construct their realities through narrating their stories" and qualitative interviewing is a way of exploring and uncovering the meanings which underpin people's lives (Arskey and Knight 1999). Flick (2006) comments on the sensitivity the interviewer requires to allow an unobstructed unfolding of narrators' views. Marshall and Rossman (2011) agree and acknowledge the importance of a trusting and open relationship between narrator and researcher in narrative inquiry. Intense active listening is required to enable the narrator's voice to be heard unabated. This level of concentration requires considerable conscious attention on the part of the researcher.

Data collected in a natural setting facilitates immediate follow-up for clarification which encourages cooperation and collaboration. In order to promote a relaxed atmosphere, the participants decided the venue and time of the meeting. The ANPs' office was the site chosen by eight of the participants for their narrative interview; a clinical room was the venue for one interview and a teaching room for one interview. Interestingly and of significance, there were disturbances during the interview in six interviews by medical staff seeking input in case management from the ANPs. This appeared to negatively affect the concentration levels of the participants, albeit temporarily.

A positive research relationship appeared to be established between the ANPs and myself, as the researcher. This assisted in developing understanding of the ways the ANPs gave meaning to their social worlds (Schutz 1972). This insight was important as the unique nature and culture of ANPs' (Emergency) perceptions are the central foci of this study.

### **5.5.2 Narrative questioning**

The narrative interviewer's role is to enable the participants to freely tell their stories (Bruner 1991). The participants for the study were asked the following request:

I want to ask you to tell me about your perceptions of your role as an ANP. The best way to do this would be for you to start from how you came to be an advanced nurse practitioner and then tell me all about what it is like for you being an advanced nurse practitioner from when you became an ANP up until

today. You can take your time in doing this, and also give examples, because for me everything is of interest that is important to you.

This open question was aimed at capturing the reality of participants' worlds thus enabling participants to share their experiences and views without being influenced by predetermined questions. Elliott (2005) highlights the importance that the interviewer does not interrupt narratives as they unfold, as interruptions potentiate the imposition of interviewer influence on the exploration. I was mindful of this, and in order to retain focus, the research question was kept on the table as an aide memoire. This seemed to be effective as a number of participants did refer back to it on occasion. The use of non-verbal prompts, such as nodding, is seen as supportive to acknowledge and encourage participants to tell their stories (Creswell 2009). These were effective and all ANPs were happy to recount their stories, one participant specifically commented that she welcomed the opportunity to narrate her journey and requested a copy of her transcript, which I supplied security protected.

I did get the impression that some participants were hesitant on certain points; therefore on completion of the narrations I sought clarification if needed. Creswell (2009) states that this is accepted as good practice. The participants, on completion of their narratives, were asked a number of additional questions pertaining to points they had raised in their recounts to seek clarification and elaboration. Interpretation starts during the narrative interviews by seeking clarification to enhance verification and meaningful dialogue, but not to influence the narrations. The lengths of the interviews were determined by the participants and varied from 30 minutes to 1 hour 20 minutes. It is the quality of original interviews that determines the quality of subsequent analysis, verification and presentation of findings.

## **5.6 The positioning of the narrative researcher**

Reflexivity started at the planning stage before I undertook each interview. It was important I was aware of my initial perspectives and any values that I brought to the topic. I could then acknowledge them and make allowances in some way. Reflexivity continued throughout the processes of data collection and data analysis. Reflexivity is said to enable an open play of reflection across various levels of interpretation. My reflexivity on praxis, through the use of research diaries and field notes, was intended to enhance and deepen my interpretation of the narrative findings. These had proved

effective during the pilot study where my self-descriptive and reflexive journaling ensured my values and beliefs were made explicit. Hammersley and Atkinson (1995) and Whittemore, Chase and Mandle (2001) state that acknowledging a researcher's perspective is a means of adding research integrity to a study.

The preparatory pilot work informed my approach to the interviews in this study and through undertaking the transcription role personally, I gained a greater in-depth awareness of the concepts contained within the data. Alvesson and Sköldberg (2000, p248) present an overall framework for incorporating reflexive elements in qualitative research methodology when they state that:

The researcher's judgement, intuition, ability to 'see and point something out'.... are not entrenched behind a research position.

In addition, Marshall and Rossman (2011) emphasise that there is also a dependence on participant openness and honesty. The participants appeared to regard me as a colleague on an equal basis, and this was reciprocated in my view of the participants. This reciprocal relationship influences the data generated as narrative inquiry is founded upon equality and trust; narrative data generation being dependent on key individuals, namely the participants and the researcher. In order to undertake this study it is important that my own positionality is defined, for as Flick (2006) claims, the researcher is required to explicitly identify biases, values and personal interest with the research topic and/or processes.

### **5.6.1 My positionality as the researcher**

In acknowledging my professional background as a nurse, my aim was to locate myself within the research. The 'value added' elements of working as a nurse within the field of healthcare can potentially enable greater depth and insight during the narrative and interpretative phases. However, I was mindful that I did not superimpose my perceptions on the narratives gained. This was to be considered through seeking confirmation from the participants of emerging concepts. Bourdieu and Wacquant (1992) advise that the researcher keeps one eye reflecting back on their own habitus so as not to impose their own habitus on the truth of their participants' narrations. My reflexivity was promoted through conscious thought aimed at enhancing and deepening the understandings that emerge through the research diary. These proved effective during the pilot study and were maintained for the duration of this study. Excerpts from

my diary entries are illustrated in Appendices H and K. The reflective diaries captured nuances during the interviews such as hesitancy, anxiety and confidence. Reflecting on the contexts of the interviews was an aid during transcription and brought depth to data analysis and interpretation.

### **5.7 The ethical implications of using narrative in research**

Marshall and Rossman (2011, p169) identify that narrative inquiry is “readily open to ethical dilemmas”. Researching life experiences can be demanding and complex as recounts are contextually value laden. The ethics of using a narrative methodology in research requires the researcher to be sensitivity to the disclosure and surfacing of emotive issues. Ensuring informed consent and safeguarding the rights of participants, whilst maintaining confidentiality, means being true to the research.

This section considers the ethics of using narrative in research. Topics to be discussed include: nursing research access approval and nursing research ethics committee approval; narrative interviewing; sensitivity to disclosure and surfacing of emotive issues; informed consent; data management and storage; safeguarding the rights of participants whilst being true to narrative analysis; and participant confidentiality.

#### **5.7.1 Nursing Research Access Committee approval and Nursing Research Ethics Committee approval**

Following sampling, research ethical committee approval and nursing research access committee approval was sought from participants’ hospitals. Nursing ethics review committees aim to ensure that the design of the study being reviewed adheres to fundamental ethical principles. In Ireland, there is currently no central research approval mechanism, although some hospitals and health boards have devised a standardised application form used across a number of sites. An example of this standardised form is illustrated in Appendix M. However, current practice is that each individual hospital/health board Research Ethics Committees sit and assess the submissions pertaining to their areas as Nursing Research Ethics Committee (NREC) and Nursing Research Access Committee (NRAC) approval mechanisms are locally based.

The location of my respondents determined which NREC and NRAC I required approval from. In addition, a significant number of hospitals have independent status. In these cases, I was required to submit individual documentation to the respective

individual hospitals in order to undertake this research within them. I submitted documentation to five research ethics committees in total to gain approval to undertake the narrative interviews with the respondents; an example of the 'Standard Application Form for Ethical Review of Health-Related Research Studies' is presented in Appendix M. This process took on average eight weeks from submission of documentation to receipt of the committee's panel decision. I was successful in all applications.

It was valuable as a researcher to have been involved with this process as it encouraged greater depth in my thinking. These formalised systems for ethical approval in nursing in Ireland are well structured. These mechanisms, although not standardised, are efficiently executed and maintain a level of autonomy for respective institutions.

### **5.7.2 Consent, confidentiality and withdrawal**

I provided an information letter and expression of interest form to participants detailing the study's outline to ensure that participants would provide informed consent (Appendix G). I verbally spoke on the telephone with each participant prior to the narrative interview and I also allocated time at the beginning of the interview to explain about the study and answer any queries participants may have had. The voluntary nature of participation was highlighted. All prospective participants gave their informed consent and a formal consent form declaring participants' consent was signed by the participants. And, as best ethical practice dictates, a copy of this written consent was given to the participants. The right of each individual ANP to withdraw up to two weeks post narrative was discussed personally with the respondents both verbally and in writing. No participant felt the need to exercise this right.

Names and any identifying characteristics of participants, locations or other personnel were anonymised throughout to protect identities. There is a limited number of ANPs nationally; therefore I removed any identifying elements to reduce the risk that the ANPs would be recognisable by colleagues or others. In line with other studies, the female gender is used when referring to participants (Begley et al. 2010). The rationale is because the majority of nurses are female and if the male term was used this would increase the likelihood of potential identification.

This study involved ANPs exploring their own personal perceptions about their role, positionality and professional identity. Due to the personal nature of this topic area

cognisance is taken that surfacing of various emotions may occur. Sensitivity to participants of this aspect was incorporated into the research process and lists of support numbers were available to the ANP if required. My study involved undertaking research with my peers as I am a registered nurse but no conflict of interest appeared to emerge as the participants did not work directly in my area of practice. Therefore there was no hierarchical management relationship involved between the participants and myself. A copy of the final submission report was made available to participants as requested and in line with recommended good research ethical practice.

### **5.7.3 Data management and storage**

All data was stored in accordance with the Data Protection Act (Government of Ireland 2011b). Electronic data, audio and text files were stored in an encrypted password protected location on my personal computer. This computer was not accessible to other personnel. All hard data was stored in a locked cupboard within my locked office. I as the principal researcher had sole access to the data collected. In addition, Professor Ann Macaskill as my Director of Studies had access to the collected data acting in the capacity of a research integrity moderator. The data will be retained in Sheffield Hallam University research archive facilities for a period of seven years post thesis submission in accordance with publication guidelines.

## **5.8 Methods for the analysis of narratives**

The analysis of the narrations require the researcher to be true to the data, to give a balanced, fair and just description of participants' views and to be honest and respectful of the views of the participants. Consideration of: transcribing the narratives; conceptual frameworks for the analysis of narrations; meanings - content, structure and form; NVivo software and manual analysis; and quality will be explored in the following sections.

### **5.8.1 Transcribing the narratives**

The verbal narratives were audio-taped to enable transcription. I commenced transcription immediately which resulted in the simultaneous dual processing of data collection and data analysis. I listened and re-listened to the interviews and then read and re-read the transcriptions to gain meaning from my significant volumes of narrative

data. Through this data emersion I was able to link elements and this enabled a clearer picture of the issues being investigated.

In order to maintain confidentiality and anonymity, I personally conducted the interviews and I transcribed them. This was intended to reduce the problematic nature of handling data interpretations and judgements inherent in transcription. Elliott (2005) explores the dichotomy that exists between the spoken taped data and the written words realised from transcription. The imposition of decisions on punctuation is complex and can shape the meanings derived from the written data. Losses of paralinguistic nuances are also significant. Marshall and Rossman (2011, p165) proposed that:

One valuable strategy is to share the transcriptions with the interview partners for their confirmation (or not) that the transcription captures their meaning and intent, if not always their precise punctuation.

The transcriber has an ethical responsibility towards the research participants namely how he/she transposes “their spoken words into text that we then manipulate and write up” (Marshall and Rossman 2011, p167). The ethical principle of respect for the person is relevant when participants’ words are formed into analysed categories and represented publically. I returned to a number of participants and gained confirmation of accuracy. This was time and labour intensive, but it was an essential strategy aimed at ensuring accuracy in interpretation. This is fundamental in narrative inquiry (Elliott 2005).

By undertaking the transcription role personally I gained an in-depth awareness of the data and the depth and wealth of information that each narrative contained. This assisted with my selection of an appropriate conceptual framework for narrative analysis that is critiqued in the following section.

### **5.8.2 Conceptual frameworks for data analysis**

There are numerous theoretical frameworks developed to support qualitative data analysis and it is the duty of the researcher to demonstrate to the reader that rigorous processes have been undertaken. The craft of qualitative data analysis is centred on drawing valid meaning and knowledge construction from the qualitative data. Miles and Huberman (1994) and Strauss and Corbin (1998) provide a detailed description of the many analytical tools available to the qualitative researcher. It is acknowledged that:

Although the actual properties emerge from the data, the techniques help analysts to recognise the properties, to get past the analytical blinders that often obstruct our view of what is in the data. (Strauss and Corbin 1998, p96)

Elliott (2005) highlights the importance of having great sensitivity in narrative inquiry during the interpretative phases as this enables researchers to move beyond initial concepts and to generate or revise conceptual frameworks. Predominantly, qualitative data is collected in text-rich descriptive forms as reflected by the narrative interviewing methods used in this study.

In the quest for explicitness and thoroughness, narrative interview data analysis requires time for the processing and coding of the large collective of text-rich narrative data. I considered a number of data analysis frameworks, including content analysis, phenomenological approaches and discourse analysis. Following a critique of the strengths and limitations of each framework, I decided that a content analysis model appeared to complement the epistemological approach of this study. Content analysis is one approach used for naturalistic data analysis that enables description from participants' perspectives through coding and categorising without imposing preconceived theories (Elo and Kyngäs 2008, Humble 2009).

### **5.8.3 Content Analysis**

Hsieh and Shannon (2005) and Humble (2009) identify that qualitative content analysis approaches are used to identify concepts and to interpret meaning from the content of text-rich data. This reflects a naturalistic paradigm where the coding of categories and themes are derived directly from textual data. Hsieh and Shannon (2005, p1285) identify that, in order to promote validity in a study, it is important for researchers to delineate the specific approach to data analysis utilised in their studies.

Creating and adhering to an analytic procedure or a coding scheme will increase trustworthiness or validity of the study. Effective coding ensures a thorough comprehensive mapping of themes is realised.

My approach included commencement of data analysis during the interview phase as I added to the initial narrative request at the end of the narration by probing elements which emerged during the narrator's storytelling. I began the data analysis process by immersing myself in the data, coding similar ideas into categories and then themes. This is a time-consuming process that requires reflection and multiple re-reading of transcripts. However, it is essential in order to ensure accurate conceptualisations. A

visual mapping of codes, categories and themes in this study are illustrated in Appendices I, J, K and L. I compared the categories and themes with constructs and theories, including Bourdieu's key concepts. This enabled the emergence of elements of ANPs' habitus, field and capital to be realised.

The narrative researcher is external to the discourse community and this may expose them to the concern of being unable to accurately interpret and understand the narratives (Walker 2007). One approach social scientists employ aimed at ensuring authenticity is to return to the narrators in an attempt to clarify cultural systems of interpretation. When a person shares their life story with a researcher, they tell a story of the real people and events in their life. Confirming authenticity with a number of participants in this study enhanced the trustworthiness of my work by illustrating congruence with the qualitative goal of representing the experiences from participants' perspectives. I returned to three participants who had consented during the data analysis stage to be contacted in order to seek clarification and confirmation of emerging themes and categories. Contact was made via email, which was the preferred mode of communication for the ANPs, and my data analysis was authenticated by the participants. This authentication added robustness in data analysis and enabled the development of accurate and valid account of the narratives. Creswell (2009) confirms that verifying between the researcher and respondent is an appropriate technique to enhance quality.

In agreement with the research literature, I found the content analysis approach to have a number of strengths and weaknesses as a research method (Elo and Kyngäs 2008). I found using it was unobtrusive in that it has no effect on the person being studied. It appealed to me as the method of choice because its systematic approach enables an objective account of the narrations. Whilst there is the potential for researcher interpretation to vary, this is not limited to content analysis approaches. The use of systematic coding and categorisation aims to address potential variance. As mentioned previously, the literature suggests that content analysis can be time-consuming; a point of critique I would concur with. However this I perceived as a positive, and not as a weakness, as I benefited greatly from time spent immersed within the data. This extended time resulted in my knowing the data fully which promoted validation of my coding, categorisations and themes.

## **5.9 Meanings - content, structure and form**

Ellis, Adams and Bochner (2010) contend that the relationship between the researcher and what is studied is important as they acknowledge that situational constraints shape the inquiry. Challenges inherent in using narrative inquiry are said to potentially lead the researcher to fixate on details which may contain misinterpretations due to cultural differences (Elliott 2005). In order to address this element, I became deeply involved in the subjective descriptions given by the ANPs of their roles, positionality and professional identity. My understandings are based only on their conceptions thereby reducing misinterpretation. This was aided by the fact that all ANP participants were from the emergency nursing specialism. A commonality of cultural understanding of this unique discipline is evident. My background knowledge and experience of nursing in an ED and of the distinctive language of nursing, meant that I could understand the rich narrative descriptions and their meanings.

Once the initial coding and categorization had been undertaken, Bourdieu's theory provided a valuable framework for analysis which enabled further conceptualisation of the elements identified. This secondary level of analytical thinking revealed the emergence of many subtle and tacit nuances that would have remained undiscovered if this dual framework approach had not been utilised. To manage the data I combined both manual and electronic data analysis methods.

### **5.9.1 NVivo software and manual data analysis**

I used the NVivo 9.2 software package. NVivo is designed for rich text-based data sets where deep levels of analysis are required (QSR International 2015). NVivo is aimed at enabling the researcher to identify trends and cross examine thematic relationships through the coding of nodes. The highlighting of words and sentences into meaningful clusters revealed combinations of subtle analysis with linking, shaping, searching and modelling aimed at exposing themes, subthemes and relationships (QSR International 2015). NVivo software was used to assist in data management as the software helps organise the data systematically and I, as the researcher, can then undertake a comprehensive analysis of the data.

Developments in formulating modes of data analysis with the use of computer packages, such as NVivo, attempt to address concerns over confidences in qualitative

data analysis (Welsh 2002). Debates surround the appropriateness of using computer-assisted packages in qualitative research data analysis. Some theorists contend that computer software represents a quantitative method within the qualitative paradigm (Baugh, Hallcom and Harris 2010). No conclusive answer has been achieved with debates continuing over 'confidence' in manual versus computer data analysis mechanisms (Miles and Huberman 1994, Basit 2003). This study required depth in analysis and NVivo aided in my search for an accurate and transparent picture of the data. Examples of this coding process are illustrated in Appendices I, J and K. However, as previously stated, I used manual formatting in order to enable the analysis of the data, make links, and identify meaningful themes. An example of this mind mapping is illustrated in Appendix I.

I had found a combined approach utilising both manual and electronic methods effective during the pilot phase. This is substantiated by Welsh (2002) who suggests that a combination of both manual and computer assisted methods are likely to achieve the best results. It was on this experiential and theoretical basis that I replicated my eclectic approach in this study. Firstly, content analysis was undertaken sequentially with Bourdieuan analysis. Applying Bourdieu's key concepts of habitus, field, and capital to the content analysis enabled the conceptual interrelations between these key concepts, and the study's question of ANPs' perceptions of their role, positionality and professional identity, to emerge from the data. These findings are further explored in the following chapter.

### **5.9.2 Quality**

Rigour remains critical in qualitative research and assessment of worth is fundamental in addressing the soundness, accuracy and integrity of empirical studies. Sandelowski (1986) terms this the 'fittingness' that is based upon the ontological and epistemological underpinnings of the study. As identified previously, Elliott, Fischer and Rennie's (1999) criteria will be revisited in the data analysis chapter, as further examples of how each criterion were addressed and met serves to strengthen the trustworthiness of this study. Central to ensuring quality is that consistency is made openly transparent, to demonstrate research integrity Appendix L illustrates a sample of my decision making trail. Issues of trustworthiness, namely reliability and validity, require versatility and

sensitivity reflective of the essence of the qualitative paradigm. This section reflects on my approaches to establish confirmatively and objectivity in this qualitative study.

I personally transcribed the narrations which enabled evidence from the descriptions to support my interpretations. Examples from the data were provided to support each theme and category development. Guba and Lincoln (1994) describe credibility as the extent to which interpretation of an individual's experiences represent those experiences. This is essential to this narrative approach, and in order to ensure findings are accurately represented in the data, two research participants in this study were given short thematic analysis of the findings and asked for their validation. The participants willingly shared their opinions which validated the results and led to a meaningful and rigorous set of findings. Thorne (2008) states that respondent validation is a formalised technique used to assist in establishing the validity of a researcher's interpretations and synthesis of data collected from research participants. Sandelowski (1993) identifies that member validation can sometimes paradoxically undermine trustworthiness as some members may find difficulty in abstract synthesis. No difficulties or conflicting issues emerged in this study.

I maintained self descriptive and reflexive journaling in which my values and beliefs were made explicit and therefore taken into account. Alvesson and Sköldbberg (2000, p248) present an overall frame for incorporating reflexive elements in qualitative research methodology. Their framework includes reflexive interpretation stating:

The researcher's judgement, intuition, ability to 'see and point something out' .... are not entrenched behind a research position.

My diary extracts added additional dimensions to illustrate the conceptual elements of coding and theme formation. In addition the narrative interviewing took place over twelve months. This prolonged data collection was seen as positive as much time was given to reflective practice. I am required to present formally my findings to interested parties, which includes the nursing research access committees. This forum will be a means to substantiate the relevance of the study and my claims to knowledge generation.

Reliability is enhanced through auditing and presentation of the decision trail. The purpose of declaring the decision trail is to enable the worth of the study to be assessed by others. My field notes detail my critical reflections on: sources of data; data

collection techniques; assumptions made; decisions taken and meanings interpreted; and reflexivity on my influences as the researcher as illustrated by excerpts in Appendices H and L. To add to reliability, the narrative transcriptions and the field notes were structured and standardised as per the conventions presented by Kirk and Miller (1986) and Silverman (2001). These elements demonstrate and provide confirmation that I remained true to the data. When no more themes were emerging I appeared to reach saturation. In order to verify my themes I returned to three participants to see whether any contradictory material emerged. They validated my themes and categories as true to the context.

### **5.10 Summary and Conclusion**

In summary, this qualitative narrative study's research design demonstrated the fit between research methodology, research questions and research design. Ten ANPs (Emergency) in seven different hospital emergency departments in various locations across Ireland were purposively sampled. Adhering to a narrative methodological approach, I conducted and transcribed the ten narrative interviews. Content analysis was used to code and categorise the narrative data into themes and categories. Bourdieu's theoretical framework was applied as a secondary analytical process. The mapping of my critically reflective diary and field notes assisted in ensuring trustworthiness in data analysis and interpretation. This enabled the empirically rigorous, accurate, and balanced report of this study's findings as illustrated in the following chapter.

In conclusion, this chapter has presented considerations pertaining to the collection and analysis of this study's narrative data. Participants' settings, sources, recruitment, access and sampling techniques utilised in this study were detailed and issues of trustworthiness addressed. Narrative interviewing, narrative questioning and the positioning of the narrative researcher were discussed. This demonstrated an ontological and epistemological 'fittingness' which Sandelowski (1986) suggests is fundamental to ensuring rigor in empirical studies. Ethical implications of the use of narrative methodology in this study were presented through critiquing issues pertaining to the transcription of narrative interviews, application of conceptual frameworks and methods for the analysis of narrative data. The explorations of these narrative findings are presented in the following chapter.

### 6.1 Introduction

This chapter presents the findings from this study. Consistent with narrative methodology, evidence from the rich narrative data is given to support my interpretations. Examples are drawn from the data to support each theme and category. These provide verification that the themes were grounded in the data with researcher perspectives being acknowledged and highlighted. I have used the female pseudonyms: Sorcha, Niamh, Caoimhe, Roisin, Erin, Ciara, Aoife, Clodagh, Saoirse and Sile to maintain confidentiality for participants. Each participant's individual voice, journey and experiences are traced through the data. This ensured that the dimensions within each of the themes were fully understood. Sorcha, Niamh and Erin were team colleagues in one ED and Caoimhe and Roisin worked together in another ED. Ciara, Aoife, Clodagh, Saoirse and Sile had ANP or ANPc colleagues. However these colleagues were not participants in this study. This made possible individual case exploration alongside team case comparisons and between case comparisons. This tripartite approach enabled the synthesis of understanding from both individual and collective experiences.

To provide an aide memoire the study aim and research questions are précised in the following paragraph. This study's aim is to explore the perceptions of ANPs (Emergency) regarding their role, positionality and professional identity through using a narrative methodological approach to address the following four key research questions:

1. How do ANPs describe their reasons for becoming an ANP and their transition from their previous nursing role to becoming an ANP?
2. What are ANPs' (Emergency) perceptions of their role?
3. What are ANPs' (Emergency) perceptions of their positionality?
4. What are ANPs' (Emergency) perceptions of their professional identity?

### 6.2 Findings

The following sections present the study's findings.

### 6.2.1 Themes

Five main themes were identified:

Theme 1	Participants' career pathways
Theme 2	Personal and professional transitions
Theme 3	Role dimensions and core concepts
Theme 4	Position within the organisation
Theme 5	Emergent professional identity

Each theme consists of a number of categories that represented participants' perspectives of their worlds and explores the nuances and complexities of ANPs' role, positionality and professional identity.

### 6.2.2 Categories

#### Theme 1 - Participants' career pathways categories

- Starting points and management roles
- The desire to be a clinician
- System changes enabling a new career trajectory.

#### Theme 2 - Personal and professional transitions categories

- Enormity and difficulty of the transition
- Educational challenges with master's degree level education

#### Theme 3 - Role dimensions and core concepts categories

- ANPs' field and multidimensional nature of practice
- Uniqueness of ANP (Emergency) nursing role
- Justifying the role and minimising waiting times as a *raison d'être*
- The ANP – Patient therapeutic relationship – importance of patient care and patient satisfaction
- Professional boundaries and expert practice
- Professional leadership, clinical leadership and research.

#### Theme 4 - Position within the organisation categories

- Team-working
- Support from key stakeholders
- ANPs' communities of practice

- ANP positionality and patients
- ANP positionality and the multidisciplinary team
- ANP positionality and nurses
- ANP positionality and medical doctors

#### Theme 5 - Emergent professional identity categories

- Status and recognition – the importance to ANPs of their ADON status
- Positive job satisfaction
- Organisational elements; ANP referral pathways
- The influence of healthcare management
- Medication and medicinal ionising radiation (X-ray) prescriptive rights,
- Scope of practice: educational and staffing requirements with practice development

These themes and categories will be discussed in detail in the following sections.

### **6.3 Theme One: Participants' career pathways**

Following content analysis the categories emerging from the data on participants' career pathways were: starting points and management roles; the desire to be a clinician; and system changes enabling a new career trajectory.

#### **6.3.1 Starting points and management roles**

All ANPs started their narrations with reflection on their nursing career trajectories. All had followed traditional career pathways which consisted of undertaking nursing training and qualification as a nurse followed by a period of consolidation in clinical nursing practice. Most participants had opted to spend their initial post-registration period working in emergency nursing. Niamh, Caoimhe, Ciara, Sile and Clodagh had nursed in EDs in other jurisdictions and all five commented on seeing nurses undertaking advanced practice roles whilst working there. Niamh commented that she had worked in a very large ED outside of Ireland where nurses were doing suturing and cannulation, Clodagh reflected on her experiences of seeing nurses referring for plaster applications, and Sile's experiences were seeing asthmatic and surgical cases looked after by emergency advanced practitioners. This indicates that nurses having experiences of advanced practice roles in action appears to positively influence nurses'

attitudes towards the potential of extending nurses' scopes of practice, both personally and professionally.

All participants had gained substantial experiential knowledge post-qualification as a requirement to become an ANP in Ireland is to have seven years post-registration experience with five years within the specialism (NCNM 2008a). They had also undertaken emergency nursing qualifications during this period. A move into nursing management was made by all of the ANPs, with Sorcha, Niamh, and Aoife also branching into dual educational roles. These were traditional pathways, as prior to the Commission on Nursing in 1998, there were no clinically-based career trajectories. In order to gain promotion, clinically-based nurses were required to move into the fields of management or education. All participants recounted the inevitability of their undertaking of nursing management roles. Sorcha, Niamh and Aoife then branched into education and practice development.

Interestingly, the dissatisfaction participants felt in these management roles were strongly reflected in all narrations. Descriptors referring to the ANPs' experiences in nursing management included 'groundhog day' (Niamh) and 'no mans land' (Roisin). These sentiments were also reflected in other ANPs' recounts. Sile and Caoimhe gave detailed insights into their negative ED management experiences with Caoimhe explaining her reasoning.

Caoimhe: I was a CNM2; I was the apologist for every mistake that went on in the hospital: waiting times, no beds, no staff and everything else that went with it.

Many nurses are content in management roles and seek that particular career pathway. Bourdieu (1990) explores how a person's structure and agency influences and is influenced by their habitus. This raises a number of questions that would be interesting to unravel: does the ANPs dissatisfaction stem from the difficult context of emergency departments that the ANPs managed or is it a personal preference for frontline practice in contrast to management that caused this lack of synergy? If for example had they been managing in another speciality would they have felt the same? Whilst acknowledging that two sets of ANPs work together, it remains that five different EDs are represented and therefore is a collective representation of difficulties in emergency nursing management in Irish social and healthcare contexts. This is evidenced in this study's literature review and reflected in Sile's excerpt.

Sile: I got a CNM post and by 2004 I had completely burnt out with that, I just really had had enough with that, it was the long waits - the trolley waits in [city] were just horrendous. I think it is a job you cannot do long term.

An important point made by many ANPs in this study was that they felt a distancing from the patient when in their management positions. This perceived distancing was judged negatively and caused a lack of synergy for the ANPs. They all expressed a strong desire to be close to the patient and this they saw was achievable by returning to frontline clinical practice. Sorcha reflected this sentiment.

Sorcha: You got further and further and further away from the patient as you became more senior in whatever role, but particularly, if you were going into the management role.

This raises the complex question: do ANPs just not like being in a nurse management role and so opt, in preference, to remain on the frontline or do they genuinely prefer the clinical advanced nursing practice role? They could of course have returned to the frontline in other capacities, such as staff nurses, rather than opting for advanced practice candidacy. This complexity is further explored in the following category.

### **6.3.2 The desire to be a clinician**

This strong motivation to move from nursing management back to clinical practice roles was illustrated by many ANPs including Saoirse, Niamh and Aoife.

Aoife: As time went on I realised that I really missed the clinical area and I missed the hands on.

The desire for direct patient care appeared to be a driving force to undertake ANP candidacy; a desire which did not appear satisfied by management roles. Sile, Sorcha and Erin echoed this motivation.

Erin: I felt to be honest that you weren't really doing much nursing as a CNM. As an ANP going back to the patient I took to it like a 'duck to water' and I loved it and I really loved being back with the patients seeing what their problems were.

This is reflective of Bourdieu's thinking in that it is the interconnectedness of agents' habitus, field and capital that produces synergy. Imbalance results in the discord experienced by the ANPs at this point in their career. This acted pivotally in them seeking a change in their career trajectories; a change only made possible in Ireland in 2001 through the Commission on Nursing recommendation to establish advanced practice roles.

Sile: I suppose from early on it [being an ANP] was something I aspired to and thought this is what I would like to do, I knew that I was never going to go down an education road, or really didn't want to go down the management road; and that seemed to be where you were at.

Interestingly, reflecting on ANPs' habitus, revealed a lack of parity between their experiences of nursing management and their expectations. A change in the field of nursing's structure and nurse's agency were required for this new career trajectory to be formed.

### **6.3.3 System changes enabling a new career trajectory**

The socio-political component required to enable system changes emerged in the form of The Commission on Nursing. This commission stemmed from a governmental initiative that reviewed the structure of nursing in Ireland. It recommended the establishment of a new nursing role to provide a clinical career pathway for experienced nurses (Government of Ireland 1998). Erin, Clodagh and Ciara reported on the significance of the Commission's recommendations personally and professionally.

Clodagh: I worked as a staff nurse here and that is when the Commission on Nursing happened and they brought in the new changes – advancing the scope.

The ANP role gave experienced nurses the option of staying in, or returning to, clinical practice. Erin commented that she really wanted to stay patient focused and these changes gave nurses in Ireland another career option, one which the ANPs in this study all opted enthusiastically to pursue. Personal and professional transitions are seen to be affected by a person's habitus. Habitus is influenced by past experiences, family upbringing, and education. Participants' initial nursing training, their master's level education and the experiential learning during their candidacy appeared to impact on their transitional journeys. This in turn appeared to impact on their personal and professional transitional experiences. ANPs' transitional journeys will be explored in the following section.

## **6.4 Theme Two: Personal and professional transitions**

ANPs' reflections on their experiences of personal and professional transitions form the basis of theme two. The categories that emerged from the data were 'Enormity and

difficulty of the transition’ and ‘Educational challenges with master’s degree level education’.

#### **6.4.1 Enormity and difficulty of the transition**

All participants described elements of their personal and professional transitional journeys from three perspectives: from nurse manager to ANP candidate, from ANP candidate to RANP, and beyond ANP registration. They all reflected upon their wide ranging personal and professional transitions. Sorcha spoke about the effects on her family life, Saoirse and Ciara commented on the need for temporary relocations and costings, and Roisin and Clodagh reflected on changing their jobs, and about their feelings about becoming students again. These were reported as significant life events which impacted both positively and negatively on the lives of the ANPs and on their habitus.

##### **6.4.1.1 From nurse manager to ANP candidate**

Initially the experiences and emotions of moving from management positions to becoming ANP candidates was reflected on by all ANPs as a positive step in their quest to move from the realm of management back to a clinical role. ANP candidacy provided this opportunity. Erin explained that she felt ‘very enthusiastic starting off’ and Niamh reiterated that sentiment also.

Niamh: I dropped the management mantle pretty quickly

All participants moved from senior management positions to a student role as an ANPc. This presented both positive and negative impacts on how they perceived themselves, and how they perceived that others in the field saw them.

Sorcha: The whole ‘novice to expert’ thing: that in itself is a transition and the transition from that point of view can often be disconcerting. The confidence that you would have in expediting one role to not being able to do much in the other can be quite stark for some people

This alteration in symbolic capital resulted in some ANPs feeling a reduction in confidence and prestige. However when support from within the field was shown, positive experiences of this transitional stage were realised by most participants. Clodagh commented on the importance of experiencing collegial support for her role. Support from colleagues is regarded as being an influence on positive habitus formation.

#### **6.4.1.2 ANP candidate to RANP**

All participants commented that they had experienced a learning curve, educationally and practically, in the second transitional phase from being an ANP candidate into becoming a RANP. One aspect of the ANP candidacy process that was commented upon by most participants was the educational challenges faced by undertaking the mandatory master's degree level study.

##### **Master's degree level education - educational challenges**

The educational requirement for master's degree level study was commented on by a number of ANPs as significant to their positioning within the field. This is reflective of Bourdieu's concept of capital, where capital is influenced by, and influences, a person's academic attainment. Attainment of higher level study was regarded as influential in raising ANP status within the field and is important to the development of positive professional identity. Aoife explained that the MSc enables ANPs to be critical thinkers and to articulate their craft.

Aoife: The master's gives you a little bit of education too in terms of to be able to articulate your craft a little bit better. People say "Oh why do you need a master's? Isn't that a load of rubbish?" No because we are no longer doers, we are thinkers as well and you have to be able to articulate your craft.

Undertaking master's degree level study did raise confidence issues for some of the ANPs, especially if the ANP candidate judged themselves to have been out of academia for a long period of time. Nursing only became a degree-level qualification in Ireland in 1999 so many of the participants had completed their nursing education at certificate level. Sile expressed initial feelings of being overwhelmed, whereas Saoirse questioned her academic abilities. This was a common response when reflecting upon embarking on master's level study, however interestingly on completion of their masters all ANPs had positive perceptions, for example Saoirse who had lacked confidence in her abilities reflected "I have never ever regretted doing it" and Sile had overcome her feelings of being overwhelmed to positively recount "I thoroughly enjoyed my training, every minute of it".

Any academic difficulties are seen to have been offset by ANPs' clinical drive to become an ANPs. Value in undertaking an ANP course was based upon an appropriately balanced academic and clinical programme of study that enabled

development of their critically reflective skills. Critical thinking skills were regarded as being a prerequisite in order to perform ANPs' roles. Interestingly Saoirse and Sorcha commented on the possibility of undertaking a professional doctorate but discounted this due to a dislike of academia. This is an important finding in the context of practice development (McCormack, Manley and Titchen 2013).

### **Being a ANP**

Transitioning from ANP candidate to ANP raised some interesting feelings of adjustment for many of the participants. Sile spoke of feelings of insecurity when comparing herself to other ANPs who had been in post for a longer period of time.

Sile: ... they [ANP colleagues] could be seeing 10 patients a day whereas you would be really happy if you confidently saw four patients and you knew you had seen four patients safely. I suppose it just took a while to get up to speed and to feel confident that you were as good.

Bourdieu describes, throughout his theory, how the development of habitus and dispositions are sensitive to change in an agent's field and capital. This is reflective of Benner's experiential stage theory where nurses experience transition from 'novice to expert'. Changes in their habitus were observed as alterations in their field and capital were experienced. The development of advanced practitioner habitus was significant in how the ANPs transcended and negotiated their transitional phases. This artistry and 'learning the craft' as Aoife defined the process is evident throughout the narratives, Bourdieu would call this the tacit, often taken for granted, dimensions of the practice world. The hidden curriculum experienced in practice results in role modelling which produces the development of ANP cultural norms. Parity between ANPs' attitudes, behaviours, perspectives and practices emerge and develop. This commonality was reflected in the narratives.

### **ANPs consolidation and resolution into their ANP role**

Reflections were made upon a third transitional stage; namely consolidation and resolution into their ANP role. This echoes Woods (1999) stage theory. The ANPs described the emergence of their habitus as a ANP. Interestingly their feelings of their journey from registration to 'becoming' established ANPs exposed feelings of transitions and insecurities.

Sorcha: Again that transition, although you think you have reached expert status, the more you work at that the more you return to the novice.

Ciara: You are not really relaxed in the role that you have for at least 3 years. I have been doing it years now, and your clinical experience obviously expands and your theoretical knowledge expands and you just develop yourself.

Ciara, Sorcha, Aoife and Saoirse commented specifically on the learning which occurs in practice 'on the job'. Aoife's commentary emphasises the enormity of this developmental stage.

Aoife: A lot of the learning occurs when you come back into the clinical area and you work independently. You have to step up to the plate then and it is huge. You don't realise how huge it is until you are actually there.

The ANPs in this study were at various stages in this process of transition. Some had been in post for many years and some were only recently qualified. However, as Benner theorises, development from 'novice to expert' is not a linear or uniform process but an individualistic one. ANPs are regarded as at expert practice level, and yet paradoxically as Sorcha reflected, she is back at a novice level but at the expert stage. This would suggest that there are stages beyond Benner's 'expert' level theory.

### **6.5 Theme Three: Role dimensions and core concepts**

Bourdieu's model is founded on theories of practice. He explains that agents within practice domains identify the importance of their field to their structure and agency. ANPs (Emergency) are regarded as having a multiplicity of roles. Theme Three presents an exploration of these through the following categories:

- ANPs' field and the multidimensional nature of advanced nursing practice;
- Uniqueness of ANPs' emergency nursing role
- Justifying the role and minimising waiting times as a *raison d'être*
- Pressures of the role
- Importance of patient care and client satisfaction and the ANP – patient therapeutic relationship
- Autonomy, accountability and responsibility in clinical practice: heightened awareness regarding accountability in decision making
- Professional boundaries and expert practice
- Insight into practice implications - professional leadership, clinical leadership and research
- Organisational factors.

### 6.5.1 ANPs' field and the multidimensional nature of advanced nursing practice

Discussion of ANPs' (Emergency) field of advanced nursing practice took place in all narratives. While the use of the labels 'ambulatory care' or 'minor injuries' are on occasion used in the literature to describe this cohort of patients, this terminology is questioned by some of the ANPs who deem the term 'minor' to undermine the importance of this patient cohort.

Aoife: The label 'minor injuries' I think does a disservice to the patient, because it is not a minor injury... it sets a mindset that it is only a minor, but it is minor relative to a major trauma. So I think that the perception all along that it is a minor, it can wait, and *it can't*. Perceptions even on the floor are 'oh yeah, it is minor injuries, sure what is that? Elbow, toe, knee. . .

The participants regarded their scope of practice as much broader than the 'minor injuries' title implies. ANPs' case management has extended and expanded since 2002 and ANPs' caseloads continue to evolve. Participants acknowledged this evolution positively as aiding their personal and professional development, maintaining their motivations and challenging their practices. However, developments were also cautiously referred to in their commentaries with references to the possible impacts that role development could entail. Concerns were raised that their role may become medicalised or less effective by taking on roles outside of their current scope of practice. Implications for practice development were also raised. Aoife, Roisin and Saoirse reviewed potential positive and negative implications of assuming further case management. All participants gave very positive perceptions of their current role and highlighted the multidimensional nature of their advanced nursing practice.

Caoimhe: The actual work itself, I love the work itself, the hands on: meet the patient; see; assess; diagnose; treat; discharge; and everything that goes with it – I love it; that is hands on, no problems with that at all.

Advanced nurse practitioners' skills sets and scope of practice are defined in the literature as demonstrating higher level skills in assessment, diagnosis and treatment as Erin confirms.

Erin: I would always have perceived it as a clinical role and a role where you would be using all your nursing skills and all your knowledge as well as the tasks to do the suturing, the plastering, the diagnostics, the reading X-rays. That is important but I would always have perceived it as a role that was going to be essentially clinically based and patient focused; very much a nursing role.

The focus on the ANP role being predominantly a nursing role reverberates throughout all the narrations as illustrated in the following section. This is an important defining element for all participants. The ANPs' perceptions expressed in this study suggest that this synergy has been achieved by them. The synergies of other professionals' perceptions are less definite and this will be further explored in the following sections.

### **6.5.2 Uniqueness of ANPs' (Emergency) nursing role**

Sorcha's statement exemplifies all participants' commentaries in that their focus is predominantly centred on the discipline of emergency nursing.

Sorcha: My own perceptions of my role is, that in this role, I get to practice being a nurse and that is the bottom line as that is what I came into nursing to do. ... It is actually really gratifying to still be able to feel that I am actually a nurse and that I am providing nursing care.

The nursing element is important as Saoirse explains "I am doing different things as well and yet I am bringing nursing to medicine rather than moving into medicine." The unique dimensions of the advanced emergency nursing role, in contrast to advanced practitioners in alternative disciplines, are highlighted as the ANPs comment that diagnosing and differentiating are key elements that make their emergency advanced practitioner role unique.

Niamh: You are assessing patients who are undiagnosed and undifferentiated; you know nothing of their past medical history for lots of the time; so you are in the dark and you have to find the light. Whereas with other nurse practitioners if you are in an orthopaedic clinic there is a chart a mile high that you can refer back to looking for the medication and everything that is going on.

### **6.5.3 Justifying the role and minimising waiting times as a *raison d'être***

The strongly reported feeling of having to quantify and justify their workload was raised by all participants. It was felt by many that management used both overt and covert methods to focus upon practitioners' throughput numbers. Interestingly there seemed to be tension as ANPs appeared to perceive that their managers' interpretations were judging negatively the numbers they were seeing. No participant reported being directly admonished over their throughput figures, but it was more a surreptitious feeling of being monitored. This reflects issues surrounding positionality, for as Bourdieu suggests, habitus is open to influence by management factors from the field.

Roisin: I suppose with the environment that we are in, they are looking for value for money for different things. We are under pressure. Our role, if you like, is under pressure.

This apparent lack of confidence was surprising when their cultural, economic and social capitals are elevated and their symbolic capital is acknowledged. Yet the fact that quality care provision is hard to measure statistically compounds their ability to provide firm data and to evidence their additional roles as teachers and educators. The focus on ANPs increasing throughput numbers and minimising waiting times is the current governmental policy aimed at standardising and reducing EDs patient waiting times (HSE 2012). All ANPs commented that this has implications for their role as illustrated by Caoimhe reflections.

Caoimhe: The consultants have bought in to the concept of ANPs for the simple reason that we are the only system that works and that is the only reason they have. They have only brought in because we see our patients, we reduce the numbers, we don't miss our fractures, we don't add to their workload, and we make the department look good because we see up to 30% of a daily presentation and we see them bang on time and we see them well. There are no complaints coming in the door. There is no messing around.

The government requirement to work within defined service needs and budgetary financial parameters appears to be a source of pressure for most participants. Pressures inherent in focusing on waiting times and throughput numbers, with regards to corresponding statistical and monetary value measures, were raised. In line with Begley et al.'s (2010) findings, ANPs suggested that organisational factors and time limitations in the field are factors that hamper performance.

#### **6.5.4 The ANP – patient therapeutic relationship - importance of patient care and patient satisfaction**

In line with international research, participants cited client satisfaction (Ball 1999, Byrne et al. 2000), reduced waiting times (Fairley and Closs 2006), and quality in care provision (Guest et al. 2004) as resultant elements of their role. The ANP – patient therapeutic relationship was a dimension that was regarded as central to quality client care provision by all participants. McCormack, Manley and Titchen (2013) concur that importance lies in person-centred cultures. Interpersonal skills are said by participants to be important advanced nurse practitioner qualities. Patience was acknowledged as an important quality as the ability to communicate effectively with patients was essential in

order to promote a trusting advanced nurse practitioner – patient therapeutic relationship.

Erin: I would like to think that we hold on to the caring, compassionate, empathic, advocacy – I know people would say that touchy feely part of nursing but essentially that is what nursing is. I personally would feel very strongly about that.

The development of therapeutic interactions was regarded as essential in ensuring appropriate patient care and in the application of these expert skills. Participants suggest that they make a value-added difference to the patient experience and that accurate identification of patients' needs enables appropriate care provision. They emphasised the importance of effective interpersonal qualities to promote truthful client disclosure.

#### **6.5.5 Autonomy and accountability - heightened awareness regarding higher-level decision-making**

The concepts of autonomy and accountability in decision-making were common themes emerging in all narrative interviews. This reflects the definition of ANPs' core concepts (NCNM 2008a). All participants commented on the importance of their role and their accountability for the care they give. They commented on the concepts of independence and autonomy as being central elements to their nursing role. It is recognised that autonomy remains bound to the ANPs' scope of practice and the importance of this regulatory framework is acknowledged. A common response was that it is in how organisations operationalise the scope of professional practice framework that influences their capital and professional boundaries.

The personal and professional magnitude of this responsibility was reflected upon in a number of ANPs including Sile.

Sile: But I think I am more aware of the risks involved, only recently, even though I have been working full-time as an ANP for years .... I just feel some nights you are going home thinking 'have I done the right thing? What if something happens? What if ... what if basically with everything.

Yet, there was an element of contention, as some participants identified that the concepts of accountability and autonomy in decision making were not as clearly defined as some authors suggest. Clodagh commented that "autonomy is a nebulous concept; nobody can do as they like" and the need for accountability was highlighted by all.

However two participants were critical of their hospital's constraints perceiving them as limiting their autonomy inappropriately:

Caoimhe: My perception of the ANPs at the time was that they were autonomous practitioners but that is all rubbish as there is no such thing as autonomous practitioners. My work is defined by the protocols that I have to work to. The protocols are set by the consultants here in [hospital]; as they are in every other hospital in the country; so what I can see is not autonomous, it is dictated to me what I can see. And even within those protocols I am limited as to what I can do.

There seemed to be disparity between what these two participants felt they should be able to do and what their organisation permitted. Interestingly Caoimhe's colleague was also interviewed and did not raise comparable issues regarding organisational constraints. This would appear to substantiate Bourdieu's suggestion that this disparity reflects complex and connected social relations that represent the fuzzy logic of practice.

#### **6.5.6 Professional boundaries and expert practice**

Participants felt that expert decision making by competent and safe practitioners was a central quality of their role. The focus on expertise is reflective of ANPs as expert level clinical practitioners and 'expert' status is regarded as a core advanced practitioner competency (NCNM 2010a). Participants gave many real life clinical practice examples illustrating their experiential skills; situational and contextual understanding; and language acquisition. Benner's (1984) seminal research on nursing practice highlights that experiential learning takes place through five levels of proficiency development. These five sequential stages are: novice, advanced beginner, competent, proficient, and expert. Furthermore, a period of transition is experienced when assuming new nursing roles and moving from 'novice to expert' (Benner 1984). This seems to have been reflected in the participants' experiences where developing critical reflective skills on and in practice are regarded as fundamental to this developmental process and this was evidenced in the narratives.

Erin: I would be much more reflective in my approach now. I think reflection is very important.

Transitional steps are recognised by the participants as they moved from being ANP candidates into working as ANPs. They all demonstrated qualities of competent individuals who were able to use their expertise and critical thinking skills in decision

making. Caoimhe, Aoife, Saoirse and Erin reiterated the importance of clinical currency gained from their experiential learning. This ensures a level of insight that adds depth and breadth to their practices.

Erin: Genuine empathy takes time to develop and the nursing skills you develop over the years with knowledge and experience.... Benner talked about 'those fundamental ways of knowing'.

A significant finding is that in the participants' perception their expertise and understanding of the wider implications of the decisions they make develops. It was clear that with expert status comes a greater awareness of potential implications and of one's limitations. This appears to add greater caution in practice for a number of participants, reflecting a heightened sense of accountability.

Sorcha: I spend as many nights, sometimes after very busy long days, I spend often nights when I wake up and ask myself 'why did I decide to do that in terms of a patient discharge?' and then I think 'this should not be happening at this stage in my life'.....Again that transition, although you think you have reached expert status, the more you work at that the more you return to the novice.

Erin: I would be much more cautious now in every case and make sure that I don't make a mistake and that you reflect on a case ...You are cautious but you are experienced and you are confident in your cautiousness.

It is interesting to note that the development of this perceptual acuity is developmental for the ANPs. Maturity is recognised as one important quality that promotes expert practice. The importance of experience is noted as significant to the development of effective communication skills with clients and multidisciplinary health care professionals. Bourdieu's theory suggests that agents develop strategies adapted to the needs of the social world which they inhabit. This finding implies that experience and maturity are qualities that promote the development of these strategies and are integral to ANPs meeting the needs of their patients.

### **6.5.7 Professional leadership, clinical leadership and research**

All participants highlighted the importance of their professional and clinical leadership roles to their positionality and capital. Examples were given of Hospital and National Boards that they sit on. Teaching was regarded as a positive part of their practice domain and all ANPs gave examples of their formal and informal teaching commitments on various academic and clinical programmes. These consisted of

intradisciplinary and interdisciplinary roles locally and nationally as illustrated in the excerpts from Ciara.

Ciara: We do teaching for the GP rotation and the docs that come in. ....We now teach the orthopaedic juniors doctors as they come on placement here.

Health education for patients was raised by participants as important aspects of client care in advanced nursing practice. This concurs with Byrne et al.'s (2000) findings who concluded that patients were significantly more likely to receive health education from emergency nurse practitioners. Bourdieu comments that experience is an important element because social agents operate according to the implicit practical logic that they perceive and as an agent gains experience their 'feel for the game' is enhanced.

As identified in the literature review, advanced practitioners are required to demonstrate researcher skills as part of their core attributes. The attribute of researcher is multilayered and represents more than purely the conduct of research. The research spectrum incorporates research application in order to promote a research culture of safe evidenced-based nursing practice through the formation of evidence-based PPPGs, journal clubs, audit, consultancy, teaching and collaboration. Interestingly, and of significant importance to ANP knowledge generation, the core concept of research received little mention in the narrative data. Roisin and Erin acknowledged that research was an area in which ANPs felt they were under-achieving. I found this reticence interesting as all participants had an established grounding in research through successful completion of their MSc theses as part of the pre-registration requirements.

Roisin suggested possible reasons and consequences this had for reaccreditation "the one thing that the Emergency group has failed to succeed in is the research. I suppose, we are not given time and that is an integral part of reaccreditation". She mentioned possible underpinning reasons were given as a lack of time and a lack of skills, but Erin's honest explanation illuminated her perceptions of the situation.

Erin: I suppose hand on heart, they [ANPs] say we don't have time, but you could make time or you could be given time but it is more you would rather be at the clinical area that would be the honest answer.

She suggested enhancing this element of her practice through linking with a 'research buddy' and she acknowledges this is an option open to her in her hospital. This was a recommendation from the SCAPE study (Begley et al. 2010) and links have been

founded between hospitals and partner academic institutions nationally. It would be valuable to assess the impact this collaboration has longitudinally upon knowledge generation and research publications. Participants did acknowledge however, that they were involved in the research spectrum through PPPG generation (Sorcha), audit activity (Clodagh), their intention to engage in research (Saoirse), research buddies (Erin) and their experiences of MSc. research (Niamh). Other research elements mentioned included conference and seminar attendance, organisation of presentations, input into curriculum design and delivery, collaborative networking and knowledge sharing, journal clubs and reading research papers.

Gerrish et al. (2012) researched the concept of positive knowledge brokering and the promotion of evidence-based practice between nurses in advanced practice roles and frontline nurses. They interviewed and observed advanced practitioners (n=23) and frontline nurses in the UK and found that advanced practitioners demonstrated the ability to promote evidence-based practice among frontline nurses. However, their ability to facilitate this was influenced by the advanced practitioners' personal attributes, relationships with key stakeholders, responsibilities and work-loading. Supportive organisational contexts were regarded as an enabler to advanced practitioners demonstrating these key clinical leadership skills. The currency of evidence-based knowledge was regarded by participants as key to their practice and to their role as educators of students and frontline nurses.

I suggest that when the wider scope of research proficiency is considered, as described through the participants' examples, participants may be underestimating their research achievements.

## **6.6 Theme Four: Position within the organisation**

Bourdieu's theoretical framework acknowledges that the practice field is a multidimensional social space. Membership of a field is represented by the doxic relationship between the objective field and the subjective agent. This theme considers the dimensions of ANPs' social worlds that define their positionality. Participants' perceptions of their position within the organisation are explored in the following categories: Team-working, Support of key stakeholders, and ANPs' communities of practice.

### 6.6.1 Team-working

Most ANPs involved in this study worked as part of a team of ANPs in their ED. SORCHA, Niamh and Erin worked together with other ANP colleagues in one ED. Caomihe and Roisin worked together in a team with other ANPs in a second ED. Sile worked also as part of a larger team in a third ED. Ciara practised in a smaller team with other ANPs; Clodagh also practised in a different smaller team of ANPs. Aoife and Saoirse worked as solo practitioners but had Medical Registrars working alongside them. Professionally, being a member of a team meant that collaboration and conferring over case-management was possible. This was regarded as being mutually positive and advantageous regarding conferring and referral.

Due to shift patterning an ANP may be the only ANP on duty at any given time. This appeared to be significant for a number of participants as the support they received from their ANP colleagues was regarded as invaluable. Ciara reflected that “we have a great relationship as ANPs and we work well together”. Contact time may not always be frequent and will depend on team size but, as Clodagh commented various modalities are used to promote effective communication. This collegiate support was important to the ANPs. Some specific issues were raised, with a number of participants reflecting on the stressors and implications of working in isolation. Niamh commented that being a solo practitioner would, in her opinion, be “quite tricky and lonely” but adds the addendum that maybe that is not the case and maybe it is only her own anxiety about it. Individual variance was evident in the narrations where personal working preferences were stated. For example, Clodagh sought collegial support whereas Saoirse reflected “I was so used to being on my own that I was quite happy.”

Bourdieu (1990) contends that the social world of practice is embodied in social dynamics and these complex social relations influence an agents' habitus by changing or developing their agency. The influence of the field is once again seen to impact upon ANPs' habitus. The value of social networks is regarded as engendering positively how agents engage with everyday practice. Support gleaned from personnel in the field was regarded as an important element to promote ANPs' synergy.

### **6.6.2 Support of key stakeholders**

The support of key stakeholders impacts positively on the positionality of ANPs within an organisation (NCNM 2005b, Small 2010). Organisational readiness is regarded as important in the development of effective workplace cultures (Manley et al. 2011). The participants acknowledged this fact and highlighted its implications.

Sorcha: The Director of Nursing and Medical Consultant are the two key figures, the key stakeholders, who need to give you the support because if you do not have support from the Director of Nursing, who professionally is really your line manager, and then from the clinical perspective from the Consultant, the governance just won't be there for it to happen.

The current proposals for the Standards and Requirements for Advanced Practice (NMBI 2015b), as previously discussed, alters the clinical governance mechanisms regarding post and site accreditation. Several ANPs mentioned the importance of gleaning support from key stakeholders in order to ensure the success of the role. If the NMBI do relinquish this control to local levels it will be interesting to see how support manifests at clinical level.

Four ANPs commented that they felt they were not supported at some point in their journeys by either senior nursing personnel or medical personnel, examples given relayed disputes over recognition of grades, status and remuneration. This demonstrates the personal situatedness of individuals within the wider contexts. Interestingly Caoimhe and Roisin who work in the same ED had very different experiences and thoughts about their organisational support, thus illuminating an understanding of the individual perspective as opposed to collective experiences. The ethos of the organisation and management, role development, and transition reflects Bourdieu's thinking that the development of new practice roles results in change in an individual's structure and agency. Eclectic elements make up the complex organisational context within which ANPs practise, and in turn, this influences their positionality within their wider communities of practice. This was explored by the ANPs.

### **6.6.3 ANPs' communities of practice**

Perceptions of the advanced practitioner role by the ANPs' communities of practice are regarded as having a bearing on ANP positionality. It was felt that recognition of ANP positionality by patients, nurses and doctors has changed since the formation of the role

in 2001. There remains however, some disparity amongst ANPs as to the level of understanding they perceive various personnel to have, as one ANP highlighted.

Sorcha: If you had said to people 5 years ago, certainly 10 years ago, “I am an ANP”, people would say ‘what’s that?’ or ‘you are what?’ And certainly in our own professional circle of nursing and medicine people would have asked you ‘what does that mean?’ and ‘what do you do?’ and again that perception that you are doing doctor’s work etc etc. Whereas now if you say you are an ANP they say ‘ok what kind of patients do you manage then?’

This may represent an important sea-change reflective of the bedding down of the ANP role. Yet participants questioned the universality of understanding amongst ANPs’ communities of practice.

#### **6.6.3.1 ANP positionality and patients**

Patients were viewed as being positive exponents of the ANP role. The ANP perceived that their patients are satisfied with the care they receive and are happy that they are seen promptly and do not have to wait a long time in the ED. Refreshingly, numerous clinical examples were offered to illustrate and substantiate this thinking: “there is never a complaint, patients are seen, they are all seen and happy that they have been seen and sorted, they tell me all this” (Caoimhe); “the vast majority 99.9% of the patients that I see are seen quickly and discharged with the appropriate care” (Roisin), and “there was a patient there this morning and when she came back she said “Oh I am glad it is you!”” (Clodagh). However, the ANPs suggested that a comparison remains in patients’ mindsets between medics and ANPs. This can influence the interrelation of habitus formation and feelings of positionality as Clodagh and Aoife illustrate.

Aoife: I always introduce myself as an ANP and nobody has ever said ‘I don’t want to see you.’ Actually they have looked for me.

Clodagh: Let them know you are a nurse and how good you are as a nurse if the patients’ education allows it.

#### **6.6.3.2 ANP positionality and nurses**

A number of ANPs, including Niamh, Clodagh, Ciara and Saoirse, commented positively about their relationships with their nurse colleagues and the support they gleaned from them. There was a perception amongst the ANPs that nursing colleagues would have insight into the ANP role and workload. However, interestingly there was an assumption made that by being in the same profession that all nurses would have an

insight and understanding of the ANP role. This was not universally experienced in practice; in fact ANPs commonly reported a lack of awareness from both frontline nurses and nurse managers. Importantly, some personnel in senior nursing management posts were regarded as having a lack of understanding of ANP positionality. This was reported by a number of ANPs and was a concern as a lack of awareness of ADON status could negatively implicate on ANPs position in the field.

Ciara: In senior nursing management there is an element of a lack of understanding of the level that we are. I am contracted as an Assistant Director of Nursing but the senior nursing management would not have that understanding and that would be the only issue.

Participants suggested that a lack of understanding can be attributable to a number of factors including: a lack of direct practice contact in the field, senior personnel being too busy, or not being involved in the role development. The participants also highlighted a lack of true understanding and awareness of the complexity of the ANP role by management. An example being that failing to see the ANP role in wider organisational contexts has negative implications for ANP work-planning and progression. As Saoirse explained “they see their waiting times aren’t big, but don’t understand why they are not.”

Participants suggested that these disparities exist because some nurses have a genuine lack of understanding of the role. Reminiscent of Woodward, Webb and Prowse’s (2006, p274) visual imagery of “swimming with the sharks” some participants reflected how this lack of understanding manifested in practice-based tensions. Some participants commented that when they transitioned into their ANP role some nursing colleagues held negative perceptions.

Sorcha: In that moving, even from a CNM position to an ANP position, culturally people would see you in a different light and would think you have gone ‘to the other side’, to use the expression ‘gone to the dark side’ and that you have changed allegiance almost.

Involvement in ANP role establishment and working in close contact with ANPs is regarded as promoting understanding through positive relational dynamics. As illustrated in the literature review, Manley (1997, p179) highlights that ‘currently there appears to be two schools of thought concerning the essence of advanced practice’. One school suggests that advanced practitioners are clinical practitioners developing at the ‘nurse-medicine interface’, retaining a nursing perspective while subsuming tasks

previously considered medical tasks. In contrast, the second school sees the advanced nurse practitioner role as a multidimensional expert nursing practice role focusing on advancement of nursing culture and nursing knowledge. The two schools of thought pose a contentious divergence which raises important issues pertaining to ANPs in practice. Sorcha clarified her perceptions.

Sorcha: There are some nurses who feel that as an ANP ‘you are doing doctors work and that you are no longer a nurse and that you have left the philosophy of nursing behind’. They are very much against that type of role development and you are really not carrying out nursing unless you have a bedpan in one hand and a thermometer in the other.

Traditionally-held nursing perspectives are possible reasons why there may be negativity towards ANP’s positionality. A number of participants suggested that some of their nursing colleagues do hold such traditionalist ideals. Interestingly and significantly, the ANPs judged in their experience that the medical profession generally held a much more positive viewpoint of the ANP role. As Aoife’s excerpt explained, “Nursing staff are less willing to embrace the role actually than medical colleagues, but you go through your literature and that is well documented”.

Bourdieu reflects on the possession of capital as a crucial source of power. As ANPs possess uniquely higher levels of capital and higher positionality in comparison to their frontline nursing colleagues, this power imbalance may be a source of negativity and intraprofessional antagonism manifesting as jealousy. However once the relevance and value of the ANP role to nursing in practice was realised, nurses were regarded as having a positive attitudinal change towards the ANP role. As identified in the literature, new role developments require periods of adjustments in organisational contexts as power differentials become established. This is illustrated by Ciara.

Ciara: There was a little bit of ‘who do you think you are?’ Until it was developed and they could see that it was actually good for nursing.

### **6.6.3.3 ANP positionality and medical doctors**

The experience of most participants reflected that the majority of medical colleagues, once au fait with the role, were positive and did not feel their positionality was compromised. Maybe this was because medics’ cultural and symbolic capital is regarded differently to ANPs in the field. Thus the nexus of power and dominance is regarded differently by ANPs and doctors and professional antagonism is not perceived

by most ANPs in their fields. Clodagh and Saoirse did comment that they had experienced some personnel issues with medical staff. This they suggested related to isolated individuals rather than universally. Generally ANPs considered their relationships with their medical colleagues as predominately positive. Senior level colleagues at consultant and registrar grades were regarded, in most instances, as enablers through being supportive of ANPs' clinical roles and of advanced practice in general. Descriptors from participants in reference to senior medical colleagues included "supportive", "good to us", "good man", "great support structures", and "very facilitating and accommodating."

Some participants described experiences of tension from some medical practitioners but this appeared to be in cases where the service was newly developed as opposed to being evidenced in an established system. They acknowledged that most medics did possess an awareness of ANPs' roles and functions in the field, however some misconceptions were experienced amongst junior hospital doctors, and it was suggested that it was a lack of clinical exposure that underpinned their limited understanding of ANPs' roles. It appeared very important to the ANPs that their clinical credibility was recognised and affirmed by medical staff.

Niamh: They [consultants] know that if you [the ANP] are worried that they should be worried so they come.

Roisin: They trust us, but you don't just earn that overnight, you earn that.

It could be inferred that this symbolic capital and prestige in turn influences ANPs positionality and identity. This enables ANPs to demonstrate the attributes of advanced practice through their role.

The participants suggested that appropriate awareness of their role is fostered through effective communication. Senior doctor grades of Consultant and Registrar were regarded as having a greater depth in understanding of the ANP role. A more mutual professional relationship was reported between medics and ANPs, in contrast to the traditionalist subservient nurse to doctor relationship. This was affirmed by participants who suggested that one example of this flattened hierarchical relationship was evidenced by ANPs greatly supporting junior doctors with their clinical education and clinical skills development. This was evidenced when three participant interviews were disturbed by doctors seeking the participants' input and advice in case management.

Suturing, patients' assessments, putting on casts, case management, and giving advice were all stated as inputs that ANPs provided to medical staff in their day to day practice. These roles enable ANPs' positionality to reflect the attributes of advanced practice.

#### **6.6.3.4 ANP positionality and the multidisciplinary team**

The healthcare field is made up of multidisciplinary teams. Physiotherapists, occupational therapists, social workers, radiographers, medics and nurses are all members of this wider multidisciplinary team network. The participants reported viewing multidisciplinary team members as equals and in turn adjudged themselves as being on a par with them. Their professional relationships were generally regarded as positive and they commented that positive multidisciplinary teamwork was grounded on trusted professional relationships and effective workplace cultures.

Roisin: Without question: plastic surgeons; orthopaedics, orthopaedics in particular as that would be the bulk of who we refer to; physiotherapists; occupational therapy; we have an amazing working relationship with them.

Acknowledgement is made that interaction between multidisciplinary team members and ANPs is key in promoting understanding of mutual roles and effective teamwork. Bourdieu explains that the development of an agent's disposition for social action is conditioned by their position in the field. However, participants identified that not all multidisciplinary members had a universal understanding of ANP positionality. Examples were given of tensions and preconceptions that had been experienced by ANPs from multidisciplinary team members.

### **6.7 Theme Five: Emergent professional identity**

Theme Five explores ANPs' perceptions of the attributes, enabling factors and consequences of their emergent professional identity. This is illustrated through the categories: Status and recognition - the importance to ANPs of their ADON status; Job satisfaction; Organisational elements - ANP referral pathways; The influence of healthcare management; Medication and medicinal ionising radiation prescriptive rights; Scope of practice; and Educational and staffing requirements with practice development.

### **6.7.1 Status and recognition - the importance to ANPs of their ADON status**

All participants identified that they are primarily nurses and affirmed that advanced nursing practice is grounded in the philosophy of nursing. ANPs' unique practice and positionality means that their identity is different to other clinicians. Their identity of being 'a nurse' held great significance for all participants.

Sorcha: It is actually really gratifying to still be able to feel that I am actually a nurse and I am able to provide nursing care.... you are more of a nurse, in fact working in this type of role.

The ability to provide holistic, competent and safe expert nursing care was regarded by participants as consequential to their advanced practice roles. Sorcha added "was that not what we came into nursing to do?" Participants suggested that the lack of acknowledgment by some senior nursing personnel of advanced practitioners' ADON status demonstrated a lack of understanding of the advanced practitioner role. Participants reflected that many nurses did not seem to understand that ANPs were comparable in grade, social status and capital to management-based ADONs. The importance of legitimising ANPs to have management authority enables their implementation of leadership and change practices. ADON status was regarded as important to the ANPs in this regard as it accorded them cultural and symbolic significance in the healthcare field.

A number of ANPs suggested that not being acknowledged as at ADON level by other senior nurse managers and frontline nurses was due to the fact that the ANP role is predominantly clinically-based. However the consequences of this lack of status included: not being listened to (Aoife), limitations in negotiation potential in meetings (Caoimhe) and being disregarded (Clodagh). This implies that nurses perceive that clinically-based roles hold less capital than nursing management roles. The implication of this perception is significant as it renders ANPs' potential influence at a disadvantage in wider nursing forums. In line with ADON status, ANPs are remunerated on a higher graded pay scale compared to other frontline nurses. Ciara reflected that advanced practitioner economic capital was a point of "professional antagonism" for some management-based ADONs who judge that they should have superior, not comparable, economic capital to ANPs. Clodagh also added that ADON status was regarded by some nursing colleagues as a point of "professional jealousy".

### 6.7.2 Positive job satisfaction

All participants expressed positive job satisfaction with the direct clinical nursing care that they personally provided. Saoirse commented that “I just love it, I just think I am born to it, I don’t know why – it is me, it is just me, and I have never been happier”, Roisin said “If anyone asks me ‘what do you do?’ I always say ‘I have the best job in the health service’”; and Aoife declared “I enjoy it, I do. I enjoy what I do. I enjoy the patient contact.” The overarching sentiment was that all participants gleaned great job satisfaction from working as ANPs and all participants demonstrated pronounced positivity when describing their own personal contribution regarding clinical practice. Reasons given for job satisfaction included: the ability to “connect with people”, “it is different”, “I have a bit of everything”, “achieved a lot professionally and academically” and of “being constantly challenged”. Roisin replied in detail as to why she thought being an ANP was the best job.

Roisin: It is the independence, autonomy when you are making the decision and the decision that you make you have to stand over it. It is even just the patient contact; you know that you are making a difference to somebody.

Synergy between the concepts of individual structure and agency is significant, for as Bourdieu (1990) highlights in his theory of practice, they are intertwined. Self reliance, confidence, commitment and clarity of thought are personality attributes displayed throughout the narrations and is reflected in their positive job satisfaction.

Patient contact was cited as being a central element to their satisfaction in practice, as discussed previously. This contrasted to the feelings of dissatisfaction experienced whilst in their management-based roles. As Sorcha reflected:

Sorcha: The job satisfaction is amazing . . . it is a very rewarding and fulfilling job. I certainly would not have felt as fulfilled if I had followed the management route.

Comparisons to previous management posts were raised with ANPs regarding their current role preferable to former management positions. Caoimhe reflected that “patients would actually thank me for what I did to them as opposed to when I was a CNM2.”

A number of participants commented that they are happy to continue in their roles ad infinitum. This is reflected in the NMBI (2014a) registration statistics where of 146 RANPS only two RANPs have moved to different posts and two have resigned/retired.

Importantly for practice development, progression and promotional opportunities did not appear to be an aspect of concern to ANPs. None of the participants expressed any discontent with their ANP career trajectory. In fact participants reflected that it would be the organisation's imposition of retirement that would decree that they would have to leave their posts as they would not opt to leave voluntarily. These excerpts reiterate this commitment "I have never had one single day that I have gotten out of bed and I didn't want to go to work" (Sorcha); "I will be dragged out of this post screaming, I am just happy out" (Roisin) and "I could see myself staying in this until I retire" (Niamh). Bourdieuan analysis would suggest that a state of synergy has been reached by the participants in their ANP role. This finding is substantiated by O'Keeffe et al.'s (2015) study which concluded that high levels of job satisfaction with their clinical care were experienced among ANPs in the Republic of Ireland.

A number of participants concluded that some personnel and organisational issues negatively impinged upon their practice. However, this did not detract from their overall job satisfaction with the direct nursing care that they provided. Organisational elements did however impact on their capacity to fulfil the five key advanced practice role extensions of: prescribing medicinal products and ionising radiation; referral rights; diagnosis; admission and discharge; and certifying certificates. These elements are illustrated in the following sections.

### **6.7.3 Organisational elements: ANP referral and prescriptive rights**

Harris (2008), Hoskins (2011b) and McConnell, Slevin and McIlfatrick (2012) consider organisational elements and their impact on ANPs' privileges. Significant advanced practice privileges include referral rights to health professionals in the field. Occupational therapy, physiotherapy, medical specialities, radiography, outpatients departments, nursing specialities and social work were identified as some of the specialities that ANPs can refer patients to.

#### **6.7.3.1 Referral rights – medics and the multidisciplinary team**

Orthopaedic doctors and teams were identified by the participants as their main referral pathway due to the nature of the specialism and ANPs' cohorts. Sile commented that generally 99% of her referrals are to the orthopaedic team. Caoimhe added she would refer to the on-call team for orthopaedics and to the fracture clinic. In general the ANPs

commonly reported that they had a good rapport with the orthopaedic team based upon an effective workplace culture as Ciara explained in her commentary.

Ciara: They know when they are getting a referral from an ANP that we are the specialists in the area, more specialist than the registrars as they come for our advice as well and they know that everything is going to be done and that it is a good referral. They like it when we refer to them.

However, some tensions were seen to exist in this process within some organisations and with some healthcare professionals. These were attributed to the initial bedding down of the role in practice and raising awareness of what the ANP role was and what their extended referral pathways were. The adaptation by organisations to the ANPs new role of referral was mixed. Sorcha, Niamh and Erin worked in organisations where the ANP role had been established for a number of years and reported that they found no difficulty with enacting referrals. In contrast, ANPs including Saoirse, Clodagh and Caoimhe, working in EDs where ANP roles had been established in recent years, commented that they had experienced some issues with referral pathways in practice. Issues related to a reticence with practitioners from various specialisms, including radiography, surgeons, and medics when referring from secondary to tertiary centres.

The ability to refer to MDT health professionals was judged as an important element in an ANP's expert skills set. Acknowledgement of the higher levels of ANP expertise and accuracy was commented upon by all ANP participants. Referral pathways to the MDT team did not raise any issues for participants. This they attributed to "you have a reputation that goes ahead that those guys know what they are talking about and generally there is no problem with the referral process" (Niamh). Bourdieu (1990) contends that the use of language can be used by agents to enhance their power and position within the field. ANPs fluency in medical discourse and professional language serves to legitimise ANPs' participation and position within this professional group.

#### **6.7.3.2 Prescriptive rights - X-ray (medicinal ionising radiation) and medication prescribing**

Alongside referral rights, following successful course completion the registered ANPs' role includes medication prescriptive authority (NMBI 2012) and medicinal ionising radiation prescriptive authority (HSE 2009). In order to undertake these prescribing duties, ANPs receive theoretical instruction and formal examination as part of their ANP course curriculum. Nine of the ANPs had certification as a RNP and one ANP had

been delayed and was due to complete certification shortly after her interview. This delay was for personal reasons and the ANP commented that she felt this hampered her efficiency in practice as she had to seek an additional step by having to ask doctors to sign off on a prescription prior to her administration.

All participants had ionising radiation prescribing certification. However organisational variance was seen as a number of participants identified that there were issues and disparity pertaining to how some individual organisations implemented their PPPGs with regards these two key advanced practice elements. The issues appeared to be multifactorial, with legislative complexity at national level concerning policies specifically regarding prescribing medicinal ionising radiation for children and their interpretation at organisational level. This legality raised issues with many participants. For example, concerns over “lack of authority” (Clodagh), “I am still working within the law as I am qualified” (Saoirse), and “there are a lot of restrictions, from the X-ray and the prescribing” (Sile). The consequences of these legal issues on ANP practise will be explored in the following sections.

Radiography was specifically mentioned by a number of participants, across a number of hospital sites, as an area of contention. Some participants seemed to find getting their medicinal ionising radiation prescribing rights accepted and supported was problematic within their organisations. Some reported initial resistance from radiology and radiographers and attributed this as stemming from a lack of understanding of the competencies and knowledge of the ANP.

Sorcha: When it was explained to radiology and radiographers that we undertook specific education, and that we could demonstrate that we were safe practitioners that was well accepted.

Higher-level clinical judgement and the use of knowledge in practice are fundamental attributes in advanced practice as critiqued earlier in this study’s literature review. Demonstration of these competencies and educational certification were regarded by participants as key to gaining acceptance by their medical and radiology counterparts of this extended role. Most ANPs remarked that they had worked ways around the issues and yet three ANPs still appeared to be facing tensions in practice as Caoimhe and Saoirse reflected.

Caoimhe: Even those X-rays that I am allowed to request are dictated as to what I can request, so I can request skeletal views only. There was an argument over facial views; an argument over chests; but you just rise above that.

The situation was compounded by national problems that existed regarding paediatric X-ray prescribing. At the time of the study prescriptive rights had been altered and ANPs in some EDs were no longer permitted to prescribe X-rays for children under the age of 16 years.

Saoirse: I have been prescribing for children for 8 years and now I am not allowed to prescribe for children because there isn't a national policy, but actually the statute states that I can prescribe for children. The fact that we can not prescribe X-rays independently for children it is a big, big problem. For me it is a major problem because 70% of what I see is children.

Some organisations had amended their local policies to enable their advanced practitioners to continue prescribing and most participants did maintain this right. However, this impacted directly on most participants' practise as their clinical caseload included children. As Clodagh noted "30% of our workload is 16 years and under". They perceived that being unable to prescribe for children impacted negatively on the efficacy of their practise as they were delayed due to the necessity of having to seek a medical person to sign their request form. The delayed submission of request forms resulted in the child having the X-ray tardily and thus compounding and increasing children's' waiting times in the EDs.

Another factor raised by participants regarding their X-ray prescribing certification was that the educational provision participants were certified in was not paediatric or adult specific as their curriculum was modelled on a generic approach. As Sile commented "they are trying to overcome this at the moment" and this resolution came when the course was revalidated to include a paediatric specific component. A bridging addendum for those already certified has been presented to satisfy the legislature.

Issues pertaining to medicinal prescribing were raised by a number of participants, Saoirse reflected on the cumbersomeness of the computer system currently in situ "Every time you write a prescription it is 13 clicks on the computer and you could have 5 prescriptions on one patient and it takes up an awful lot of time. It is a big, big problem." Whereas Caoimhe commented on the organisational element she experienced: "the drugs I prescribe; I have undertaken the registered nurse prescribing course, so I have done that, but even the drugs I prescribe that are circumscribed by my

CPA (collaborative practice agreement) so I have get permission from my consultants as to what drugs I prescribe.” Issues raised were not regarded as insurmountable and communication was commented upon as the key to conflict resolution. Interestingly in their experience, involvement by medical, not nursing, personnel was required to resolve conflict and remove practice barriers. Some ANPs reflected that organisational tensions and issues resulted in them feeling vulnerable as their perception was that they occupied a precarious position within the practice domain. This is substantiated by the relevant international literature. Interestingly, a number of the ANPs who expressed a sense of vulnerability were in roles that had been established for a number of years. From the narrative analysis it was found that the individual participant’s length of time in post did not appear to relate to their sense of vulnerability or their professional identity.

Clodagh: I do think we are at the whim of our medical colleagues who at any time could draw or pull the rug from under our feet.

This sense of vulnerability appears subtly in a number of the narrations which may be reflective of the relative immaturity of the ANP role in the Irish healthcare field and a lack of legatorial cultural capital (Bourdieu 1990). Social actors are vying to occupy dominant positions within the field and ANPs represent another layering to this hierarchical social world. Medicine and management were regarded as key structures in ANPs’ struggle to legitimize their own professional power and dominance.

#### **6.7.4 The influence of hospital management**

A number of issues surrounding hospital management were raised by some participants. These issues resulted in tensions for some participants as the management ethos of the participants’ hospitals seemed to have a significant bearing on their experiences. Both positive and negative management styles were discussed. Roisin who had previously worked as a senior clinical nurse manager reflected that her previous management role aided her understanding of the wider organisation and contextual elements in healthcare practice; “I know how they think” and this understanding made her “a lot more acceptable to management negotiations”. In contrast, some other participants who had worked in middle management failed to empathise with the organisational constraints that they perceived. Management styles were seen to influence the culture within an organisation, and wider social contextual factors such as funding and management strategies, were seen to impact on ANPs’ practice experiences.

Following ANP registration some participants experienced varying difficulties within their organisation.

Clodagh: When I came back there were just so many walls put up in front of me but I think that everybody who sets up an ANP practice has that.

This links, and adds to, the points raised earlier regarding the establishment of new professional roles and the importance of key stakeholder support. Following qualification and registration as ANPs, Clodagh and Caoimhe were initially not appointed by their respective hospital managements to the ANP grade. This was regarded by Clodagh and Caoimhe as significant because initially they were working as ANPs but were not accorded ADON status. They were also not remunerated at the appropriate grade. Both participants expressed concerns that professionally this impacted negatively on their status within the organisation, and personally this evoked negative feelings towards hospital management.

Recognition of their position within their organisation was very important to the participants. The ANPs' perceptions of themselves and of their professional identity were imbued with their role and positioning. When these were not aligned, the consequence was that their professional identity was adversely affected. Clodagh and Caoimhe's narrative interviews revealed that even though the situation had been resolved they remained emotive that they had personally been treated unjustly by hospital management. This personal dimension is reflected in Clodagh's excerpt with the marked multiple usage of 'I'.

Clodagh: Unfortunately when I came back I was working as an ANP at a staff nurse grade so I was taking on different roles and taking on a lot of responsibilities ... so something has to give.

Importantly their experiences did not appear to negate the commitment to the care that they provided and the satisfaction that they gleaned from the role, but it was evident in their narrations that the experiences had upset them and had negatively clouded their perceptions towards their organisations. Interestingly Roisin who works with Caoimhe did not express any problems with her organisation or appointment. This again may reflect the individuality of situational experiences. However the fact that issues related to funding and appointments in two different hospitals would indicate that it was reflective of the wider contextual budgetary constraints indicative in the Irish health service as discussed previously in Chapter 2.

It was noted that limited funding had also led to a moratorium on appointments and reduction in recruitment of ANPs. The moratorium is no longer imposed but the legacies of low staffing levels are problematic currently in the field of healthcare. However, as detailed in the literature review, the current HSE (2012) emergency medicine programme is capacity building by increasing numbers of ANPs nationally (HSE 2013). All of the participants commented about the future of advanced practice and their evolving roles, position and identities.

Erin: It will be interesting to see how things will evolve by the rolling out the roles of ANPs regarding remuneration and employing nurse practitioners.

Bourdieu (1990) acknowledges that external social structures, for example healthcare management, serve to enable social reproduction by generating and regulating practices that make up social life. Social structures can also hamper practice as explored in the following section.

#### **6.7.5 Scope of practice - educational and staffing requirements with practice development**

Participants highlighted a number of potential areas for practice development that included extension and expansion of ANPs' scope of practice. Inclusions of case presentations such as 'dislocated shoulders' and 'additional trauma presentations' were considered by some participants as expansion options. The Working Group on Advanced Practice review (NMBI 2014a) highlighted a number of possible developmental areas, however it was suggested by some participants that the scope of ANP practice may be at its optimum point and that adding further case presentation may detract from their nursing philosophical foundation.

Erin: I think expansion of the role probably will happen and I can see why. If the outcome for the patient is good then it is good. The concern would be that it might become seen as elitist, that you would be seen as top-notch diagnosticians and that other professionals might see that you are 'doctors'. I think it is important to maintain the nursing element of the role.

Participants cited additional educational requirements as potential barriers to their practice expansion. Bourdieu asserts that education is crucial to enhance cultural capital as assets, skills, and qualifications mobilise cultural authority. ANPs' clinical governance includes a submission to the NMBI for reaccreditation every five years, during which ANPs are required to evidence the fulfilment of their core concepts.

Implicit in this is the requirement for continuing professional development (CPD). A lack of availability of applied courses, Funding and protected time in the healthcare field were highlighted by most participants as impeding their CPD.

    Roisin: If we look at expanding protocols there is a huge education component to it.

A concern voiced by the participants was that a lack of specialist courses nationally impedes the development of ANPs' practice and their CPD. This negatively impacts on the enhancement of their cultural authority and, as they pointed out, has the potential to interfere with their reaccreditation. This resulted in a resurfacing of feelings of vulnerability as they were unable to access appropriate advanced practice specific courses. In light of this concern the Emergency Medicine Programme has subsequently set up an advanced practice forum which provides applied educational sessions nationally.

External factors including healthcare professionals, service need and governmental policy were highlighted as features driving change. Participants added that in line with current capacity building there would be additional staffing requirements. If expansion of their case management were to take place, Roisin explained that "although I do not have a problem with expanding protocols I do want it done right." Professional identity was regarded by all participants as an important enabler to the fulfilment of advanced practice roles.

## **6.8 Summary**

The aim of this study was to explore ANPs' (Emergency) perceptions of their role, positionality and professional identity. The enablers, process and consequences of the key concepts of role, positionality and professional identity were explored thus ensuring Sorcha, Niamh, Caoimhe, Roisin, Erin, Ciara, Aoife, Clodagh, Saoirse and Sile's individual voices could be heard throughout the analysis. Within and between case comparisons were made providing a synthesised understanding of individual and collective experiences. This content analysis of the rich narrative data enabled findings to the four key research questions to be revealed.

### **How do ANPs describe their reasons for becoming an ANP and their transition from their previous nursing role to becoming an ANP?**

ANPs' career pathways (theme 1) and personal and professional transitioning (theme two) considered this first key question. Sorcha, Niamh, Caoimhe, Roisin, Erin, Ciara, Aoife, Clodagh, Saoirse and Sile's reasons for becoming ANPs and the transitions they experienced from their previous nursing role to becoming an ANP were explored. All the ANPs' narrations began with reflections on their individual journeys and experiences. They identified career trajectories including starting points and management roles. All participants expressed dissatisfaction with working in nursing management and this was coupled with a strong 'desire to be a clinician'. Clinical career progression pathways had not been possible in Ireland until changes to the nursing system occurred in 1998 with the Commission on Nursing. This established the ANP nursing role and it was to this new position that participants aspired to and which subsequently led to their personal and professional transitions.

Participants' reflected on their personal and professional transitioning and the 'enormity and difficulty of the transition' experienced when moving from being an ANP candidate into being an ANP emerged. A focus upon the role of education and the educational challenges of undertaking master's degree level studies was presented. The subsequent influence on their emerging roles was explored. Challenges were seen with master's level education and yet it was their clinical drive that was seen as central in overcoming potential and actual barriers.

### **What are ANPs' (Emergency) perceptions of their role?**

Theme three illustrated ANPs' perceptions of their multidimensional role. Participants' analysis of their scope of practice highlighted the complex multidimensional nature of advanced practice. Their focus centred upon the concepts of nursing; autonomy in clinical practice; responsibility; role requirements and expertise. Professional boundaries and the uniqueness of ANP (Emergency) practice were significant elements for participants. The ability to provide quality patient care was commented on and seemed central to participants demonstrating the attributes of heightened levels of decision making and professional accountability. Minimising waiting times, pressures of the role, and justifying the role were also highlighted as important aspects in their practice.

### **What are ANPs' (Emergency) perceptions of their positionality?**

Theme four presented participants' perceptions of their position within the organisation. Categories discussed included analysis of the enablers of positive job satisfaction; team working; and support of key stakeholder in the promotion of effective workplace cultures. ANPs' communities of practice were focused upon with ANP positionality to: the patient, the multidisciplinary team, nurses and medical doctors. Participants regarded their positionality and capital as unique. On occasion the immaturity of the role was seen as a contributory factor to a lack of awareness of their position. Practice-based tensions were seen as a consequence of the immaturity role.

### **What are ANPs' (Emergency) perceptions of their professional identity?**

Theme five detailed ANPs' perceptions of their emergent professional identity. All participants commented on the importance that their status and capital held for them in the healthcare field. Recognition of their ADON grading was regarded as a significant enabler for advanced practice. The significance of their attributes in referral pathways and the influence of healthcare management on their prescriptive rights of medicinal medication and ionising radiation were considered. Scopes of practice extension and expansion developments were explored alongside educational and practice development needs.

## **6.9 Conclusion**

This chapter has identified that ANPs collectively expressed experiences on issues related to their challenging roles in nursing management coupled with a desire to be a clinician prompted their transitioning to becoming an ANP. There was also universal agreement that they were satisfied in the hands-on care that they as ANPs provided and that their patients were generally highly satisfied with the care received from the ANP. Medication and medicinal ionising radiation prescriptive rights were commented upon by a number of participants as problematic. Interestingly however the perceived problematic issues were variable amongst and between participants. Organisational pressures of patient waiting times and throughput numbers were identified as consequential of current governmental and organisational policy (Conlon et al. 2009). However, how individual hospitals implemented their practices resulted in participants'

expressing a mirage of experiences. Some, but not all, participants expressed frustration with their individual organisation's macro and micro management structures and strategies.

Comparing individuals who worked with other ANPS with those who were solo practitioners did not identify any great differences. Indeed the evidence would suggest that the individual experience was more important as practitioners within the same organisation perceived problems differently. This was illustrated when comparing team-members Roisin and Caoimhe's perceptions of management. A wide variance in their perceptions and experiences was observed thus reflective of Bourdieu's thinking on the individuality of structure and agency. Individual variance was also seen in participants' experiences of intraprofessional and interprofessional relationships. Participants expressed differing and individualistic feelings relating to their experiences of practice-based tensions, personal and professional transitions and organisational elements.

In conclusion, this chapter has presented this study's findings through five key themes exploring participants' perceptions of their role, positionality and professional identity. Thematically participants' career pathways; personal and professional transitions; role dimensions and core concepts; position within the organisation; and emergent professional identity were discussed. Participants described the complex multidimensional nature of their role, positionality and professional identity. Many factors were seen to influence their journeys to becoming an ANP and subsequently in their experiences of working as ANPs. Using content analysis with Bourdieu's conceptual framework aided in analysing the dynamic and relational key concepts of habitus, field and capital from within the narrative data. This enabled the often subtle tacit and contextually situated dimensions of ANPs' experiences in their social world to be illustrated. It emerged that the three concepts of role, positionality and professional identity form part of one framework. The concepts of positionality and identity are enablers to ANPs' roles and this in turn results in ANPs' roles reflecting the attributes of advanced practice.

In line with the content analysis approach the following chapter discusses these findings in the context of contemporary literature.

## CHAPTER 7 DISCUSSION

### 7.1 Introduction

This chapter presents a discussion of the findings of the study and critiques their relationship to previous research and published literature. Comparing these findings with those of other studies allows the significance of them to be explored and their distinctive and innovative elements to be emphasised. The purpose of this study was to explore ANPs' (Emergency) perceptions of their role, positionality and professional identity. The narrative interviews and their content analysis yielded a wealth of answers to my research questions. The application of Bourdieu's key concepts and their relational mapping to the findings illuminated many subtle, contextual and tacit dimensions.

### 7.2 Discussion of key themes from the findings

Exploration of ANPs' (Emergency) perceptions of their role, positionality and professional identity requires consideration of the complexity and distinctiveness of ANPs' structure and agency, the healthcare field, social and governmental contexts, and the interrelation of these elements. Bourdieu's key concepts (1990) aided in exploring ANPs' worlds through illuminating many of the social and contextual components from individual narratives. The following discussion is founded on the emergent concepts: (i) Habitus – role transitioning from nurse to ANP, (ii) Field - reconstructing advanced practitioner positionality, and (iii) Capital - structure and agency that influence ANPs' professional identity.

### 7.3 Habitus – role transitioning from nurse to ANP

- How do ANPs describe their transitioning from their previous nursing role to becoming an ANP?
- ANPs' (Emergency) perceptions of their role

Bourdieu (1990) defines habitus as the historical and sociocultural background, embodied norms, values and dispositions through which agents understand and interpret the social world and its relations. Habitus, comprising of internalised history and experiences, works as a structure which generates and organises practice. System changes with the implementation of the Commission on Nursing allowed for the new clinical career trajectory of advanced nurse practitioner (Government of Ireland 1998). Identification of structural determinants in participants' trajectories emerged through

reflexivity about their management roles and experiences. Bourdieu's thinking tools profess that structuring conditions and structural changes play a central role in determining agents' habitus (Bourdieu 1998). This highlights the relational elements of choices taken and links collective narrative reasoning to wider social trends and influences.

Whilst each participant's story was unique, many similarities emerged between the descriptions of their journeys to becoming ANPs. Collectively all participants had worked in various nursing management roles in the Irish healthcare system. They all reported dissatisfaction with their management experiences and this coupled with, or maybe motivated by, a desire to return to clinical practice led to their decision to become ANPs. Management roles were regarded as being removed from patient contact and were marred with legatorial difficulties from within the healthcare system. For example, bed shortages, long waiting times, and poor staffing were all such issues. Yet paradoxically, management roles directly influence patient care. It would be valuable to ascertain if it was management per se that the participants disliked or the situational context of emergency nursing that led to their dissatisfaction. It seems that these two elements were juxtaposed. Participants were dissatisfied with current management roles and this motivated a desire to return to clinical practice. Maybe this dichotomy reflects Gladwell's (2006) 'tipping point' that resulted in advanced practice role development. The literature refers to pressures from service needs and organisational influences as perceived 'tipping points' whereas O'Shea (2008) contends that nurses' motivations acting as catalysts for change in the healthcare field have not been generally debated.

What motivates some nurses to seek to become ANPs poses an interesting point for analysis. Bourdieu's theory acknowledges an interdependent relationship between objective and subjective elements of practice. He theorises that observing the complexity of the contextual field gleans insight into an agent's norms, values and dispositions (Bourdieu 1990). This raises the question: is it nurses' clinical and managerial experiences that influences them to opt for the ANP career trajectory or is there a personality psyche that leads some nurses to seek advanced practice roles? Alternatively could it be simply opportunistic, experiential or situational? The multifaceted complexity of people and practice makes a definitive answer to this conundrum elusive. However, this study's findings infer that nurses have a mirage of

personal, contextual and professional factors that motivate and influence their career pathways towards advanced practice. Influencing factors include contexts, events, opportunities and barriers and Bourdieu would say that this is the fuzzy logic of practice where actors are predisposed to see a course of action as obvious and others as impossible. One ANP, Roisin, reflected that her path was chosen by “being at the right place at the right time” but maybe there is some underlying reason as to why she was in that position to start with. Other nurses may be in the same position but do not opt for the ANP trajectory. Contemporary literature does not provide any conclusive answers on this point. My findings suggest that it is often a combination of factors, but the driving force appears to come from within the nurses themselves in response to dissatisfaction with their nursing management experiences, coupled with a desire to be based clinically close to the patient. It is important to develop this understanding as it serves to inform ANP recruitment and retention strategies and practices.

Theme two focused on participants’ personal and professional transitioning. It was found that collectively all participants demonstrated commitment to advanced practice as a nursing concept, and personally to them becoming ANPs. However, the transition from nurse to ANP was acknowledged in the enormity and difficulty of ‘becoming an ANP’. ANPs’ habitus develops through formal master’s degree level nurse education, and informal experiential learning. The theory that the discernment of rules, patterns of interpretation, behaviours and values are learned is presented in Bourdieu’s key concept of habitus. Habitus is the embodied reality of a person’s world influenced by history, tradition, customs and principles (Bourdieu 1990). Jenkins (2008) identifies that these are often not explicit as it is through this process that ANPs’ habitus is differentiated from other frontline nurses’ habitus. ANP candidates work alongside a registered ANP for their clinical placements during their candidacy period of two years. This ‘human flourishing’ and ‘learning the craft’ extends beyond the pure acquisition of clinical skills and includes learning the artistry of how to be an ANP through practice development methodologies including role modelling (McCormack, Manley and Titchen 2013). An individual’s habitus is reformed and reinforced by their candidacy and thus their dispositions are borne from a collective habitus. This consolidation was judged by participants as important in the development of the professional discipline of advanced nursing practice.

All participants reflected on their transitional journeys from nurse manager to ANP candidate and from ANP candidate to RANP. They all recounted various challenging experiences personally and professionally. As previously identified in the literature, transitioning is a period of change where dispositions, levels of capital, fields and habitus alter. Bourdieu (2000) contends that it is looking at these changes that provide an understanding of the logic of practice. This was illustrated in my findings where participants' reflections on their changes centred on how they perceived their colleagues saw them and how they saw themselves. Initial changes from management positions to an ANP candidate resulted in a reframing of their role and status. This reframing again reconfigured when they qualified as ANPs. It was concluded that participants experienced these dual transitional periods of change personally and experienced some disparity amongst their collegial members professionally. Transitional support scaffolding is suggested by Kennedy et al. (2011) to help ANPs in their process of transitioning as the deconstruction of their former habitus takes place simultaneously with the reconstruction of their new habitus. This new role, positionality and identity bring differing capital and dispositions. This reflects Benner's (1984) transitional stages in moving from 'novice to expert' and Woods (1999) transitional stage theory.

The literature identified that a heightened sense of the concepts of accountability, responsibility and autonomy in decision-making are synonymous with higher level expert practice. Participants confirmed this theory was realised in their practice. The enormity of the concept of accountability was illustrated throughout all narrations. Carryer et al. (2007) comment that advanced practice roles brings to the fore the notions of professional efficacy through the concepts of autonomy and accountability. Humphreys et al. (2007) argue that advanced practice roles extend professional boundaries, in which authority, accountability and autonomy are reviewed and revised. As critiqued in the literature review, the literature illustrates that autonomy and accountability are distinguished as critical features in expert practice (Daly and Carnwell 2003). Benner's research on expert nursing practice defines expert skills development as a move from reliance on abstract principles to the use of past concrete experiences. Her theory outlines a change from viewing a situation as multiple fragments to seeing a more holistic picture as experts move from detached observer to active performer (Benner, 1984, Altman, 2007). This sensitivity and insight was

demonstrated in the practice-based examples that participants gave throughout the narratives.

One participant, Caoimhe, reflected that in her experience higher levels of accountability and autonomy were curtailed by medical and nursing management. However, as discussed by a number of other participants, ANPs are legally required to practice within their scope of practice and are required to continue to follow PPPGs. I suggest that it is through the interpretation and application of these algorithms by ANPs in their case management, that higher level autonomy and accountability are demonstrated. O'Shea (2008) states that acting as an advanced practitioner involves demonstrating clinical wisdom in their clinical judgements. This results in ANPs having a unique habitus in comparison to other frontline nurses. Whilst not always explicit to the ANPs at the time, the development of their unique dispositions and habitus during and after their candidacy is reflected in their narrations. This is representative of Bourdieu's theory of practice. For some participants their personal and professional transitions, from candidacy through to becoming registered ANPs, were influenced by the master's degree level educational challenges they experienced. This is a unique observation from this study in the context of advanced practice nationally. Master's degree level education is currently not prerequisite internationally to register as an advanced practitioner, although many countries are reviewing the criterion of adding master's degree level attainment to their registration criteria. Currently this finding is contextually significant in Ireland. However this finding may be transferrable to other jurisdictions, such as Wales where master's level education is a requirement for ANP registration (NHS 2010). Significantly many nations, including England, do not currently have this educational criterion, although this is presently under review.

Challenges with master's degree level were highlighted and opinions were mixed regarding the experiences of their educational journeys. Many commented positively on the critical thinking skills promoted by master's degree level study. The difficulties experienced were attributed to the perceived academic jump from their initial educational base. This may be reflective of the professional drive evident in nursing in recent years toward higher educational attainment, thus promoting parity with aligned healthcare professionals. Significantly higher level study is seen to impact positively on all forms of capital and this had positive implications for ANP positionality in the field.

Bourdieu theorises that social and cultural capital is increased with higher academic attainment and this is represented by ANPs being positioned at ADON level. Overall my findings infer that higher level study adds positively to ANPs' habitus, capital and position in the field of healthcare. Interestingly, when participants spoke of their personal and continuing professional developmental needs they tended to refer to predominantly clinically-focused courses. The desire to undertake additional level academic study, at for example doctorate level, was focused on by only one participant, Saoirse. She recounted thinking about the possibility of further professional doctoral study but dismissed this due to her dislike of academia. Student support scaffolding in universities may assist the bridging of ANPs actual and perceived academic needs with the move to professional doctoral level. This would aim to imbue confidence and motivation amongst ANPs to undertake doctoral level study.

Hardy et al. (2013, p1) provide insight into educating advanced level practice within complex healthcare workplace environments. Transformational practice development is structured to enable workplace complexity to be understood. Understanding the complexity of the field can promote the development of effective workplace cultures. Participants identified a number of complex workplace issues including: difficulties with funding; availability of appropriate programmes of study at advanced level; protected time, and being released from clinical duties as impediments to undertaking continuing professional development. A lack of relevant and applied nursing courses nationally was also cited by the participants. This would impact financially upon them due to the additional cost of having to undertake overseas travel to avail of appropriate courses. These are important factors to be considered if, as a group, ANPs' professional development is to be consolidated, maintained and promoted. Multiple implications emerge regarding patient safety, ANP reaccreditation and role development if ANPs are not facilitated and enabled to maintain clinical currency, competency and mastery. A need for continuing education, particularly clinical education has been identified.

Looking at this period of transition, and the impact it has on ANPs' field, capital and habitus through Bourdieu's conceptual lens, gives insight into the uniqueness of ANPs' role, positionality and identity. In addition this acts as a means of exploring ANPs' social inclusion in the wider healthcare workforce. The empirical data confirms elements of Bourdieu's theorisation of habitus as illustrated by his favourite metaphor

depicting the interrelation between habitus and field as ‘the feel for the game’ and ‘the game itself’ (Bourdieu 1990). This ‘feel for the game’ was reflected on by ANPs as they reconstructed their professional positionality in the healthcare field.

#### **7.4 Field - reconstructing advanced practitioner positionality**

- ANPs’ (Emergency) perceptions of their position within the organisation and experience of any practice-based tensions

Changes in the organisational infrastructure of the healthcare field, and the reorganisation of professional boundaries in this new advanced practitioner role, have led to reconstruction in the habitus of ANPs. Bourdieu theorises that meanings develop over time in relation to the contexts in which agents operate (Bourdieu 1990). This enables agents to make sense of themselves and develop an identity that they regard as socially legitimate. ANPs’ (Emergency) field and scope of practice is acknowledged in the literature as unique and multidimensional in nature. O’Shea (2008) contends that nurses and midwives have an important part to play in adapting to the demands of economic organisational change but neither the medical nor economic model should dominate. She contends that ANPs need to practise in line with their own care values “while remaining true to their own professional identity” (O’Shea 2008, p11). The findings in this study illustrate that participants’ focus is on nursing and the uniqueness of their ANP emergency nursing role.

The literature review identified that ANPs (Emergency) have a uniquely defined scope of practice and agency differentiated from other nursing and medical roles in the healthcare field (Lloyd Jones 2005). Arslanian-Engoren et al. (2005) contend that advanced nurse practitioners’ scope of practice is positioned on a blending of nursing and medical roles and that the blended nature of this contemporary nursing role results in a blurring of traditional professional nursing boundaries and domains. This is a debated point amongst nurse theorists with regards advanced practice roles. Significantly the ANPs in this study emphatically acknowledged that their beliefs are grounded within the philosophy of nursing. This allegiance to nursing philosophy was voiced with great conviction and purpose by all participants. The issue of extending and expanding ANPs’ scope of practice was spoken about by all participants with great caution as not to transcend that fine line from nursing into medicine.

It is documented in the literature that the ANP role exists within a specialist field (Begley et al. 2010). Current debate raises concerns of ‘specialism’ in preference to acknowledging the ‘generalist’ domain. Generality is posited as being holistically focused and more aligned to the nursing paradigm than the reductionist focus of medical philosophy (Daly and Carnwell 2003). Many commentators question the legitimacy of the ANP role being aligned to the medical model in preference to the nursing paradigm (Arstianian-Engoren et al. 2005, Woodward, Webb and Prowse 2005). This is an important point as, in light of the possible emergence of the dissolution of nursing philosophy, far reaching consequences for the profession of nursing and the advancement of nursing knowledge may be realised. Arslanian-Engoren et al. (2005, p315) emphasise that:

Without a clear distinction of our metatheoretical space, we risk blindly adopting the practice value of other disciplines, which may not necessarily reflect those of nursing.

Reflection on the findings of this study, reveal that participants appear to feel great stress in the need to justify their roles on the basis of minimising waiting times as a *raison d’être*. The pressure this places on their role is reflected in their narrations. It is valuable to understand the source of this pressure as some participants comment on a perceived expectation from management for throughput numbers. However the subtlety with which this is inferred appears to intensify and heighten their stress level. Conlon et al. (2009) and Begley et al. (2010) acknowledge that ANPs are influential in reducing waiting times for some clients. The fact that ANPs are conscious of the number of clients that they see, and that they are compared to the throughput numbers of their medical colleagues appears to add to ANP stress levels. The participants in this study appeared very conscious of their client throughput numbers, and yet strongly acknowledge the importance of quality care provision above client figures. A tension exists between balancing the provision of quality nursing care and keeping waiting times to within governmental set parameters. This appears to be a marker against which nursing and medical managers assess advanced practitioners’ achievements. This appears to be a point of tension for ANPs, as one participant, Erin, aligned it to “big brother is watching you”.

Participants in this study commented positively on the therapeutic relationships they formed with patients. This correlated with patients’ positivity and satisfaction with their

care. The literature acknowledges that the advanced practitioners – patient therapeutic relationship is important in patient care. Begley et al.'s (2010) research concludes that ANP care results in improvements to patient outcomes and increased patient satisfaction. Participants' reflections in this study confirm this perception as all participants unanimously narrate positive comments about their personal job satisfaction. The value-added therapeutic relationships which ANPs form with their patients were recounted as great sources of personal and professional satisfaction.

Professional clinical leadership and research are classified as core components of the ANP role as defined by the NCCNM (2008a) and explored by Elliott et al. (2014). This is reflected in the development of the Emergency Medicine Programme (HSE 2012) which accords ANPs (Emergency) key roles in service delivery reforms. This has a positive effect on agents' capital and thus on practice development and on ANPs' position in their field. Contemporary literature notes that there are many factors influencing ANPs' evolving identity and achieving their unique roles and positions has taken place over time and continues in its evolution.

## **7.5 Capital - structure and agency that influence ANPs' professional identity**

### **The professional identity of ANPs (Emergency)**

The theoretical complexities of researching practice are acknowledged by Kemmis (2010) who presents a comprehensive critique of praxis. New developments in approaches to researching praxis include Bourdieu's theories of habitus, field and capital. Grenfell (2008, p46), considering Bourdieu's concepts, concludes:

It is therefore possible to analyse the way the same structural relations are actualised in both the social and the individual through studying structures of organisation, thought and practice, and the ways in which they mutually constitute each other.

It is proposed that through studying ANP capital through the structures of ANPs' organisations, thoughts and practice, an insight into their role, position and professional identity can be explicated as Grenfell suggests.

### **7.5.1 Structures of organisations**

Structural determinants of hospital management and organisational factors influence ANP role developments. In this study reference to individual hospital's management structures included both positive and negative elements which were the foci for much

debate. ANPs have governance from two managers, as clinically they are accountable to the Medical Consultant and for nursing they are accountable to their Director of Nursing. This reporting relationship is unique to ANPs and practically this structure impacts on ANP identity as their governance is multidimensional (Small 2010). Protocols and role developments have to be agreed by multiple personnel who may not always have the same agenda. The participants in this study did give examples of some conflicting issues that they had encountered. Interestingly, this was more frequently perpetuated by nursing personnel rather than medical personnel.

There is great variance in nursing management structures throughout the various hospital settings in Ireland. For example the ten participants in this study came from seven different hospitals. Each hospital had a different geographical profile that represented both rural and urban locations and populations and the numbers of ANPs per site varied greatly from solo practitioners to small teams. Bourdieu's (1990) empirically grounded theory of practice involves a relational perspective in which practice depends on structures and social relations. Social capital is represented by lasting social relations, networks and contacts both formal and informal. The ANPs reflected on the wealth and importance of the support they gleaned from colleagues, both from within advanced practice domains and from the wider cohort of nurses and healthcare personnel. Social capital is essential to an agent's practice, as according to Bourdieu, practice is determined both by rational decisions and embodied dispositions of an agent's habitus. It is important therefore to consider the influence the structure of organisations have in relation to ANPs' identity.

ANPs are part of a changing pattern of work in healthcare organisations (NCNM 2005b, NCNM 2008b and 2010b, HSE 2013). Wilson and Bunnell (2007) confirm that the complexities of operationalising ANP practice roles are subject to the nature of the organisation into which they relate. Professional institutions have professional hierarchies and power differentials and when new positions are made problems can arise with boundary-spanning. In this study all participants commented that their organisation had an influence on their identity both personally and professionally. Duty patterns vary depending on the organisation in which the ANP practises. The benefit of working independently was acknowledged, and yet, the value of having a colleague, be it another ANP or medical registrar, to seek their opinions if needed was regarded as valuable. The

participants' reflections on their respective organisation raised both positive and negative responses. The responses were significantly varied and interestingly, even when a number of ANPs came from the same hospital, they did not express the same opinions of their organisation. This highlights the individuality of an agent's experience and perception which supports Abercrombie et al.'s comment that "social relations, not individuals, are the proper objects of analysis" (Abercrombie, Hill and Turner 2006, p9). Supportive and facilitative management structures were positively experienced by some participants, and yet unsupportive ones were also cited. The ANP's attitude towards their practice and thus their professional identity appeared dependent upon the organisational structure in which they perceived they worked

This organisational influence is acknowledged within the literature and in order to develop a positive frame for the implementation of the advanced practice role in Ireland the NCNM set up the system for ANP site accreditation (NCNM 2008c). Management from a proposed site wishing to appoint an ANP are required to complete a written submission detailing their institutional arrangements to comply with the NCNM guidelines regarding ANP practice and support structures. This acknowledges the importance of organisational structures to ANP practice. Site development and preparation culminates in an assessment visit undertaken by the NMBI. The National Council had been pioneers in promoting site accreditation practices (NCNM 2008c). Currently the NMBI are responsible for ANP registration and regulation and as part of an overall review of advanced practice structures, NMBI site accreditation practices are currently being reviewed. One participant raised concerns over possible dissolution of site accreditations and highlighted the negative impact this could have on clinical governance and on securing the support of key stakeholders.

Interestingly, all sites in this study had undertaken this accreditation process so it could be questioned as to why some ANPs experienced a perceived lack of support and understanding. The literature suggests other factors such as changes in management personnel, national and hospital structural changes, and alteration in hospital policy agendas appear to positively or negatively influence organisational and management attitudes towards ANP practice. This is in agreement with Coster et al.'s (2006) suggestion that the healthcare field is influenced by multiple structural elements. These elements include hierarchies, markets and policies, service need, communities of

practice and cultural factors from both nursing and aligned professions. This reflects Bourdieu's thinking on the logic of practice.

### **7.5.2 ADON Status and Recognition**

The importance to ANPs of their ADON status is illustrated throughout the narratives. It is documented in the literature that within ANPs' communities of practice their positionality with the patient, the multidisciplinary team, doctors and nursing colleagues realises an altered dynamic (Woodward, Webb and Prowse 2005). Grenfell and James (1998) explain that status and recognition is determined through agents' capital formed from cultural, objectified, embodied and institutionalised elements. Bourdieuan theory suggests that wealth in capital is socially designated and therefore the complex dynamics of practice domains manifest in varying perceptions of capital as agents vie for ascendancy to top positioning. Optimising and mobilising of capital can manifest in power struggles, practice-based tensions, professional antagonism and professional jealousy from interprofessional and intraprofessional colleagues (Woodward, Webb and Prowse 2005, Fairley and Closs 2006, Kennedy et al 2011). Bourdieu's theory states that agents' economic capital is determined by income, financial resources and assets and, as ANP care is regarded as fundamental to HSE policies, ANPs are accorded a position of positive economic capital in comparison to their frontline nursing colleagues.

It can be argued that all nurses are exposed to practice challenges. However by virtue of their unique roles and positions within the organisation, ANPs are regarded as having potentially additional areas for possible conflict and tension as Tye and Ross (2000) identified. Their case study did highlight that participants had experienced, to varying degrees, tensions with various members of the multidisciplinary team. The tensions did not emanate from any one profession in particular, but was variable across professions and across personnel. It was suggested that it was more to do with a lack of understanding of the role that a negative attitude of the role per se. Participants suggested that effective communication was key to ensuring the promotion of understanding amongst colleagues. Whilst this was a small study and lacked generalisability in an empirical sense, the authors assert that theoretical generalisation is possible based upon the breadth of the wider study's data collection sources and profiles. If this is accepted then the positive interprofessional and intraprofessional

relationships are recognised as important in enabling effective role transition. Role ambiguity and changes in role boundaries can create uncertainty in relation to professional identities (MacDonald and Ritzer 1988, Lloyd Jones 2005). Clarity is seen as central to promote effective working relations between ANPs and their colleagues.

Bourdieu highlights that social capital is built up over time and operates as a tool for cultural reproduction (Bourdieu 1998). Most participants reported in this study that they did have good working relationships with most of their colleagues. However incidences of staff conflict, between differing grades of staff and differing professions, were raised by some participants. Organisational theory suggests that differing personalities play a significant role in professional working relationships. This study considers that the promotion of teamwork and enhancement of the support of key stakeholders is integral to the successful implementation and continued advancement of advanced practice roles. This would also promote effective communication channels to increase understanding of roles and reduce practice-based tensions. Current initiatives such as the Emergency Medicine Programme are being developed and implemented nationally (HSE 2012, HSE 2013). They aim to develop and standardise emergency care provision across Ireland and increasing ANP (Emergency) numbers is a central element in this plan. It can be seen therefore that ANPs are key to current policy driven discourse and practice development.

### **7.5.3 Scope of Practice**

The literature critiques that ANPs' scope of practice is complex and multifaceted (Manley 1997, Lloyd Jones 2005, Fairley and Closs 2006, Carryer et al. 2007, Humphreys et al. 2007, NCNM 2008a). In this study a number of practice-based elements were highlighted as important by the participants. In order to enable and achieve higher level practice, ANPs' scope of practice and referral pathways are continuously being updated and reviewed regarding patient and service need. Extension and expansion options to develop ANPs' scope further to include additional case presentations have been muted within national and international literature. In some jurisdictions, for example America, the ANP skills set has been extended into the realms of medical procedures. The participants in this study spoke cautiously about extending their scope of practice because of their concern about medicalising their nursing role. The inclusion of certain conditions to their caseload, for example back and hip injuries,

were raised by a number of participants. Concerns over the increased time implications managing this client group would have, and the subsequent negative impact on their practice efficiency and throughput figures were cited. Time limitations impinge on practice by limiting the capacity of ANPs to fulfil their multidimensional roles and responsibilities.

Innovative clinical practices such as ANP review clinics have been developed and a number of new ideas were expressed by participants. One example being escalation strategies by ANPs during periods of raised capacity within the wider emergency department. The health service agenda is influenced by service need. An increasing number of people attending emergency departments coupled with current budgetary constraints results in ANPs being looked at to alleviate waiting times and augment throughput numbers. Nationally and internationally this has resulted in a number of developments in advanced practice roles and their efficacy is currently being reviewed and audited. Discussion on practice expansion was raised cautiously, as additional requirements for supplemental skills training and increasing ANP numbers were judged by the participants as prerequisite; a prerequisite that requires investment in finance and personnel. If these commitments are not made then dissolution of the ANP role could ensue.

#### **7.5.4 Educational and staffing requirements with practice development**

ANPs have a positive impact on practice through assisting in the development of the healthcare field (Small 2010). The ability of advanced practitioners to act as educational resources through knowledge-brokering and positive role-modelling represents important qualities. The structure of the healthcare field has changed over the last fifteen years since the Commission on Nursing recommendations were formulated (Government of Ireland 1998). A large number of experienced nurses have either retired or are in ANP posts already and one concern is the availability of ANP candidates from within the current nursing population pool. Ensuring appropriate staffing numbers are important elements when planning and implementing any practice-based expansion. Educational requirements exist when any up-skilling or additional skills set is required. Postgraduate education programmes and research supports have been developed in partnership between third level institutions and service providers, based on service needs of the partner organisations (Trinity College Dublin 2014). This is significant as

ANPs are required to be reaccredited every five years and this reaccreditation process involves demonstrating evidence of core competency attainment (NCNM 2008c). Accessing additional education and undertaking research are part of ANPs' core roles.

Medication and medicinal ionising radiation (X-ray) prescriptive rights are regarded as part of ANPs' practice upon successful completion of the medicinal products and medicinal ionising radiation prescribing courses (An Bord Altranais 2008 and 2010b). This capital enables autonomous practice with regards medication and X-ray management that is a fundamental part of ANP case management. There appeared again to be organisational variance in ANPs' permissible practises at local level. Some ANPs were facilitated to exercise their prescribing rights whereas some ANPs had limitations on their practice imposed by their organisations. The implications of limitations on practice result in time wastage, duplication and frustration in practice. The nurse prescribing computer processing database was regarded as unnecessarily time-consuming and cumbersome by a number of participants. An additional national problem surrounding the legal entitlement for ANPs to prescribe X-rays for children is currently impacting upon ANP practise (HSE 2012). The participants acknowledged that policies are currently being reviewed at national and local levels regarding X-ray prescription in an attempt to resolve this conflict. The medication computer database remains protracted at present and a review would be advantageous to enable the advanced practitioner time to be free to nurse.

## **7.6 Summary and Conclusion**

In summary, the findings discussed in this chapter identify that:

- ANPs' experience multiple personal and professional transitional experiences on their journeys to becoming an ANP. This includes challenges with undertaking master's degree level education.
- ANPs experience a heightened awareness of their accountability and autonomy in clinical decision making.
- ANPs express high levels of job satisfaction in their personal provision of timely and expert patient care.

- Organisational elements including difficulties with waiting times, throughput numbers, referral pathways, X-ray and medicinal prescribing rights are stressors to ANPs.
- Practice-based tensions exist regarding colleagues' recognition that ANPs are graded at ADON level and variable communities of practice relations exist. This is regarded as impacting negatively upon the exercise of ANPs' clinical and professional leadership attributes.
- ANPs perceive that they are underachieving in the core concept of research. However if the full spectrum of the research domain is considered ANPs demonstrate proficiency in many dimensions, for example through the promotion of evidence-based practice and by attendance at conferences/presentations.

ANPs' perceptions of their role, positionality and professional identity are presented through discussion of the findings in relation to contemporary literature. New insights have emerged from this discussion with regards to the generation of new knowledge on ANPs' (Emergency) perceptions. Evidence suggests that both individual and collective experiences are important as practitioners perceive and make sense of their worlds. This suggests that the concepts of ANPs' positionality and professional identity enable their role-fulfilment. The consequence of this is that ANPs' roles reflect the attributes of advanced practice.

## CHAPTER 8 CONCLUSIONS AND RECOMMENDATIONS

### 8.1 Introduction

This chapter presents conclusions and critiques the study's strengths and limitations. The implications of my findings and subsequent recommendations for nursing practice, education, management, and research are presented. This study's contribution to knowledge is also summarised.

### 8.2 Conclusions

This research study aim was to study ANPs' (Emergency) perceptions of their role, positionality and professional identity. The findings that emerged from this study suggest that ensuring timely and quality expert nursing care to patients are strong motivational factors for ANPs. All participants showed a high level of satisfaction in the care that they provided despite/because of internal and external organisational practice-based barriers and enablers. These findings reflect national and international literature. However, there are a number of areas in which these findings reflect Ireland's uniqueness; for example issues pertaining to limitations in referral and prescriptive rights. These rights are important factors in promoting and enacting higher level practice and therefore the implications of this finding supports the need for changes to, and development of referral pathways and prescribing practices. If the tentative conclusions of my study are confirmed by further research, there will be a case for further development of the ANP (Emergency) role.

#### 8.2.1 Contribution to knowledge

As identified, research regarding ANPs in Ireland is immature and thus related literature is limited. The relative newness of the topic area makes this study distinctive. It is important to situate this study in the context of its independent and original contribution to the body of knowledge on advanced nursing practitioners and advanced nursing practice from an Irish context.

#### Practice-based knowledge

This study represents an innovative way of investigating ANPs' perceptions and confirms that ANPs' perceive their role as securing safe, quality and timely nursing care

to a specific cohort of patients attending EDs. Understanding the transitioning challenges faced by ANPc's is useful in informing the development of effective recruitment and retention practices, and support scaffolding. This also serves as a prequel to the development of applied practice-developmental methodologies for RANPs. Therefore, I hope that the findings of my study will attract attention to these concepts.

### **Education-based knowledge**

Educational-based knowledge is contributed to by this study's exposition of ANPs' feelings of anxiety from undertaking master's level study. The educational implications arising from this knowledge informs curriculum design and development, and induction training for ANPc and ANPs. The findings suggest that support scaffolding to bridge from certificate/post-graduate level study to master's level is required. Successful transitioning may also encourage ANPs to undertake doctoral level study and thus contribute to the development of empirics on the complexities of ANP practice. The reluctance of participants to engage in doctoral study suggests that progression is problematic. Higher Education Institutions' curriculum design and development of professional doctorates should consider these findings. Investigation of the concepts of role, positionality and identity increased the originality of my study and as a result knowledge of these concepts should be enhanced.

### **Methodological-based knowledge**

My study was conducted in the field of nursing practice and was methodologically grounded on a bricolage approach of narrative inquiry and Bourdieu's theoretical framework. This combined model was used as a means of exploring ANPs' practice worlds. The relative novelty and effectiveness of applying Bourdieu's theoretical framework in the analysis of nursing practice provided additional insights about the impact that structure and agency has on ANPs' habitus and capital. This validates the potential for using Bourdieu's model in empirical studies in the discipline of nursing and highlights the potential of this model to be used in other practice-based disciplines. This would contribute to the research community through widening methodological debate and developing conceptual thinking.

### **8.3 Strengths and limitations of the study**

This section evaluates the methodological and ethical strengths and limitations of my research and identifies any issues that arose during the research study. Reflexivity on methodological and ethical dilemmas experienced during this study requires analysis. In line with best research practice, as expressed in key social theory texts of Craib (1992), Crotty (1998), Silverman (2001), Creswell (2009) and Denzin and Lincoln (2011), it is imperative that empirical studies are critiqued for their strengths and limitations as this enables exploration of their validity. The researcher's purpose in critiquing specific challenges encountered during the research processes aims to reflect upon potential impacts; explain and justify choices made; and promote learning from them to inform future research. Reflecting on the study in totality can highlight if coherence in terms of methods and methodology were realised. This critical review is a critique on the rigour of my research design.

For the purpose of demonstrating this study's research integrity I would like to revisit Elliott, Fischer and Rennie's (1999) qualitative validity criteria framework that I introduced previously. I applied their validity criteria as a guideline for assuring quality in this study and thus it served to strengthen the trustworthiness of the study. This was effectively employed during the research to add validity to this study and how each criterion was met is illustrated in Appendix N and summarily presented in the following paragraphs.

Firstly, I was required to own my perspectives and demonstrate reflexivity through the disclosure of values and assumptions which were considered in the opening chapters and maintained throughout by my reflective journaling. An extract from my reflective journal are contained in Appendices H and K. Reflexivity on my perspectives involved situating the sample population by describing the study's participants. Details of the types of hospitals they worked within and their client profiles were identified. The study's findings are consolidated by examples from across all the narrative data sets to provide evidence of grounding the analysis and interpretation in the data. I returned to three participants to provide credibility checks by seeking confirmation of themes and categories that emerged from employing the content analysis approach as illustrated in Appendix L. The participants confirmed that the themes and categories were in their opinion accurate and appropriate. I maintained coherence in the telling of the

participants' stories and accomplished the specific focus of this study's aims and objectives. It was my intention that the study resonates with the readers through their development of a greater depth in understanding ANPs' (Emergency) perceptions of their role, positionality and professional identity. In line with best research practice, further analysis of this study from methodological and ethical perspectives is considered in the following sections.

### **8.3.1 Methodological dilemmas**

In line with qualitative methodology this study was not intended to draw firm inferences. This study's methodology has however provided useful insights that could inform national healthcare policy, planning and development; curriculum and educational provision for ANPs; and national and international nursing strategies. Limitations to the conclusions drawn from my literature review occurred as literature nationally and internationally are limited surrounding ANPs' (Emergency) role, positionality and professional identity.

This study used a narrative methodological approach and, in line with this approach, the narrative interview was the method of data collection used. The formulation of the narrative question was appropriate to the aims and objectives of this study. Lankshear and Knobel (2004) identify the importance of expressing research purposes through defining research questions, research aims and research objectives. Robson (2002) adds that good research questions need to be clear, unambiguous, specific and answerable. I had been concerned that the participants may not narrate at length. However, my research narrative question did produce appropriate responses from the participants and all narrative interviews were extensive, in-depth, and produced breadth of detail.

Intense active listening is required to enable participants' voices to be heard unabated. This level of concentration required considerable conscious attention on my part. My interviewing skills, developed from previous experiences, assisted in enabling me to maintain the required levels of concentration. This is reflected in the extensiveness of the data collected. Data collected in a natural setting facilitates immediate follow-up for clarification which encourages cooperation and collaboration. The ANPs had access to an office which was the site used for most narrative interviews. This appeared to promote a positive research relationship between the ANP and myself, as the researcher.

This assisted in developing my understanding of the ways in which the ANPs gave meaning to their social phenomena (Schutz 1972).

The challenges inherent in using narrative inquiry are said to potentially lead the researcher to fixate on details which may contain misinterpretations due to cultural differences (Elliott 2005). In order to address this element I became deeply involved in the subjective descriptions given by the ANPs on their social worlds. My understandings are based only on their conceptions thereby reducing misinterpretation. This was aided by the fact that the participants were from the emergency nursing discipline and a commonality of cultural understanding of this unique discipline was evident. I have worked within this field and have some insight into the cultural nuances.

The researcher is required to consider a number of points when selecting and evaluating potential data sources. Teddie and Tashakkori (2009, p169) comment that:

Sampling involves selecting units of analysis in a manner that maximises the researcher's ability to answer the research question.

Units of analysis refer to people, groups, artefacts and settings. These units are then the foci for data collection. Qualitative purposive sampling technique is "selecting units based on specific purposes associated with answering a research study's questions" (Teddie and Tashakkori 2009, p170). My deliberate selection of units was based on the value of the information that could be gleaned from them. Mason (2002, p53) states the sources must also possess the potential to generate knowledge and consideration is required.

How well does the use of these data sources match the ontological perspective on what constitutes the social world, and the epistemological perspective on how knowledge about that world can be produced?

However, a methodological conflict arose in undertaking this qualitative approach. I was concerned regarding my lack of control over the sample selection. The population was hidden as following my request no direct contact listing was made available from the NMBI. I submitted my introductory letter and expression of interest form to IAANMP AGM to ask for recruitment of ANP (Emergency) respondents. This ensured a wide population were aware of my study and had an opportunity to participate. Interestingly, despite the fact that ANP (Emergency) have a large number of members in the IAANMP, no participants came forward from this request. I did however use multiple sites which meant that many individual experiences and institutional variances

could be explored ensuring that I would glean true reflections of ANPs' perceptions. I had anticipated from my previous pilot study experience that ANPs would engage positively with this study. However, recruitment proved more problematic with less participants self selecting and therefore greater networking was required on my part to actively seek links to ANPs. This sampling approach however proved advantageous as access was secured and the appropriateness of sample selection was realised.

Baker and Edwards (2012) in their expert review paper 'How many qualitative interviews is enough?' contend that it is important to consider the purpose of the research when attempting to answer this question. Ultimately their riposte is that 'it depends'. The quality and depth of narrative rich data obtained from ANPs' narrations offsets a lack of generalisation. My concerns over representativeness of samples are nullified as, in essence, generalisability and representativeness are not ontological or epistemological perspectives of the narrative paradigm.

One of the strengths of this study is in how Bourdieu's key concepts provided an important analytical framework for understanding the interrelationship and interconnectedness between ANPs' social, economic, cultural and symbolic capital. Applying his theoretical model enhanced understanding of the power dynamics at play in the field of healthcare. This illuminated the struggles for ascendancy of agents' interests and the capacity to optimise and mobilise their individual capitals. A critique of Bourdieuan theory is that it is under-utilised within the nursing paradigm as I could only locate a small number of empirical studies from the nursing domain. However, education and sociological paradigms have utilised Bourdieuan theory widely and effectively for a number of years (Reay 2004). Due to the success of the methodological approach used in this study, the potential for further applying Bourdieuan theory in nursing research is confirmed.

### **8.3.2 Ethical dilemmas**

One main ethical and technical issue that arose was gaining institutional approval for access to participants. This was a complex process which required multiple application forms to be produced and submitted. Currently there is not a standardised approach between different hospitals in different health board areas. Non-standardisation meant I had to undertake different processes for submission to the five Research Ethics

Committees and five Nursing Research Access Committees. In addition it was a requirement that I obtain personal Director of Nursing access approval within the various hospitals. This proved to be very time-consuming as the Directors of Nursing offices were often very busy and a delay in reply was experienced. On four occasions follow up telephone calls and repeat submissions were required to gain approval. However the NRAC and REC applications are clearly defined and are workable as they can be processed simultaneously. They do however take time to be approved as the formal boards only sit on scheduled dates and only assess a limited number at each board meeting. This did not however cause any impediment as I forward planned and factored in the time management needed. In hindsight this was good experiential learning to have undertaken personally for my future research studies.

#### **8.4 Recommendations**

Hart (1998) proposes that summative, analytical and formative evaluation enables clarity and coherence in recommendation formation. A significant number of recommendations emerged from this empirical study for the fields of clinical practice, education, management, and related research.

##### **8.4.1 Recommendations for clinical practice**

This study has demonstrated that ANPs' (Emergency) clinical roles are multidimensional within their field and communities of practice. This gives rise to the following recommendations:

- a. Given that ANPs work in complex organisational structures and practice across professional and organisational boundaries, it is recommended that all nurses and MDT practitioners increase their awareness of ANPs' (Emergency) roles and scope of practice as this would enable full utilisation of all healthcare practitioners' skills.
- b. The findings from this study identify that whilst ANPs have positive job satisfaction in the care that they provide, some practice-based stressors and tensions, such as throughput numbers and waiting times, exist for ANPs. It is recommended that acknowledging and addressing their causes would inform possible strategies and support scaffolding for ANPs to deal with these tensions.

c. Given that the ANP (Emergency) role is regarded as central to current healthcare policy initiatives, it is recommended that ANPs' role development is promoted and enhanced through service delivery and service planning to augment the provision of their unique value-added contribution to nursing and quality holistic patient care.

d. It would be advantageous to increase awareness and acknowledgement by all levels of nursing personnel of the fact that ANPs have ADON status. This will facilitate ANPs' professional cultural capital and legitimise/enhance their influence and negotiation potential within the clinical area.

e. Based on the findings of this study transitioning from nurse to RANP is a process. It is recommended that promoting effective workplace cultures through role-modelling would help each ANPc negotiate and potentiate success in their transitional stages.

#### **8.4.2 Recommendations for education**

This study has identified that ANPs provide and facilitate formal and informally-based education on macro and micro scales for a number of practitioners including frontline nurses, patients, doctors, and MDT members. The following recommendations are realised from this study in the domain of education.

a. The findings from this study provide insight into the relevance that formal and informal education has to ANPs' (Emergency) habitus, field and capital formation. It is recommended that ongoing supports are needed to continue to build upon these formal and informal networks thereby increasing the potential for further developments to add to ANPs' skill set.

b. This research found that links between nursing academia and clinicians are developing. It is recommended that these links be extended and developed to inform approaches to ANP candidates' course curriculum and ANPs' continuing professional development. This would ensure that ANPc educational course curriculum is current, appropriate and applied.

c. Based upon the findings of this study it is recommended that further development of induction training and support scaffolding, (both academic and emotional), takes place

in order to enable preparation for, and inform educational and academic transitioning for ANP candidates and registered ANPs.

d. Given that this study identifies that master's level study raises some educational challenges for participants regarding feelings of academic inadequacy, it is recommended that academic bridging supports are developed. This may encourage ANPs to undertake professional doctorate level study thereby extending their cultural capital and adding to nursing's paradigmatic body of knowledge on advanced practice.

e. It is acknowledged in this study that ANPs are required to successfully produce a comprehensive MSc thesis as a part of their academic component of their eligibility for RANP status. This means that to date eighty-eight ANPs have produced MSc theses in Ireland which represents a large body of contemporary applied knowledge. It is recommended that this knowledge base be promoted through publications and national/international databases. This would ensure dissemination of currently under-reported ANPs' research studies that would inform evidenced-based practices and PPPGs to promote patient safety.

f. The findings of this study identify that ANPs have a heightened awareness of their autonomy and accountability in decision-making at advanced levels. In order to maintain clinical competency it is recommended that continuing professional development for ANPs is promoted through organisational augmentation of educational opportunities, resources, protected time, funding and facilitation.

g. The ANPs acknowledge in this study that the core concept of research and audit requires further promotion and facilitation. In order to encourage proficiency in this core skill it is recommended that local and national writing groups and blogs be promoted. Awarding CPD credits may act to incentivise ANPs to produce quality research that adds to nursing's body of knowledge.

#### **8.4.3 Recommendations for management**

This study's findings identify that ANPs (Emergency) have a distinct position within the field of healthcare both internationally and in Ireland. ANPs' governance structures span across the nursing-medicine interface which results in ANPs having a uniquely

reconstructed and defined management structure. This gives rise to a number of recommendations for healthcare management.

a. Based on the findings of this study ANPs are located in a unique position within their organisations. In order to enhance cohesion, both locally and nationally, it is recommended that future planning of nursing roles should include ANPs at strategic planning level in order to enable effective workforce planning.

b. ANPs' clinical governance mechanisms are managed locally and maintained nationally through registration and regulatory frameworks. It is recommended that in order to facilitate ANPs' role development, there should be transparency in the targeting of waiting times and throughput numbers by management. This would serve to demonstrate clear lines of accountability and lessen the potential for personal bias.

c. Given the changing nature of healthcare in Ireland, it is recommended that attention to ANP recruitment and retention practices is required to ensure that the aims and objectives of the current Emergency Medicine Programme are achieved. This would potentiate the augmentation of organisational professional partnerships, collaboration, supports and mentoring between ANPs and relevant personnel.

d. Given that this study identifies that ANPs (Emergency) play a key role in the safe and efficient delivery of care to their cohort of patients, it is recommended that human resource support systems are required to ensure funding of posts is maintained and increased in response to service need. The undertaking of service needs analysis and audits, in line with governmental Emergency Medicine Programme at local and national levels, would promote coherent, comprehensive and appropriate ANP service development.

#### **8.4.4 Recommendations for related research**

This study illustrates that ANPs' roles, positionality and professional identity is a vastly under-researched domain. In light of this there are many potential areas for further development. I think that future research on ANPs might usefully focus on ANPs additional dimensions and contexts as identified in the following section. It is recognised that knowledge generation is an emergent process and therefore the

following recommendations are offered for related research in the fields of healthcare practice, education and management.

a. As identified in this study, given the changing nature of healthcare practice, it may be advantageous to conduct research to assess the effectiveness of collaborative networks between clinicians and academics. This would promote maximisation of potential for knowledge generation in the discipline of emergency nursing.

b. Based upon the results of this research, there are multiple personal and professional factors that impact upon ANPs' decision to undertake professional doctorates. It is recommended that qualitative research be conducted that considers these elements. This knowledge could aid in addressing how to maximise ANPs' uptake and access to doctoral level study thereby adding to nursing's paradigmatic body of knowledge.

c. The transitional journeys of ANPs are under-researched domains as evidenced in this study. It would be advantageous to conduct a series of longitudinal research studies that consider exploration of Benner's stage theory and/or Woods stage theory applied to the post-ANP registration period. This would document trends and thereby increase understanding of any experiential parities or commonalities. Gleaning this knowledge would aid in developing informed support strategies to enable time-appropriate transitioning of ANPs.

d. Given that this study provides a basis for concluding that ANPs are exposed to practice-based tensions from within their own profession and their wider communities of practice, it is recommended that further evaluative research into ANPs' (Emergency) motivators and stressors be conducted. This would enable exploration of the impact that organisations and communities of practice have on ANPs' (Emergency) capacity to fulfil their core concepts.

e. The positive applicability of using Bourdieuan theory as a theoretical framework for researching nursing is demonstrated in this study. Based on this positive evaluation of Bourdieu's theoretical framework, it is recommended to widen the research profile to include additional healthcare practice domains.

f. This study acknowledges that a small number of qualitative studies have been conducted on the ANP (Emergency). It is recommended that additional methodological

studies exploring ANPs' (Emergency) role, positionality and professional identity be conducted. This would explore the potential for further knowledge generation by the use of different qualitative methodologies.

### **8.5 Dissemination of this study's findings**

An integral component of the research process is the dissemination of new knowledge. The dissemination of this study's findings will be through a number of local, national and international stages. Locally, a requirement of ethical approval was that upon completion of the study, presentations to regional hospital meetings be made and summary synopsis of the research will be submitted to participating hospital ethics departments for local dissemination. Two participants requested that upon completion they be furnished with the summary findings and this will be supplied. Nationally I have been given the opportunity upon completion of the study to present my research findings at an advanced practice annual symposium. It is my intention to present at appropriate conferences and to submit material worthy of publication to national and international peer-reviewed journals in the fields of nursing, research and education as a means of contributing to the body of knowledge on healthcare education. My thesis will be available in an online format through my university's database and NMBI online resource database, Lexus.

### **8.6 Autobiographical reflection**

Undertaking this research study has been a valuable learning experience for me personally and professionally. The nature of research and of the research process has been an interesting exploration in practical and theoretical terms, mostly enjoyable but on occasion protracted. For example, the system for ethical and nursing research access approval in Ireland was elongated and fastidious and yet I recognised its importance for this study. This was offset by the elation at being granted each REC and NRAC approval. I immensely enjoyed the experience of visiting the participants in their own practice areas and hearing their stories unfold, however long the journeys took physically and metaphorically. This research study has enabled me to examine my own professional values and this in turn has prompted my reflection on nursing as a whole, and the ANP as a part of that whole. The research process has also encouraged me to

view my own context within the wider educational field with renewed optimism and motivation.

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**APPENDIX A**

**Studies that explore advanced nurse practitioners' role**

<b>Author (s)</b>	<b>Aim of study</b>	<b>Population and Methods</b>	<b>Findings</b>
Benner (1984) From Novice to Expert US	To evaluate the practicality of applying the Dreyfus model to nursing and to clarify the characteristics of nurse performance at different stages of skill acquisition,	Research Descriptive study interviews and participant observations were conducted n=5  experienced nurse clinicians, 11 new graduate nurses, and 5 senior nursing students in six different hospitals	Much confirming and no disconfirming evidence was found for use of the Dreyfus Model of Skill Acquisition in clinical nursing practice
Manley (1997) A conceptual framework for advanced practice: an action research project operationalising an advanced practitioner/consultant nurse role UK	To operationalise an advanced practitioner/consultant nurse role	3 year action research study Working diary – 2 years of project – 195 different work items recorded	Operationalisation of a NC role in a practice development unit Transformational culture central to skill and processes used within the role Implications for the preparation and accreditation of the advanced practitioner/consultant nurse are highlighted
Baill (1999) Revealing higher levels of nursing practice Multinational US, UK, Aus, NZ	Exploring higher level nursing practice	Doctoral study - Grounded Theory approach Interviews and Part Obs.	Patient satisfaction, enhancing patient stay & outcome, promoting the role; trustworthiness; tenacity and survival improving patient outcome, promoting the role, trustworthiness.
Tye and Ross (2000) Blurring boundaries: professional perspectives of the ENP role in a major A&E dept UK	Evaluation of Emergency Nurse Practitioner role	Case study – semi interviews 2 ED consultants, 2 ENPs, A&E manager, 2 junior ward sisters, 1 SHO, DNS, CEO 9	5 themes – blurring role boundaries, managing uncertainty; individual variation; quality v quantity; organisational context
Ingersoll et al. (2000) nurse sensitive outcomes of advanced practice US	To determine the outcome indicators ANPs recommended for use in measuring their effect on care delivery outcomes	Research Modified Delphi study N=66 mailed in survey to ANPs in one state	27 potential indicators – ANPs identified both direct and indirect measures of effect on care delivery outcomes Additional research recommended to validate indicators
Byrne et al (2000) Patient satisfaction with emergency nurse practitioners in A & E UK	To compare patients satisfaction with care given by emergency nurse practitioners with that provided by doctors and nurses	Research Quantitative part of larger study comparing 3 different types of care provision - Patient satisfaction	Patients significantly more likely to have health education and first aid advice from ENP and written take home instructions Patients less worried about health with ENP care

<p>Brown and Draye (2003) Experiences of pioneer nurse practitioners in establishing advanced practice roles US</p>	<p>provided in a traditional A&amp;E To describe pioneers' experiences of establishing the nurse practitioner role and their experiences in maintaining and building the NP role</p>	<p>questionnaire Research Descriptive study NPs N=50 interviews/focus groups</p>	<p>Advancing autonomy – 6 broad themes: breaking free; moulding the clay; encountering obstacles; surviving the proving ground; staying committed and building the eldership</p>
<p>Ball and Cox (2003) Part 1: Restoring patients to health – outcomes and indicators of advanced nursing practice in adult critical care UK</p>	<p>To examine advanced clinical practice in adult acute critical care</p>	<p>Grounded theory methodology</p>	<p>Develops from Ball 1999 preliminary paper</p>
<p>Ball and Cox (2004) Part 2: the core components of legitimate influence and the conditions that constrain or facilitate advanced nursing practice in adult critical care. UK</p>	<p>To describe the intervening conditions that might constrain or facilitate the exercise of legitimate influence</p>	<p>Grounded theory methodology</p>	<p>Develops from Ball 1999 preliminary paper</p>
<p>Guest et al. (2004) An evaluation of the impact of the nurse, midwife and health visitor consultants UK</p>	<p>To explore Nurse Consultants impact on patient care leadership; service development; education; expert practice; achievements; view of impacts</p>	<p>Quantitative and Qualitative research with 3 phases - Phase 1 – NC n=162, phase 2 NC n=448; phase 3 NC n=528 face to face focus groups Telephone / face to face interviews; survey</p>	<p>Findings under 4 pillars of expert practice, education, leadership and research</p>
<p>Charters et al (2005) Learning from the past to inform the future – a survey of consultant nurses in emergency care UK</p>	<p>To explore transitional elements and role of the consultant nurse in emergency care</p>	<p>Quantitative Survey semi-structured questions emailed total n=44, Response rate = 25 58%</p>	<p>The nurse consultants in emergency care felt under prepared – inequity in level of preparation for role especially transformational leadership, education &amp; training</p>
<p>Fairley and Closs (2005) Evaluation of a nurse consultant's clinical activities and the search for patient outcomes in critical care UK</p>	<p>To describe the actual clinical activities undertaken by a critical care nurse consultant</p>	<p>Research 1 NC on an 8 bedded adult surgical HDU large NHS hospital Diary 4 month period Qualitative and quantitative</p>	<p>Clinical activities included direct care activities, clinical leadership, education and training Clinical reasoning and clinical instruction</p>
<p>Furlong and Smith (2005) Advanced nursing practice: policy, education and role development Ireland</p>	<p>To explore the critical elements of advanced nursing practice in relation to policy, education and role development in order to</p>	<p>Peer reviewed paper</p>	<p>The value of policy to guide the development of advanced practice. Educational curricula needs to be flexible and visionary to prepare the ANP for practice. To achieve the ANP core concepts the ANP must develop advanced</p>

	highlight an optimal structure for clinical practice			theoretical and clinical skills, meet the needs of the client, family and community.
Lloyd Jones (2005) Role development and effective practice in specialist and advanced practice roles Multinational	To identify and synthesize qualitative research studies reporting barriers and facilitators to role development and/or effective practice in advanced nursing roles in acute hospital settings.	Systematic review and Meta-synthesis	14 relevant studies were identified – mainly from the UK Range of barriers and facilitators: practitioners personal characteristics and previous experience; professional and educational issues; managerial and organisational issues; relationships with health care professionals, and resources.	
NCNM (2005a). A preliminary evaluation of the role of the advanced nurse practitioner. Ireland	To provide a preliminary evaluation of the role of the ANP that will guide the development of the role.	Research evaluation study had a mixed methodological approach – review of documentary evidence - interviews with ANPs (n=8) nurse managers (n=7), Doctors (n=4), Patients (n=5), Clinical nurse specialists (n=1)	Key findings – - provide education, leadership, undertake research - key role in leading services and nursing practice development - providing holistic, clinical, autonomous, timely care	
Woodward et al (2005) Nurse Consultants: their characteristics and achievements UK	To report on Nurse Consultants: characteristics and achievements	Part of larger study Cross sectional design Convenience sample of 10 nurse consultants	4 themes were identified: themes in this paper presented characteristics of the post holder and role achievement – revealed nurse consultants varied in their academic background and previous experience – this influenced their ability to achieve the four domains of the role	
Barton (2006) Nurse practitioners – or advanced clinical nurses? UK	To explore the nurse practitioner transitional elements	Ethnographic study – 2 year period 10 student nurse practitioners 11 others – clinicians, managers, educationalists	Evolution of identity Framework for development – strategic policy development of career framework	
Booth et al. (2006) New nursing roles: the experience of Scotland's consultant nurse/midwives Scotland	To Explore the experience of Scotland's consultant nurses and midwives	Postal survey Nurse / midwife Consultants n=16	Key themes important factors to NC/M were: mentorship, autonomy, clinical credibility Barriers to role delivery: lack of understanding of role Recommendations: recognised career pathway and consistency in employment/support	
Carrier et al. (2006) The core role of the nurse practitioner: practice, professionalism and clinical leadership Australia and New Zealand	To investigate the core role of the nurse practitioner	Interpretative study – multi data sources – data documents Interviews 15 NP x 2 times	3 components: dynamic practice, professional efficacy and clinical leadership. Extended range of autonomy	

<p>Considine et al. (2006) Defining the scope of practice of the emergency nurse practitioner role in a metropolitan emergency department Australian</p>	<p>To examine the Emergency nurse practitioner candidate scope of practice</p>	<p>Retrospective exploratory study of 476 patients who had been cared for by ENPC</p>	<p>The majority of ENPC (77.2 %) patients were discharged from the ED, 55% of ENPC time was in clinical practice, the development of clinical guideline was 25%, prescriptive and referral rights where used</p>
<p>Coster et al. (2006) Impact of the role of nurse, midwife and health visitor consultant (relates to Guest et al 2004) UK</p>	<p>To explore Nurse Consultants perceived impact of the role</p>	<p>Multi-method Evaluation study 2002-2003 Focus groups n=22 Telephone interviews n=32</p>	<p>NC role and impact on patient care Variant levels of impact declared Areas of activities chart in paper</p>
<p>Fisher et al (2006) Developing the A&amp;E nurse practitioner role UK</p>	<p>To explore the development of the emergency nurse practitioner role</p>	<p>Qualitative Grounded theory – semi structured interviews with staff in 2 A&amp;E departments with established nurse practitioners</p>	<p>Thematic Analysis – values and beliefs ~ quality of service, patient satisfaction. Professional boundaries, barriers, future direction</p>
<p>Griffin &amp; Melby (2006) Developing an advanced practitioner service in Emergency care: attitudes of nurses and doctors Ireland</p>	<p>To investigate the attitudes of emergency nurses, DR and GPs to dev of ANP service in Ireland.</p>	<p>Quantitative methodology questionnaire survey and attitudinal likert scaling GP, Emergency nurses, Emergency Drs (n = 74.8%)</p>	<p>11% clear understanding of ANP role All positive but GP less positive</p>
<p>Mantzoukas and Watkinson (2006) Review of advanced nursing practice: the international literature and developing the generic features UK</p>	<p>Review of advanced nursing practice: the international literature</p>	<p>Systematic literature review</p>	<p>Generic features emerged – the use of knowledge in practice, critical thinking and analytical skills; clinical judgement and decision making skills; professional leadership and clinical inquiry; coaching and mentoring skills; research skills; and changing practice.</p>
<p>Woodward et al (2006) Nurse consultants: organisational influences on role achievement</p>	<p>To investigate the Nurse Consultant role and organisational influences.</p>	<p>Qualitative cross sectional design - 10 NC in-depth interviews various hospitals one region</p>	<p>Support systems important for NC role achievement; NC gave and received support – empower other nurses Organisation influential to NC role – traditional medically dominated culture</p>
<p>Barton (2007) Student nurse practitioners – a rite of passage? The universality of Van Genneep's model of social interaction UK</p>	<p>To explore the educational experiences of student nurse practitioners</p>	<p>Qualitative practitioner ethnography study – 2 years at beginning of programme of study and then on completion - 10 student nurse practitioners, 5 medical mentors, 3 educators, 3 senior nurse academic staff Semi structured interviews and</p>	<p>Student nurse practitioners' development characterised as a complex three stage composite of social, cultural and professional transitions comparable to the rite of passage model proposed by Van Genneep.</p>

		field notes		
Gardner et al (2007) Making nursing work: breaking through the role confusion of advanced practice nursing Australia	To develop a research-informed model of the service parameters and an analysis framework for advanced practice nursing roles	Research - Interpretive qualitative examination of the practice of 9 advanced practitioners in 3 acute care hospitals – in-depth interviews	Data supported the Strong model of advanced practice – definition of service parameters and design of operational framework implementing and evaluating ad practice roles	
Humphreys et al (2007) Evaluating the effectiveness of nurse, midwife/allied health professional consultants: a systematic review and meta-synthesis UK	To evaluate the effectiveness of nurse, midwife/allied health professional consultants	Systematic review + meta synthesis - 14 studies critically appraised and thematic analysis	Evaluation of role – four pillars Limited data on actual benefits of role, 40% did not understand the procedural requirements of NP endorsement	
Lee and Bailey (2007) An exploration of staff knowledge on the nurse practitioners' role in the emergency department Australia	To explore staff knowledge of the NP role	Quantitative Survey n=76 ED personnel including medical and nursing staff	The role of the NP was favourably reported by staff with 90% agreeing to statements about the role. Knowledge gaps were found in one third of respondents in relation to the scope of practice and clinical practice guidelines and over 40% (n=31) did not understand the procedural requirements for NP endorsement.	
McGee and Kaplan (2007) Factors influencing the decision to use nurse practitioners in the emergency department USA	To determine factors that influence the decision to use nurse practitioners in the emergency department	Qualitative method – pilot exploratory study Interviews conducted with ED managers in hospital which both employed and did not employ nurse practitioner in the ED	Concerns about liability issues, excellent clinical skills, high levels of satisfaction with ENPs performance, Reduced overcrowding and waiting times	
Plager and Congar (2007) Advanced Practice Nursing USA	To describe APNs constraints to role fulfilment	Secondary analysis of data from an outcomes study of advanced practice nurse graduates. Interpretive phenomenology – focus groups and telephone interviews n=30 APNs	4 themes – practice setting, healthcare systems, legal systems and environmental constraints	
Currie and Crouch (2008) How far is too far? Exploring the perceptions of professions on their current and future roles in Emergency care UK	To explore the perceptions of professions on their current and future roles in Emergency care	Qualitative design – semi-structured interviews 8 staff in ED in a large teaching hospital – doctors and nurses of all grades – purposefully sampling Thematic analysis	5 main themes – blurring of role boundaries – collaborative working; Training – lack of standardisation; drivers for change; managing risk; future roles  Findings lack of standardisation within expansion of healthcare roles – greater clarity of training and scope of practice is required to enable clinical roles to develop more	

Sheer and Wong (2008) The development of Advanced Nursing Practice Globally International	To review internationally the advanced nursing practice role	Quantitative survey across 14 countries	consistently Echoed Tye and Ross (2000) Analysis = development of AP facilitated by need for better access to health care and cost containment Education level
O'Shea (2008) A Strategy for the professional development in a changing health service Key Text - Ireland	To review the changing face of the Irish healthcare service	Research: Doctoral thesis – multi method research detailed interviews with over 150 senior figures involved in designing, managing and delivering the health services in Ireland. Observational study over 8 month period	Professional development Potential for stronger leadership Need to build up skills and competencies
Conlon, Ciaran et al (2009) Minor Injury attendance times to the ED. Ireland	To observe patient attendances in one city ED	a systematic review	7768 attendances 73% n ANP caseload main attendances of this cohort presentation 08.00 – 20.00hrs
Wilson et al (2009) The clinical effectiveness of nurse practitioners' management of minor injuries in an adult emergency department: a systematic review Australia	Examine the best available evidence to determine the clinical effectiveness of emergency department nurse practitioners in the assessment, treatment and management of minor injuries in adults	Mixed methodology study Quantitative survey (n=144) and Qualitative interview (n=10)	When comparable data were pooled, there were no significant differences ( $P<0.05$ ) between nurse practitioners and junior doctors The results emphasise the need for more high-quality research using appropriate outcome measures in the area of clinical effectiveness of nurse practitioners, particularly interventions that improve outcomes for presentations to emergency departments and address issues of waiting and congestion. Health professionals generally supportive of an ENP service – some concerns role and functions. Potential conflictual issues and barriers
Melby et al (2010) Emergency nurse practitioners: the views of patients and hospital staff in a major acute trust in the UK UK	To explore the views of patients and allied professional to the emergency nurse practitioner role	Research - Mixed methods Delphi, Survey, observation Focus groups, interviews	Extensive evaluation SPO Cost neutral
Begley et al (2010) SCAPE Ireland	To evaluate the role of the ANP and CNS	Systematic literature review	Revealed gaps in the literature regarding EDs staff profile – finding from review showed that Senior staffing, matching peak staffing levels with peak patient demand, having appropriately skilled staff mixes and designing the staff profile based on individual hospital needs produces the most
Callander and Schofield (2011) Emergency Department Workforce models: what the literature can tell us Australian	To look at the literature from 1995-2011 on staffing, skill mix in EDs		

Fotheringham, Dickie and Cooper (2011) The evolution of the role of the emergency nurse practitioner in Scotland: a longitudinal study. Scotland	To examine how the role of the emergency nurse practitioner has evolved in Scotland	Research – Longitudinal survey n=190	effective outcomes – there is a need for assessment of the effectiveness of various ED-wide staffing profiles ENPs practice in the majority of EDs – ENPs dual role
Hoskins (2011) Evaluating new roles within emergency care: a literature review UK	To produce a systematic literature review evaluating new roles within emergency care	Systematic literature review	A high level of patient satisfaction Scope of practice for emergency NPs most limited in UK compared to international counterparts
Kennedy et al (2011) Evaluation of the impact of nurse consultant roles in the United Kingdom: a mixed method systematic literature review UK	To evaluate the impact of nurse consultant roles	A mixed method systematic literature review of 36 studies	Findings largely positive influence of nurse consultants on a range of clinical and professional outcomes – little robust evidence and methodologically weak Proposes framework for measuring outcome
Maylone et al (2011) Collaboration and autonomy: perceptions among nurse practitioners USA	To explore the relationship between nurse practitioners and perceptions of collaboration with physicians and levels of autonomy	Qualitative Descriptive study – Convenience sample n=99 NPs attending a national clinical conference completed Dempster Practice Behaviour Scale and the Collaborative Practice Scale modified for advanced practice nurses	NPs rated their perceptions of collaboration with physician colleagues – improve quality and cost of health outcomes and professional satisfaction
Stevenson et al. (2011) Nurse and allied health professional consultants: perceptions and experiences of the role. UK	To explore the perceptions and experiences of nurse and allied health professional consultant and key stakeholders	Qualitative study, purposive sample, focus group, content analysis 7 non-medical consultants – nurses (n=5), physiotherapist (n=1), pharmacist (n=1), stakeholders (n=8)	4 main themes: role interpretation role implementation, role impact, challenges included lack of organisational and administrative support Consensus amongst the 2 groups regarding the value of the role, key functions and skills and their impact on clinical practice
Johnson et al. (2012) Professional identity and nursing: contemporary theoretical developments and future research challenges Australia	To develop a professional identity pathway	Theoretical critique	Nurses' professional identities develop throughout their lifetimes – education is a key period Call for longitudinal studies

<p>McConnell et al (2012) Emergency Nurse Practitioners' perceptions of their role and scope of practice: is it advanced practice? UK (NI)</p>	<p>- To determine the role and scope of ENPs' practice in Northern Ireland and establish the extent to which they could fulfil the criteria for an ANP - To examine the education undertaken in preparation for the ENP role - To explore current roles and scope of practice and determine extent ENPs fulfil ANP competencies</p>	<p>Quantitative Research Self-report postal Survey population n=60 - returned questionnaires n=42 (70%) response rate</p>	<p>Relatively homogenous group clinical aspect of role dominated SOP influenced internal factors but prescribing, protocol use, prescribing authority, referral rights ways indirectly controlled management &amp; medics ENPs were working at a level significantly beyond registration yet do not fulfil NMC criteria for ANP</p>
<p>Thompson and Meskell (2012) Evaluation of an advanced nurse practitioner (emergency care) – an Irish perspective Ireland</p>	<p>To evaluate an advanced nurse practitioner (emergency care) outcomes of care and comparability of ANPs with other medical clinicians</p>	<p>Retrospective Comparative Audit in ED of a general hospital. Records of 964 patients Comparison of ANPs with other clinicians working in ED</p>	<p>Outcomes of care Radiological investigations, analgesia administration, waiting times Positive evaluation in 3 domains</p>
<p>Gardner, Glenn et al. (2013). Delineating the practice profile of advanced practice nursing: a cross-sectional survey using the modified strong model of advanced practice. Australian</p>	<p>To identify and delineate advanced practice from other levels of nursing practice through examination of a national nursing workforce.</p>	<p>A cross-sectional electronic survey of nurses using the validated Advanced Practice Role Delineation tool based on the Strong Model of Advanced Practice. Study participants were registered nurses employed in a clinical service environment across all states and territories of Australia. A sample of 5662 registered nurses participated in the study.</p>	<p>The study results show that the nurse practitioner, advanced practice nurse and foundation level registered nurse have different patterns of practice and the Advanced Practice Role Delineation tool has the capacity to clearly delineate and define advanced practice nursing. These findings make a significant contribution to the international debate and show that the profession can now identify what is and what is not advanced practice in nursing.</p>
<p>Elliott et al (2014) The development of leadership outcome-indicators evaluating the contribution of clinical specialists and advanced practitioners to health care: a secondary analysis. Ireland</p>	<p>To report a secondary analysis of data collected from the case study phase of a national study of advanced practitioners and develop leadership outcome-indicators appropriate for</p>	<p>Research – Secondary Analysis from SCAPE Study</p>	<p>The four categories of leadership outcomes for advanced practitioner developed were: i) capacity and capability building of multidisciplinary team; ii) measure of esteem; iii) new initiatives for clinical practice and healthcare delivery and iv) clinical practice based on evidence. The proposed set of leadership outcome-indicators</p>

	advanced practitioners.		derived from a secondary analysis captures the complexity of leadership in practice. They add to existing clinical outcomes measuring advanced practice.
Higgins, Agnes et al (2014) Factors influencing advanced practitioners' ability to enact leadership: a case study within Irish healthcare Ireland	To report the factors that influence ANPs' ability to enact their clinical and professional leadership roles	Research – Secondary Analysis from SCAPE Study	Four mediating factors influence the ANPs' ability to perform a leadership role – the presence of a framework for the professional development of the role, opportunities to act as leaders, mechanisms for sustaining leadership, and personal attributes of practitioners. Managers have a key role in supporting leadership potential
Ingram, Shirley (2014) Advanced nurse practitioner registration in Ireland: An RANP cardiology's experience Ireland	Exploring the key aspects of the ANP registration process in Ireland	Peer reviewed paper	Regulation, legislation and the NMBI functions and processes are identified. The scope of practice and core competencies are explored.
McDonnell, Ann et al. (2015) An evaluation of the implementation of Advanced Nurse Practitioner (ANP) roles in an acute hospital setting. England	To report on a study to evaluate the impact of implementing Advanced Nurse Practitioner roles on patients, staff and organisational outcomes in an acute hospital.	A collective case study in a district general hospital in England was undertaken in 2011-12. interviews with strategic stakeholders (n = 13), were followed by three individual case studies. Each case study represented the clinical area within which the roles had been introduced: medicine, surgery and orthopaedics and included interviews (n = 32) and non-participant observation of practice.	The ANPs had a positive impact on patient experience, outcomes and safety. They improved staff knowledge, skills and competence as well as enhancing quality of working life, distribution of workload and teamworking. ANPs contributed to the achievement of organisational priorities and targets and development of policy.
O'Keefe, Ann et al (2015) Measuring job satisfaction of ANPs and AMPs in the Republic of Ireland Ireland	To measure the job satisfaction of ANPs and AMPs in the Republic of Ireland	Survey of 47ANPs	High levels of job satisfaction in areas relating to clinical practice, dissatisfaction demonstrated with organisational empowerment

### Studies that explore advanced nurse practitioners' positional

Author (s)	Aim of study	Population and Methods	Findings
Benner (1984) From Novice to Expert US	To evaluate the practicality of applying the Dreyfus model to nursing and to clarify the characteristics of nurse performance at different stages of skill acquisition.	Research Descriptive study interviews and participant observations were conducted n=51 experienced nurse clinicians, 11 new graduate nurses, and 5 senior nursing students in six different hospitals	Much confirming and no disconfirming evidence was found for use of the Dreyfus Model of Skill Acquisition in clinical nursing practice
Tye and Ross (2000) Blurring boundaries: professional perspectives of the ENP role in a major A&E dept UK	Evaluation of Emergency Nurse Practitioner role	Case study – semi interviews 2 ED consultants, 2 ENPs, A&E manager, 2 junior ward sisters, 1 SHO, DNS, CEO 9	5 themes – blurring role boundaries, managing uncertainty; individual variation; quality v quantity; organisational context
Ball and Cox (2004) Part 2: the core components of legitimate influence and the conditions that constrain or facilitate advanced nursing practice in adult critical care UK	To describe the intervening conditions that might constrain or facilitate the exercise of legitimate influence	Grounded theory methodology	Develops from Ball 1999 preliminary paper
Roberts and Vasquez (2004) Power an application of the Nursing image and advanced practice US	To discuss power through a review of the literature in order to better understand the term as it applies to advanced practice nursing.	Literature review	Professional status of advanced practitioners - Regardless of how nurses perceive power, it is through power that advanced practice nurses (APNs) will be acknowledged as members of a profession versus an occupation. With a better understanding of power, APNs may be able to improve their use of power to advance the profession.
Lloyd Jones (2005) Role development and effective practice in specialist and advanced practice roles Multinational	To identify and synthesize qualitative research studies reporting barriers and facilitators to role development and/or effective practice in advanced nursing roles in acute hospital settings.	Systematic review and Meta-synthesis	14 relevant studies were identified – mainly from the UK Range of barriers and facilitators: practitioners personal characteristics and previous experience; professional and educational issues; managerial and organisational issues; relationships with health care professionals, and resources.
Martin and Considine (2005) Knowledge and attitudes of ED staff before and after implementation of the emergency nurse practitioner role	To examine attitudes before and after implementation of the emergency nurse practitioner role	Quantitative survey Pre and post test design - Staff n=104 pre survey n=79 post methodology	Pre- generally supportive but poor understanding of function of role – post increased understanding

<p>Australia</p> <p>NCNM (2005a). A preliminary evaluation of the role of the advanced nurse practitioner. Ireland</p>	<p>To provide a preliminary evaluation of the role of the ANP that will guide the development of the role.</p>	<p>Research evaluation study had a mixed methodological approach – review of documentary evidence</p> <ul style="list-style-type: none"> <li>- interviews with ANPs (n=8)</li> <li>- nurse managers (n=7), Doctors (n=4), Patients (n=5), Clinical nurse specialists (n=1)</li> </ul>	<p>Key findings –</p> <ul style="list-style-type: none"> <li>- provide education, leadership, undertake research</li> <li>- key role in leading services and nursing practice development</li> <li>- providing holistic, clinical, autonomous, timely care</li> </ul>
<p>Fisher et al (2006) Developing the A&amp;E nurse practitioner role</p> <p>UK</p>	<p>To explore the development of the emergency nurse practitioner role</p>	<p>Qualitative Grounded theory – semi structured interviews with staff in 2 A&amp;E departments with established nurse practitioners</p>	<p>Thematic Analysis – values and beliefs ~ quality of service, patient satisfaction. Professional boundaries, barriers, future direction</p>
<p>Griffin &amp; Melby (2006) Developing an advanced practitioner service in Emergency care: attitudes of nurses and doctors</p> <p>Ireland</p>	<p>To investigate the attitudes of emergency nurses, DR and GPs to dev of ANP service in Ireland.</p>	<p>Quantitative methodology questionnaire survey and attitudinal likert scaling</p> <p>GP, Emergency nurses, Emergency Drs (n = 74.8%)</p>	<p>11% clear understanding of ANP role</p> <p>All positive but GP less positive</p>
<p>Norris and Melby (2006) The acute care nurse practitioner – challenging existing boundaries of emergency nurses in the United Kingdom. UK</p>	<p>This study explored the opinions of nurses and doctors working in emergency departments towards the development of the Acute Care Nurse Practitioner service in the United Kingdom.</p>	<p>Descriptive exploratory research</p> <p>N=98 questionnaires</p> <p>N= 6 semi-structured interviews</p>	<p>3 themes:</p> <ul style="list-style-type: none"> <li>Interprofessional conflict</li> <li>Autonomy</li> <li>Advanced practitioners</li> </ul>
<p>Woodward et al (2006) Nurse consultants: organisational influences on role achievement</p> <p>UK</p>	<p>To investigate the Nurse Consultant role and organisational influences.</p>	<p>Qualitative cross sectional design - 10 NC in-depth interviews various hospitals one region</p>	<p>Support systems important for NC role achievement; NC gave and received support – empower other nurses</p> <p>Organisation influential to NC role – traditional medically dominated culture</p>
<p>Gardner et al (2007) Making nursing work: breaking through the role confusion of advanced practice nursing</p> <p>Australia</p>	<p>To develop a research-informed model of the service parameters and an analysis framework for advanced practice nursing roles</p>	<p>Research - Interpretive qualitative examination of the practice of 9 advanced practitioners in 3 acute care hospitals – in-depth interviews</p> <p>Quantitative Survey</p> <p>n=76 ED personnel including</p>	<p>Data supported the Strong model of advanced practice – definition of service parameters and design of operational framework implementing and evaluating ad practice roles</p>
<p>Lee and Bailey (2007) An exploration of staff knowledge on the nurse</p>	<p>To explore staff knowledge of the NP role</p>		<p>The role of the NP was favourably reported by staff with 90% agreeing to statements about the role. Knowledge gaps</p>

practitioners' role in the emergency department Australia		medical and nursing staff	were found in one third of respondents in relation to the scope of practice and clinical practice guidelines and over 40% (n=31) did not understand the procedural requirements for NP endorsement.
McGee and Kaplan (2007) Factors influencing the decision to use nurse practitioners in the emergency department USA	To determine factors that influence the decision to use nurse practitioners in the emergency department	Qualitative method – pilot exploratory study Interviews conducted with ED managers in hospital which both employed and did not employ nurse practitioner in the ED	Concerns about liability issues, excellent clinical skills, high levels of satisfaction with ENPs performance, Reduced overcrowding and waiting times
Baxter and Brumfit (2008) Professional differences in interprofessional working UK	To describe the influence of professional knowledge and skills, role and identity, and power and status considerations in interprofessional working	Qualitative case studies sites n=3 Individual semi-structured interviews (n=37) MDT staff, in conjunction with fieldwork observations (n=30) and a research diary	3 elements of professional groupings which are significant to interprofessional working: professional knowledge and skills role and identity power and status
Currie and Crouch (2008) How far is too far? Exploring the perceptions of professions on their current and future roles in Emergency care UK	To explore the perceptions of professions on their current and future roles in Emergency care	Qualitative design – semi-structured interviews 8 staff in ED in a large teaching hospital – doctors and nurses of all grades – purposefully sampling Thematic analysis	5 main themes – blurring of role boundaries – collaborative working; Training – lack of standardisation; drivers for change; managing risk; future roles  Findings lack of standardisation within expansion of healthcare roles – greater clarity of training and scope of practice is required to enable clinical roles to develop more consistently
O'Shea (2008) A Strategy for the professional development in a changing health service Key Text - Ireland	To review the changing face of the Irish healthcare service	Research: Doctoral thesis – multi method research detailed interviews with over 150 senior figures involved in designing, managing and delivering the health services in Ireland.	Echoed Tye and Ross (2000) Professional development Potential for stronger leadership Need to build up skills and competencies
Melby et al (2010) Emergency nurse practitioners: the views of patients and hospital staff in a major acute trust in the UK. UK	To explore the views of patients and allied professional to the emergency nurse practitioner role	Mixed methodology study Quantitative survey (n=144) and Qualitative interview (n=10)	Health professionals generally supportive of an ENP service – some concerns role and functions. Potential conflictual issues and barriers

<p>Begley et al (2010) SCAPE Ireland</p>	<p>To evaluate the role of the ANP and CNS</p>	<p>Research - Mixed methods Delphi, Survey, observation Focus groups, interviews Systematic literature review</p>	<p>Extensive evaluation SPO model Cost neutral</p>
<p>Callander and Schofield (2011) Emergency Department Workforce models: what the literature can tell us Australian</p>	<p>To look at the literature from 1995-2011 on staffing, skill mix in ED</p>		<p>Revealed gaps in the literature regarding ED staff profile – finding from review showed that Senior staffing, matching peak staffing levels with peak patient demand, having appropriately skilled staff mixes and designing the staff profile based on individual hospital needs produces the most effective outcomes – there is a need for assessment of the effectiveness of various ED-wide staffing profiles</p>
<p>Manley et al (2011) Becoming and being a Nurse Consultant UK</p>	<p>The aims of the project were to: _ enable NCs and ANCs to become more effective through a programme of support (including action learning) which focused on developing expertise across the range of nurse consultant functions _ facilitate ANCs in developing expertise in all NC functions _ examine the impact of the programme of support on NCs and ANCs _ explore the impact of NCs through evaluation approaches that can be used in the workplace - cascade development by developing facilitation skills that will help prepare future NCs.</p>	<p>The project used emancipatory action research (EAR) (Grundy, 1982) integrated with fourth generation evaluation (Guba and Lincoln, 1989).</p>	<p>Participants in the study demonstrated that as they moved towards being practitioner researchers, they achieved greater effectiveness in their multiple roles and through these processes demonstrated their impact on others, their organisation and services. The study concludes that the facilitation skills based on 10 principles derived from a concept analysis of work-based learning (Manley et al., 2009) are key to achieving transformation in practice. These skills, when combined with other multiple roles and leadership, results in change that is transformational, strategic and political.</p>
<p>Maylone et al (2011) Collaboration and autonomy: perceptions among nurse practitioners USA</p>	<p>To explore the relationship between nurse practitioners and perceptions of collaboration with physicians and levels of autonomy</p>	<p>Qualitative Descriptive study – Convenience sample n=99 NPs attending a national clinical conference completed Dempster Practice Behaviour Scale and the Collaborative Practice Scale</p>	<p>NPs rated their perceptions of collaboration with physician colleagues – improve quality and cost of health outcomes and professional satisfaction</p>

<p>McCormell et al (2012) Emergency Nurse Practitioners' perceptions of their role and scope of practice: is it advanced practice? UK (NI)</p>	<p>modified for advanced practice nurses Quantitative Research Self-report postal Survey population n=60 - returned questionnaires n=42 (70%) response rate</p>	<p>Relatively homogenous group clinical aspect of role dominated SOP influenced internal factors but prescribing, protocol use, prescribing authority, referral rights ways indirectly controlled management &amp; medics ENPs were working at a level significantly beyond registration yet do not fulfil NMC criteria for ANP</p>
<p>- To determine the role and scope of ENPs' practice in Northern Ireland and establish the extent to which they could fulfil the criteria for an ANP - To examine the education undertaken in preparation for the ENP role - To explore current roles and scope of practice and determine extent ENPs fulfil ANP competencies</p>	<p>Retrospective Comparative Audit in ED of a general hospital. Records of 964 patients Comparison of ANPs with other clinicians working in ED</p>	<p>Outcomes of care Radiological investigations, analgesia administration, waiting times Positive evaluation in 3 domains</p>
<p>Thompson and Meskell (2012) Evaluation of an advanced nurse practitioner (emergency care) – an Irish perspective Ireland</p>	<p>To evaluate an advanced nurse practitioner (emergency care) outcomes of care and comparability of ANPs with other medical clinicians</p>	

### Studies that explore advanced nurse practitioners' professional identity

<p><b>Author (s)</b> Woods (1999) The contingent nature of advanced nursing practice UK</p>	<p><b>Aim of study</b> - To explore the expectations of the advanced practice role held by ANPs and their colleagues. - To examine the personal and practice development of the ANPs during role transition - To gain understanding of the factors that facilitated and/or impeded role development and performance and how these</p>	<p><b>Population and Methods</b> Research Longitudinal 2 year (1996-1998) period data collection- from graduates of masters degree programme Interviews, observations of clinical practice, self report</p>
<p><b>Findings</b> Contingent nature of advanced nursing practice – reconstruct their practice and professional frame of reference Transitional stages - linear 1. idealism 2. organisational governance 3. resolution</p>		

Brown and Draye (2003) Experiences of pioneer nurse practitioners in establishing advanced practice roles US	influenced transition To describe pioneers' experiences of establishing the nurse practitioner role and their experiences in maintaining and building the NP role	Research Descriptive study NPs N=50 interviews/focus groups	Advancing autonomy – 6 broad themes: breaking free; moulding the clay; encountering obstacles; surviving the proving ground; staying committed and building the eldership
Nairn (2004) Emergency care and narrative knowledge UK	To examine the usefulness of narrative as a means of exploring the world of emergency nursing practice and its contribution to the emotional lifeworld of clinicians	Discourse Analysis of nursing narratives	Use of narrative can open up social worlds Contingent and subversive knowledge can contribute to understanding the emotional impact of emergency care
Charters et al (2005) Learning from the past to inform the future – a survey of consultant nurses in emergency care UK	To explore transitional elements and role of the consultant nurse in emergency care	Quantitative Survey semi-structured questions emailed total n=44, Response rate = 25 58%	The nurse consultants in emergency care felt under prepared – inequity in level of preparation for role especially transformational leadership, education & training
Lloyd Jones (2005) Role development and effective practice in specialist and advanced practice roles Multinational	To identify and synthesize qualitative research studies reporting barriers and facilitators to role development and/or effective practice in advanced nursing roles in acute hospital settings.	Systematic review and Meta-synthesis	14 relevant studies were identified – mainly from the UK Range of barriers and facilitators: practitioners personal characteristics and previous experience; professional and educational issues; managerial and organisational issues; relationships with health care professionals, and resources.
Woodward et al (2005) Nurse Consultants: their characteristics and achievements UK	To report on Nurse Consultants: characteristics and achievements	Part of larger study Cross sectional design Convenience sample of 10 nurse consultants	4 themes were identified: themes in this paper presented characteristics of the post holder and role achievement – revealed nurse consultants varied in their academic background and previous experience – this influenced their ability to achieve the four domains of the role
Barton (2006) Nurse practitioners – or advanced clinical nurses? UK	To explore the nurse practitioner transitional elements	Ethnographic study – 2 year period 10 student nurse practitioners 11 others – clinicians, managers, educationalists	Evolution of identity Framework for development – strategic policy development of career framework
Barton (2007) Student nurse practitioners – a rite of passage? The universality of Van Gennep's model of	To explore the educational experiences of student nurse practitioners	Qualitative practitioner ethnography study – 2 years at beginning of programme of	Student nurse practitioners' development characterised as a complex three stage composite of social, cultural and professional transitions comparable to the rite of passage

social interaction UK			study and then on completion - 10 student nurse practitioners 5 medical mentors, 3 educators, 3 senior nurse academic staff Semi structured interviews and field notes	model proposed by Van Gemep.
Lee and Bailey (2007) An exploration of staff knowledge on the nurse practitioners' role in the emergency department Australia	To explore staff knowledge of the NP role		Quantitative Survey n=76 ED personnel including medical and nursing staff	The role of the NP was favourably reported by staff with 90% agreeing to statements about the role. Knowledge gaps were found in one third of respondents in relation to the scope of practice and clinical practice guidelines and over 40% (n=31) did not understand the procedural requirements for NP endorsement.
Baxter and Brumfitt (2008) Professional differences in interprofessional working UK	To describe the influence of professional knowledge and skills, role and identity, and power and status considerations in interprofessional working		Qualitative case studies sites n=3 Individual semi-structured interviews (n=37) MDT staff, in conjunction with fieldwork observations (n=30) and a research diary	3 elements of professional groupings which are significant to interprofessional working: professional knowledge and skills role and identity power and status
Melby et al (2010) Emergency nurse practitioners: the views of patients and hospital staff in a major acute trust in the UK. UK	To explore the views of patients and allied professional to the emergency nurse practitioner role		Mixed methodology study Quantitative survey (n=144) and Qualitative interview (n=10)	Health professionals generally supportive of an ENP service – some concerns role and functions. Potential conflictual issues and barriers
Begley et al (2010) SCAPE Ireland	To evaluate the role of the ANP and CNS		Research - Mixed methods Delphi, Survey, observation Focus groups, interviews	Extensive evaluation SPO Cost neutral
Maylone et al (2011) Collaboration and autonomy: perceptions among nurse practitioners USA	To explore the relationship between nurse practitioners and perceptions of collaboration with physicians and levels of autonomy		Qualitative Descriptive study – Convenience sample n=99 NPs attending a national clinical conference completed Dempster Practice Behaviour Scale and the Collaborative Practice Scale modified for advanced practice nurses	NPs rated their perceptions of collaboration with physician colleagues – improve quality and cost of health outcomes and professional satisfaction
Johnson et al. (2012) Professional identity and nursing: contemporary	To develop a professional identity pathway		Theoretical critique	Nurses' professional identities develop throughout their lifetimes – education is a key period

theoretical developments and future research challenges Australia			Call for longitudinal studies
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## APPENDIX B

### Extracts from Hart (1998) Doing a literature review: releasing the social science researcher imagination

‘Literature search and review on your topic

What are the key sources?

What are the key theories, concepts and ideas?

What are the major issues and debates about the topic?

What are the epistemological and ontological grounds for the discipline?

What are the political standpoints?

What are the main questions and problems that have been addressed to date?

What are the origins and definitions of the topic?

How is knowledge on the topic structured and organized?

How have approaches to these questions increased our understanding and knowledge?’

(Hart 1998, p14, figure 1.2)

‘There are some basic ‘does and don’ts’ when writing a literature review. Here are some of the major rules for good literature reviewers.

Do ...

- identify and discuss the relevant key landmark studies on the topic;
- include as much up-to-date material as possible;
- check the details, such as how names are spelled;
- try to be reflexive, examine your own bias and make it clear;
- critically evaluate the material and show your analyses;
- use extracts, illustrations and examples to justify your analyses and argument;
- be analytical, evaluate and critical and show this in your review;
- manage the information that your review produces: have a system for records management
- make your review worth reading by making yourself clear, systematic and coherent; explain why the topic is interesting

Don’t ...

- omit classical works and landmarks or discuss core ideas without proper reference;
- discuss outdated or only old materials;
- misspell names or get dates of publications wrong;
- use concepts to impress but without definition;
- use jargon and discriminatory language to justify a parochial standpoint;
- produce a list of terms, even if annotated; a list is not a review;
- accept any position at face value or believe everything that is written;
- only produce a description of the content of what you have read;
- drown in information by not keeping control and an accurate record of materials;
- make silly mistakes, for example orgasm in the place of organism;
- be boring by using hackneyed jargon, pretentious language and only description’

(Hart 1998, p219)

'The purpose of the following procedure, adapted from Fisher (1993), is to extract the conclusions (C) and reasons (R) of an argument. 1 First look quickly through the text in order to get an initial sense of the author ' s project and purpose. 3 Look for conclusions and any stated reasons for these. Underline the conclusions and place in brackets < > any reasons. 4 Attempt at this stage to summarize the author's argument. If there is no clear argument, ask what point(s) the author is trying to make and why. 5 Identify what you take to be conclusions by marking them up with a C - remember that there may be interim conclusions as well as the main one. Typical indications of a conclusion are the use of the following words: therefore, thus, hence, consequently, and so on. Be careful not to assume that a summary or formulation provided by the author of their argument so far must be the conclusion. 6 Taking the main conclusion, ask yourself what reasons are presented in the text for believing this conclusion or why you are being asked to accept this conclusion. Typical indications of reasons are words and phrases such as: because, since, it follows, and so on. 7 The reasons provided for the argument can be ranked into a structure. Go through each reason (R) asking whether it is essential or secondary backing for the argument. From this, you will be left with the core reasons for the argument. You will then be able to construct an argument diagram with the following structures:  $R1 + R2 = (\text{therefore}) C$  [for joint reasons]  $R1 \text{ or } R2 = (\text{therefore}) C$  [for independent reasons] Variations on these structures are common. For example, a main conclusion might be supported by an interim conclusion and several basic reasons. So, taking the first equation above:  $R1 + R2 = (\text{therefore}) C1$  (interim conclusion)  $C1 + R3 = (\text{therefore}) C2$  (main conclusion)' (Hart 1998, p94)

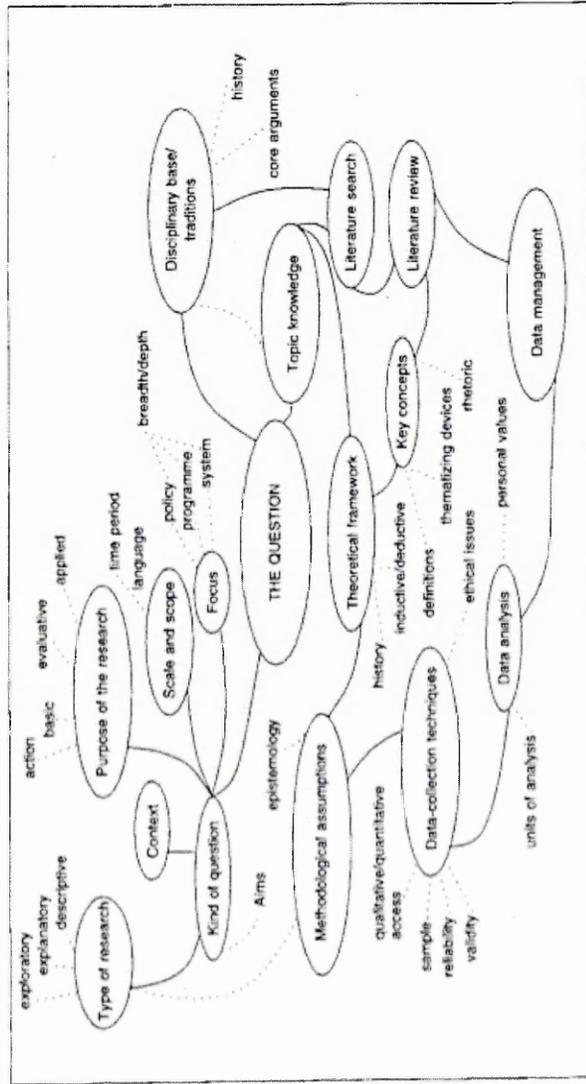
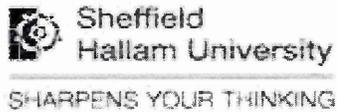


Figure 6.10 Concept map (mind map): the context of research

(Hart 1998, p157, Chapter 6: Mapping and analysing ideas)

**Appendix C**  
**Letter seeking access from the Director of Nursing to study participants**



Address

DON Name & Address

2012- 2013

Dear [name],

I would like to request your permission to undertake a research study with ANPs (Emergency) at your hospital. I have applied for Research Ethics Approval form the HSE [name] Area and am awaiting their decision. I am undertaking the research as part of a Doctorate in Education programme that I am undertaking at Sheffield Hallam University. My interest in the ANP role stems initially from my experiences of working with advanced nurse practitioners and being a research assistant on the SCAPE study. I would like to present a short synopsis of the proposed research study for your consideration.

Proposed Research Study Outline and Rationale

My literature review and pilot study, undertaken as part of my doctoral programme, identified a dearth of national and international literature on debates surrounding advanced nurse practitioners' perceptions of their role. In order to address this deficit my proposed research aims to critically explore the perceptions ANPs (Emergency) have of their role, professional identity and positionality. It is hoped my study will add to the body of knowledge for nursing and the wider social sciences. Dependent on the results of the study, it is intended that the study will contribute to: informing induction training for ANPs and other healthcare professionals; inform curriculum and continuing professional development for ANPs; develop strategies for dealing with any tensions experienced; and inform policy developments for future nursing roles.

**My key research questions are:**

**Advanced Nurse Practitioners' (Emergency) perceptions of their role, positionality and professional identity**

1. How do ANPs describe their transition from their previous nursing role to becoming an ANP?
2. What are ANPs' (Emergency) perceptions of their role?
3. What is the professional identity of ANPs (Emergency)?
4. What are the ANPs' (Emergency) perceptions of their professional positionality?

**The main aims of my study are:**

- To explore how ANPs describe their reasons for becoming an ANP and their transition from their previous nursing role to becoming an ANP
- To explore ANPs' (Emergency) perceptions of their role
- To explore the professional identity of ANPs (Emergency)
- To explore ANPs' (Emergency) perceptions of their professional positionality

**The objectives of my study are:**

- o To review the literature on the experiences of ANPs nationally and internationally and specifically to review the literature on the experiences of ANPs (Emergency) nationally and internationally
- o To explore their transitional experiences from their previous nursing roles to becoming an ANP
- o To examine the perceptions ANPs have of their role
- o To collect ten narrative accounts through narrative interviewing from ANPs (Emergency)
- o To develop an in-depth analysis of data using NVivo qualitative software and manual analysis
- o To produce a final original doctoral thesis that will clearly identify the essence of the ANPs' (Emergency) perceptions of their role, professional identity and positionality.

If you require any additional information please do not hesitate to contact me, I can be contacted via telephone on 087-6442859 or email [lisa.m.kerr2@student.shu.ac.uk](mailto:lisa.m.kerr2@student.shu.ac.uk)  
I would be grateful if you would consider my application to undertake this research study with ANPs (Emergency) at your hospital. I enclose the Site Specific Assessment form for your approval if acceptable. I look forward to hearing from you at your convenience.

Yours sincerely,

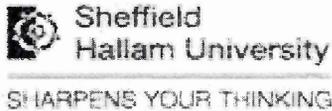
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Lisa Kerr  
Nurse Researcher

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Director of Studies: Professor Ann Macaskill      E-mail: [a.macaskill@shu.ac.uk](mailto:a.macaskill@shu.ac.uk)  
Research Supervisor Dr. Irene Garland      E-mail: [i.garland@shu.ac.uk](mailto:i.garland@shu.ac.uk)  
Faculty of Development and Society  
Sheffield Hallam University City Campus Howard Street Sheffield S1 1WB  
Telephone +44(0)114 225 5555 [www.shu.ac.uk](http://www.shu.ac.uk)

**Appendix D**  
**Letter of invitation to ANPs (Emergency) to participate in the study**



2012

Dear Advanced Nurse Practitioner (Emergency),

**Research study: Advanced Nurse Practitioners' (Emergency) perceptions of their role, positionality and professional identity**

Thank you for taking the time to read my introductory letter, and I hope that you will consider taking part in my study. This research forms part of my doctoral studies based at Sheffield Hallam University.

The title of my research study is:

**Advanced Nurse Practitioners' (Emergency) perceptions of their role, positionality and professional identity**

The aim of the study is to explore advanced nurse practitioners' perceptions of their role, positionality and identity. Across Ireland I am hoping to ask fifteen ANPs (Emergency) to provide their thoughts through a narrative approach that seeks to explore ANPs' perceptions of their role, positionality and identity as an ANP.

The verbal narrative interview will be audio-taped for transcription purposes by myself and will be conducted at a venue and time convenient to you. It is anticipated that this will take one meeting but additional meetings can occur if you wish. The length of the meeting will be decided by you. Once the data is analysed I will return personally via email/telephone to you to seek confirmation of the accuracy of the emerging themes.

Participation in this research is voluntary and you have the right to withhold information and withdraw from the study up to two weeks after giving the narrative interview. Any information that is given will be anonymised and any identifying elements will be removed. All information will be treated in the strictest confidence in line with An Bord Altranais (2007) ethical principles of respect for persons' autonomy, beneficence, non-maleficence, justice/fairness, veracity, fidelity and confidentiality.  
*Continued overleaf<sup>d</sup>*

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Director of Studies: Professor Ann Macaskill  
Research Supervisor Dr. Irene Garland  
Faculty of Development and Society

E-mail: a.macaskill@shu.ac.uk  
E-mail: i.garland@shu.ac.uk

<sup>1</sup>Sheffield Hallam University City Campus Howard Street Sheffield S1 1WB  
Telephone +44(0)114 225 5555 www.shu.ac.uk

This study has been granted approval by Sheffield Hallam University. In addition I will seek ethical and access approval from each respondent's Hospital/Health Board. On completion I will be submitting the thesis to Sheffield Hallam University and a summary report to the Nursing Research Access Committee if required. Following successful completion I hope to produce articles for publication in peer reviewed nursing and educational journals. The study report and articles will be available to you if you would like them.

Given the importance of this study I would value your support in conducting it and hope very much that you will be willing to take part. If you are willing to participate in this study, please could you return the attached form via email/telephone and I will then contact you directly.

If you would like any additional information please do not hesitate to contact me on 087-6442859 or [Lisa.M.Kerr2@student.shu.ac.uk](mailto:Lisa.M.Kerr2@student.shu.ac.uk).

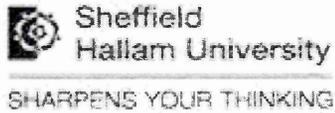
I would like to thank you for taking the time to read this introductory letter and I hope that you will choose to participate in my research study. If you would be interested in participating please can you return the reply slip at your earliest convenience, with many thanks.

Yours sincerely,

---

Lisa Kerr  
Nurse Researcher

## Appendix E Study Information Letter



2012

Thank you for taking the time to read my information leaflet, and I hope that you will consider taking part in my study. This research forms part of my doctoral studies based at Sheffield Hallam University.

The title of my research study is:

**Advanced Nurse Practitioners' (Emergency) perceptions of their role, positionality and professional identity**

The aim of the study is to explore advanced nurse practitioners' perceptions of their role, positionality and identity. Across Ireland I am hoping to ask fifteen ANPs (Emergency) to provide their thoughts through a narrative approach that seeks to explore ANPs' perceptions of their role, professional identity and positionality as an ANP.

The verbal narrative interview will be audio-taped for transcription purposes by myself and will be conducted at a venue and time convenient to you. It is anticipated that this will take one meeting but additional meetings can occur if you wish. The length of the meeting will be decided by you. Once the data is analysed I will return personally via email/telephone to you to seek confirmation of the accuracy of the emerging themes.

Participation in this research is voluntary and participants have the right to withhold information and withdraw from the study up to two weeks after giving the narrative interview. Any information that is given will be anonymised and any identifying elements will be removed. All information will be treated in the strictest confidence in line with An Bord Altranais (2007) ethical principles of respect for persons' autonomy, beneficence, non-maleficence, justice/fairness, veracity, fidelity and confidentiality.  
*Continued overleaf<sup>2</sup>*

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Director of Studies: Professor Ann Macaskill  
Research Supervisor Dr. Irene Garland  
Faculty of Development and Society

E-mail: a.macaskill@shu.ac.uk  
E-mail: i.garland@shu.ac.uk

<sup>2</sup>Sheffield Hallam University City Campus Howard Street Sheffield S1 1WB  
Telephone +44(0)114 225 5555 www.shu.ac.uk

This study has been granted approval by Sheffield Hallam University. In addition I will seek ethical and access approval from each respondent's Hospital/Health Board. On completion I will be submitting the thesis to Sheffield Hallam University and a summary report to the Nursing Research Access Committee if required. Following successful completion I hope to produce articles for publication in peer reviewed nursing and educational journals. The study report and articles will be available to you if you would like them.

Given the importance of this study I would value your support in conducting it and hope very much that you will be willing to take part. If you are willing to participate in this study, please could you return the attached form via email/telephone and I will then contact you directly.

If you would like any additional information please do not hesitate to contact me on 087-6442859 or [Lisa.M.Kerr2@student.shu.ac.uk](mailto:Lisa.M.Kerr2@student.shu.ac.uk).

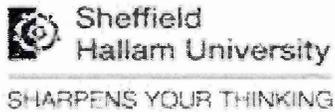
I would like to thank you for taking the time to read this information leaflet and I hope that you will choose to participate in my research study. If you would be interested in participating please can you return the reply slip at your earliest convenience, with many thanks.

Yours sincerely,

---

Lisa Kerr  
Nurse Researcher

## Appendix F Reply Form



### Reply Form

I would be willing to be a participant in the study entitled 'Advanced Nurse Practitioners' (Emergency) perceptions of their role, positionality and professional identity' and I give my permission to be contacted by Lisa Kerr, the nurse researcher.

Please email/telephone your details and I will contact you directly – if you could specify the mode and time which is more convenient for you to be contacted, I would be very grateful, with many thanks, Lisa

### Contact Details

**Name:** \_\_\_\_\_

**Email address:** \_\_\_\_\_ **or**

**Telephone number:** \_\_\_\_\_

**Preferred mode of contact:**

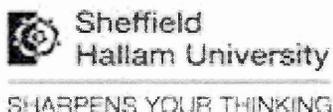
- Telephone
- Email

**Preferred time if via telephone:** \_\_\_\_\_

---

Director of Studies: Professor Ann Macaskill      E-mail: a.macaskill@shu.ac.uk  
Research Supervisor Dr. Irene Garland      E-mail: i.garland@shu.ac.uk  
Faculty of Development and Society  
Sheffield Hallam University City Campus Howard Street Sheffield S1 1WB  
Telephone +44(0)114 225 5555 www.shu.ac.uk

Appendix G  
Informed Consent Form



**CONSENT FOR PARTICIPATION IN THE RESEARCH STUDY**

**STUDY TITLE:** Advanced Nurse Practitioners' (Emergency) perceptions of their role, positionality and professional identity

**PRINCIPAL INVESTIGATOR:** Lisa Kerr

This research study is undertaken by the principal investigator as part fulfilment for a Doctorate in Education award at Sheffield Hallam University. The overall aim of this study is to produce a focused insight into advanced nurse practitioners' perceptions of their role, professional positionality and professional identity. Participation involves the respondent taking part in a focused verbal narrative which will be audio-taped with Lisa Kerr, the nurse researcher. This meeting will be conducted at a time and venue chosen by the respondent. The study adheres to the principles of ethical conduct for nurse researchers with respect for persons/autonomy, beneficence, non-maleficence, justice/fairness, veracity, fidelity and confidentiality (An Bord Altranais 2007) and has been granted ethical board approval from Sheffield Hallam University and the respondent's Ethics and Access Committees.

**DECLARATION:**

I have read, or had read to me, the information leaflet for this study and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study. I understand that I do not have to participate in this research and that I may withdraw from the study and have the data destroyed if wished up to two weeks after giving the narrative interview. I have received a copy of this agreement.

**PARTICIPANT'S NAME:** .....

**CONTACT DETAILS:** .....

**PARTICIPANT'S SIGNATURE:** ..... **Date:** .....

**Statement of investigator's responsibility:**

I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

**INVESTIGATOR'S SIGNATURE:** .....**Date**<sup>3</sup>: .....

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Director of Studies: Professor Ann Macaskill      E-mail: a.macaskill@shu.ac.uk  
Research Supervisor Dr. Irene Garland      E-mail: i.garland@shu.ac.uk  
Faculty of Development and Society

<sup>3</sup> Sheffield Hallam University City Campus Howard Street Sheffield S1 1WB Telephone +44(0)114 225 5555 www.shu.ac.uk

## Appendix H

### Extracts from my Reflective Diary on contextual elements

The following are my jottings of contextual factors I noted in my reflective diary while I was in the research settings. I decided that as I was in their domains that therefore the venues for the interviews were selected by the participants themselves to ease access, comfort and promote discussion.

Interestingly there were many commonalities in undertaking narrative interviews with participants.

*'ANP work in really busy clinical areas.  
There is always someone to see and something to do.'*

ANP 1 - Clinical area was very busy, many personnel were present, and she shares a big office with clinical colleagues, treatment room (close by). Interview progressed in her office that was made available to her for the interview as planned (a couple of staff members were there when I arrived but left) , there were no disturbances, relaxed atmosphere, and confidently freely expressed her thoughts giving a detailed and lengthy interview. Relationship with staff member appeared professional and positive.

ANP 2 – Clinical area was very busy. Same resources and shared office with other ANPs and interview took place in shared office. Was quiet as Saturday morning and no one in the office when we arrived and she seemed very at ease and spoke freely and at length. There were no disturbances and relationship with staff colleagues was very positive.

ANP 3 - Clinical area busy, clinical room off from main ED zone – felt a bit removed. Small shared office with other ANP in ED department a little way down a corridor from treatment room. Interview was emotive and tense – I had the feeling that she was unpacking her feelings. There were external environmental sounds but no direct disturbances.

ANP 4 - Clinical area busy, clinical room off from main ED – Small shared office with other ANP in ED department. Interview was direct; tone was business like but she seemed comfortable. I think she has just a direct personality. It was one of the shortest interviews time-wise but content was insightful.

ANP 5 - Clinical area was very busy. We went to the clinical education room which was past her shared office – ‘as it will be quieter here’ and it was there were no disturbances and she spoke freely and in great depth. It was a big room so I was concerned it might be impersonal and effect the interaction and quality of the interview. It didn’t and this was one of the most open interviews. Very patient focused and kind.

ANP 6 – Interview took place in the ANPs (emergency) shared office just off from the ANP clinical room. The ANP clinical room was off from the main ED. There were no other personnel in the clinical room and so the interview was not disturbed – ANP informed me that she had asked the registrar to hold her patients as she was doing the interview. She seemed relaxed, was factual and informative but seemed to be conscious of time and workload during the interview.

ANP 7 – Very busy department, ANP clinical room to the side of main ED. Interview took place in a small office in the ED which was shared with other nursing staff. The interview was disturbed by people needing to access their belongings. ANP appeared open and relaxed.

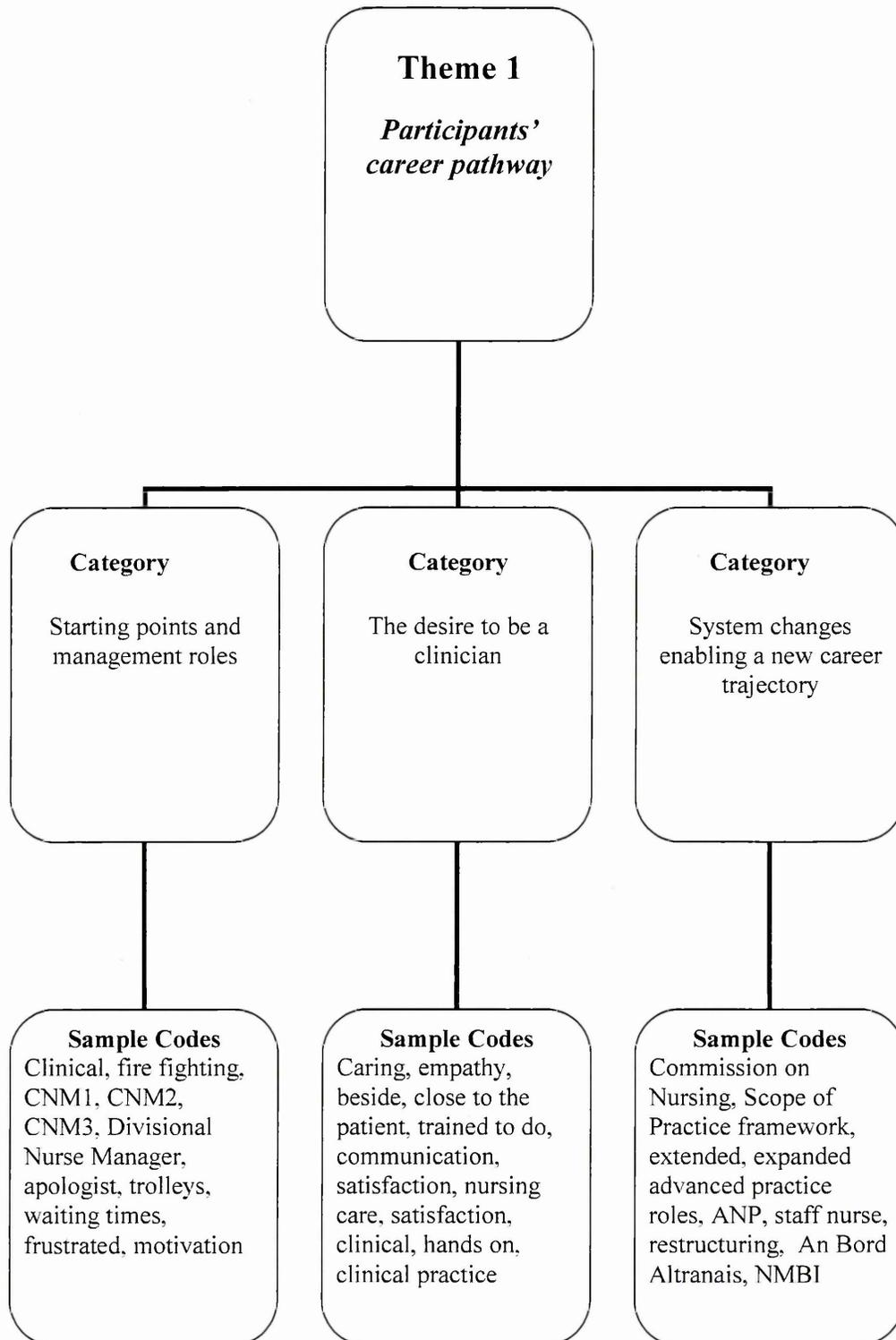
ANP 8 – Department was busy, ANP clinical room to the side of the main ED – seemed a little environmentally separated. Interview took place in clinical room. There were a number of disturbances by medical staff – ANP explained they were doing the interview but still was disturbed a further time. ANP seemed perturbed by this – it was an emotional interview where a number of issues were aired.

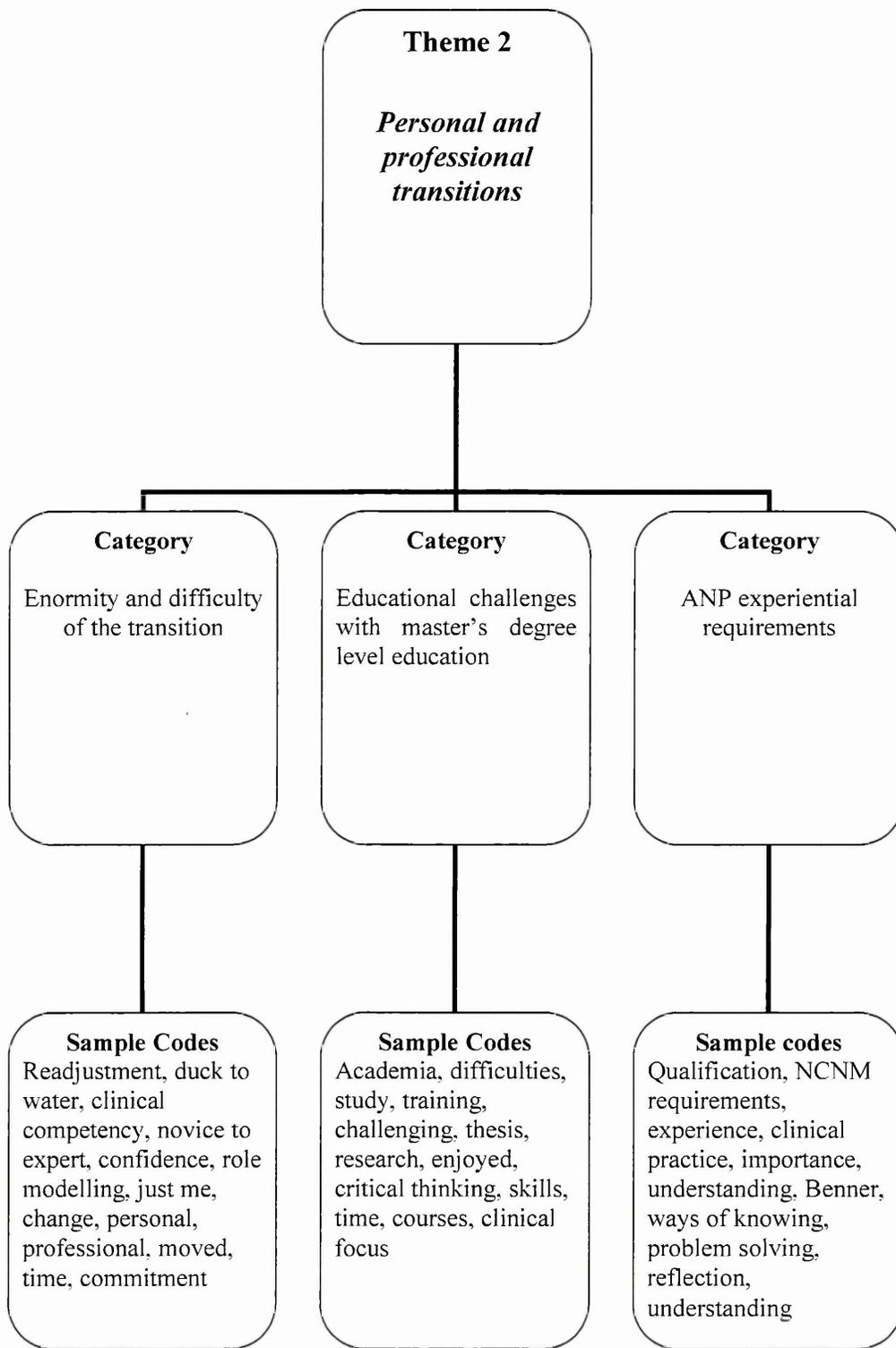
ANP 9 – A very busy department, clinical room was a nice welcoming large room situated in the department. This was where the interview took place – there were disturbances by telephone as the ANP was in the middle of arranging an ambulance transfer for her client and she had to liaise with registrar in receiving hospital. ANP was very confident and eloquent and appeared to describe thoughts openly. Towards the end of the interview a registrar called to the clinical room as there were some patients waiting to ‘see what the ANP was doing?’ She explained about the research but I got the impression from him that numbers were more important and I think the reason for this disturbance and subsequent attitude appeared to annoy the ANP.

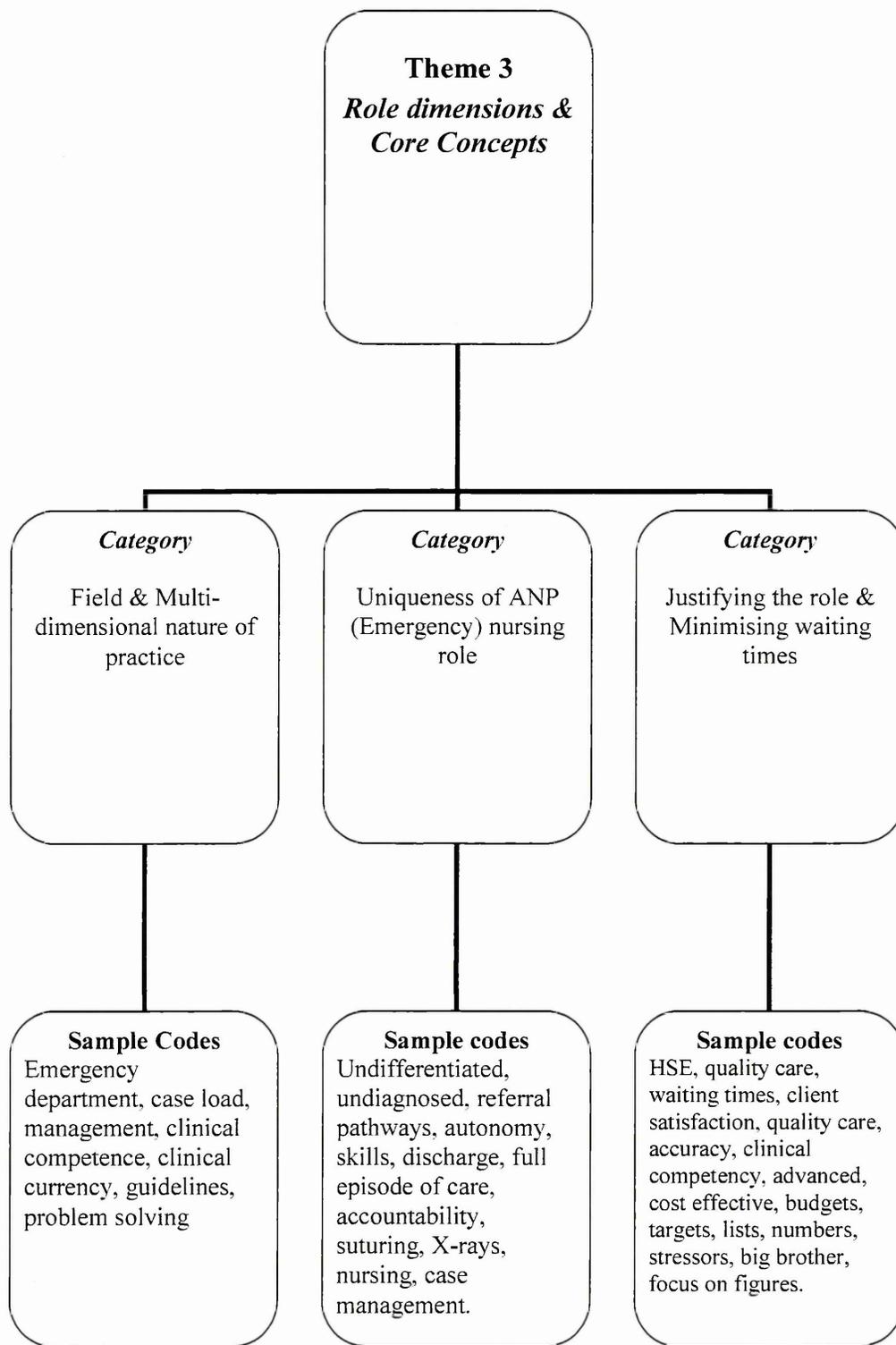
ANP 10 – A busy unit, large clinical room off main ED unit. Interview was conducted in small shared office and was disturbed once by a medic getting his coat. Felt rushed – was one of the shortest interviews and ANP a little hesitant to begin with but relaxed a little as interview progressed. I came away feeling there was more that could have been reflected upon.

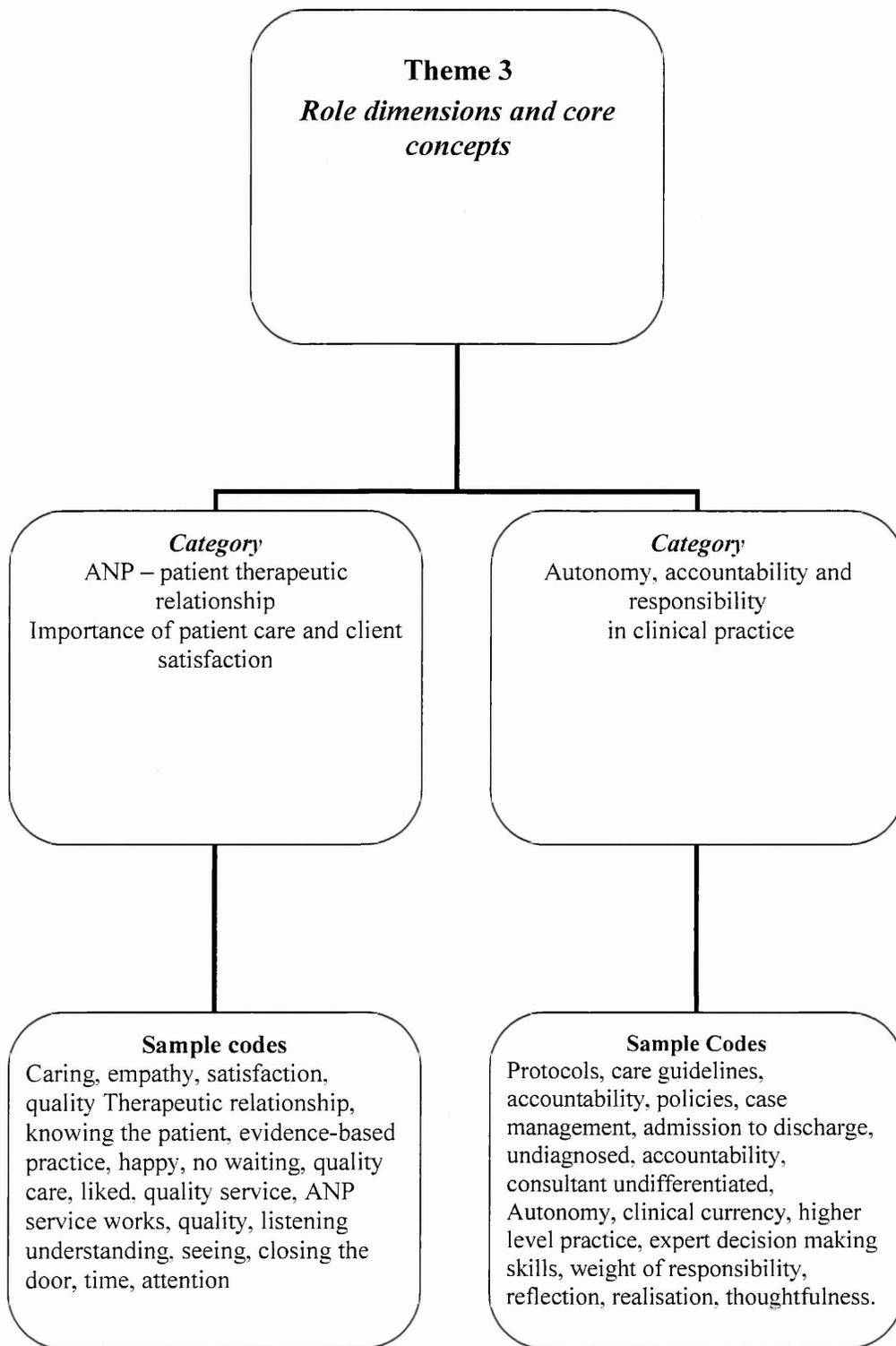


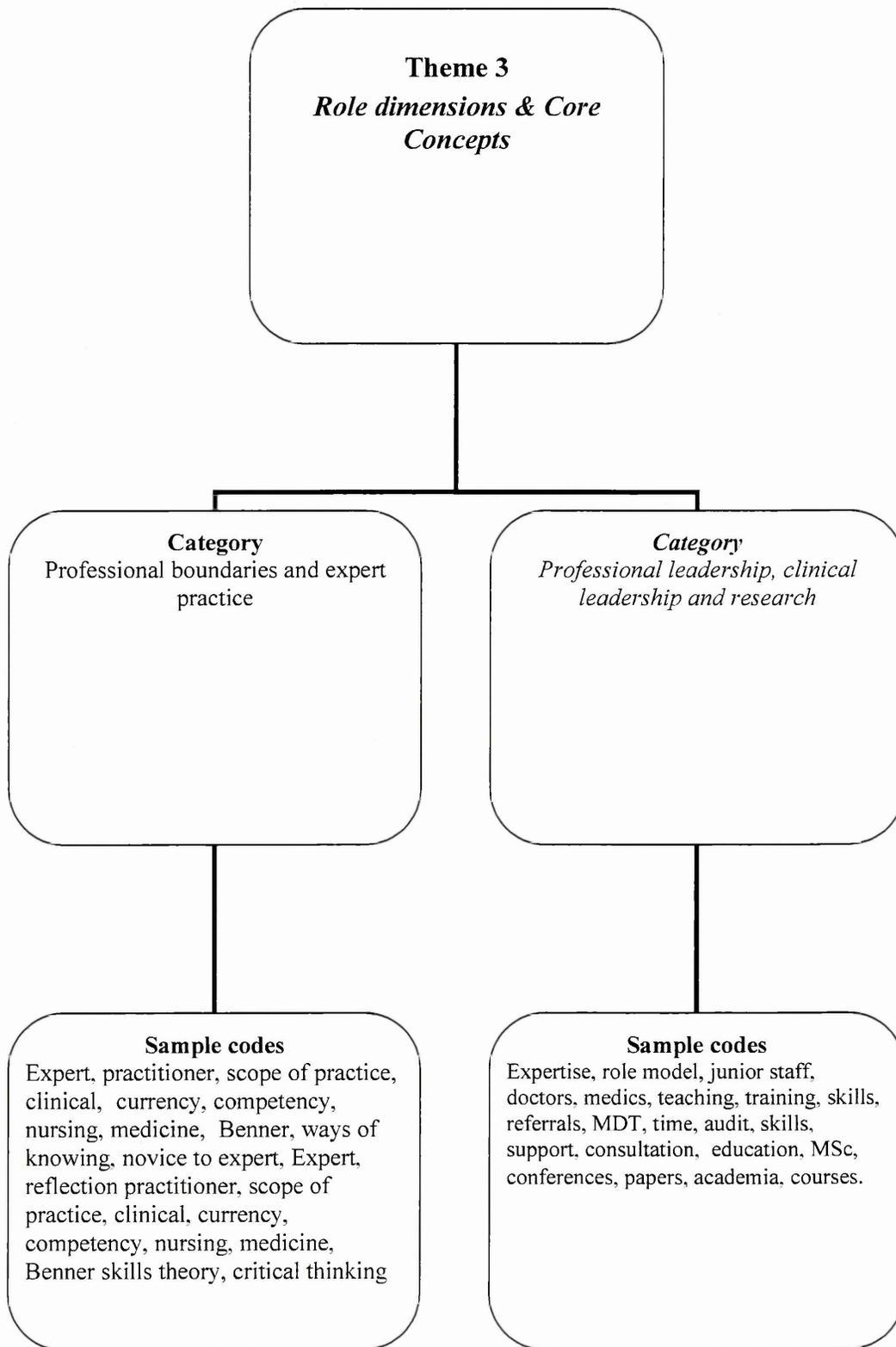
**Appendix J**  
**Coding, category and theme formation**

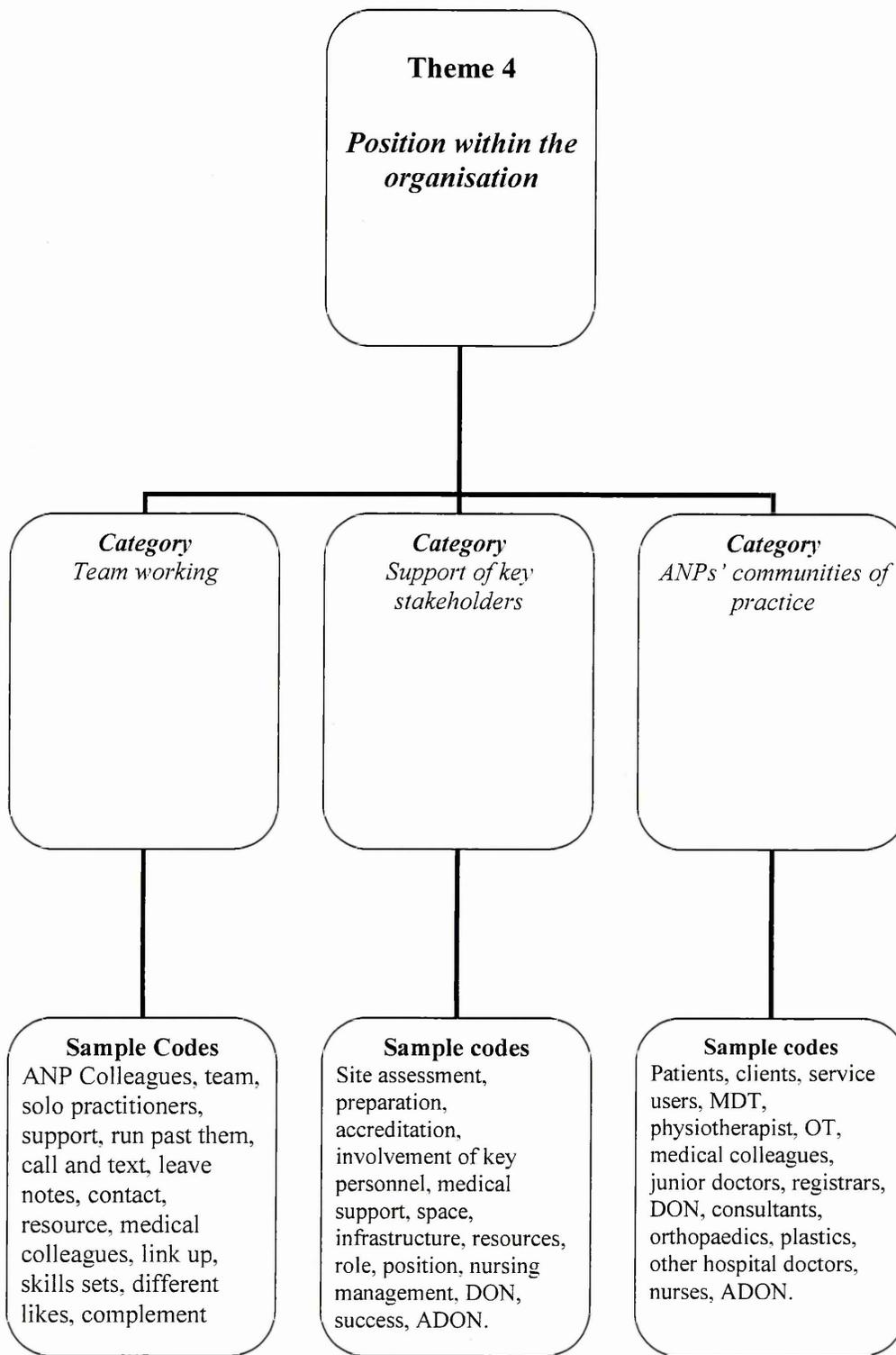


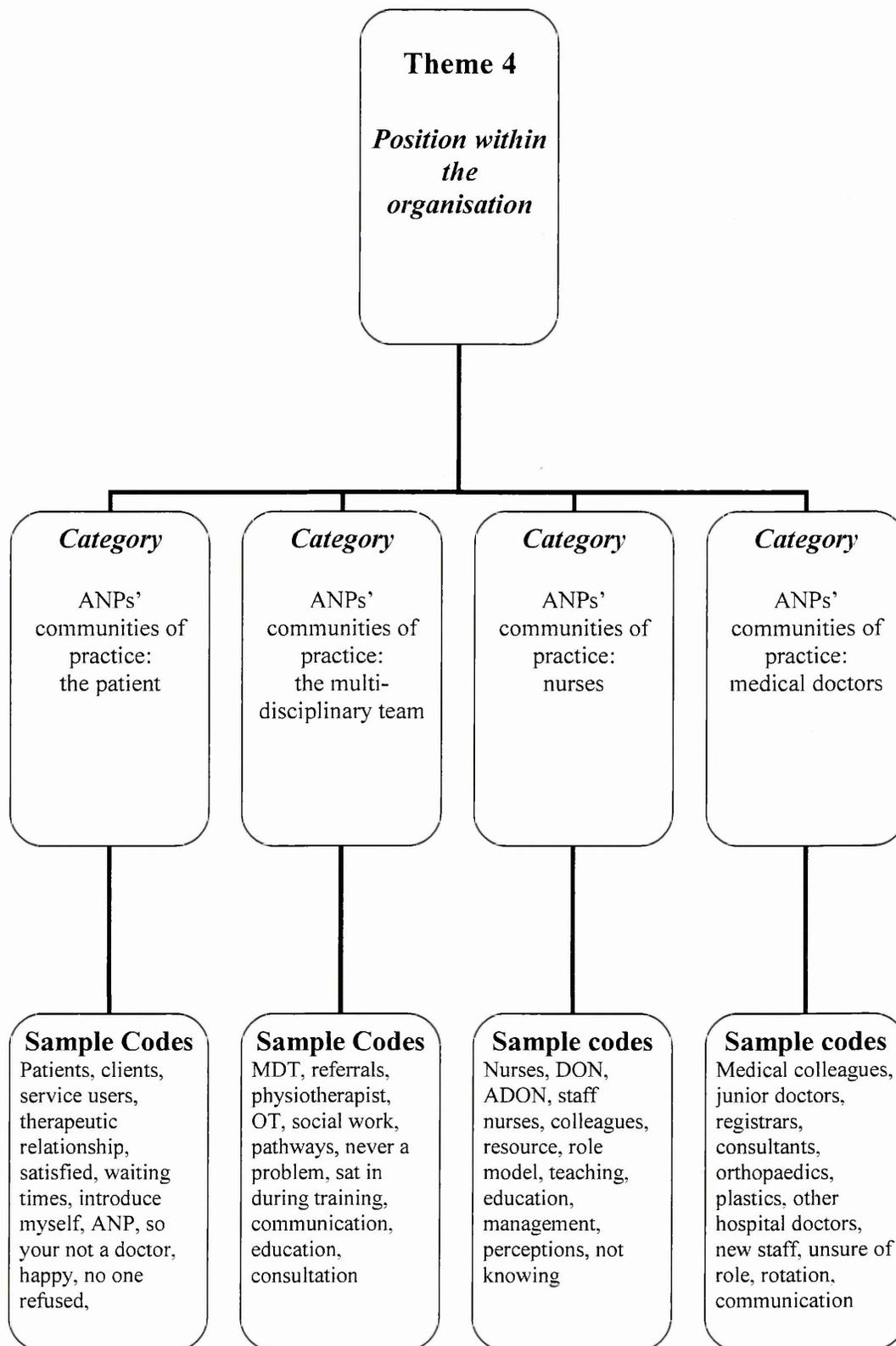


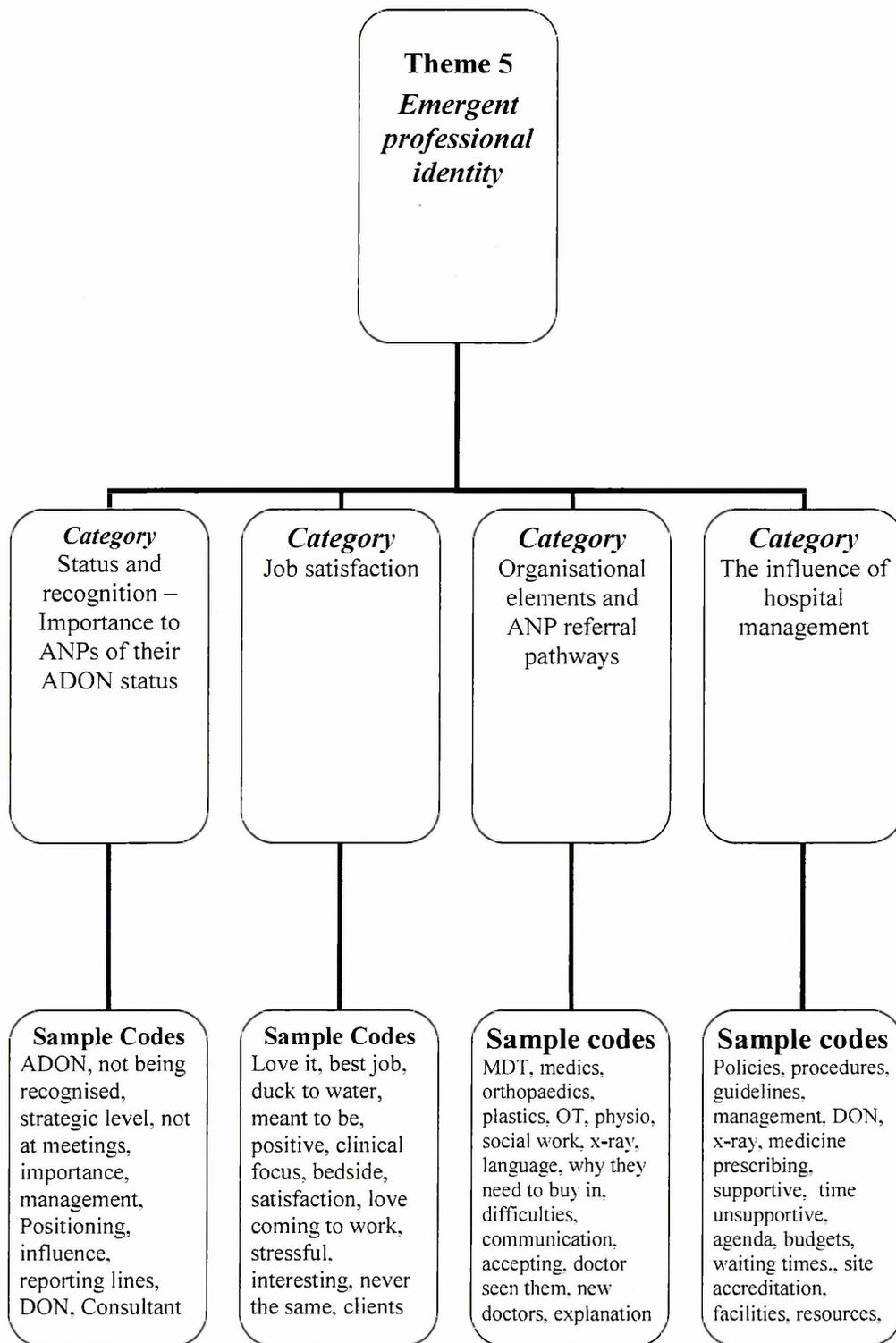


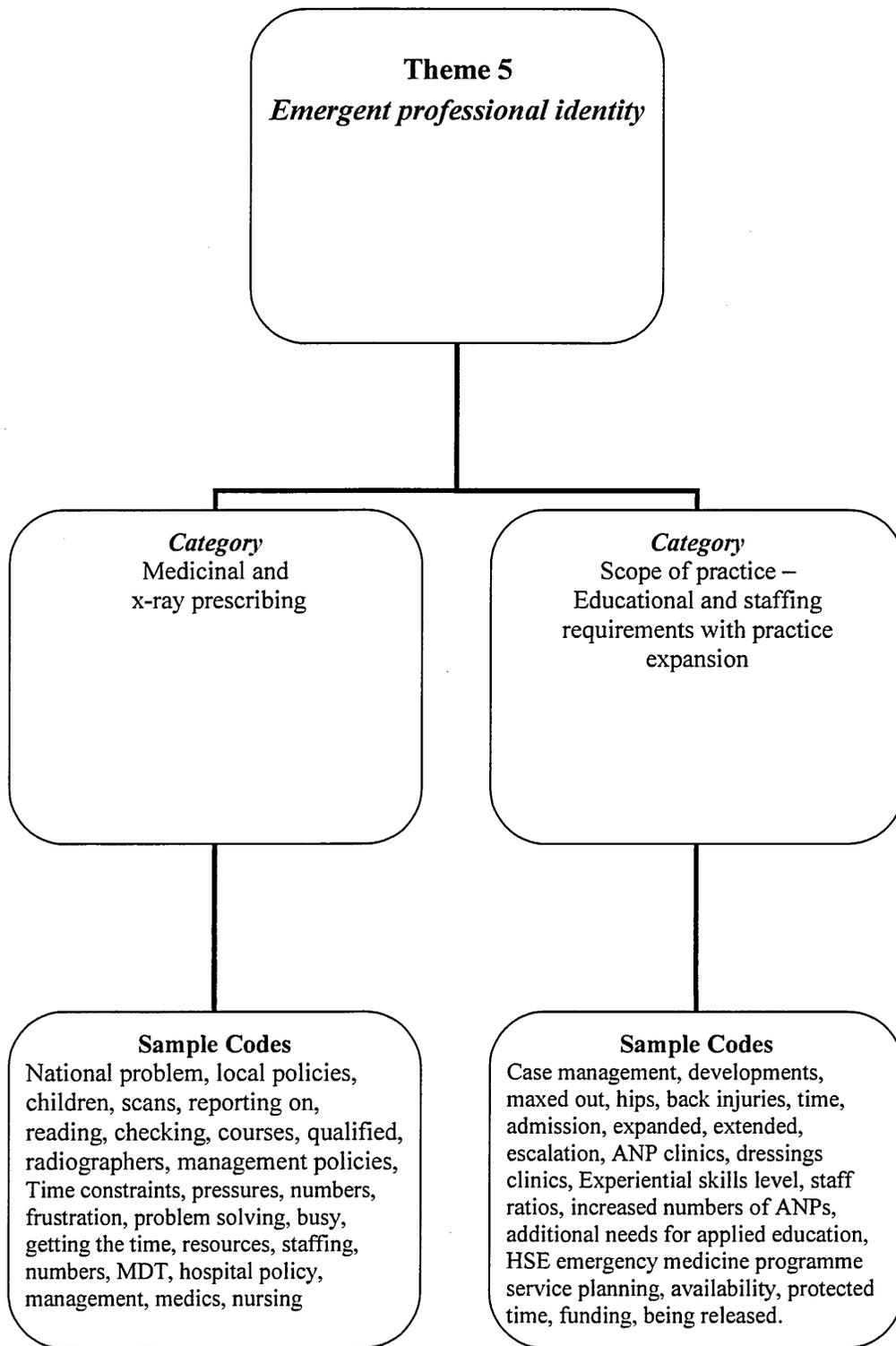












## Appendix K

### My reflective diary entries illustrating '*Participants' career pathways*' themes, category and code formation

- Theme: Participants' career pathways
- Categories: starting points and management roles; desire to be a clinician; and system changes to allow new career trajectory.
- Codes: Clinical, fire fighting, CNM1, CNM2, CNM3, Divisional Nurse Manager, apologist, trolleys, waiting times, frustrated, motivation Caring, empathy, beside, close to the patient, trained to do, communication, satisfaction, nursing care, clinical, hands on, clinical practice, Commission on Nursing, Scope of Practice framework, extended, expanded advanced practice roles, ANP, staff nurse, restructuring, An Bord Altranais, NMBI

#### November 2012

ANP 1 describes today how she '*is as close to the patient today as she was when she came into nursing*'. I loved this comment – it is so to the heart of clinical nursing care that I empathise with - but I imagined this sentiment had lessened but may be not amongst ANP. Could this be the sentiment that motivates a nurse to journey towards becoming an ANP? Why do they choose the clinical ANP position above management and over education? In 1995 I chose education as there were limited options available at that time to progress in the clinical domain. I definitely would not have chosen management due to personnel and monetary issues this entailed. The Nurse Consultant role had not been established in the UK at that time, but would I have chosen this role if an option?? I am not sure and that sparked an interest in exploring the motivations behind wanting to become and be an ANP.

#### November 2012

It is so hard to hear the stories of how much ANP 2 disliked their nursing management role – CNM1, CNM2, CNM3 I just wonder did this make them seek the ANP role as a way out which came first the chicken or the egg – their dislike of nursing management roles or their wish to return to patient care ?? I wonder...my gut instinct says it feels equal ... management sounded so hard with patients on trolleys, long waiting times, '*being the apologist for all the ills in the department.*' It seems as though the participants had had a hard time in their careers up to opting to undertake ANP candidacy. System changes were important to allow the ANP role to come into existence – the Commission on Nursing, the Scope of Practice framework, nursing restructuring, An Bord Altranais and now the Nursing and Midwifery Board of Ireland. I must go back to the historical documents and context to locate my current study. What happened to these nurses before the Commission on Nursing was set up and the ANP role was developed... this raises so many questions for me – did they stay unhappy in management? Did they go back to staff nurse role? Did they leave the profession altogether? Had things bettered as a result of the ANP role developing and how? There are so many questions I have to think about.

#### November 2012

I was not expecting this after the positivity of my first two narrations but ANP 3 seems really disillusioned with her ANP role – is the ANP role not the panacea she was

looking for? Or is it bigger than her and bigger than the ANP role?? I read an article which spoke about the transitional stages that people go through in their professional careers which suggested that the period after role assumption can be marred by a dip in enthusiasm and motivation where it seems to me that the 'rose tinted glasses' donned during training and initial registration wane. I must come back to this after all the narrations as my previous two participants did not express this sentiment.

### **November 2012**

Interesting ANP 4 worked in the same team as ANP 3 so I was really keen to see how she viewed things. She had a different attitude to ANP 3 and while she did raise issues about management she was much more philosophical. Bourdieu's thinking tools helped me to make some sense here – habitus plays a big role in making sense of the field for the agent. She had previously worked as a CNM3 and seemed, in contrast to his colleague, to have insight into the workings of management – habitus again. This ANP was content with his career choice '*I tell everyone I have the best job in the HSE.*' She said that a few times.

### **January 2013**

I have been thinking over Christmas about my narrative interview with ANP 3 as it perturbed me, but I have been reflecting why did it perturb me? I think the reason why this one ANP was disillusioned had a lot to do with the organisation that she works in and the personnel that she works with ... but again may be each determines the other. Bourdieu theoretical reasoning helped me to think rationally about her structure and agency. I feel it comes down to personality and past experience – her habitus.

### **February 2013**

This was a lovely interview with ANP 5 full of warmth, caring and genuinely nursing focused. Her stories were full of 'real people' – about their lives and care needs. My two pilot study narrations had been just like this one. They showed that caring, empathy, being close to the patient, and hands on, clinical practice were part of their careers. I thought she must be a really good ANP – I started to think that maybe there is a 'type' of ANP nurse – is there a psyche which complements the ANP role and leads those nurses to this career trajectory? Is it choice or is it opportunity? All seem happy with most elements of their role and had a desire to stay in clinical practice as ANPs post registration and demonstrated strong intentions to remain so. I would be interesting to look into recruitment and retention amongst ANPs – over time I wonder what it would reveal. One ANP had moved to another hospital for relocation reasons otherwise they had remained at their bases and in their role some for many years. Is it a life choice? Or is there no where else to go except back to management or education? Are they so specialised that they have an advanced practice niche post .... And they all seem contented with the client contact and challenged by their extended and expanded skills set.... It would be insightful to come back to participants and see how they were thinking over time. They seem to grow in insight about decision making and the grey areas – maybe there is a stage above Benner's expert.

### **April 2013**

I have been reading an article on professional role development that Ann (my Director of Studies) had suggested. It prompted me to reflect on the role that ANPs find themselves in and how they got there in nursing developmental terms. Bourdieu's concept of habitus and field helped me to try and work out influential factors and their effects.

Interestingly ANP1 had told me about a book which she had read called 'The Tipping Point' by Michael Gladwell. I had been meaning to get it and so I decided that maybe it might give me some answers to this so I got it from the library and I couldn't put it down. I was fascinated by how the multiple elements must be right for developments to happen. I think this is akin to the nursing ANP role development from the scope of practice framework, Commission on Nursing and restructuring that enabled advance practice roles to emerge. There are so many elements at play; it really must have reached Gladwell's 'tipping point'.

### **July 2013**

The National Council for the Professional Development of Nursing and Midwifery had been disbanded in the governmental rationalisation and An Bord Altranais had been changed to the new structure of NMBI in December 2012. Serious changes were devolving that impact on ANPs. I wonder what is going to happen - a precarious time and I could feel the tension when I spoke to ANP 6 – she raised concerns about job security.

### **Autumn - Winter 2013**

I have been privileged to meet four more ANPs who shared their worlds with me during some really interesting narrative interviews and I have completed my 10 narrative interviews and now completed transcribing. I really need to work out what it is that leads the ANPs to make the choice of this career trajectory? In transcribing the interviews I keep thinking of is it choice? Is it circumstance? Is it aspirations embedded deep with their psyches? Is it from their individual experience? Is there a commonality of experience because nursing is a homogeneous profession? But is it as nurses are part of a wider structure and community of practice which Bourdieu considers influential in structure and agency? I went back to the raw data to seek the participant's sense of purpose. I feel that it is often a combination of elements.

### **Spring – Summer 2014**

I feel as though I have been sitting with the transcripts around me (actually as well as theoretically for months and months! Being immersed – honestly feeling a bit swamped at times and then things coming together at others). I am working on my data analysis and writing up my draft results – I am feeling a bit disjointed and I am hoping that the linkages will come in my mind and through my writing. I keep returning to the data to ensure that the participants' stories can be heard. My supervisors have been very constructive and supportive in their advice and feedback. I do feel it is coming together ... slowly.

### **Autumn 2014**

I returned to my initial gatekeeper and forwarded my findings for her opinion and I have submitted hopefully a near complete draft to my supervisors. I do feel that I have given an accurate and just study from the honest and thoughtful words of my participants who kindly gave me their time in the midst of patient lists and waiting times!

## Appendix L

### Narrative audit trail of 'Participants' career pathways' theme which identifies use of codes to form categories with extracts from transcripts

#### Grouping of codes to form categories

1. The following *codes*:

Clinical, fire fighting, CNM1, CNM2, CNM3, Divisional Nurse  
Manager, apologist, trolleys, waiting times, frustrated, motivation

Contribute to the *category* 'Starting point and management role.'

2. The following *codes*:

Caring, empathy, beside, close to the patient, trained to do,  
communication, satisfaction, nursing care, satisfaction, clinical, hands  
on, clinical practice.

Contribute to the *category* 'Desire to be a clinician'

3. The following *codes*:

Commission on Nursing, Scope of Practice framework, extended,  
expanded advanced practice roles, ANP, staff nurse, restructuring, An  
Bord Altranais, NMBI

Contribute to the *category* 'System changes to allow new career trajectory'

**Sorcha:** How I came to be an ANP – I suppose my background has always been pretty much in emergency nursing. When I qualified first we were lucky to be employed as staff nurses really, and we were deployed where we were needed in terms of hands on and I went to work in the Care of the Elderly setting and I worked there for a period of about nine months to a year. About half way through that first year we actually had the [major incident]. When this event happened a major incident plan went into action and they asked for all nurses working in the hospital, especially nurses who had worked in our own Casualty (as it was called at the time) to come and volunteer to help out. As it turned out we didn't really get very many casualties as most went to the burns unit because of the nature of what happened. I had spend my student time here and really enjoyed it and coming back as a staff nurse, and looking as an outsider in, I thought that is really the place I would really like to be.... It was a very small unit at the time, and we really did not have anything like the attendances that we have now, and it gave me an opportunity to learn the job and to learn the business. Even though I had no formal education around A&E and there wasn't, it was very difficult to get on an A&E course at that time and we didn't run an A&E course here. It was kind of learn on the job, learn from your peers and learn from other people who were more senior. I went along with that until the early 90s when the course was set up here. I was in the first group for the A&E course that was run here, and that was almost like opening Pandora's Box and I thought 'this is just fantastic'. It was my first exposure to a post registration education programme and it was post registration, it wasn't post graduate, it was a certificate programme and certificate course. But it was really the opportunity to go back to education and as a student to revisit and to feel comfortable about asking the questions that you were shy to ask when you were on the floor. That created its' own 'Pandora's

Box,' the possibilities that opened up to me were endless, and that was definitely the start of a journey that I knew I was going to stay on forever and that my goal was to stay and remain in this speciality probably forever.

**Niamh:** I think my journey to this came from way back when I did my [discipline] in that I worked at a Victorian institution. But there were a few people there who were doing interesting things and had advanced their practice within the madness that was there. There were registered general nurses who were psychiatric nurses and they were catheterising and putting up cannulae and I thought this was really fantastic. There were a few patients who were tube fed as well which I thought was really cool. So I suppose I had a couple of role models way back before I even knew what advanced practice was. I got out of there fairly fast because there were no jobs at the time as there was a recession and I went to the UK to do my general and I worked at a very large Emergency Department in the UK, the biggest one and they were doing suturing and cannulation by nurses and defibrillation. I probably enjoyed that side of things, being involved in what was going on. I came back here to Ireland in 1990 because well the economy had picked up and things were kind of looking good here at the time. But when I came back things were quiet, they were still kind of 1950s nurses weren't doing any thing, they weren't covered, it wasn't part of their thing so. I started teaching the A&E Certificate course and I started to include cannulation, venepuncture and defibrillation. I suppose the diplomat side came in there because it was the first time advanced practice was ever spoken of here.

**Caoimhe:** Prior to that I was a CNM2 in the Emergency Department at [Name Hospital] and I was there for 7 years. And prior to that I was a G Grade in [London Hospital]. While I was in the UK I undertook the ENP training and that was in the University of [Name]. I loved it, I absolutely loved it.

**Roisin:** With ANPs, we all come from various different backgrounds, with me I started off as a staff nurse and I have come up through the management ranks. I would have been a Clinical Nurse Manager 1, Clinical Nurse Manager 2 and I was a Clinical Nurse Manager 3 and I did a little stint as a divisional nurse manager for a year and that was covering absent leave. I always felt that I wanted to do management and hence that is the reason I was looking towards the clinical nurse manager role going that way. But when I look back on it, it was very much, all the courses that I was doing always had a clinical component rather than a management component in it. So I was doing an awful lot of that type of stuff even when I had done my master's, people were saying 'ok you need to look at administration or management type master's.' But I'd say 'I am not really interested in that I want to do clinical Master's Programmes.' Then we got a new divisional nurse manager here and I suppose she was absolutely fantastic and I go this, it was nearly like a 'ah hah! moment', when a light-bulb all of a sudden got lit one day from a conversation that I had with a colleague and I thought no, I want to go back to clinical, I want to stay in clinical.

**Erin:** Well I suppose I started off way back [name] had started in 1996 and then I came on board in 1998 and it was kind of unofficial, it wasn't that there was a major recruitment drive though there were interviews and I was interested in it when I saw [name] the work that she did. I was essentially interested in sports injuries that would have really been my thing. I was really interested in sports injuries – ankles, shoulders. I

played sport myself so I was really interested in that aspect of it, so from that point of view I was very interested in so called 'minor injuries'.

**Ciara:** I first started off, I worked in England originally and then came over to Ireland and started working here in [name hospital]. I applied for the Clinical Nurse Manager 2 (CNM2) post which I did for 4 and half years. With the Commission on Nursing, and that I was very clinical, I didn't want to go down the road of the management line. I wanted to stay clinical, but I wanted to develop myself clinically and professionally. Through the National Council (NCNM) there was a road there for me to develop, and to be part of the advanced nurse practitioner back in 2004. When we started there was no advanced nurse practitioner outside of [city] at the time, so myself and another colleague went and lived in [city] for 6 months.

**Aoife:** As time went on I realised that I really missed the clinical area and I missed the hands on, and whilst this negotiation is fine it was not for me full time. There was a lot of stuff in it that just didn't sit well with me. I decided that I would go back to the clinical area and that I would go training. I would finish work at 5pm in [name] office and because I had been out of the clinical area I was hugely aware that my clinical currency may not be so I got clearance and worked voluntarily as an observer with the ANPs in [hospital]. I got myself up to speed again. In the meantime I was developing [name] service and I got myself up to speed and when the job was advertised I applied and here I am. That was 7 years ago now and it was a great opportunity for me to get back. There are other factors that you have to take into account when you are looking at your professional development, there are also personal issues in terms of your finance and where you are and what you will be able to do.

**Clodagh:** My background is emergency nursing, I trained in the UK in [name city] and you were put in to places and that is how you selected and I was put into the emergency department. I always liked that I don't know if it is because of the vibe or because I liked the speed of it, when I was looking at the whole nursing role I didn't really like the patients not moving on. In emergency you got quick patient in sort them there and then and get on to the next one. It was the longevity of treating a patient, I didn't want that and that really didn't appeal to me so the medical end of it like geriatrics didn't appeal to me. The longstanding treatment of orthopaedics didn't appeal to me. More so the acuteness of the patient and sorting them out there and then and seeing an outcome there at the end – that is what I always liked about emergency.

So I worked in [name city] for a couple of months and then I thought I might like to travel and I went to [country] and lived in [city] for about a year and a half as an agency staff and of course where did I get put only in the emergency department. Again trying to experience other things but ended up in the emergency department. So I couldn't get away from it, even though I wasn't trying to get away from it but just try something different that didn't really happen and I stayed in emergency. That is where I learnt nursing out there and their role and saw that some of the shift leaders, which they weren't shift leaders, were doing advanced roles and weren't getting the credit for it but they were doing suturing and referring for plaster applications and stuff like that – the advanced role which probably would not have been seen when I worked in the UK. But probably because I was only a junior nurse at that stage and maybe it was there but it wasn't obvious to me.

**Saoirse:** I was a nurse manager, and my background was [discipline] and general, and I had worked in an acting in a [name] ward for years, then I worked in [name hospital] I didn't work here. The service in the [name] ward they were closing it and taking me out of the ward and I went and worked in critical care for 4-5 years and then a post came up in outpatients. In [name hospital] we didn't have an A&E; we didn't have a casualty; all our patients came directly to the ward for treatment and assessment and all that. We were supposed to be getting an A&E in 1997-1998. I became the sister of outpatients and the treatment room, as we called it, which was a 9am to 5pm service. I did that for a few years and there were rumours that eventually the hospital would be downgraded and that we would have a nurse practitioner led service. There were few of them in Ireland so in 2000 I went and I did my H Dip in A&E and I did that in [Name University]. When I came back in 2001, we at that stage became a 24 hour service and we started seeing medical patients as well.

It was still going on that we were going to be a nurse practitioner led service. I didn't want to be a manager, I am a very clinical person, I love the interaction with the patients, it is not that I couldn't manage I would have been a good manager but it just wasn't me. I sat down and talked with the DON and a surgeon, who is since dead, they were saying I should go, and in 2003 I went and ended up in [name hospital] for 2 years because we didn't have an A&E consultant so I went to [name hospital] and the A&E Consultant at [name hospital] was my mentor. I did advanced practice through [university] and I got my clinical experience in [name hospital]. When I finished I came back to [name] in 2005 and we set up, [name] is the first minor injuries unit in the country and then it was the first one to have an advanced nurse practitioner and then we would have had a registrar in it as well.

So when I came back I did the whole accreditation process, [name] in [place name] and I worked together and we did our two site approvals and we got them so [name hospital] was the first for that. To me it was fantastic because I felt it was the way we were going and where we were going so I set up the department and we developed all our policies and protocols regionally so that where you worked you got the same service everywhere.

**Sile:** I started my ANP training in 2004 when I worked in [name hospital] because there had been a service there that had just started in 1997. Previous to that I had trained in [name hospital] and I went straight to A&E from qualifying. They had one of the first ANP in the UK but she was a little bit different than what became the Emergency Nurse Practitioner role then in the UK, she didn't just do minor injuries she did asthmatics and some medical cases as well. So I suppose from early on it was something I aspired to and thought this is what I would like to do, I knew that I was never going to go down an education road, or really didn't want to go down the management road; and that seemed to be where you were at. I remember thinking as a student nurse that the nurse managers that would come on the ward, back in the day they were like the old matrons, I would say 'how did they get their jobs? I wouldn't like that if that was the top of my career.' Then I was told that they were people who were useless at what they did so they put them in those jobs.

From there, it was really probably in [name hospital] that I thought no this is where I want to go, so I had been a staff nurse from 1993 to 1996 in the UK and then from 1996 – 2001 in [Irish city]. I got a CNM post and by 2004 I had completely burnt out with that, just really had had enough with that it was the long waits; the trolley waits in [city] were just horrendous. I think it is a job you can not do long term, so I had asked my manager what was the story was there any ... did it look like they were going to do

the ANP because they had talked about it for a while. She said 'no' so I took a seconded post in [name] starting up the [service] and during that time, I was about 3 months into it, when they got funding for an ANP post; so that was where I was up to with that.

### **Grouping of categories in theme formation**

These three categories are grouped together to form the theme '**Participants' career pathways.**' I judged this to be an important theme and one that would contextualise the remaining thematic developments, the starting point from which participants developed their career trajectories would impact upon their experiences and perceptions.

# STANDARD APPLICATION FORM

For the Ethical Review of  
Health-Related Research Studies,  
which are not Clinical Trials of  
Medicinal Products For Human Use  
as defined in S.I. 190/2004

DO NOT COMPLETE THIS APPLICATION FORM  
IF YOUR STUDY IS A CLINICAL TRIAL OF A MEDICINAL  
PRODUCT

Title of Study: Advanced Nurse Practitioners' (Emergency) perceptions of  
their role, positionality and professional identity

Principal Investigator: Lisa Kerr

Applicant's Signature: \_\_\_\_\_

For Official Use Only – Date Stamp of Receipt by REC:

TABLE OF CONTENTS	MANDATORY /OPTIONAL
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SECTION K COST AND RESOURCE IMPLICATIONS AND FUNDING	MANDATORY
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This Application Form is divided into Sections.

Sections A, B, C, D, E, J, K, L are **Mandatory**.

Sections F, G, H, and I are optional. Please delete Sections F, G, H, and I if these sections do not apply to the application being submitted for review.

**IMPORTANT NOTE:** Please refer to **Section I** within the form before any attempt to complete the Standard Application Form. **Section I** is designed to assist applicants in ascertaining if their research study is in fact a clinical trial of a medicinal product.

**IMPORTANT NOTE:** This application form permits the applicant to delete individual questions within each section depending on their response to the preceding questions. Please respond to each question carefully and refer to the accompanying *Guidance Manual* for more in-depth advice prior to deleting any question.

# 1 SECTION A GENERAL INFORMATION

## SECTION A IS MANDATORY

**IMPORTANT NOTE:** This application form permits the applicant to delete individual questions within each section depending on their response to the preceding questions. Please respond to each question carefully and refer to the accompanying *Guidance Manual* for more in-depth advice prior to deleting any question.

### A1 Title of the Research Study:

Advanced Nurse Practitioners' (Emergency) perceptions of their role, professional positionality and professional identity

### A2 Principal Investigator(s):

**Title:**  **Name:**   
**Qualifications:**   
**Position:**   
**Dept:**   
**Organisation:**   
**Address:**  
**Tel:**  
**E-mail:**

**A3 (a) Is this a multi-site study?**

**A3 (b) Please name each site where this study is proposed to take place and state the lead investigator for each site:**

Site:	Lead Investigator:
MULTISITE	LISA KERR

**A3 (c) For any of the sites listed above, have you got an outcome from the research ethics committee (where applicable)?**

#### A4. Co-Investigators:

Name of site

All sites

**Title:** Prof. **Name:** Ann Macaskill

**Qualifications:** MA PHD C Psychol FHEA AFBPS

**Position:** Head of Research Ethics/Professor of Health Psychology

**Organisation:** Sheffield Hallam University

**Address:** Sheffield Hallam University, Development and Society,  
Room 4, Unit 1 Science Park, Sheffield. South Yorkshire. S1 2WB  
England

**Role in Research:** Director of Studies

#### A5. Lead contact person who is to receive correspondence in relation to this application or be contacted with queries about this application.

**Title:** Ms. **Name:** LISA KERR

**Address:**

**Tel (work):** **Tel (mob.):**

**E-mail:**

#### A6. Please provide a lay description of the study.

Multiple reasons for the ANP (Emergency) role development are cited within the national and international literature (Begley et al. 2010). In the Irish context, the Commission on Nursing report contained a directive that senior nurses should be provided with a clinical career trajectory to optimise their clinical expertise, thus the ANP role came into existence (Government of Ireland 1998). My interest in the ANP role stems initially from my experiences of working with advanced nurse practitioners and being a research assistant on the SCAPE study (Begley et al. 2010). My literature review and pilot study, undertaken as part of my doctoral programme, identified a dearth of national and international literature on debates surrounding advanced nurse practitioners' perceptions of their role.

In order to address this deficit my proposed research aims to critically explore the perceptions ANPs (Emergency) have of their role, professional identity and positionality. It is hoped my study will add to the body of knowledge for nursing and the wider social sciences. Dependent on the results of the study, it is intended that the study will contribute to: informing induction training for ANPs and other healthcare professionals; inform curriculum and continuing professional development for ANPs; develop strategies for dealing with any tensions experienced; and inform policy developments for future nursing roles.

BEGLEY et al. (2010) *Evaluation of Clinical Nurse and Midwife Specialist and Advanced Nurse and Midwife Practitioner Roles in Ireland*. Dublin, NCNM.

GOVERNMENT OF IRELAND (1998) *The Report of the Commission on Nursing*. Dublin, Government of Ireland.

NCNM (2010) [www.ncnm.ie](http://www.ncnm.ie) accessed 14<sup>th</sup> August 2010.

**A7 (a) Is this study being undertaken as part of an academic qualification?**  Yes

**A7 (b) If yes, please complete the following:**

**Student Name:** Lisa Kerr      **Course:** Doctorate in Education

**Institution:**

**Academic Supervisor:** Prof. Ann Macaskill

## 2 SECTION B      STUDY DESCRIPTORS

### SECTION B IS MANDATORY

#### **B1. Provide information on the study background.**

I propose to undertake a research study to develop an insight into ANPs' (Emergency) perceptions of their role, positionality and professional identity. In Ireland the first ANP was accredited comparatively recently in 2002. The main reasons for the development of advanced practice roles cited in the literature are: role development and career trajectory for clinically based nurses; reduction in doctor numbers and hours following the European Working Time Directive; increased service demand; need for cost effective quality care provision; and service user demand for satisfaction (NCNM 2008; Begley et al. 2010; Small 2010). In the Irish context, the Commission on Nursing report contained a directive that senior nurses should be provided with a clinical career trajectory to optimise their clinical expertise. This was to be the ANP role. In 2009 there were 100 ANPs registered with An Bord Altranais in various different specialisms, and approximately 50 are employed as ANPs (Emergency) (Small 2010). The ANP (Emergency) is the largest cohort of ANPs currently practicing in Ireland with over 50 registered ANPs on the emergency section. Lloyd Jones' (2005) systematic review critiqued role development and effective practice in ANP roles, it highlights identification of role ambiguity can hamper the full development of ANP identity. The advanced nurse practitioner is a new and differing nursing role which results in a differing professional world for the ANP and realises a different professional identity. The ANP role has '*transformed the professions in recent years and promises to provide a platform for the further development of the contribution of the professions to the health services of the future*' (O'Shea, 2008 p22).

The advanced practice role in emergency nursing has a number of distinctive features as the ANP (Emergency) nurse patients whose attendance is unplanned, and whose conditions are undiagnosed. The rationale for focusing my research study upon the ANP (Emergency) is based upon a number of important and significant elements: the ANP (Emergency) is the largest cohort and the longest established cohort of ANPs nationally; they may be part of a team of ANPs in the Emergency Department [ED] unlike the majority of other ANPs; and the ANP (Emergency) has a distinctive role and practice domain. My proposed research seeks to critically explore the perceptions ANPs (Emergency) have of their role, positionality and identity. It is hoped that the benefits from undertaking this doctoral research study are to add to the body of knowledge for nursing and the wider social sciences; and that my research study will make a contribution to the understanding of ANPs' (Emergency) role, positionality and identity.

### References

1. BEGLEY Cecily et al. (2010) *Evaluation of Clinical Nurse and Midwife Specialist and Advanced Nurse and Midwife Practitioner Roles in Ireland*. Dublin, NCNM.
2. GOVERNMENT OF IRELAND (1998) *The Report of the Commission on Nursing*. Dublin, Government of Ireland.
3. LLOYD JONES, Myfanwy Lloyd. (2005). Role developments and effective practice in specialist and advanced practice roles in acute hospital settings: Systematic review and meta-synthesis. *Journal of advanced nursing*, **49** (2), 191-209.
4. O'SHEA, Yvonne (2008) *Nursing and midwifery in Ireland: a strategy for professional development in a changing health service*. Dublin, Blackhall publishing.
5. SMALL Valerie (2010) The development of an Advanced Practice Role in Emergency Nursing: insights from an Irish experience. *Emergencias* **22** 220-225.

## **B2. List the study aims and objectives.**

Research question.

**Advanced Nurse Practitioners' (Emergency) perceptions of their role, positionality and professional identity**

My key research questions are:

1. How do ANPs describe their transition from their previous nursing role to becoming an ANP?
2. What are ANPs' (Emergency) perceptions of their role?
3. What is the professional identity of ANPs (Emergency)?
4. What are the ANPs' (Emergency) perceptions of their professional positionality?

The main aims of my study are:

- To explore how ANPs describe their reasons for becoming an ANP and their transition from their previous nursing role to becoming an ANP
- To explore ANPs' (Emergency) perceptions of their role
- To explore the professional identity of ANPs (Emergency)
- To explore ANPs' (Emergency) perceptions of their professional positionality

The objectives of my study are:

- To review the literature on the experiences of ANPs nationally and internationally
- Specifically to review the literature on the experiences of ANPs (Emergency) nationally and internationally
- To explore their transitional experiences from their previous nursing roles to becoming an ANP
- To examine the perceptions ANPs have of their role
- To collect fifteen narrative accounts through narrative interviewing from ANPs (Emergency)

- To develop an in-depth analysis of data using NVivo qualitative software and manual analysis
- To produce a final original doctoral thesis that will clearly identify the essence of the ANPs' (Emergency) perceptions of their role, professional identity and positionality.

### **B3. List the study endpoints (if applicable).**

This research is intended to add to the limited current body of knowledge on the ANP (Emergency) by:

- Exploring how ANPs describe their transition from their previous nursing role to ANP, and knowing how easy or difficulty the transition, would be valuable as it could be used to assist in preparation for, and inform induction training for ANPs.
- Exploring ANPs' (Emergency) perceptions of their role will enable a greater understanding of the lived experiences of the ANPs' role. This will serve to inform both ANP candidates' course curriculum and ANPs continuing professional development.
- Developing an insight into how ANPs (Emergency) describe their professional identity will enable a greater understanding of this contemporary professional nursing role. This will inform future planning of nursing roles.
- Developing an insight into how ANPs (Emergency) describe their professional positionality, and exploring their experience of any practice-based tensions, would help to inform possible strategies for dealing with these tensions.

### **B4. Provide information on the study design.**

This study will use convenience sampling of fifteen ANPs (Emergency) in total across all sites. This is representative of approximately 30% of the target population. This is a significant sample population for a qualitative study but remains manageable to allow an appropriate depth of analysis. The narrative interviews will be given to me as the researcher at a location and time chosen by the respondent. This will ensure respect for the participants and the sites of research.

A requirement of this study will be to ensure that the ANPs are fully informed about the purpose and procedures of the study so that participants understand the nature of the study. The letter of introduction to my study and respondent reply form will be provided as detailed in the appendix. This method will ensure that anonymity and confidentiality for the participants are assured. It is appropriate ethical practice that informed written consent is given by the respondents and the written consent form is detailed in the appendix. The rights of the participants to withdraw from the study up to two weeks post narrative interview will be discussed prior to giving informed consent.

As best ethical practice dictates, a copy of this written consent will be given to the respondents.

The fifteen ANP (Emergency) respondents for the study will be asked verbally with the following request: 'I want to ask you to tell me about your perceptions of your role as an ANP (Emergency). The best way to do this would be for you to start from how you came to be an advanced nurse practitioner and then tell me all about what it is like for you being an advanced nurse practitioner from when you became an ANP up until today. You can take your time in doing this, and also give examples, because for me everything is of interest that is important to you.'

The verbal narrative will be audio-taped to enable transcription. I will personally transcribe the audio data in order to maintain confidentiality and anonymity. In cognisance that there is a small number of ANPs nationally, I will also remove any identifying elements to reduce the risk that the ANP would be recognizable by colleagues or others. Undertaking the transcription role personally will also enable me to gain a greater in-depth awareness of the data. Data analysis will utilise NVivo software which I have used in previous research and found effective in qualitative data analysis. I propose to return to the individual respondents during the data analysis stage to seek clarification and confirmation of emerging themes and concepts. This will add to the robustness of my data analysis.

## **B5. Provide information on the study methodology.**

My study seeks to gain narrative accounts of fifteen ANPs (Emergency) through narrative interview in order to explore advanced nurse practitioners' perceptions of their role, professional positionality and professional identity. Methodologically I propose using a narrative approach. Watson and Watson-Franke (1985, p.2) state that narrative 'is any retrospective account by the individual of his life in whole or part, in written or oral form, that was elicited or prompted by another person.' An individual person presents a biographical personal view of their experiences as they perceive them. It is said to represent a culturally produced account while at the same time being an interpretive document. It seems appropriate that in order to explore the ANPs' perceptions of their role, positionality and identity I need to gain insight into their worlds and culture from their perspective. The exploration of the ANPs' perceptions of their role, position and identity will be through the ANPs own narratives.

Data analysis will commence during the interview phase as I will add to the initial research question by probing elements which emerge during the narrator's storytelling. The cyclical nature of questioning and verifying in qualitative data analysis is important in order to discover meanings (Streubert and Carpenter 1999). I will use Miles and Huberman's (1994, p.9) sequential 'analytic moves'. These include affixing codes to the field notes drawn from the interviews; noting reflections on the transcripts; identifying similar phrases, patterns, themes and common sequences; isolating patterns; and developing commonalities and differences. These findings I will compare with constructs and theories. I will utilise NVivo software which I used in the pilot study and I found effective in conjunction with manual analysis.

I plan to return to the individual respondents during the data analysis stage to seek clarification and confirmation of emerging themes and concepts. This will add to the robustness of my data analysis. Following analysis the research findings will be finalised. Conclusions and recommendations will then be presented.

MILES, Matthew and HUBERMAN, A. Michael (1994) *Qualitative data analysis*. London, Sage.

STREUBERT, Helen and CARPENTER, Dona (1999) *Qualitative Research in Nursing: advancing the humanistic imperative*. New York, Lippincott.

WATSON, L. C. and WATSON-FRANKE, M. (1985) *Interpreting life histories*. New Brunswick, NJ. Rutgers University Press

**B6. What is the anticipated start date of this study?**

October 2012

**B7. What is the anticipated duration of this study?**

2 years

**B8 (a) How many research participants are to be recruited in total?**

Fifteen

**B8 (b) Provide information on the statistical approach to be used (if appropriate) / source of any statistical advice.**

No statistical approach is used

**B8 (c) Please justify the proposed sample size and provide details of its calculation (including minimum clinically important difference).**

This study sample size is fifteen participants which is approximately 35% of the target population. This sample size represents a high proportion for a qualitative study and is sufficient to gain a spectrum of views.

**B8 (d) Where sample size calculation is impossible (e.g. It is a pilot study and previous studies cannot be used to provide the required estimates) then please explain why the sample size to be used has been chosen.**

The sample size was selected as it represents approximately 35% of the target population. This sample size represents a high proportion for a qualitative study and is sufficient to gain a spectrum of views.

### 3 SECTION C study PARTICIPANTS

SECTION C IS MANDATORY

**IMPORTANT NOTE:** This application form permits the applicant to delete individual questions within each section depending on their response to the preceding questions. Please respond to each question carefully and refer to the accompanying *Guidance Manual* for more in-depth advice prior to deleting any question.

### 4 SECTION C1 PARTICIPANTS – SELECTION AND RECRUITMENT

**C1. 1 How many research participants are to be recruited? At each site (if applicable)? And in each treatment group of the study (if applicable)?**

Name of site:	Names of Treatment Group (if applicable)		
	Insert name of group:	Insert name of group:	Insert name of group:
	ANP		

	(EMERGENCY) - 5 STUDY PARTICIPANTS		
	ANP (EMERGENCY) - 10 STUDY PARTICIPANTS		

**C1.2 How will the participants in the study be selected?**

**A sample size of 15 ANPs (Emergency) are to be recruited nationally. The participants will voluntarily self select as a letter of invitation will be sent to ANPs (Emergency) in the area and it will be their choosing if they wish to become a participant. There is no formal gatekeeper involved.**

**C1.3 How will the participants in the study be recruited?**

**A request will be made through the DON (gatekeeper) to forward the letter of invitation and information to the ANP's employed in their area. The ANP's can then contact the researcher directly via the reply slip/contact details supplied.**

**C1.4 What are the main inclusion criteria for research participants? (please justify)**

**The main inclusion criteria for research participants are that they are registered with the Nursing and Midwifery Board of Ireland as an ANP (Emergency). ANP candidates who have completed training but are not yet registered with Nursing and Midwifery Board of Ireland are not eligible for inclusion in this study.**

**C1.5 What are the main exclusion criteria for research participants? (please justify)**

Not being registered with **The Nursing and Midwifery Board of Ireland** as an ANP (Emergency)

**C1.6 Will any participants recruited to this research study be simultaneously involved in any other research project?**

Not to my knowledge

## 5 SECTION C2 PARTICIPANTS – INFORMED CONSENT

**C2.1 (a) Will informed consent be obtained?**  Yes

**C2.1 (c) If yes, how will informed consent be obtained and by whom?**

By the researcher in written and verbal form following information giving – copy of consent form detailed in Appendix

**C2.1 (d) Will participants be informed of their right to refuse to participate and their right to withdraw from this research study?**

Yes, the participants will be informed verbally and in writing that participation is voluntary and that they have the right to withdraw from the study up to two weeks following the narrative interview.

**C2.1 (f) Will there be a time interval between giving information and seeking consent?**  Yes

**C2.1 (g) If yes, please elaborate.**

There will be a request that consent is sought at least 7 days following information giving to enable a period of reflection

## 6 SECTION C3 adult participants - CAPACITY

**C3.1 (a) Will all adult research participants have the capacity to give informed consent?**  Yes

## 7 SECTION c4 participants under the age of 18

**C4.1 (a) Will any research participants be under the age of 18 i.e. Children?**

No

## 8 SECTION C5 PARTICIPANTS - CHECKLIST

**Please confirm if any of the following groups will participate in this study. This is a quick checklist for research ethics committee members and it is recognised that not all groups in this listing will automatically be vulnerable or lacking in capacity.**

- C5.1 Patients  No
- C5.2 Unconscious patients  No
- C5.3 Current psychiatric in-patients  No
- C5.4 Patients in an emergency medical setting  No
- C5.5 Relatives / Carers of patients  No
- C5.6 Healthy Volunteers  No
- C5.7 Students  No
- C5.8 Employees / staff members  Yes
- C5.9 Prisoners  No
- C5.10 Residents of nursing homes  No
- C5.11 Pregnant women  yes
- C5.12 Women of child bearing potential  yes
- C5.13 Breastfeeding mothers  yes
- C5.14 Persons with an acquired brain injury  No
- C5.15 Intellectually impaired persons  No
- C5.16 Persons aged > 65 years  No

**C5.17 If yes to any of the above, what special arrangements have been made to deal with issues of consent and assent (if any)?**

Informed consent verbally and in writing is to be obtained. Consent form exemplar in the appendices. ANP (Emergency) staff members from the Emergency Department will be in a position to give informed consent. There is no hierarchical structure as being a colleague I am positioned on an equal status. My proposed study involves undertaking research with work colleagues as I am a registered nurse. However, I do not envisage any conflict of interest as the participants will be colleagues but they will not be working directly in my area of practice and therefore there will be no hierarchical management relationship involved between the participants and myself.

Support for respondents who are pregnant, of childbearing potential, or breastfeeding will be accorded appropriate measures to ensure their comfort and safety throughout the research process.

## 9 SECTION D Research PROCEDURES

### SECTION D IS MANDATORY

**IMPORTANT NOTE:** This application form permits the applicant to delete individual questions within each section depending on their response to the preceding questions. Please respond to each question carefully and refer to the accompanying *Guidance Manual* for more in-depth advice prior to deleting any question.

**D1. What research procedures or interventions (over and above those clinically indicated and/or over and above those which are part of routine care) will research participants undergo whilst participating in this study?**

ANPs will be participating in a narrative interview

**D2. If there are any potential harms resulting from any of the above listed procedures, provide details below:**

This proposed study involves the advanced nurse practitioners exploring their own personal perceptions about their role, professional positionality and professional identity. It is not anticipated that the narrations would raise controversial or sensitive issues for the participants. However cognisance is taken that this research approach may result in the surfacing of various emotions. Sensitivity to participants of this aspect will be incorporated into the research process and a list of support numbers will be given to the ANP if required. *These contacts will include details for Occupational Health Services and their local HSE Employee Assistance Programme (EAP) which is available to all employees for support with both personal and work-related concerns.*

**D3. What is the potential benefit that may occur as a result of this study?**

Dependent on the results, the potential benefit of this study is intended to increase nursing's body of knowledge through:

- Exploring how ANPs describe their transition from their previous nursing role to ANP, and knowing how easy or difficulty the transition, would be valuable as it could be used to assist in preparation for, and inform induction training for ANPs.
- Exploring ANPs' (Emergency) perceptions of their role will enable a greater understanding of the lived experiences of the ANPs' role. This will serve to inform both ANP candidates' course curriculum and ANPs continuing professional development.

- Developing an insight into how ANPs (Emergency) describe their professional identity will enable a greater understanding of this contemporary professional nursing role. This will inform future planning of nursing roles.
- Developing an insight into how ANPs (Emergency) describe their professional positionality, and exploring their experience of any practice-based tensions, would help to inform possible strategies for dealing with these tensions.

**D4 (a) Will the study involve the withholding of treatment?**

No

**D5. How will the health of participants be monitored during and after the study?**

As per application guidelines 'It is recognised that in many research studies, especially those involving staff members, monitoring of the health of participants is neither appropriate nor necessary' therefore normal adult interaction will apply.

**D6 (a) Will the interventions provided during the study be available if needed after the termination of the study?**  No

**D7. Please comment on how individual results will be managed.**

Creswell (1993) states that debriefing between the researcher and participation is required. Once I have transcribed the narratives, it is my intention to personally liaise with the individual ANPs with my initial thematic analysis in order to ensure I have interpreted their data to their satisfaction. This debriefing will promote validation through confirming accuracy of the data with my participants. A copy of the final submission report will be available to participants as requested as recommended as good ethical practice.

CRESWELL, John (2009) *Research design – qualitative, quantitative and mixed methods approaches*. 3<sup>rd</sup> ed. Thousand Island, CA, Sage.

**D8. Please comment on how aggregated study results will be made available.**

I confirm that a research report will be forwarded to the Nursing Research Access Committee/Chairperson on completion as required. I acknowledge that researchers will be expected to feed back results to the committee and relevant personnel. A copy of the report will be available to the fifteen ANPs. This will be then written in a thesis submitted to Sheffield Hallam University as part fulfillment for my

Doctorate in Education programme. Following successful completion I hope to produce articles for publication in peer reviewed nursing and educational journals.

**D9. Will the research participant's general practitioner be informed the research participant is taking part in the study (if appropriate)?**

**D10. Will the research participant's hospital consultant be informed the research participant is taking part in the study (if appropriate)?**

## 10 SECTION E data protection

SECTION E IS MANDATORY

**IMPORTANT NOTE:** This application form permits the applicant to delete individual questions within each section depending on their response to the preceding questions. Please respond to each question carefully and refer to the accompanying *Guidance Manual* for more in-depth advice prior to deleting any question.

### SECTION E1 data processing - consent

**E1.1 (a) Will consent be sought for the processing of data?**

## 12 SECTION E2 data processing - GENERAL

**E2.1 Who will have access to the data which is collected?**

Myself, Lisa Kerr, as the principal researcher will have access to the data which is collected. In addition Professor Ann Macaskill as my Director of Studies will have access to the collected data acting in the capacity of a research integrity moderator.

**E2.2 What media of data will be collected?**

Audio data – Dictaphone recording

**E2.3 (a) Would you class the data collected in this study as anonymous, irrevocably anonymised, pseudonymised, coded or identifiable data?**

Irrevocably anonymised

**E2.4 Where will data which is collected be stored?**

All hard data will be stored in a locked cupboard within my locked office.

**E2.5 Please comment on security measures which have been put in place to ensure the security of collected data.**

All data will be stored in accordance with the Data Protection Act. Electronic data, audio and text files will be stored in an encrypted password protected location on my personal computer which is not accessible to other personnel. All hard data will be stored in a locked cupboard within my locked office.

**E2.6 (a) Will data collected be at any stage leaving the site of origin?**

Yes

**E2.6 (b) If yes, please elaborate.**

The audio data will be transported by the researcher personally to her office where it will be transcribed, analysed and stored in her locked office

**E2.7 Where will data analysis take place and who will perform data analysis (if known)?**

The audio data will be personally analysed by the researcher in her office.

**E2.8 (a) After data analysis has taken place, will data be destroyed or retained?**

Retained

**E2.8 (b) Please elaborate.**

Retained for the required period of 7 years

**E2.8 (d) If retained, for how long, for what purpose, and where will it be retained?**

The data will be retained in the University research archive facility in an anonymised form for 7 years.

**E2.9 Please comment on the confidentiality of collected data.**

Names and any identifying characteristics of participants, locations or other personnel will be anonymised to protect identities. In cognisance that there is a limited number of ANPs nationally, I will also remove any identifying elements thereby reducing the risk that the ANPs would be recognizable by colleagues or others. In line with other nursing research studies, respondents will be referred to in a female gender. The rationale is based upon the fact that the majority of ANPs are female and if a male term was used this would increase the likelihood of potential identification.

**E2.10 (a) Will any of the interview data collected consist of audio recordings / video recordings?**  Yes

**E2.10 (b) If yes, will participants be given the opportunity to review and amend transcripts of the tapes?**

Yes

**E2.11 (a) Will any of the study data collected consist of photographs/ video recordings?**  No

**SECTION e3 ACCESS TO HEALTHCARE RECORDS**

**E3.1 (a) Does the study involve access to healthcare records (hard copy / electronic)?**  No

**14 SECTION f HUMAN BIOLOGICAL MATERIAL**

## **15 f1Bodily Tissue / Bodily Fluid Samples - general**

**F1 1 (a) Does this study involve human biological material?**

**No**

If answer is No. Please delete following questions in Section F.

## **16 section G radioactive material / diagnostic or therapeutic ionising radiation**

## **17 G1 radioactive material / diagnostic or therapeutic ionising radiation - general**

**G1.1 (a) Does this study/trial involve exposure to radioactive materials or does this study/trial involve other diagnostic or therapeutic ionising radiation?**  **No**

## **18 SECTION H MEDICAL DEVICES**

**H1 (a) Is the focus of this study/trial to investigate/evaluate a medical device?**  **No**

## **SECTION I MEDICINAL PRODUCTS / COSMETICS / FOOD AND FOODSTUFFS**

Section I is designed to assist applicants in ascertaining if their research study is in fact a clinical trial of a medicinal product. Section I is optional. Please delete if this section does not apply.

## **20 SECTION I.1 NON-INTERVENTIONAL TRIALS OF MEDICINAL PRODUCTS**

**I1.1 (a) Does this study involve a medicinal product?**  **No**

## **21 SECTION j INDEMNITY**

SECTION J IS MANDATORY

**IMPORTANT NOTE:** This application form permits the applicant to delete individual questions within each section depending on their response to the preceding questions. Please respond to each question carefully and refer to the accompanying *Guidance Manual* for more in-depth advice prior to deleting any question.

**J1 (a) Is each site in which this study is to take place covered by the Clinical Indemnity Scheme (CIS)?**  Yes

**J2 (a) Is each member of the investigative team covered by the Clinical Indemnity Scheme (CIS)?**  No

**J2 (b) If no, do members of the investigative team not covered by the Clinical Indemnity Scheme (CIS) have either current individual medical malpractice insurance (applies to medical practitioners) or current professional liability insurance either individually or as provided by their hosting/employing institution (generally applies to allied healthcare professionals, university employees, scientists engineers etc.)?**

I have professional liability insurance as an individual through membership of the Irish Nurses and Midwives Organisation. Insurance letter attached (postal copy).

**J3 (a) Who or what legal entity is the sponsor of this research study?**

Sheffield Hallam University

**J3 (b) What additional indemnity arrangements has the sponsor put in place for this research study in case of harm being caused to a research participant (if any)?**

I have professional liability insurance through the Irish Nurses and Midwives Organisation as a member appropriate to doctoral student practice.

## **22 SECTION K COST AND RESOURCE IMPLICATIONS and funding**

SECTION K IS MANDATORY

**IMPORTANT NOTE:** This application form permits the applicant to delete individual questions within each section depending on their response to the preceding questions. Please respond to each question carefully and refer to the accompanying *Guidance Manual* for more in-depth advice prior to deleting any question.

**K1 (a) Are there any cost / resource implications related to this study?**  No

**K2 (a) Is funding in place to conduct this study?**  Yes

**K2 (c) Please state the source of funding (industry, grant or other) and the amount of funding.**

I am self funding

**K2 (d) Is the study being funded by an external agency?**  No

## 23 SECTION I ETHICAL ISSUES

### SECTION L IS MANDATORY

**L1. Please identify any particular additional ethical issues that this project raises and discuss how you have addressed them.**

A formal consent form declaring participants' consent will be signed by the participants and me. As best research ethical practice dictates a copy of the consent form will be given to each participant for their records. The right of each individual ANP not to participate or to withdraw up to two weeks after giving the narrative interview will be discussed by me with the respondents verbally and in written media as illustrated in the appendix.

Creswell (1993) states that debriefing between the researcher and participation is required. Once I have transcribed the narratives, it is my intention to personally liaise with the individual ANPs with my initial thematic analysis in order to ensure I have interpreted their data to their satisfaction. This debriefing will promote validation through confirming accuracy of the data with my participants and across different data sources. A copy of the final submission report will be available to participants as recommended as good ethical practice. This proposed study involves the advanced

nurse practitioners exploring their own personal perceptions about their role, professional positionality and professional identity. It is not anticipated that the narrations would raise any controversial or sensitive issues for the participants. However as a precaution I will have a list of support personnel available for the ANP, if required, following the narrative interview. It is not anticipated that there will be any specific negative consequences of participation in this research. My proposed study involves undertaking research with colleagues as I am a registered nurse. However, I do not envisage any conflict of interest as the participants will be colleagues but they will not be working directly in my area of practice and therefore there will be no hierarchical management relationship involved between the participants and myself.

At the briefing stage before the narrative interview commences I will discuss with the respondents that in the unlikely event of anything untoward regarding poor practice being revealed during the interview I will be duty bound to discuss this with their supervisor. It will be acknowledged that this will be a highly unlikely occurrence.

Names and any identifying characteristics of participants, locations or other personnel will be anonymised to protect identities. In cognisance that there is a limited number of ANPs nationally, I will also remove any identifying elements thereby reducing the risk that the ANPs would be recognizable by colleagues or others. In line with other studies, respondents will be referred to in a female gender. The rationale is based upon the fact that the majority of ANPs are female and if a male term was used this would increase the likelihood of potential identification.

All data will be stored in accordance with the Data Protection Act. Electronic data, audio and text files will be stored in an encrypted password protected location on my personal computer which is not accessible to other personnel. All hard data will be stored in a locked cupboard within my locked office. Upon completion of the study the data will be securely archived in the university facility.

I have study approval from Sheffield Hallam University.

### **Appendices**

- 1. Participant Information Leaflet**
- 2. Participant Contact Leaflet**
- 3. Informed Consent Form**

Date

Dear Advanced Nurse Practitioner (Emergency),

**Research Study Title: Advanced Nurse Practitioners' (Emergency) perceptions of their role, positionality and professional identity**

Thank you for taking the time to read my introductory letter, and I hope that you will consider taking part in my study. My name is Lisa Kerr and I am the researcher for this study. I am a Registered General Nurse and Nurse Tutor in Ireland and I am currently studying for a Doctorate in Education at Sheffield Hallam University. This research forms part of my studies.

The aim of the study is to explore advanced nurse practitioners' perceptions of their role, positionality and identity. Across Ireland I am hoping to ask fifteen ANPs (Emergency) to provide their thoughts through a narrative approach that seeks to explore ANPs' perceptions of their role, positionality and identity as an ANP.

The verbal narrative interview will be conducted at a venue and time that is convenient to you. It is anticipated that this will take one meeting but additional meetings can occur if you wish. The length of the meeting will be decided by you. The narrative interview will be audio-taped for transcription purposes by me and once the data is analysed I will return personally via email/telephone to you to seek confirmation of the accuracy of the emerging themes.

Participation in this research is voluntary and you have the right to withhold information and *withdraw from the study up to two weeks post narrative interview.* Any information that is given will be anonymised and any identifying elements will be removed. All information will be treated in the strictest confidence in line with An Bord Altranais (2007) ethical principles. Confidentiality is conditional in that I am duty bound to report any allegations of professional misconduct and in the unlikely event of anything untoward being revealed during the interview I will be required to report this with your supervisor. I acknowledge that is a very highly unlikely occurrence.

Continued overleaf<sup>4</sup>

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This study has been granted study and ethical approval by Sheffield Hallam University. In addition I am in the process of seeking access and ethical board approval from the HSE North East. On completion I will be submitting the thesis to Sheffield Hallam University and a summary report to the Nursing Research Access Committee if required. Following successful completion I hope to produce articles for publication in peer reviewed nursing and educational journals. The study report and articles will be available to you if you would like them.

Given the importance of this study I would value your support in conducting it and hope very much that you will be willing to take part. If you are willing to participate in this study, please could you reply via email/telephone and I will then contact you directly. If you would like any additional information please do not hesitate to contact me on 087-6442859 or [Lisa.M.Kerr2@student.shu.ac.uk](mailto:Lisa.M.Kerr2@student.shu.ac.uk).

I would like to thank you for taking the time to read this introductory letter and I hope that you will choose to participate in my research study. If you would be interested in participating please can you return the reply slip at your earliest convenience, with many thanks.  
Yours sincerely,

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Lisa Kerr  
Nurse Researcher

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Reply slip

I would be willing to be a participant in the study entitled 'Advanced Nurse Practitioners' (Emergency) perceptions of their role, positionality and professional identity' and I give my permission to be contacted by Lisa Kerr, the nurse researcher. Please email/telephone your details and I will contact you directly – if you could specify the mode and time which is more convenient for you to be contacted, I would be very grateful, with many thanks, Lisa

**Contact Details**

**Name:** \_\_\_\_\_

**Email address:** \_\_\_\_\_

**Telephone number:** \_\_\_\_\_

**Preferred mode of contact:**

- Telephone
- Email

**Preferred time if via telephone:** \_\_\_\_\_

**CONSENT FOR PARTICIPATION IN THE RESEARCH STUDY**

**STUDY PROJECT:** Advanced Nurse Practitioners' (Emergency) perceptions of their role, positionality and professional identity

**PRINCIPAL INVESTIGATOR:** Lisa Kerr

This research study is undertaken by the principal investigator as part fulfilment for a Doctorate in Education award at Sheffield Hallam University. The overall aim of this study is to produce a focused insight into advanced nurse practitioners' perceptions of their role, professional positionality and professional identity. Participation involves the respondent taking part in a focused verbal narrative which will be audio-taped with Lisa Kerr, the nurse researcher. This meeting will be conducted at a time and venue chosen by the respondent. The study adheres to the principles of ethical conduct for nurse researchers with respect for persons/autonomy, beneficence, non-maleficence, justice/fairness, veracity, fidelity and confidentiality (An Bord Altranais 2007) and has been granted Ethical Board approval from Sheffield Hallam University and the respondent's Ethics and Access Committees.

**DECLARATION:**

I have read, or had read to me, the information leaflet for this study and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study. I understand that I do not have to participate in this research and that I may withdraw from the study and have the data destroyed if wished up to two weeks after giving the narrative interview. I have received a copy of this agreement.

**PARTICIPANT'S NAME:** .....

**CONTACT DETAILS:** .....

**PARTICIPANT'S SIGNATURE:** .....

**Date:** .....

Continued overleaf

**Statement of investigator's responsibility:**

I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

**INVESTIGATOR'S SIGNATURE: .....Date<sup>5</sup>: .....**

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**Appendix N**  
**Framework of Criteria for Rigor in Qualitative Research**  
**adapted from: Elliott, Fischer and Rennie (1999)**

<b>Guideline</b>	<b>Rationale</b>	<b>Evidence of Achievement</b>
1. Owning one's perspective.	Disclosure and recognition of values, interests and assumptions and the role these play in the understanding (reflexivity).	Chapter 2 Background to the study details my position and reflections on my assumptions of ANPs role, position and identity. Reflexivity was maintained by my reflective journaling through diary entries and field notes as illustrated in Appendices H and K. My decision making trail is illustrated in Appendix L
2. Situating the sample.	Detailed description of participants and their life circumstances.	Chapter 5 details the study's research design (p69-88) provides a detailed description of the participants' demographic data (p74). The findings in Chapter 6 build on these details and discuss all participants' holistic life circumstances.
3. Grounding in examples.	Using examples of the data to provide evidence of the analytic procedures used in the study and the analysis and interpretations.	I personally transcribed the narratives which enabled accurate representation of the narrative data. Chapter 6 (p89-126) details the presentation of the findings and uses examples from the text-rich narrative data to substantiate the findings raised. The use of content analysis to code and categorise the data is illustrated in Appendices J, K and L. Chapters 7 & 8 Discussion, Recommendations, Conclusions provides evidence of the study's analytical procedures, analysis and interpretations.
4. Providing credibility checks.	Accuracy checking with the original participants; or in relation to different methods of analysis.	Upon completion of content analysis I returned to three original participants and sought their confirmation of the categories and themes that had emerged as detailed in Chapter 5 Research Design. The participants responded that the themes and categories were in

		their opinion accurate and appropriate. I maintained coherence in the telling of the participants' stories and accomplished the specific focus of this study's aims and objectives
5. Coherence.	Findings are presented in a coherent and integrated manner that preserves nuances in the data (e.g. through a story/narrative, framework, map or underlying structure).	Chapter 6 presents the findings and multiple examples from across all the narrative data are illustrated to provide evidence of grounding the analysis and interpretation in the data. A content analysis structure was used to code and categorise the data to ensure comprehension in narrative mapping as illustrated in appendices I, J, K and L.
6. Accomplishing general vs. specific research tasks.	Specifically stating the research objective (e.g. if the researcher aims to produce a general understanding then focus should be on a number of suitable instances; if the focus is on a specific case then comprehensive analysis should be carried out.	The clear research aim and research question is presented throughout the study. Chapters 4-5 illustrated this study's research tasks.
7. Resonating with readers.	The research should stimulate resonance in the reader. Specifically the research should be presented in a way to expand or clarify understanding of the research topic.	Chapter 2 (Background) and Chapter 3 (Literature Review) present the rationale for the study to expand and clarify understanding of the ANP (Emergency) role, position and identity. Chapter 7 Discussion, Recommendations and Conclusions presented the reader with further development of understanding and insight into ANPs' role, positionality and professional identity.