

An exploration of advanced nursing  
in a hospital context:  
People, Processes, Frameworks

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**Abstract: An exploration of advanced nursing in a hospital context: People, Processes, Frameworks. Hilary Walsgrove**

This thesis for Doctor of Professional Practice (DProf) Health and Social Care presents a study with synthesis of in-depth research, conducted simultaneously with practice development (PD), informed by a relevant literature review. Exploration of advanced nursing, with a valuable addition to local and national discussion of advanced nurses; their roles and positive contributions to patient care and health service delivery is presented. Whilst contextual, this work also adds to international understanding of advanced nursing and its practice. The most significant contribution to knowledge, is a model of advanced nursing, created from synergy of the PD and research. This helps unravel some of the mystery around the concept, whilst contributing a tool for articulating professional identity and a framework for being an advanced nurse in the hospital context.

Advanced nurses practice is at a higher level compared to entry-level registrant nurses, with a greater degree of independent and autonomous practice. This draws on advanced skills and a knowledge-base enabling leadership of holistic patient assessment, critical reasoning and diagnostic decision-making that is often complex and unpredictable, within the context of individualised, person-centred care. The ever-changing, challenging political and professional environment of the United Kingdom [UK] National Health Service [NHS] is characterised by increasing workforce demands and population requirements for complex healthcare practices. Advanced nursing has responded by evolving and adapting innovatively, to help meet care deficits and gaps in services.

The study commenced with two inter-linked PD projects. Project 1 [PD1]: 'Specialised Nurse Review' [SNR] based in an acute hospital focused on production and implementation of an advanced nursing framework. Project 2 [PD2] involved leading on education curriculum development for advanced nursing, at a local university. The PD successfully increased interest in and facilitated better understanding of advanced nursing, and supported role and practice development, alongside development of relevant education, all aimed at improving care and healthcare service delivery. Parallel to and drawing on PD1 and PD2, was a qualitative research study, which explored experiences of being an advanced nurse in the same hospital, using Interpretative Phenomenological Analysis (IPA). The research culminated in creation of an original

advanced nursing model, conceptualised by three core, synthesised themes. Firstly, the four pillars of advanced practice, which enabled the advanced nurses' practice to be extrapolated and categorised. The two further themes of the 6Cs nursing values and dimensions of humanisation encapsulated the strong nursing and caring focus, at the heart of how they function. The model offers an innovative interpretation of advanced nursing features, underpinned by the intertwined themes. These were relatively new concepts that had not been applied to advanced nursing, in this synthesised manner previously.

Throughout the DProf personal narrative articulated my lived experience, aiding development of my personal model of advanced nurse, practice developer, educator and researcher. Building contemplative scholarship resulted in my embodiment as a 'scholarly professional' embedded in advanced nursing. This has been a dynamic, transformative process, fostering appreciation of how this study can and is contributing locally and beyond, to development of advanced nursing. With increased confidence and capabilities, my personal contributions were recognised, through the research and PD, resulting in me leading and managing two additional PD projects, alongside participation in linked initiatives, regionally and nationally. The first of these, mirrored PD1, albeit within another hospital and the second was further validation of the advanced practice education curriculum originally developed through PD2. Thus, on reaching the final DProf destination, a new, enriched journey of advanced nursing is in motion.

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## **Chapter 1 Introducing this Doctor of Professional Practice (DProf) and setting the scene for the thesis**

### **1.1 Introduction**

This thesis of Doctor of Professional Practice, hereafter called DProf, presents exploration and development of advanced nursing through a specific hospital setting. The research was conducted in parallel with practice development within my workplace settings of the hospital where the research was conducted and the university, local to the hospital. The study was informed by a robust literature review, which provided insight into relevant research, grey literature, systematic reviews, and practice and service development initiatives. This was further supported by anecdotal evidence from colleagues and other interested parties, and personal immersion in advanced nursing through my professional role. Significant contributions to the knowledge-base resulted from this work, which have become my unique selling point, as an advanced nurse. This included the newly created conceptual model of advanced nurse, with the four pillars of advanced practice (NHS Education for Scotland [NES] 2010), underpinned by humanisation dimensions (Todres et al 2009) and 6Cs nursing values (Department of Health [DH] 2012), as its core themes. Alongside this work, there were ongoing practice and role developments (all focused on advanced nursing and its practice) concomitantly realised.

Meeting the aims and objectives (Section 1.2), resulted in achievement of the overarching goal of exploring advanced nursing in a hospital context, through synthesis of all four DProf elements, illustrated in Figure 1, p. 6. Figure 4 (Section 8.1) built on figure 1 from activities undertaken in the end stage of this DProf. This involved additional outcomes, including two further cycles of PD, not anticipated at the start and which are beyond the scope of this thesis. This was all instrumental in harnessing a positive impact of the whole study locally and further afield. This was pivotal to my leadership and participation in creation and brokering of knowledge, supporting development of advanced nursing, subsequent to and resulting from the original study.

Key to a professional doctorate is academic and professional development within the individual's professional context. Thus, I maintain personal presence throughout, advocated by authors, including Gilgun (2010), to acknowledge personal inclusion and presence throughout such a scholarly journey. Personal narrative supported my implicit, active role in achieving goals within and alongside the study, ultimately making

a meaningful contribution to advanced nursing knowledge and practice. Personal narrative in written format best suits the approach to sharing participants' and my own experiences and is distinguishable by speech marks ("..."). It is interspersed across the thesis, but also in a distinct personal narrative chapter (Chapter 2), to enable logical, chronological flow of the reflective and reflexive journey. This is accompanied with explanatory notes and critical analysis, in a quest to understand, interpret and chart events on the study's voyage of enquiry and discovery, which are implicit to the DProf elements. Reflective accounts of my academic and professional practice development reveal a scholarly professional by the end of the journey, who has contributed significantly to the knowledge-base and development of advanced nursing locally and is influencing ongoing developments locally, regionally and nationally. .

This commences with '*situating self within this DProf.*' (Section 1.3), highlighting particular significance of advanced nursing, as it represents my own professional practice and that of the research and PD participants. This narrative culminates in chapter 8, with reflection on the unique, significant contributions made and reaching the final destination and the onward journey. This is steeped in a consistent, strong focus on advanced nursing, its development and contributions to its knowledge-base, and broadening of the advanced practice concept for non-nursing advanced practice roles.

Broadly speaking and briefly described in the abstract, advanced nursing is referred to as practice significantly beyond that expected of a registered nurse on initial registration. For the UK, which is the setting for this study, registration is with the Nursing and Midwifery Council [NMC] (NMC 2015). Within this introductory chapter, relevant historical, professional and political aspects of advanced nursing set the scene and contextualise this study. Key concepts and people, processes and frameworks that feature throughout this work are briefly discussed and the three themes that emerged from the research are introduced as the four pillars of advanced practice, 6Cs nursing values and humanisation dimensions. Advanced nurse and advanced nursing are mostly used to distinguish the different level of registered nurse and practice that is the focus of this study. A significant proportion of PD participants, some of whom became the research participants, have the title Advanced Nurse Practitioner [ANP], also used for the academic programme at the university, so this is utilised here. Consultant nurse [CN] tends to distinguish a higher level on the advanced practice continuum, invariably describing a more senior role, with wider function of consultancy and leadership than that expected of most advanced nurses, such as ANPs. One

research participant sits under the overarching umbrella of advanced nurse, but fits this category and is referred to by job title of CN.

The PD consisted of two inter-linked initiatives. PD project 1 [PD1]: 'Specialised Nurse Review' [SNR], was a review of non-standard clinical nursing roles in the acute hospital and subsequent development of an advanced nursing framework for the organisation. PD Project 2 [PD2]: 'Advanced Practice education curriculum development' was a new education programme developed at the university whose catchment area included the hospital where PD1 was undertaken and was strongly informed by this hospital project. Chapter 3 covers the projects in more detail. As a result of this PD and the literature review, I co-authored a book chapter on advanced practice careers and career development. These combined endeavours were implicit to undertaking the qualitative research study. The research became inseparable from the PD, leading to a synthesised entity contributing to the knowledge-base, from the synergy of these two elements, supported by the literature review. This was a relatively novel study to have pursued, particularly for advanced nursing, where individual PD or research studies are more prevalent. There is no current evidence of a model of advanced nursing with synthesis of the four pillars of advanced practice, humanisation dimensions and 6Cs nursing values, as its framework. Hence, my quest, through this innovative, creative approach, was to contribute something original and valuable to the knowledge-base of advanced nursing, which is what resulted and which is captured within this thesis.

## 1.2 Aims and objectives of this DProf

Aims and objectives were considered, enhanced through reflective discussions with fellow students, tutors, and colleagues at the hospital and university, who contributed valuable thoughts and ideas. At the heart of this DProf is exploration of theory and practice, identifying and acting on innovations to improve care, whilst maintaining values inherent to humanisation and 6Cs values pertinent to advanced nursing.

<p><b>Aim 1:</b> To create a body of work of academic and professional practice that demonstrates coherence across the four elements, culminating in presentation and defence of the doctoral thesis.</p>	<p><b>Doctoral thesis objectives:</b></p> <ol style="list-style-type: none"> <li>1. To meet DProf milestones of first review, progression report, final presentation and defence of thesis with advanced nursing as the main subject area.</li> <li>2. To create a conceptual model of advanced nurse, within the four pillars of advanced practice, using this model as a template for other advanced nurses, developed from academic and professional practice work, with an underpinning of humanisation and 6Cs values basis</li> </ol>
<p><b>Aim 2:</b> To conduct a literature review of advanced nursing and its practice to inform the DProf, its practice development and research elements.</p>	<p><b>Literature review objectives:</b></p> <ol style="list-style-type: none"> <li>1. Conduct staged literature review of advanced nursing, as basis for the DProf and to inform PD and research (stage 1).</li> <li>2. Undertake an-going review of literature for understanding and application of reflective practice, personal narrative and personal development.</li> <li>3. Review literature to inform the selection and use of research methodology, processes and methods and plan research study in line with this.</li> <li>4. Conduct robust literature review for research study (stage 2 and updated) and inform ongoing data analysis and findings.</li> </ol>
<p><b>Aim 3:</b> To undertake Practice Development (PD) that contributes to new, innovative, improved ways of working related to advanced nursing and its practice.</p> <p>A. Within the hospital where I work (PD Project 1)  B. At the university where I work (PD Project 2)</p>	<p><b>Practice development objectives:</b></p> <p>A. Undertake PD project 1: Specialised Nurse Review (SNR) with project team at hospital, based on PD methodology and action research.</p> <p>A1. Identify, review, evaluate SNR participants roles and service delivery to create a hospital framework that meets organisational and professional requirements.</p> <p>A2. Write up project report with other project team members and present at strategic level within hospital.</p> <p>A3. Act as expert advisor on advanced nursing and education, advise, guide, support individuals and teams with changes to services/roles.</p> <p>A4. Devise and implement hospital education strategy for advanced and specialist nurses, based on findings from project.</p> <p>A5. Disseminate framework locally and widely - regional and national networks.</p> <p>A6. 2nd cycle of project in different hospital (added 2016).</p>

	<p>B. PD Project 2: Develop advanced nursing practice education curriculum, work towards validation and delivery</p> <p>B1. Use knowledge and data from literature review and PD1 to inform curriculum development.</p> <p>B2. Commence delivery of new programme, monitor and evaluate 1st cohort who graduate, continue to monitor and evaluate programme as continues.</p> <p>B3. Use literature review and PD Project 1 and knowledge generated from book chapter as addition to content for programme delivery.</p> <p>B4. Disseminate regionally, nationally, Internationally, write up progress in thesis.</p> <p>B5. 2nd cycle PD project 2, building on success of programme in line with new national framework, demand for broader advanced nurse programme and parallel programme for allied health professionals - lead validation and delivery of revised and new programmes (added objective 2016/17).</p>
<p><b>Aim 4:</b> To conduct research study using PD as foundation and informing research, at the forefront of advanced nursing, making a contribution to its knowledge-base, with new knowledge generation, aimed at improving professional practice, underpinned by humanisation and 6Cs nursing values.</p>	<p><b>Research objectives:</b></p> <ol style="list-style-type: none"> <li>1. Present research proposal, gain ethics approval for study.</li> <li>2. Utilise Interpretative Phenomenological Analysis (IPA) methodology, to explore experiences of advanced nurses who were participants PD Project 1.</li> <li>3. Report findings and discussion in line with IPA methodology and draw together outputs from synergy of Research and PD.</li> <li>4. Researcher diary - charts development, support enquiry.</li> <li>5. Develop researcher skills and chart development in personal narrative.</li> <li>6. Contribute to knowledge of advanced nursing through research and PD.</li> <li>7. Disseminate new and developing advanced nursing knowledge locally, nationally, International through networks, presentations, publication</li> </ol>
<p><b>Aim 5:</b> To conceptualise and reflectively articulate personal narrative, charting my post-graduate researcher journey, demonstrating contemplative scholarship, in relation to professional practice of advanced nursing, its education and research</p>	<p><b>Personal narrative objectives:</b></p> <ol style="list-style-type: none"> <li>1. Review literature of personal narrative, reflection, reflexivity, develop knowledge and understanding to doctoral level and apply to personal narrative writing.</li> <li>2. Build and achieve mastery of reflective and reflexive skills based on three levels of reflexivity - personal, relational, organisation/system, embedded within the context of professional practice role informed by 1, developing contemplative scholarship to doctoral level.</li> <li>3. Reflect on significant stages progressing towards completion of DProf, as a researching professional, using personal narrative to demonstrate development and mastery of new academic and professional practice skills, through my holistic lifeworld and emergent knowledge-base.</li> </ol>

Table 1: Aims and objectives for this DProf

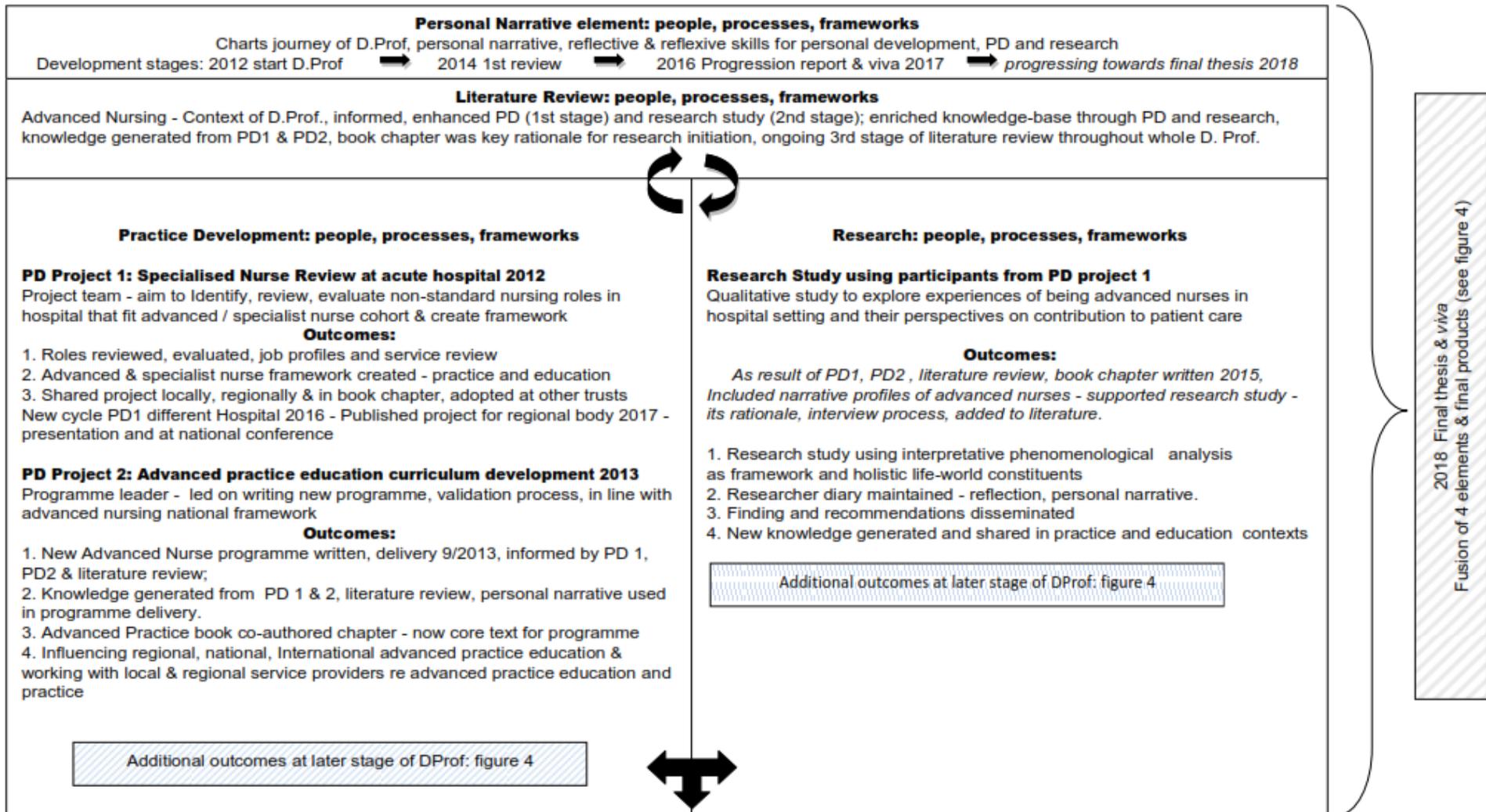


Figure 1 Elements of DProf: An exploration of advanced nursing in a hospital context

### 1.3 Situating self within this DProf

"I am situating myself here, as doctoral student and researcher, which I feel is significant to understanding my context and DProf aspirations and actions. Fifteen years after qualifying as a Registered Nurse, I undertook a Nurse Practitioner degree and consolidated skills and knowledge at an advanced level of nursing, congruent with the four pillars of advanced practice. A Masters degree in practice development, enhanced practice development and leadership/management skills and provided an opportunity to conduct a practice development project focused on advanced nurses (Walsgrove and Fulbrook 2005). A practice education qualification supported progression into programme leader for the Advanced Nurse Practitioner course. I remain in a joint role between hospital and university, as lead advanced nurse and academic programme leader.

On reflection, I had good experience and knowledge and desire to link this with new experiences and learning that would, in time, inform all areas of advanced nursing, including my own advanced nursing role. In my hospital role, I was invited to be a member of PD1's project team. Simultaneously, as course leader at the university, I was rewriting the advanced nurse practitioner programme [PD2]. This gave me impetus to embark on this doctoral journey, with a desire to undertake doctoral level studies, whilst ensuring whatever I did had a practice focus. At the first hospital project group meeting, a comment from a senior nurse colleague, *"you should make a doctorate out of this project,"* gave me the push I needed. Thus my journey began.(11/2011).

The opportunity to positively contribute to patient care, significant benefits being seen where advanced nurses are employed, was the main rationale for selecting the topic. This is to be found in the literature and comes from immersion in advanced nursing and experiences of healthcare communities I am part of. Concomitantly, there is lack of understanding of advanced nursing, confusion and misconceptions, within the local and wider context. As a result, the advanced nurses themselves, do not function within a coherent framework and thus lack a clear professional identity that harnesses what being an advanced nurse is. It is through research into practice that a body of knowledge, in this case, advanced nursing, can be enriched. Additionally, being an advanced nurse and educator and developing practitioner researcher makes the DProf an appropriate academic pathway for me to follow, offering further personal rationale for its pursuit." (4/2012)

#### **1.4 Historical, professional, political context of advanced nursing for this study**

The evolution and understanding of advanced nursing and its practice, as a developing healthcare paradigm, has been a long and complex journey, encompassing diversity and multiple ways of delivering care and contributing to healthcare service delivery. Evidence presents emergence, adaptation and development of advanced nursing aimed at improving patient care and enhancing healthcare service delivery, such as that reported by Marsden et al (2003) and Callaghan (2008). The reported innovative and flexibly developed initiatives, although displaying positive outcomes, have also led to an unclear picture of what advanced nursing is. This has led to confusion and misconceptions about the concept and its potential benefits, which played a part in the initiation of PD1 and the research for this DProf study.

Historically, clinical nurse specialists, rooted within nursing practice, are argued to be the starting point for advanced nursing. Advanced nursing, more akin to the model incorporating elements traditionally associated with medical practice, started in the 1960s in the United States of America [USA], by Ford and Silver (1967). As argued by Daly and Carnwell (2003), this tended to shift from the primary focus of nursing care embedded within specialist nurse roles, towards more advanced generalist ones that were absorbing more medically-focused aspects. From origins in the USA, initially in primary care, and at the interface between medicine and nursing, spread of advanced nursing spanned the globe over the next thirty years.

Advanced nursing within the UK dates back to around the 1980s when nurses looked to the USA and other nations, in a similar pursuit to improve patient care and fill gaps in an ever-changing health service. The first reported 'nurse practitioner' (now ANP) in the UK, was Barbara Stilwell who developed her role in response to deficits in healthcare services for Muslim women in Birmingham (Stilwell 1982). She identified potential for advanced nursing to make a positive contribution to patient care within primary care. Barbara Burke-Masters (1986) developed a largely doctor substitution role, similar to Stilwell's, aimed at meeting healthcare needs of homeless alcoholics in London. From late 1980s onwards in the UK, advanced nursing roles arose in both primary and secondary care settings, similarly, in response to addressing healthcare deficits.

A number of definitions of advanced nursing have been proposed over the years. From a global perspective, the International Council of Nurses' [ICN] / Advanced Practice Nurse Network [APNN] definition of advanced nurse as:

*"...registered nurse who has acquired the expert knowledge-base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and country in which s/he is credentialed to practice. A Masters degree is recommended for entry level"* (ICN/APNN 2002).

This acknowledges variations, depending on contexts of roles and advocates Masters level education as a minimum. (In 2018, this continues as ICN/APNN's published definition, remaining in the original form since inception).

For the UK, the Royal College of Nursing [RCN] definition was similar to ICN/APNN (2002), but included:

*"..a registered nurse ...who makes professional autonomous decisions,..receives patients with undifferentiated and undiagnosed problems and makes an assessment of their health care needs,..including skills not usually exercised by nurses, such as physical examination..."* (RCN 2002, page 2).

These and other definitions have been useful but remained as guidance rather than being definitive, as a static, prescribed basis for advanced nursing in the UK. However, they continued to influence and provide a starting point for frameworks and models that subsequently developed, such as the revised RCN (2008) ANP domains and competencies and the DH (2010) Advanced level nursing document.

The hallmark of advanced nursing roles came to be largely based on exercising increased professional autonomy with patient management, distinguished from other registered nurses, through higher level practice. The central facet was the clinical component, delivered through a range of diverse roles and working for patient and healthcare service benefits (Schober and Affara 2006). However, in the UK in the 1990s and early 2000s, debate remained parochial. The focus was on describing specific roles invariably through nebulous titles, in an unregulated attempt to carve out an identity of its own, as distinct from its origins embedded in medical practice. This was accompanied by activities aimed at comparing practice of doctors with advanced nurses, in an effort to demonstrate their worth and position in a healthcare professional hierarchy dominated by medicine.

Interest and support for advanced nursing development has been variable and inconsistent across the UK, in relation to levels of acceptance and resources to enable new roles and ways of working to be initiated and implemented. There are examples of nurses creating and attempting to define distinct roles for themselves, often in unwelcoming, inhospitable practice contexts. This required and continues to demand well-developed negotiation skills and personal attributes including resilience, assertiveness, courage and determination (Maclellan et al 2016). There have been reports of opposition to advanced nursing roles from doctors and allied health professionals, and nurses themselves (Lloyd-Jones 2004). This has led to challenges to role and service developments and struggles for advanced nurses in gaining acceptance and support (Yeager 2010). There are numerous exemplars that highlight issues of power, powerlessness and political issues, invariably linked to the considered place within the healthcare team's hierarchy for advanced nurses. Situations are described where medical colleagues, other nurses and allied health professionals have exerted negative influences, in terms of perceived positional power within organisational cultures, which have challenged advanced nursing, thwarting individuals' attempts to develop.

Despite such a political and cultural climate, there are also numerous examples of strongly collaborative, positive developments of advanced nursing roles, characterised by good working relationships with medical colleagues and other stakeholders, including the hospital where PD1 was conducted. At this hospital, in the 1990s, a number of nurses were employed as nurse practitioners [ANPs]. This was in direct response to reduction in junior doctors hours and deficits in assessing and managing patients that this created. They were employed as largely doctor substitute roles in these early years, with impetus for creating these roles coming mainly from a supportive medical consultant body and forward-thinking strategic-level nursing team. They were attached to medical teams, working in roles similar to that of junior doctors, initially with limited professional autonomy and independence. They received in-house training from medical staff targeted to task-driven requirements of the role; this was in lieu of any available education or training in the local area at the time. There were instances of power struggles and barriers created that affected the progressive development of advanced nursing across the organisation, similar to what had been reported elsewhere (Lloyd-Jones 2004;Yeager 2010). To a certain extent, after the flurry of activity and initial establishment of post-holders who were employed, interest in further development seemed to wane, perhaps due to changes in priorities and

organisational needs. There was also minimal funding available to employ or fund education for aspiring ANPs, further compounding role and service developments.

A number of titles broadly cover the overarching descriptor of advanced nurse, including nurse practitioner [NP], advanced nurse practitioner [ANP] and advanced practice nurse [APN]. However, there are also a plethora of variations on titles. This adds to confusion and lack of clarity around the nature of advanced nursing, as without title protection, anyone can call themselves an advanced nurse. This is regardless of what this denotes from the features and characteristics, inherent to frameworks that describe what the concept means and without the requirement for the 'advanced nurse' to demonstrate their competence. This creates potential concerns and difficulties with governance elements for post-holders and employers, in devising safe standards of practice and ensuring competence frameworks and education that can assure that they are fit for practice at the higher expected level of advanced practice.

Pulcini et al (2010) reported advanced nursing as formally recognised through regulatory mechanisms in twenty three countries, with accompanying requirement for specified education and clinical experience. However, this is not the case in the UK, where there have been no formal regulatory requirements, argued by Brook and Rushforth (2011) to be behind some of the confusion and lack of consistency around roles, titles, education and practice that continues to exist. No single title is used, due to the lack of distinct regulation in the UK, with advanced nursing embraced within the scope of initial registration with the NMC (2015), rather than separate to it. Some of these regulatory and governance aspects, as well as lack of understanding of the meaning of post-holders practice and titles, were pertinent for initiation of PD1 and the research, as this was mirrored in the hospital setting where the study was undertaken. It also influenced PD2: advanced practice education curriculum development, as the education being delivered needed to closely align to advanced nursing practice, within the context of the local interpretation of advanced nursing and its practice, if it was to effectively and safely meet the requirements of practice for advanced nursing.

Despite such difficulties advanced nursing continued to evolve and develop in the 1990s and 2000s, mainly based on patient and service need and nurses willing and able to support changing healthcare demands. Often roles developed based on post-holders' personal expertise rather than driven from a strategic perspective, whilst invariably challenging the boundaries and scope of practice of post-holders, in line with

such requirements. Clegg and Mansfield (2003) and Sheer and Wong (2008) also reported on advanced nursing roles tending to be set up in opportunistic, fragmented ways, sometimes following policy changes or when funds were available to improve practice through workforce development. Key driving forces originated from concerns with meeting demands as a result of issues, including reduction in junior doctors' hours and other political influences, such as need for more efficient use of healthcare workers in the UK. This was further identified and solutions proposed in Department of Health [DH] papers, including *'A Health Service for all Talents'* (NHS 1999), *'The NHS Plan'* (NHS 2000) and more recently *'Agenda for Change'* (DH 2004) and *'Modernising nursing careers'* (DH 2006).

It is within this context that advanced nursing has grown and developed, often in a haphazard and unclear way with this as the background to its development within the hospital where PD1 and the research for this study were conducted. Although the first ANPs at the hospital were introduced from a systems-based approach with organisational support and financial backing, other roles emerged through less structured, strategically-managed processes, in line with evidence of what was occurring elsewhere in the UK. At the time of initiating PD1, there had been minimal financial and organisational interest, and support, funding for education or release from duties for development, had been lacking. This left role and service developments to individuals or department teams. This did not stop roles developing but this seemed to be a 'hidden workforce' with little known or understood about them from an organisational or general public perspective, unless there was direct involvement with the individual post-holders themselves.

Anecdotal evidence of developments locally added to the general picture of advanced nursing at the time, with more empirical evidence through research studies. This included Callaghan (2008), who reported on positive developments of advanced nursing over time and across different healthcare settings. This was also with emerging evidence of advanced nurses assuming responsibility for providing care and treatment previously the sole preserve of the medical profession, as was seen in the PD1 hospital. New ways of thinking and delivering healthcare through advanced nursing practice was being recognised by employers. However, this was invariably without clear insight into its implementation, alongside challenges posed from other professions and organisations themselves, as briefly discussed previously. Within the UK NHS, where this study was situated, there was and continues to be a rigid culture

with professional hierarchies, power issues and tensions. This creates threats that advanced nursing might potentially pose to medicine and other healthcare professions, with implications related to elements such as transgression of professional boundaries and de-skilling junior doctors.

This has led to challenges for nurses advancing their practice, in accessing appropriate education and being able to develop, to meet patient and service needs, in a medically-dominated, hierarchical healthcare team environment. Although this has been reported across the UK, it is also something that appears to be dependent upon geographical and organisational cultures and perspectives of individuals, teams and clinical settings within which the advancing nurses are situated. Despite being employed in the same organisation, for some of the PD1 and research participant nurses, their pathways to advancing their practice have been straightforward and well-supported. As posts became well-established and flourished, and seen to provide high quality care for patients, who were satisfied with the input of the ANPs, investments continued for advancing nursing, in certain departments.

However, for others, there have been significant challenges and barriers, often related to relationships with management teams, medical colleagues, other healthcare professions and patients. There has been lack of awareness and understanding of what advanced nursing is; a culture of stifling innovation and blocks to development. Preference has been for funding posts and education and training tending to favour medical staff and other healthcare professions, as opposed to advancing nursing and its practice. Patients had not been exposed to advanced nurses in some areas and were therefore sceptical and unsure of what their roles entailed. There was, therefore a mixed picture of advanced nursing and its development, across PD1's hospital, which was also seen elsewhere across the UK and reported in literature.

In some areas there has been a perception that advanced nursing undermines the professional foundations of nursing, according to Barton and East (2015). Although such challenges have prevailed, there are also areas where advanced nursing has been able to flourish and organisations have encouraged and supported developments, realising benefits of transforming the workforce and progressing innovative and creative ways of working. Within the hospital where PD1 and the research were undertaken, much like other settings, there were challenges to meet and difficulties encountered over the years. Nursing colleagues had been seen to exhibit professional

jealousy, feeling threatened and showing lack of support for their advanced nursing colleagues. However, at the same time, there were and remain positive examples of advanced nursing roles embedded as an established part of the organisational structure, accepted and relied on throughout individual departments and wards.

#### **1.4.1 Competencies and capabilities**

The United States of America's [USA] National Organisation of Nurse Practitioner faculties [NONPF], developed a comprehensive framework during the 1990s, including key domains of practice and competencies for advanced nurses in clinically-focused roles (NONPF 2002). In the UK, the RCN looked to NONPF as it developed similar competencies for nurse practitioners (RCN 2002), as there was no UK guidance to draw on, as advanced nursing was evolving. Thus, in these formative years in the UK, advanced nursing was focused very much on competence, with regards to clinical skills and a task basis, invariably adopting aspects, traditionally seen as exercised by doctors. However, the RCN was keen to follow the lead of NONPF, in line with evidence emerging for advanced nursing and its practice, by incorporating a range of competencies across domains that encompassed more nursing and caring elements associated with the nursing profession.

The RCN competencies became a useful measure against which ANPs could judge competence; equated academically to first degree level or above. With diversity of roles across a wide array of healthcare settings, for which specific competencies are required, it was and remains difficult and arguably unnecessary to articulate a definitive competency set for advanced nursing. Thus the competencies are commensurate with an advanced generalist focus rather than having specific, specialist descriptors.

It can be argued that advanced nursing has moved beyond requirement for a set of definitive competencies linked to a particular role, with RCN guidance (2002; 2008) defining the ANP role and competencies in the UK. At the time of publication, these competencies were instrumental in characterising advanced nursing practice and providing standards of education. Advanced practice has continued to evolve for nursing and other healthcare professions. This has been supported by more recent guidance documents, particularly for Scotland with NES (2010), DH for England (2010) and the Welsh National Leadership and Innovation Agency for Health[NLIAH] (2010), alongside concurrent literature and anecdotally in practice.

This has progressed towards advanced practice, as a level of practice, rather than distinct role or specific skill-set and competencies. The generic criteria and principles within these more recent documents are thus more akin to the start of a capability framework for advanced practice. This broader approach linked to depth and breadth of critical thinking, decision-making and professional autonomy, with a predominant focus on behaviours and depth of thinking and acting rather than clinical 'tasks' and skills. This is accompanied by expectations related to meeting capabilities within such a framework, requiring educational preparation at Masters level. This is now argued as commensurate with functioning at an advanced level of practice. It is purported that advanced nurses use their existing knowledge, skills and experience as registrants to inform and further develop their practice, through clinical experience and accompanying education and training, usually at academic level of Masters or equivalent (Inman 2003). More recently, Jakimowicz et al (2017) further qualify the level at which advanced nurses operate by professing that this includes additional responsibilities including critical reasoning and diagnostic decision-making, not usually exhibited by more junior nurses. This all fits with progression of advanced nursing and its practice within the broader realms of advanced level capabilities. This provides an overarching framework for a wider range of competencies for practical and technical clinical skills, associated with advanced nursing practice.

#### **1.4.2 Education for advanced nursing**

From the late 1990s, a number of the nurses at the PD1 hospital were accessing the newly-developed degree programme for nurse practitioners accredited by the RCN and benchmarked against its competencies (RCN 2002) at the local university. This was pioneering at the time, as there were few examples in the UK of such roles. However, their development was fraught with difficulties, albeit still proving to lead to safe and effective practice and establishment of their roles, as part of the hospital workforce by the beginning of the 2000s. Although the programme attracted primary care nurses at first, with roles starting to develop in secondary care settings, more hospital nurses, including those from the PD1 hospital, were undertaking the programme. However, this came mainly from nurses themselves, identifying the need and putting themselves forward for the course. This was not considered a requisite for the post of ANP and, therefore, funding was difficult to come by, with competing demands on organisational budgets, invariably prioritised to other staff, along with release time for taught elements.

This was similar to other universities across the UK that were offering similar courses. However, this was another area where there was significant variety and lack of consistency in programmes offered, adding to the unclear picture and challenges faced with development of advanced nursing. The Association of Advanced Nursing Practice Educators [AANPE] (now Association of Advanced Practice Educators UK [AAPE UK]) was set up for higher education institutions delivering advanced practice courses, to work towards establishing consistent, agreed standards of education. This was along with other advanced practice developments, aiming to achieve more consensus on roles, services and education across the UK. The local university, where PD2 was undertaken, has been a member of this association since its inception, working with other members on key initiatives. Thus, the programmes developed at the local university have progressed in line with this joined-up thinking. It has benefitted from the plethora of knowledge and experience of advanced nursing, its practice and education shared through AAPE UK, to help inform and ensure the university's education programmes are consistent with current schools of thought and practice.

## **1.5 Introducing main conceptual aspects and themes within the thesis**

### **1.5.1 The people, processes, frameworks**

Exploratory and development aspects of this study fit into three inter-linked categories - *people*, *processes* and *frameworks*, which helped make sense of and provided some order to the different facets.

*People:* I was a member of each practice development team for both PD projects and these initiatives involved a group of relevant participants. I was the researcher for the research study, with participants drawn from the PD participant cohort, thus fusing the research and PD from a *people* perspective. Other people involved in the research supported data analysis, namely my supervisory team and a colleague from another hospital. Although personal narrative within a DProf tends to denote one's own personal narrative, this was also the approach used by the research participants, capturing personal experiences through their narratives.

*Processes:* All four elements were the vehicle for exploration of advanced nursing, with the DProf process helping structure and validate the work. As individual processes progressed and links were made throughout, this culminated in four synthesised

elements, with the whole greater than the individual parts, in terms of outcomes, with particular emphasis on the resultant PD and research synergy. In line with the four pillars of advanced practice, enhancement of PD skills embedded in the leadership/management pillar, and development of researcher skills, aligned to the research pillar, were key areas developed during my DProf journey. With personal narrative, immersion in reflective and reflexive processes, was how I illuminated personal development, facilitating growth of researcher and improved professional practice skills.

*Frameworks:* The DProf provides the framework for this study, providing a structure and overarching umbrella, to encapsulate the synthesised whole. Within the four elements, frameworks were utilised specific to individual elements. For the PD this included PD methodology drawing on principles of participatory action research (Reason and Bradbury 2008). For the research, a qualitative research framework, structured by IPA (Smith et al 2009), was utilised. Review of the literature used structured frameworks to guide and support searching and appraising the literature. Reflective models supported capture of personal narrative, enabling demonstration of depth of contemplative scholarship expected for doctoral level thinking, as conceptualised by Levy (2007). Although not prescriptive, Bolton's (2014) reflective practice model and John's (2005) cognitive to mindful reflective model created an adapted framework to guide my story-telling. This is an approach advocated by Leamon et al (2009), as appropriate to support personal reflection on experiences. A conceptual model of advanced nurse within the hospital context was created within the four pillars of advanced practice, underpinned by 6Cs nursing values (DH 2012) and humanising care dimensions (Todres et al 2009), as its synthesised framework. This creation now offers a new and unique portrayal of advanced nursing in the specific hospital context, providing a clearer picture of its unique selling point, as part of the healthcare workforce.

### **1.5.2 Synergy and fusion**

Professional practice synergy is considered a hallmark of professional doctorates. Lee (2009) asserts that the legitimacy of professional knowledge and practice are inherent, with students implicitly engaging with knowledge and expertise through exploration within professional contexts, thus aiming to enhance practice. In this DProf, synergy is evident at a number of levels. Although each element makes a contribution in its own right, there is then fusion of all parts working inter-dependently, creating a synthesised

whole. Synergy is a culmination of this, with results being greater from the combined effort, rather than the separate, individual parts. Firstly, the research and PD were undertaken separately, albeit concurrently and inter-twined and fused, with achievement of synergy, combining research methodology expertise and professional practice understanding and development. This was enhanced by personal narrative and underpinned by insight into the literature, thus achieving synergy through fusion of all four elements into a coherent whole piece of work.

At a personal level, synergy is demonstrated through my practitioner researcher persona, drawing on leadership capabilities and professional expertise beyond development of methodological skills for the research and PD. Although evidence-based practice is, without question, a necessity for healthcare practice, on the basis of best knowledge and expertise, it does have critics. According to Grover (2007) evidence-based practice does not, to the same extent, value knowledge and skill developed through extensive professional practice experience. This may create conflict between academic and professional cultures, and add to complexities around the practical reality of conducting research and creating knowledge in ever-changing professional practice contexts. Processes are invariably unstructured and fraught with competing, conflicting agendas and shifting professional settings. This was pertinent here, but I feel I was adept at addressing some of this, resulting in showcasing what can be achieved from synergy at personal, process and framework levels, related to exploration of advanced nursing. Fusion of my professional role, encompassing all four pillars of advanced practice, and joint employment in both the academic and clinical practice environments, may have reduced the potential challenges related to research and practice-based agendas and enhanced the synergy in relation to exploration and development of advanced nursing in this study.

### **1.5.3 Three main themes: four pillars of advanced practice, dimensions of humanisation, 6Cs nursing values**

In the UK; Scotland's. 'Advanced practice toolkit.' (NES 2010); the 'Framework for advanced nursing, midwifery and allied health professional practice in Wales' (NLIAH 2010) and 'Advanced Level Nursing - A position statement.' DH (England) (2010) were seminal government documents published shortly before commencing this study. They brought to the forefront the four pillars of advanced practice for advanced nursing and other advanced healthcare professionals. Professional practice is broadly categorised into clinical, education, leadership/management and research pillars. As mentioned

previously, this indicated progression of advanced practice as a level of practice and one comprised of amalgamation of elements other than clinical practice, in isolation. This was moving away from perspectives on advanced nursing as role-focused skills and knowledge. As a level of practice, advanced nursing was being described more in terms of capabilities, steeped in higher level thinking and behaviours cognisant of such a level. This was building on the earlier competency approach related more to tasks and activities, without underpinning depth and breadth of critical thinking and equated to academic level of Masters. Although this did not necessarily result in clarity or consensus on advanced nursing, it certainly offered steps in such a direction. It could be argued that, until there is a move towards more national recognition, through regulation of advanced nursing, there will continue to be variability on what it means.

Prior to publication of NES (2010); NLIAH (2010) and DH (2010) advanced nursing tended to be seen as situated either within a traditional nursing identity of the entry-level registrant nurse. This did not entirely reflect the level or breadth of practice advanced nurses were practising within. This was in addition to being seen as more of a doctor substitution model. These government-level documents offered more consensus on the meaning of advanced practice, including advanced nursing, thus influencing perceptions, utilisation and support for development of advanced nurses. Depiction of an advanced nursing concept as an entity in its own right, with more of an agreement on a distinct professional identity, still immersed in nursing but also with characteristics, that tend not to be seen in non-advanced nursing, was emerging. However, despite agreement that advanced nurses function within the four pillars, there remains contention about this, in relation to spread of practice across the pillars. Although there tends to be a primary focus in the clinical pillar, there are examples of roles, where other pillars take precedence. There is some debate about whether this is appropriate for characterising advanced nursing or not and other iterations that suggest that advanced nursing should fit equally across each of the four pillars. Within the context of this study and it's PD and research participants, the clinical pillar is core to all and requirement for equal standing for each pillar was not considered to be a hallmark for advanced nursing within this context.

These publications were one of the main catalysts for the PD, with PD1 conducted using the four pillars and criteria that fitted into them, to explore and subsequently support development of the advanced nursing framework for the hospital. For PD2, the DH (2010) document provided the template for curriculum development, with intended

learning outcomes written similarly, using the four pillars and criteria, to ensure a course fit for practice and purpose, within the developing picture of advanced nursing. This was with a focus on both competencies and capabilities for advanced nursing and its practice. With the four pillars of advanced practice playing a central role in the PD, it was congruent to adopt a similar approach for the research, particularly as analysis of the research data revealed the pillars, as core to the advanced nurses' practice, and that was also evident in literature reviewed.

The dimensions of humanisation constitute a comprehensive, values-based framework, theoretically informed and conceptualised by Todres et al (2009, p.70). Their seminal work articulates humanising and dehumanising caring practices, with bipolar terms along a spectrum, but with consideration of the specific context, as a key, influencing aspect. A humanising approach is seen as a means of enhancing caring practices. It could be argued that these are not new dimensions, if one considers writings of nursing theorists and other eminent authors. For instance, Watson (1985), portrays humanising factors in relation to nursing, through characterisation of inter-related aspects of nursing with caring. Subsequently, Roach (2002) argues that caring is part of being human and represents the core of nursing. However, what does appear to set these dimensions apart, is the bipolar spectrum of humanising and dehumanising dimensions and greater focus on the person, their well-being and health, with emphasis on facilitating and supporting the person to achieve their goals. This differs from the more patient-orientated, caring and nursing in illness focus, whereby the nurse 'does for or to' the patient, that tends to predominate in nursing theory and that has been seen to characterise advanced nursing during its evolutionary years.

More recently, articulation of humanising approaches appears to have emerged in response to increasingly complex healthcare practice. There has been a tendency towards care demanding more biomedical, less person-centric approaches with the person seen from a reductionist view of the body that may obscure other, more human dimensions. It would appear, anecdotally, that this has been seen to have influenced developments of advanced nursing, with advanced nurses being drawn away from a focus on the holistic elements of care and management of patients. Prior to publication of Todres et al (2009) there does not seem to be clear articulation of component parts of what constitutes humanisation, which is offered through their work. This is a really useful tool that enables individuals across a wide array of contexts, to benchmark how they function against the humanisation framework, supporting them in articulating their

own practice in accordance with a strongly humanising approach or to consider strategies for how they may aspire to working towards a more humanising approach.

However, this does come with some complexity, as each dimension requires a depth of explanation and interpretation to grasp its meaning, and how it can be viewed in context for individual situations, within which it is used. Acknowledgement that the dimensions can be applied from a broad-based approach and contextually, ensures the flexible and adaptable nature of the framework, along with the bipolarity of each individual dimension. The expectation is not that each dimension needs to be applicable to each situation and that within every context each individual should be at the highest point on the humanising continuum. This does not reflect the reality of health and care practice; an example might be nursing within an acute or critical care environment, where a less humanising approach may be necessary for certain dimensions. In other situations and for particular individuals, some dimensions may not be applicable, but this does not necessarily mean they are not functioning within a humanising care approach.

An understanding of this flexible and contextual nature of the dimensions as a framework is important to articulate and disseminate. To a certain extent, when the dimensions are used within the context of nursing, and more specifically, advanced nursing, this is likely to require a degree of translation and interpretation. The language used and definitions of the dimensions are not particularly familiar to the nursing profession and the context of its practice. In addition, the bipolar spectrum of the dimensions requires critical analysis and reflection, for individuals to be able to appreciate or refute their complementarity as a theme to benchmark against. This is when considering applicability to particular situations or individuals or from an aspirational perspective, helping to support progress towards more humanising approaches for advanced nursing practice. However, it can be argued that these points are not necessarily negative; rather that they are valuable, in terms of encouraging and facilitating depth of critical analysis and evaluation and a critically reflective stance on the dimensions in context. This is as opposed to them being used as a 'tick-box' exercise for individuals, in whatever context, to see how humanising their practice is, which is also not conducive to the high levels of autonomy, critical thinking, and reflective practice expected to be inherent to advanced nursing. .

Review of literature on application of the humanising dimensions is fairly limited but there are examples of their use in a variety of contexts, with good outcomes. Morris et al's (2007) study on the importance and value of more equal consideration of social and psychological dimensions, along with physical elements, reported such elements as core to humanising, caring practice. Hemingway et al (2012) extracted pertinent aspects of the humanising dimensions for nursing, perhaps offering an insight into how a similar approach can be used in the context of advanced nursing. However, there appears to be an expectation that all dimensions need to be 'adhered to,' if proposed as a framework for nursing, without consideration of contextual or individual aspects. This potentially influences how it might be applied in relation to development of nursing students, and perhaps this demands this more prescriptive approach. This may not necessarily be the case when viewed from the perspective of advanced nurses, who have been immersed in nursing, invariably for some significant time.

Borbasi et al's (2013) case studies demonstrated application of humanisation dimensions for supporting improvements to care for patients with dementia, with a range of care-givers involved in the study. What came to the fore was the requirement for facilitating understanding of the humanisation framework, rather than expecting those involved to apply the dimensions to their practice, without support and guidance. All these points needed careful consideration, when it became apparent that these were dimensions that were applicable to advanced nursing, within the context of the PD and more specifically, the research within this study.

Discovering this defining framework whilst considering my researcher role was valuable, whilst planning and conducting my research study, particularly as a novice researcher. The dimensions were not used as an overarching framework for my researcher role, but supported me in terms of keeping me grounded and mindful of ensuring I was functioning from the perspective of a humanising approach. This also linked with how I practised as an advanced nurse, educator and practice developer. Reflection on this led to consideration of the dimensions, which emerged as a theme for depicting a range of humanising care aspects, cognisant with the lived experiences of the advanced nurse participants in the study. This was not used as a rigid, prescribed framework. It also did not come to the fore until the analytical stages of the research, so there was not a sense of fitting the data to the framework, but rather the other way around. It was valuable for uncovering and in some cases, giving meaning to some behavioural and cognitive aspects of the lived experience of being an

advanced nurse. Again, this was not necessarily in terms of a 'one size fits all' approach, as not all dimensions were applicable to each participant or each different context that they functioned within.

Often it is these human dimensions that are hard to articulate and that are hidden aspects, in relation to delivery of quality patient care. However, the framework offered a means of uncovering some core tenets, when used flexibly and not with the expectation of categorising experiences of the advanced nurses within tight parameters. It appears that this is in line with how Todres et al (2009) envisaged its applicability to caring practices, which also fits with the fluid, flexible and adaptable nature of an IPA research process, and thus was congruent with this study.

The 6Cs nursing values were introduced in the chief nursing officer for England's DH vision and strategy for nursing (DH 2012, p. 5). This strategy emphasised the need to revisit, build on and improve the culture of care based on the six fundamental values of "*caring, compassion, competence, communication, courage and commitment.*" This was around the time of a number of public inquiries into inadequacies in caring practices, following which the Francis Report (NHS 2013) recommended activities for improving the culture of caring within healthcare and nursing, across the UK. This included the "*Five Year Forward View*" (NHS England 2014), whose aim was to promote better patient outcomes and experiences for people's healthcare and better use of resources, with which the 6Cs strategy was also aligned. NHS England's (NHS 2016) "*Leading change, adding value*" framework for nursing, midwifery and care staff followed the initial 6Cs strategy, reporting on consultation that revealed substantial, continued support for the 6Cs. Thus it was included in the newly developed framework and considered as "*the foundation of our (nursing) value base*" (NHS England 2016, p. 7).

Despite this positive focus, it is also argued that the 6Cs were hurriedly published as a reaction to negative images from the Francis report and similarly damning reports on nursing and as an attempt to show that highlighted failings and poor practice were being addressed. Critics refer to the 6Cs as already core to nursing, embedded in the NMC Code (2015), and thus, holding no meaningful additional purpose, in re-launching them as defining values of nursing. Critics of the 6Cs argue that they do not ensure standards of care, the context within which they were introduced, nor do they describe complexity of nursing roles. Although such criticisms amongst others, are likely valid,

this does not detract from them as appropriate descriptors of the values-base of nursing. It is this point that made me consider the values within the context of the research; they were certainly coming to the fore, not only from the research, but through previous discussions and profiles of PD participants. These established, familiar values resonate strongly with nurses and in response to their criticism, there seemed to be value in re-iterating them and considering them in the context of advanced nursing. Staying connected with these values, in a milieu of perceptions of advanced nursing moving away from nursing roots and losing the nursing and caring identity, offered a way of these values re-surfacing, embedded in the model of advanced nursing created through this study. The 6Cs articulate the baseline for underpinning how advanced nurses function, with dimensions of humanisation adding a more comprehensive, deeper level, building on, enhancing and enriching this overarching framework.

Critical review of humanising care dimensions and 6Cs nursing values together, came to the fore as core themes as part of the emergent framework, with nursing as the central feature of this study. The more recent nursing strategy (NHS 2016) reported on integrating the 6Cs nursing values into practice, which further confirmed the relevance of the 6Cs, for underpinning advanced nursing and its practice, borne out through the PD and research participants. The familiarity and perhaps more simplistic, narrowly-focused representation of 6Cs nursing values, together with the less familiar, albeit more flexible dimensions of the humanisation framework, created a comprehensive, broader structure for the conceptual model of advanced nursing that developed.

With the DProf introduced and scene set, chapter 2 focuses on the personal narrative, enabling readers to join me on the journey, chronologically charting reflection on my development and achievements; with positive outcomes from synergy of the PD and research, informed and enriched by the literature review. This was supported and enhanced through personal narrative and the embedded reflective and reflexive aspects. Synthesis of all four elements of the study, culminated in the conceptual model of advanced nurse in the hospital context chronicled through the ensuing chapters of this thesis.

## Chapter 2 My journey through the DProf using personal narrative

### 2.1 Personal Narrative in a professional doctorate

Personal narrative is a core characteristic integral to a Professional Doctorate and, according to Fenge (2010), represents exploration of a student researcher's journey of learning and development and key to helping make sense of a doctoral study, as a whole. Polkinghorne (1995) refers to use of narrative, in such a context, as a form of story telling with a central '*plot*' as the main focus. Narrative is described as a retrospective written account of an experience or event, bringing together different aspects into a coherent whole, and thus making sense of it. Bolton (2014), captures a poignant quote, from an ancient writer, Cicero "*Wherever we walk we put our feet on story.*" and she goes on to quote Winter (1988, p. 235), "*We do not 'store' experience as data, like a computer: we 'story' it.*"

(4/2012) "As I write my personal narrative, from start to final submission of the thesis, I hope to create my own story of the journey, capturing triumphs, surprises, challenges and obstacles in a meaningful, open way."

### 2.2 Selecting a Professional Doctorate route

(4/2012) "At the embryonic stage of my journey, similar to findings in Galvin and Carr's (2003) study, I was drawn towards a professional doctorate, rather than PhD, as the catalyst to prepare me for higher level professional practice and leadership. This was alongside the opportunity to apply existing and new knowledge to strengthen the evidence-base of advanced nursing. I have a thirst for learning and practice development through academia and in the practice environment. Adding advanced nursing and its practice, then I am passionate and full of enthusiasm to lead developments, if improving patient care is the outcome. I feel I can add a more scholarly and research-based focus to my role, facilitated through pursuit of a DProf, albeit not losing clinical and education practice input and my strong philosophical underpinning of nursing and caring within a framework of humanisation."

In line with Fenge's (2010) own professional doctorate experience, selecting a professional doctorate route offered the chance to identify research and PD activities embedded within my professional role, as well as being beneficial to organisations where I worked. Galvin and Carr's (2003) study found participants wanted to ensure their doctoral studies would have an impact on patient care, as a major consideration.

As Lester (2004) suggests, a practitioner doctorate is concerned with managing change and PD, which fits my personal perspective and was at the heart of my own drive. Galvin and Carr (2003, p. 294) continue this theme, arguing that professional doctorates generate and utilise new knowledge through practice-based scholarship. This shows differences between traditional PhDs and professional doctorates, with the former associated with development of '*professional scholars*,' the latter with '*scholarly professionals*.' Meleis et al (1994) advocate for doctoral education that promotes scholarliness in nursing, which they believe can make a significant contribution to nursing and caring, helping to cement my personal drive for such a pathway.

(4/2013) "I believe I am a developing scholarly professional in my advanced nursing role and can contribute in the way Meleis et al (1994) assert. As I progress towards my goal, I feel I will know when I have met doctoral level and consider myself really to be a scholarly professional, drawing on Benner's (1984) '*novice to expert skills acquisition model*' as a benchmarking guide. This will be when I see myself in the seamless way of being, as an advanced nurse, rather than sum of knowledge arenas required for each pillar of advanced practice. On reflection, I am likely to move back and forth between the two positions of scholarly professional and professional scholar as I progress my career in a joint role between hospital and university, dependent on which element I am functioning within at the time. I anticipate these two positions will become my lifeworld experience; embodiment as advanced nurse, educator, practice developer and researcher. The DProf will enable creation of my own model of advanced nursing, in keeping with the scholarship model espoused by Boyer (1990), which integrates domains, such as research, teaching and application. The domains I expect to merge are the four pillars of advanced practice, remaining mindful and ensuring incorporation of humanisation and 6Cs nursing values."

Galvin and Todres (2007, p.37), draw on Boyer's (1990) scholarship model, advocating

*"scholarship as a seamless way of being, rather than the integration of separate domains of knowledge..."*

### **2.3 A scary start line and getting over the first hurdles**

(6/2012) "At the start, I was a novice researcher, at the level expected of a doctorate, and 'rusty', in what I had done so far, academically, so concerned about starting."

Such feelings are not uncommon for practitioners, such as myself. Ellis (2005) reported concerns about professional doctorates, with students' perceptions of

academic ability and scrutiny they would be under, and competing demands of practice workload pressures and academic requirements. Bolton (2014) reiterates the point about doctoral students self-doubt in their abilities, but argues that these can be overcome through reflective processes.

My DProf programme has been built with group supervision providing a supportive environment for learning and development.

(7/2012) "I attended the first group session with trepidation. I would be lost amongst a group of 'academically-minded' individuals who were experienced researchers. However, by the end of this session, I felt I had something to offer and they had a wealth of information and experience that could help me."

This fits with Fenge's (2011, p. 412) findings from her study of Professional Doctorate students.

*"Group supervision on ...programmes enables students to engage with their changing and contested professional/researcher identities through discursive processes, and enables reflexivity about the nature of practice to take place."*

Such an approach is also seen within action research and thus akin to PD and other collaborative methodologies (McNiff 2014). This tends not to be characteristic of traditional PhD studies, where students tend to work more in isolation, with individual focus and structure, not always conducive to senior high pressure practice roles (McKenna and Cutcliffe 2001).

(10/2012) "Personal speculation would suggest that professional practice focus of our professional doctorates and why, as students, we were drawn to this approach, is grounded in our professional lives demanding work in collaborative teams. We are, therefore, comfortable working in such an environment in our student roles, as it is embedded in our professional practice roles."

I considered aims and objectives that would be 'SMART' (Specific, Measurable, Achievable, Realistic and Time-manageable) (Doran 1981), and reflected on what the final goal might be, through Bolton's (2014, p. 25) '*certain uncertainty*' and '*unquestioning questioning*' and '*serious playfulness*.' A sporting analogy was an important support early in my journey, as a familiar arena and helped me feel comfortable in unfamiliar territory.

(1/2013) "At '*the first stride out of the starting blocks*' I reflected on the four pillars of advanced practice. I felt competent and confident as an advanced clinical nurse,

recognised my skills as a lead nurse involved with service development and was continuously developing my educator role. However, I lacked experience and competence as a researcher and felt I could enhance expertise in practice development, both areas reported as having barriers for advanced nurses to really engage with, to any great extent (Van Veeramah 2004). I recognised undertaking a doctorate would build on my strengths and experience, whilst facilitating growth and development of emergent research and practice development skills and build reflective and reflexive expertise. Once I started I was '*propelled at top speed out of the starting blocks, somewhat confused about what event I had entered!*' With time, personal reflection and with my student cohort and tutors, use of my sporting analogy emerged (Appendix 1.1). This was valuable early on, supporting thought processes and helping make sense of stages I was working through and struggling to understand.

(6/2013) My personal narrative began to draw on a personally-orientated analogy of Jessica Ennis' pursuing her gold medal in Heptathlon in 2012 Olympics, comparing her sporting journey, with my academic and practice development journey (Appendix 1).

(6/2014) Now I am no longer struggling to understand what I am doing, negating the need for this representation but have kept in touch with it, to demonstrate processes used to support learning and development and highlight my progress. Looking back on this part of my journey, using Bolton's (2014) reflective model, the sporting analogy fit with 'serious playfulness' and 'certain uncertainty' and 'unquestioning questioning' with what I had embarked on."

With '*certain uncertainty*' and '*unquestioning questioning*' I reflected at a deeper level, with more confidence as I progressed along my DProf journey.

(10/2014) "There is a high level of inter-subjectivity between me as doctoral student, my professional role and overarching theme of advanced nursing emanating through every aspect of my work. There is congruence between the literature review, personal narrative, PD projects and research and ongoing inter-related professional activities, all relating to advanced nursing. This is all cognisant of the various levels of professional practice and personal role synergy that was characteristic of this study, with myself at the centre of each element. The destination I aspire to, at the end of this epic journey is a place where my personal fusion model of advanced nurse is realised and is the hallmark of my professional practice and exemplar for other advancing nurses, created through a synthesised whole study, with particular synergy of the PD and research. This underpins my personal philosophy of practice and is at the heart of my desire to

develop personally and professionally. I feel I have responsibility to my profession and want to make a useful contribution to the knowledge-base of advanced nursing, for colleagues and patients, through valuable practice development and research."

Moule and Hek (2011, p.4), assert that a body of knowledge is developed and enhanced through relevant research into practice, which is the ultimate goal of my studies.

*"Excellence in practice is dependent on the research and evidence-base of each professional group and we all have a responsibility in some way to contribute to our own profession's knowledge through research."*

## **2.4 Reflection and reflexivity inherent within my DProf**

Ghaye and Lillyman (2011) propose that reflection involves learning to account positively for oneself and one's work. The reflective and reflexive approach inherent to the learning process, is said to involve reflexivity, representative of greater depth and breadth of reflection, whereby an interpretative element is added to reflection.

Reflexivity and reflexivity are seen on a continuum, pertinent to learning and development and managing change in oneself. The following quotations encapsulate how I was making sense of reflection and reflexivity as tools to support development and growth from critical reflector to reflexive practitioner.

Bolton (2014, p.7) discusses *"thinking from within experiences"* and *"examining the limits of our knowledge"*.

Richardson (2000, p. 254) purports,

*"Self-reflexivity brings to consciousness some of the complex political / ideological agendas hidden in our writing"*.

And Sparkes (2003, p. 221) argues that

*"who I am affects what I observe, what I write and how others react to what I say."*

Further consideration led to Johns (2005) two different modes of reflection - '*cognitive and mindful reflection*', that closely align to the aforementioned reflection and reflexivity.

(7/2014) "If I review my development, the type of reflective processes used, start to err towards mindful, building from cognitive reflection. However, both types are likely to be employed, depending on situations I am reflecting upon. I anticipate development from reflective to reflexive practitioner, within all aspects of my advanced nurse role, moving

from cognitive to mindful reflection, as expertise and experience builds across all four pillars of advanced practice and as I develop skills and depth of understanding through the DProf. From a personally reflective perspective, this is another example of professional practice synergy as these four pillars of advanced practice fuse and inter-relate with one another. For me, being reflexive means making sense of the lived experience of my doctoral pursuits and becoming part of the process as I progress. Thus, it becomes a living, breathing endeavour echoing throughout every aspect of my professional life, influencing and moulding how I practice, as I develop.

(7/2014) I am mindful of how such thinking can influence the work I do within the DProf, and in so doing, draw on literature to guide reflective and reflexive activities, with personal learning and development achieved, as I progress my studies. However, knowledge will also build more generally, with advanced nursing and its practice through the PD and research. Studying at doctoral level as an advanced nurse can combine the art and science of nursing with reflective practice to produce praxis, as advanced nursing practice based on scholarship, expertise and critical thinking, which I aspire to achieve through this work. Reflection and reflexivity are considered important elements for PD, indicated by Boomer and McCormack (2010) and experiential qualitative research, such as IPA, according to Shaw (2010). Both methodologies require a high degree of reflection and reflexivity for the practice developer/researcher, as key aspects of enquiry and, therefore, play a key part as I continue through these elements."

## **2.5 Writing my personal narrative**

My personal narrative is a process of exploration and articulation, utilising a reflective and reflexive writing approach. Bolton (2014, p.14) supports such an endeavour, when she states,

*"The writing IS the reflection,..questioning everything, turning our world inside out, outside in and back to front."*

She continues to assert that the process of reflective writing enables one to engage critically and learn and facilitate change in practice; both of which are key to my studies. The personal narrative writing is used to represent my journey of learning and the professional enquiry inherent within it, as the whole process unfolds and progresses towards its final destination, culminating in the final thesis and its defence, returning to my sporting analogy, with me visualising "the finish line."

Bolton (2014, p.116) states

*"Reflective and reflexive writing can collate and make sense of the muddle of stuff in our minds."*

Other authors advocate the power of reflective writing including Richardson (2000) who considers it a means of discovery and Van Manen (1995, p. 37) who asserts,

*"To write is to measure the depth of things, as well as to come to a sense of one's own depth."*

(9/2014) "This was starting to make sense as I worked through the chaos I was in when starting my DProf journey in 2012. Reviewing my narrative log, I could see the first written pieces were matter of fact reflections on where I saw myself and what I was going to do. This was in line with reflection-on-experience typified as a form of cognitive reflection, rather than mindful practice as a way of being (Johns and Freshwater 2005). This was an objective, outsider view of my personal world and there was a sense of holding back on sharing feelings and thoughts and lack of knowledge of how I was going to use my creativity to pursue doctoral studies. I lacked confidence to let go and write from inside and unsure about sharing feelings. It was exposing and I was afraid of not being good enough, of ideas being ridiculed and failing to move forward. Although there is some critical reflection within my writing, it lacks depth of analysis and personal interpretation required, that characterises the reflexive being, I feel I am growing into and that is more commensurate with mindful practice. This is coming with experience as I progress my studies and develop understanding of my topic from empirical, ethical, personal and aesthetic ways of knowing (Carper 1978).

I feel I am beginning to have full authority over my writing, taking an unprescribed approach, being selective of aspects I share and open and self-revealing, without feeling restrained or uncomfortable by concerns about how I am perceived by others. The process of writing is facilitating a more reflexive and pragmatic approach to academic and practice activities, helping me engage critically and learn and empowering me to change practice. The flexible and unprescribed 'permission' to create such written pieces, has led to transforming my work from being poorly informed and immature to more informed and enlightened, commensurate with doctoral level thinking and immersion in my subject. Dialogue with myself through reflective writing and sharing with others, is the medium through which I am able to put into action, critical reflection and reflexivity, leading to transformations in meaning and practice. Use of narrative and thinking, feeling and acting as a reflexive practitioner, moving from cognitive to mindful reflector, has been difficult to grasp, but I am getting there.

The feeling of writing a 'story' just didn't seem right and made me feel exposed when I was introduced to such an approach within DProf sessions in 2013. At this point I discovered Bochner's (1997) *'Narrative and the Divided Self'*, which rang true and made me feel 'being academic' is not necessarily something demanding complex dialogue and writing, out of most people's reach. In contrast, it can be achieved through simpler, clearer approaches to knowledge sharing and development, using narrative. As a practical, hands-on nurse and educator, it felt like this enlightening dialogue was giving me permission to use my experiences as the basis for sharing and developing knowledge and now, in 2014, I fully understand its power and influence and how important it is for professional and practice development."

Bochner (1997) argues that the academic persona is often isolated from the normal, experiential one, making one feel disconnected in pursuit of theory, with expectations of being an objective spectator role. He suggests this is not the only way of *'being academic'* and there is value in taking a more subjective, experiential view of the world. He found this a valuable approach with students, with whom he shared tacit knowledge, connecting their experiences to his own.

I continue to be drawn to *Bochner's (1997, p. 436)* ideas about narrative inquiry as an academic pursuit,

*"where theory meets story when we think with a story rather than about it."*

This is alongside the school of thought supported by Smith (2008) that functioning at doctoral level, should demonstrate innovation, creativity, and originality, aiming to develop new knowledge.

(1/2015) "I believe this is coming to fruition through my innovative approach. Previously I was rule-driven, guided by the prescriptive nature of an academic programme. Bochner's writing has helped me think outside the box and feel confident that it is acceptable to *'run a different race.'* taking a leap of faith into what was originally uncharted territory, in pursuit of a personal journey of exploration and discovery. This created my own approach to the DProf, perhaps challenging a more conventional format and meeting innovative, creative requirements of doctoral studies, which I believe is emerging as I progress through all four elements, making my doctorate really meaningful."

As I worked through each DProf element concurrently, it made sense to capture personal narrative for each one. This was once I reached a point where I could stop to consider personal progress and development in terms of outcomes. Thus, an extract of narrative concludes each of the chapters on literature review, practice development and research, as well as extracts of narrative captured at pertinent points within individual chapters, where reflective and reflexive aspects are articulated.

## **2.6 Personal narrative at progression stage**

(2/2017) "As I approached progression stage, I reflected on my progress.

Unfortunately, due to a bereavement, I took a break in studying. In retrospect, this was beneficial for my development as I continued to read and reflect, deepening my understanding of my subject and increasing self-awareness of my personal and professional self. I slowed down and took stock of what I was doing and why, realising I was rushing things, which was not helping me fully embrace the learning experience. I returned with renewed vigour and different approach to completing my studies, in a more measured way, ensuring depth of my learning was commensurate with that expected. I have been moving along a continuum from thinking objectively about myself as a scholarly professional and developing professionally, building each pillar of advanced practice. This is becoming my way of being in the world, as a mindful reflector and embracing a reflexive approach to my world of advanced nursing. This fits with '*serious playfulness*', with my thoughts quite abstract, and focused on an innovative approach to embodiment of my personal identity. However, there is work to do before I feel fully competent in this emerging lifeworld, with remaining aspects of '*unquestioning questioning*' and '*certain uncertainty*' to transform.

My doctorate is now part of my identity as a scholarly professional locally and within the world of advanced nursing - my own '*Olympic community*' (returning to my sporting analogy). Submission of my progression report enabled me to gauge how far I had come and view this as a significant point, in achievement. I enjoyed the opportunity to share my work and articulate my plans for the final thesis. I continued to feel '*certain uncertainty*' about the level I was working at and lacked confidence in my abilities as a researcher and doctoral level scholar. However, going through this process, gave me the confidence boost I needed, confirming I was functioning at a reasonable level and my researcher skills were developing, moving towards '*certain certainty*'. I was starting to understand the power and strength of reflective writing, moving from a cognitive to

mindful approach, articulating this using personal narrative emanating through all four DProf elements and demonstrating my reflective and reflexive stance, in scholarly and practice-based activities that was now being drawn through a second phase of PD and a core aspect of the research being undertaken."

## **2.7 Moving towards the final DProf destination with personal narrative**

"I was more than ready to progress as a researcher, able to use personal narrative in various ways and as an important part of the research element and as the glue combining all four elements of DProf."

Sandelowski et al (1991, p.161) believe that narrative provides an opportunity for nursing researchers to have,

*"special access to the human experience of time, order and change, and it obligates us to listen to the human impulse to tell tales."*

This is further supported by Coles (1989, p.128) when he states,

*"You don't do that with theories. You don't do that with a system of ideas. You do it with a story."*

(6/2017) "I moved forward with literature review and research elements, as the next steps in this journey." A brief summary of reflective aspects was captured in my researcher diary, extracts of which are in Appendix 5. There is more detailed narrative included, where appropriate, within the research chapters, including summary reflections at key points in the following chapters. Further personal narrative charts progress towards the final destination and is similarly captured in the final sections of this thesis. This is congruent with fusing all four elements, outlining my personal, professional development through the synergistic whole, culminating in meeting all expected outcomes, and with additional outcomes resulting at a later stage.

## **Chapter 3 Practice development**

PD Project 1: Specialised Nurse Review (SNR) was conducted in the hospital where I worked (Appendix 2.1). It involved creation of an advanced and specialist nursing framework for the hospital, after evaluation of advancing and advanced nursing roles (Appendix 2.2). PD project 2 involved advanced practice education curriculum development (Appendix 2.3), culminating in a new Advanced Nurse Practitioner programme being written and implemented at the university where I work (Appendix 2.4). An outcome from these projects was the book chapter on advanced practice careers and career development that I co-authored. These projects and book chapter were pivotal to and a catalyst for initiating and continuing to inform the research study. This came from a desire to get close to the personal experiences of advanced nurse participants from PD1.

### **3.1 Practice Development methodology drawing on Action Research**

The PD projects were guided by a framework of practice development, drawing on principles of action research, which are often used synonymously, according to Coughlan and Brydon-Miller (2014). Practice Development has been recognised as a methodology that contributes to health and social care services through focusing on workplace cultures (McCormack et al 2006), as was the case for both PD Projects.

The projects followed their own cyclical processes as separate entities, featuring spirals of data collection, analysis, evaluation and embedding into practice (McNiff 2013). They were interlinked by the overarching subject matter of advanced nursing, with each cycle informing and informed by the other. Although the distinct projects came to an end and outcomes were achieved, activities continued, building on what was done, shaping and re-shaping what was developing as a result of ongoing work and emerging developments. This is congruent with the nature of both action research and practice development methodology, as discussed by eminent healthcare practice developers, including Garbett and McCormack (2002). Boomer and McCormack (2010) argue that PD supports change, and depending on size and complexity, structures and processes are established to ensure collaboration, inclusivity and participation, to maximise potential outcomes.

As Garbett and McCormack 2002, p.87) state, (particularly with healthcare and nursing practice),

*“Practice development is a systematic process with the intended outcome of improving the patient’s experience, by helping nurses and teams to develop the knowledge and skills to enable them to transform the culture and context of care.”*

In using PD to identify key attributes, Unsworth (2000) suggests this involves direct measurable improvement in care through new ways of working, patient need or problems responded to through specific changes; effective services developed through change and maintaining or expanding current work. These aspects were pertinent to undertaking the PD. Drawing together theory and practice, termed by Jones (1997, p.34) as ‘*theory-practice*’ or ‘*praxis*’, the PD adds to the body of knowledge of advanced nursing (theory; general) and contributes to development of advanced nursing roles within the specific hospital setting (PD 1: SNR project) (practice; local) and through university education curriculum development (PD 2 :Advanced practice education curriculum development) (theory/practice; local). This is also another example of synergy with theoretical aspects being fused with practice, leading to synthesised exploration and development of advanced nursing through PD.

### **3.2 PD Project 1: Specialised nurse review (SNR)**

This PD project was a comprehensive review and evaluation of nursing roles, identified within a loose framework of advancing or advanced practice within the hospital (Appendix 2.1). General agreement by staff across the hospital was that more effective and efficient use could be made of roles, within redesigned, more person-centred services. More supportive structures and processes could enable roles to function more effectively and post-holders could be better supported and developed, alongside approaches that enhance quality services and promote improvements in care.

PD1 was characterised by collaboration, along similar lines to participatory action research, as described by Reason and Bradbury (2008). A hospital service development team was brought together, alongside the nurses and their managers, as the project participants. I joined the project team, using expertise from my joint role, embedded in advanced nursing. This was an appropriate project team, to support effectiveness of processes. McCormack et al (2006) purport that effectiveness of PD is enhanced by using internal roles for practice development, combined with or that are a sub-role of other role functions, as was the case with my colleagues and myself, with

authority from our senior roles, contributing to effectiveness of the project. Critical reflection individually and collectively by people involved is considered vital to PD and Action Research, when engaging in collaborative change and development within healthcare, according to Bellman (2003). Critical practitioners need to be skilled and knowledgeable, open to and value alternative ideas and perspectives and to be self-aware, reflective and critical thinkers. This featured within PD1 and PD2, from my own perspective and colleagues working on the project teams.

### **3.3 First stage literature review for practice development**

On initiation of PD1, the first stage of literature review was rather organic in nature, less structured and systematic, with less critical analysis than expected of more scholarly-focused activity. Nonetheless, it proved useful for informing the PD. This provided an appropriate background to support planned role evaluation and developments, in line with the current evidence-base of advanced nursing. Findings from the review were shared with the project team, with evidence from published literature, adding to anecdotal evidence that prompted PD1 originally. This also supported development of the advanced practice education curriculum for PD2. This review started to set the scene and led to a more robust second stage literature review for the research.

Shared themes were extracted from reviewing the small number of papers, focusing on what advanced nurses did. Rolfe and Phillips (1997) and Manley (1997) conducted action research projects of eighteen months and three years duration, respectively, both within hospital settings in the UK. Hicks and Hennessy (1998) took a triangulation approach with a questionnaire survey of acute care nurses, their managers and doctors, also in the UK. Brown (1998) undertook a narrative literature review focused on conceptual frameworks of advanced nursing. This is merely a snapshot, and from studies undertaken some years earlier. Although there is useful data to draw on, this needs appraising in the context of advanced nursing in the UK at the time. It is not clear what level of practice participants were working at or their educational preparation, as guidance was limited in the 1990s. However, these studies were conducted in similar settings to PD1 and mirrored what was happening within this hospital setting. Additionally, the findings from these studies were borne out, some years later and prior to the PD, in the documents that started to provide guidance on advanced nursing practice and education, including RCN (2002; 2008), and DH (2010). This all provided a basis on which to build the hospital framework for PD1 and guided

curriculum development for PD2. The themes indicated prevalence for the clinical pillar, with advanced nurses functioning at higher level than entry-level registered nurses, with additional activities usually seen within the domain of doctors.

Shared themes revealed advanced nurses in enhanced clinical roles, with Manley (1997) referring to them in terms of expert clinical practitioners who fitted into a conceptual framework focused on patient-centred care. Clinical practice comprised of comprehensive patient assessments using advanced clinical skills identified as history taking and physical examination skills, ordering, undertaking and interpreting investigations and carrying out procedures. Their practice was seen to incorporate clinical and diagnostic reasoning and decision-making and a critical approach to problem-solving in assessing and managing patient care. Rolfe and Phillips (1997) made reference to the independent, autonomous nature of ANP roles in making decisions and planning care. These clinical facets were argued as usually aligned with medical practice, according to Brown (1998). She also made reference to patient care characteristics that fitted a conceptual model with a wide scope of practice characterised by strong nursing orientation and nursing values-base. This was also echoed in the other papers. Manley (1997) and Brown (1998) reported on a more holistic and empowerment approach to patient care, working in partnership and as a patient advocate. The main focus was clinical skills and demonstration of competence, but these papers were the start of a move from advanced nurses assuming medical skills, towards practice that was regaining its nursing and caring focus.

Within the leadership/management pillar, advanced nurses were seen leading and managing patient care with more authority, albeit within the context of multidisciplinary team working. They were reported in all three research studies as leading on change, responding to changing needs and demonstrating a pioneering approach through advancing clinical practice and managing risk. The education pillar was cited by Manley (1997) as part of the advanced nursing role, which was mirrored in the other papers, for patients and staff. The research pillar was seen within the context of evidence-based care provision and from a wider remit of practice and service development. However, this was not a strong focus and perhaps was more an indication of the researchers' perspectives on promoting the concept of advanced nursing in a medically-dominated environment, where advanced nurses at the time, were viewed in terms of clinical acumen, with an emphasis on doctor substitution.

Wiseman (2007) purports that advanced nursing roles need developing within a recognised framework, taking account of organisational environment, education and professional development requirements, professional, ethical and legal accountability issues, with clarity around scope and remit of roles that are in line with patient needs. This was an indication of gaps in terms of robust and consistent practice criteria or standards of education in the UK, in the early 2000s. If advanced nursing was to establish itself as an entity in its own right and not merely a role that supported the practice of other healthcare professionals, work was required to achieve such status.

A number of operational frameworks for identifying, establishing and evaluating advanced nursing posts were reported in countries with slightly different health care systems to the UK, including Bryant-Lukosius and Di Censo (2004) in Canada and Gardner et al 2010 in Australia. The PD project drew on this broad-ranging evidence-base to create a suitable framework for identifying, implementing and evaluating the nursing roles in question. However, there seemed to be limited data to guide successful implementation and best use of such roles and evaluation processes and they appear as complex and dynamic as the roles themselves. This resonated within PD project 1's hospital and was something that made the project complex and challenging.

### **3.4 Practice development project 1; 'Specialised Nurse Review'**

PD 1: 'Specialised Nurse Review' (SNR) focused on advanced and specialist nursing roles at the specific acute hospital trust (Appendix 2.1 and 2.2). The main aim was to identify savings, whilst maintaining and improving patient services, through role identification, review and evaluation. It was anticipated that this would lead to recommendations for and activities focused on role and service transformation. This was one of a number of projects within the trust's transformation programme, aimed at meeting NHS quality and efficiency agendas including DH (2008) and DH (2010a). The project culminated in development of an advanced and specialist nursing framework for the hospital, covering practice, education and training, career identification and development of nurses in post and nurses aspiring to such career pathways. On completion of the project, a process was implemented to ensure ongoing review of the framework, in line with the hospital's governance structure, keeping abreast of evolving national guidance for advanced nursing and other non-medical healthcare professional roles in England.

### 3.4.1 National and local context for PD1

Around the time PD1 started, a plethora of guidance and recommendations was published relating to areas, such as improving quality of patient care whilst making cash-releasing savings. This was aligned to focusing on healthcare staff, such as nurses; in '*Modernising nursing careers*' (DH 2006) and '*A high quality workforce: next stage review*' (Darzi Report, DH 2008). Such pertinent initiatives were followed by publications more relevant to advanced and specialist nursing, leading to emergence of a slightly clearer picture of advanced practice for the UK. A move towards more local governance within NHS organisations was emerging, from a general perspective and specifically, advanced practice roles, such as those within PD1. This is highlighted within key documents, including 'Advanced Nursing Practice Roles Guidance for NHS Boards' (NES 2010). This stated that good governance of advanced nursing role development and implementation should be based on consistent expectations of the level of practice needed for patient services, through benchmarking roles against nationally agreed standards.

It is amidst the turmoil of the ever-changing healthcare arena, characterised by paucity of resources and rather hazy picture of advanced practice, that PD1 commenced. As briefly discussed in the first stage literature review and from anecdotal evidence locally and nationally, there was little in the way of a defined background of advanced nursing available at the time (1990s to early 2000s), when most of the roles were implemented at the PD1 hospital. As a result, there was wide divergence and variety in the numerous roles developed, featuring an array of different levels and parameters of individual posts, not dissimilar to experiences elsewhere, nationally and globally (Pulcini et al 2010). Currie and Grundy (2011) demonstrated, through a small-scale evaluation study in Scotland, healthcare organisations employed numerous individuals in 'advanced' roles, with different titles but with little understanding of what roles involved and with profiles emerging with little coherence. They concluded that there was need to review the workforce, make best use of resources and work more effectively, safely and efficiently, to ensure delivery of quality patient services. Anecdotally, this is mirrored elsewhere in the UK, where organisations embraced the authors' challenge to address their own, similar issues; it certainly formed part of the rationale for PD1.

DH England's 'Advanced level nursing' (DH 2010) was published not long before the start of the project, at the same time as the similar publications from Scotland and

Wales respectively (NES 2010; NLIAH 2010). From the local viewpoint, there had not been any targeted guidance from a UK governmental perspective previously; although RCN (2008) had offered informative guidance on ANP practice and proposed education standards. A fair proportion, although not all of the ANPs at the PD project hospital had undertaken the ANP degree course at the local university that used RCN domains and competences for benchmarking its programme against. Thus, DH (2010), NES (2010) and NLIAH (2010) were critical for guidance nationally and locally for PD1 and impetus for initiating the project, as there was something more tangible on which to base the review of roles. They were also key documents for informing the new curriculum developed through PD2, along with RCN domains and competencies (RCN 2008) that previously informed it. However, it is important to note that these were not policy documents but did provide a foundation on which to build, with some consensus agreement on advanced nursing and guidance for developments.

### **3.4.2 Rationale for undertaking PD1 and its project aims**

The origin of PD1 within the hospital's transformation programme was part of the hospital trust's five year strategy, aimed to identify improvements and efficiency savings, through projects launched to save money whilst not reducing efficiency and effectiveness of services. The Director of Nursing and senior managers were keen to ensure that, despite savings targets, quality of care was not affected. Conversely, the project was seen as potential opportunity for service and staff development, in line with Department of Health quality agendas.

Early on, with lack of consistency around job titles and profiles, it was not clear how to categorise these roles or whether all relevant roles had been identified. It was decided to keep the title broad and generic, so the goal was to review all 'specialised' nursing posts (a term coined to cover all roles without giving them a specific title), to encompass the whole array of specialist and advanced nursing roles. Lack of cohesion, little understanding of what these roles involved, how individuals worked or what contribution they made to patient care or the organisation as a whole, was of concern, particularly following recommendations from papers such as the Darzi Report and 'Quality, Innovation, Productivity and Prevention' (QIPP) agenda (DH 2010a).

At the start of PD1, the following points were considered, with regards to the rationale for its undertaking (Table 2), which led to the main aims of the project (Table 3), as agreed by the project steering board and delivery group.

<p>Little known about roles in hospital at organisational and departmental level, despite significant numbers employed</p> <ul style="list-style-type: none"> <li>• Need to develop awareness and understanding and build a clear, agreed picture of individuals that fitted this part of nursing workforce.</li> </ul>
<p>Roles evolved - ad hoc fashion, single entities, no clear plans or direction, no cohesion across trust. No organisational strategy to manage education, training, succession planning, career development, aimed at improving patient care delivery</p> <ul style="list-style-type: none"> <li>• Governance perspective - potential risk needing addressing, potential wasted resources that could be better utilised</li> </ul>
<p>Numerous diverse roles initially identified, seen to provide range of quality services but not initiated from service or coherent, systems-based approach, little known of their contribution to patient care</p> <ul style="list-style-type: none"> <li>• Strategy required to improve introduction, management, evaluation of roles/services</li> </ul>
<p>Nurses and their managers needed to review and plan to meet development needs to facilitate role advancement to fit purpose of services required.</p> <ul style="list-style-type: none"> <li>• Minimal investment in workforce since initial inception - minimal support and funding to support role / service development, despite evidence of efficacy of such workforce</li> </ul>
<p>Hospital trust required to make savings whilst improving patient services - felt review and remodelling of 150+ roles identified could realise savings and support delivery of improved patient services</p> <ul style="list-style-type: none"> <li>• Lack of knowledge and understanding of roles / services, no strategy for managing them, to meeting these requirements, no clear framework to build and re-model specialised nurse roles.</li> </ul>

Table 2: Why PD project 1: 'Specialised Nurse Review' (SNR) was needed

	Aims
1	To identify current establishment of staff employed across 'specialised' nursing roles.
2	To review roles and job plans to assess consistency across roles.
3	To propose a simplified structure and controls on job titles, avoiding inconsistencies and identifying opportunities to reduce costs while ensuring continued service levels.
4	To devise generic job descriptions and job titles for a range of specialised nurse roles.
5	To develop an advanced and specialist nurse framework and career progression pathway.
6	To create a clear organisational strategy for managing roles - development, education, succession planning, career advancement, aim to maintain and improve patient care

Table 3 PD Project 1: 'Specialised Nurse' Review aims

### **3.4.3 People involved in the SNR project**

#### **Project team**

An experienced project leader, with a good track record for facilitating success in hospital projects, was appointed, who assumed responsibility for day-to-day project management. A multi-professional steering board consisted of Director of Human Resources, Director of Nursing, General Manager, Senior Nurse Manager and senior medical consultants. This board was responsible for leading on direction, establishing project aims, monitoring progress and making high level decisions on processes and outcomes and escalating information to the trust executive board. According to Langley et al (2009) critical to meeting project goals and achieving sustainability, is stakeholder engagement and involvement at strategic, senior management level. This was instrumental in putting the project at the forefront of the trust's strategy and appears to have been key to maintaining engagement and meeting project goals.

A delivery group was established, tasked with undertaking activities within their own areas. This comprised senior nurse managers from each directorate, senior human resources personnel and a senior clinical nurse with expertise in advanced practice (myself). They were key stakeholders at organisational level and first point of contact for their directorates. "I was asked by my line manager to represent the directorate I worked within on the delivery group. I was approached by the project manager, who was keen to involve me more than department representation, due to my knowledge and involvement at trust level and as programme leader at the university."

#### **Participant population: 'Specialised Nurses'**

The participant population was identified as band 6 to 8 (Agenda for Change) posts, not in standard ward or department nursing roles, providing advanced or specialist nursing services.. Some anomalies were identified and agreement made for inclusion in this review, or a review of Allied health professionals (another Transformation Programme project) or who did not fit category descriptors. Participation of senior personnel ensured good depth of engagement and supported ownership and active involvement. Maurer (2010) identifies senior management and leadership support as vital for ensuring sustainability for changes, as a result of service improvement. Additionally, active involvement and participation from the project outset, with the 'specialised nurses', developed sense of ownership and inclusivity.

### **3.4.4 PD Project 1: SNR project process**

#### **Communication**

The project initiation document included terms of reference for the steering board and delivery group. After preliminary meetings, an inaugural communication event was arranged, which all identified 'specialised nurses' were invited to. This introduced the project and provided a forum for sharing initial thoughts and ideas and information about the project and how it fitted into the transformation programme. Providing individuals with a significant voice can support commitment and ownership in a project like this (Boomer and McCormack 2010). The 'specialised nurses' were introduced to the steering board and delivery group and encouraged to use their own department's link delivery group member, as point of contact. The reception to this event was mixed, with some viewing it as an opportunity for recognition of good work they were doing, an opportunity to improve patient services and create a strong voice of 'Specialised nurses' for the organisation.

Conversely, there was some resistance and feelings of threat to posts, with savings attached to the project. Such resistance is a common reaction when faced with potential changes, perceived to undermine confidence and threaten people's sense of purpose, according to Holbeche (2006). A great deal of effort was put into managing and dealing with this resistance, which tended to dissipate, as time went by and as benefits of the project came to a fore.

Communication events were held at key stages, enabling the 'specialised nurses' and project team to continue sharing information and to keep abreast of progress and direction of the project. Ongoing communication was maintained through email correspondence, meetings, and some face-to-face, individual informal interviews. A shared drive on the hospital's intranet site created space for shared communication and information. Communication channels were not always as good as they could be and individuals and teams did require some encouragement to interact. There was some negativity and challenges encountered along the way, which was invariably related to lack of agreed consensus on particular aspects of roles and services. On occasions the steering board was consulted and human resources approached to deal with difficult situations. However, in general communication was good and there was a good level of engagement and interest throughout the project. This was apparent with nurses who were keen to share their experiences as they never felt they had been listened to or given the platform to celebrate what they did. Good engagement in

developing and implementing changes has been identified with Iles and Cranfield (2004) reporting this as a way to encourage ownership and interest in sustaining them.

### **3.4.5 PD1 data gathering and analysis**

A multi-method approach to data collection using a variety of quantitative and qualitative methods was used. This included questionnaires, activity diaries, audit materials, other diary approaches, workshops and group meetings.

Each 'specialised' nurse completed a qualifications' pro-forma detailing education and training, and overview of key aspects of their role and job title. The delivery group collaboratively created a template analysis document that helped them build a profile of each post-holder from data, facilitating an objective, un-biased approach. Despite similarities, job titles varied, often not accurately representing the nature of roles. This could be confusing and misleading for the organisation, patients and wider public. A range of education and training featured, from PhD and Masters level courses, to none; high levels of training and assessment of competence to minimal amounts that might reasonably be expected of such roles. Job descriptions were reviewed alongside this activity, mapped against key criteria. Some were up-to-date and had been regularly reviewed through appraisal, were comprehensive and in keeping with hospital governance requirements. Conversely, some were poor quality, lacked clear role descriptors, were out-of-date and a potential risk to post-holders and the organisation.

It was important for senior nurses who managed these 'specialised nurses' to be involved, as they were responsible for taking action on improvements required as a consequence of findings. It also gave them ownership of the project and enabled immersion in the subject matter, for individuals and group members. This was an illuminating experience for the group, who identified diversity as well as numerous similarities between individual nurses, with a picture emerging of categories of different 'specialised nurse.' This was not something to be viewed negatively. Thought needs to be put into re-organisation of working patterns, with titles and roles they describe, being measured against specific standards defining scope and level of practice, according to Barton (2006). Anecdotally, evidence was emerging that the 'specialised nurses' were not dissimilar to those identified elsewhere.

Further data was gathered from electronic activities' diaries, completed by individual participants. This was based on similar work elsewhere, with particular relevance being an Australian study by Gardner et al (2010), who used work sampling methods to provide data for evaluating advanced nursing posts within different settings. Diary activities were compiled following consultation with the 'specialised nurses' individually and in groups. This provided another forum for discussion around roles, responsibilities and activities, through collaboration, sharing thoughts and best practice and creating a platform for uncovering 'mysteries' of their roles.

Data was analysed by categorising activities and matching activity groupings with job descriptions. Despite the different approach used, diaries contained similar activities to the thirty individual items in Gardner et al's (2010) study. Thus, these categories provided a useful means of sorting and analysing data for PD1 (Table 4).

<b>Direct patient care</b>
All activities performed for and in presence of patient/family/caregiver including explanation given to patient/family/caregiver about these activities
<b>Indirect patient care</b>
Activities performed away from patient but on a specific patient's behalf, including co- ordination of care, collaboration with other health care professionals and documentation
<b>Service-related activities</b>
Not patient-specific activities and included attending meetings, teaching/in-service, research, audit, administration
<b>Personal</b>
Activities not related to above categories including breaks, adjusting personal schedules, personal phone calls and socialising with colleagues, education and professional development, socialisation and care of self in terms of providing time

Table 4 Categories of activities from analysis of electronic activities

This provided clarity on workflow and working practices by recording time spent doing certain activities. The 'specialised nurses' reported this as a useful exercise, highlighting what they did on a day-to-day basis, appropriateness to their role, time taken over activities and potential savings that could be made. It also helped keep them at the heart of the project, maintaining ownership of data collection and analysis. This exercise was undertaken by all, except the Consultant Nurses for whom a slightly

different approach was adopted, using an adapted version of the medical consultants' electronic diary. As a small, diverse group, it was felt more appropriate for them to be a separate group, and although included in the project, a decision was made to continue reviewing their roles through a second phase of the project at a later date. A number of categories, grouping different roles emerged, which formed groups for individual workshops to gather more qualitative data about roles and responsibilities, and considering role developments to maintain and develop quality patient care. A workshop approach is a good mechanism for giving individuals a voice in proceedings, fostering increased commitment and ownership. This facilitated good networking opportunities and generated shared ideas for service developments.

#### **3.4.6 Findings and subsequent developments from PD1**

This project raised awareness and made visible the 'specialised' nurses at the hospital, with greater understanding related to the nursing workforce, fostering interest from across the organisation, in terms of contributions they could make in other areas. Importantly, more focus on ensuring good governance of the roles was discussed and strategies put in place. An ongoing, strongly collaborative, inclusive approach drew diverse groups of staff together to work on the review, evaluation and developments.

Over 160 roles from band 6 to band 8b, with numerous different titles, variety of job descriptions, some good, some weak, and varied education, training and professional development were identified and reviewed. The 'specialised' nurses were delivering a range of quality patient services across the organisation. However, in some cases, they were undertaking tasks, which if relinquished, would free time for more quality nursing aspects, drawing on their strengths and competence. The roles were allocated to seven categories, with titles of consultant nurse, advanced nurse practitioner, nurse practitioner, advanced specialist nurse, specialist nurse, senior research nurse and research nurse. Template job descriptions for levels and categories of posts were created, providing parity and consistency of role descriptors and person specifications, regardless of area of practice. DH (2010) advanced level nursing document was used to benchmark criteria within each job description against.

The job descriptions are part of the framework devised as the main project product (Appendix 2.2), offering an overview of 'specialised' nurse roles. A career progression pathway illustrates flexible routes for career progression and succession planning.

This should enable consistent competency and qualification levels across 'specialised' nursing roles, with education and training identified for individuals to develop and maintain competence, to ensure fitness for practice and purpose. This is in line with organisational requirements and advanced nursing nationally and fits the local governance remit for advanced nursing roles, around which there was little clarity within the UK and specifically within the local area, at the time of the project.

Check and challenge meetings were arranged with individual directorate teams to discuss the way forward, savings identified and plans for improvements and streamlining services. A number of sessions had to be arranged because engagement from directorates generally was poor. For future projects, it was suggested that check and challenge sessions would be undertaken earlier in the project cycle. Each directorate did, in time, compile detailed report findings from their own areas and used information to explore how changes could be made for each post, in order to provide good quality patient services; plan education and training and consider how to realise savings. This was in line with a whole systems' approach, aiming for consistency and parity across the organisation.

Savings were made through a variety of initiatives and more effective use of 'specialised' nurse roles, whilst maintaining, and improving delivery of patient services. A better understanding of appropriate education, training and ongoing development was highlighted. Managers were able to guide 'specialised' nurses towards opportunities that would meet service and patient need, alongside career development. A more robust, appropriate training needs analysis resulted, as there was heightened awareness and better understanding of advanced nursing. A final report was compiled by the project team, outlining the review process and outcomes and recommendations for ongoing review and evaluation.

#### **3.4.7 Using findings to influence policy, practice, research, education**

- Development of the hospital framework for advanced and specialist nursing roles being used as a template for other organisations for nurses and other non-medical healthcare professionals;
- The framework fits into the remit of the hospital's governance of advanced and specialist roles, which has not been a clear feature in the UK to date, but this project helped to inform this element locally and regionally;

- Shaping of a new curriculum for post-registration courses at the local university, most notably, the new advanced practice education programme. This is being shared across the UK through the network of advanced practice educators in the UK - working towards standardisation of education nationally;
- This PD project was undertaken in parallel with and as the catalyst for the IPA research study exploring experiences of advanced nurses and their contribution to patient care. This adds to knowledge of advanced nursing locally and widely.

PD1 was successfully completed and processes established to enable sustainability of project outcomes. Development work continued, with commitment across the organisation to develop roles in a more structured, cohesive manner, representing a hospital-wide strategy. The advanced nursing framework is an illustration of how an organisation can develop its own workforce, supported by the evolving knowledge-base of advanced practice that was available. This was a small, locally-based example of advanced practice development but, nevertheless, worthy of noting potential transferability of its process and products, to other organisations, regionally and nationally. The interest it has generated and requests to share work and offer advice and support elsewhere, is testament to this.

#### **3.4.8 Reflection on PD project 1: Specialised Nurse Review**

(4/2015) "My involvement in this project brought me up-to-date with current developments in advanced nursing. I enhanced and further developed practice development and project management skills and knowledge. My researcher skills were building, in terms of methods used, albeit within the context of PD. The PD literature review informed the project team of the background and current knowledge of advanced nursing, which was an area they were not familiar with, as well as ensuring currency of my knowledge. This was important as I was providing an expert advisor role for the project. Reflecting on this aspect of the project, the literature review was not undertaken in a scholarly manner and if I was to pursue a similar activity, I now have hindsight to realise this is equally important for PD as it is for more 'formal' research and a more robust approach may have added value to the early stages of the project. As the project progressed I became a key, influential player and my expertise as an advanced nurse and educator was sought throughout. In addition, being on this project team was an opportunity to put my skills and knowledge to good use in helping investigate and shape advanced nursing at the hospital. This felt like 'certain uncertainty' was progressing to 'certain certainty' and the innovative approach, using the project within the DProf, as 'serious playfulness.'

As a proactive member of the delivery group, I undertook many activities for data gathering and analysis and product development. I worked closely with the delivery group and 'specialised' nurses, building close, functional relationships, which helped support progress through the project. Within a diverse, multi-professional team, there were numerous challenges, with individuals working together with different opinions, agendas and priorities. Negotiating and potential conflict management skills needed to be adopted, to manage situations and enable the project to proceed smoothly. I felt that, although uncomfortable, I dealt well with difficult aspects, building confidence and competence in my abilities, alongside other members of the team. As I reflect back now, dissemination of the project via various methods appears to be helping to demystify a small corner of the advanced nursing concept and is making a valuable contribution to its body of knowledge.

(4/2015) I reflected on using experiences and findings from the project as the starting point for the research; by this stage, feeling the PD embedded as part of what I contributed professionally. Having the opportunity to investigate in-depth, personal perspectives of nurses who were participants in PD1, was an exciting prospect. There was a significant amount of data gathered during PD1, from workshops, interactive meetings and informal interviews with participants and managers. Although some of this data was used to build the framework, which also supported curriculum development in PD2, this was not in a formal or structured way, through a research process. I wanted to turn this into a meaningful contribution through other means. Therefore, I felt this investigation, through my research, would potentially add value and new insight into advanced nursing, enriching its knowledge-base and embedding data gathered but not used in the PD.

Although it achieved what it set out to, with good outcomes realised, my personal inquiring nature wanted to know more about experiences of the nurses involved. During PD1, I strengthened these thoughts, reinforcing focus on this topic for my research as a means of making more positive contributions to my own profession and specifically, advanced nursing, in addition to more practical, albeit useful findings from the PD ('serious playfulness' and 'certain certainty' in relation to the project and what I could do as a result)." The potential for synergy of the PD and research was coming to the fore and even at this early stage, key themes were starting to emerge that ended up forming part of the conceptual model of advanced nurse in the hospital context."

### **3.5 PD Project 2: Advanced practice education curriculum development**

Advanced practice education curriculum development became PD Project 2 (PD2) (Appendix 2.3 and 2.4), informed by PD1. This supported development of a robust, appropriate advanced practice education programme at the university where I work, and same locality as the PD1 hospital. It was designed to educate and support professional development of advanced nurses within and beyond this specific hospital setting, covering a large geographical area. It was designed to meet requirements for advanced nursing students from hospital and community settings. A similar collaborative team approach was adopted for PD2, where the curriculum was developed by members of the teaching team and university's academic community. As programme leader, I led on curriculum development and writing the programme, supported by a well-established team of advanced nurses who work in joint roles between practice and university, like myself, and other academic and administrative staff, linked to the programme.

The programme was developed, and built on the original one, that had run for many years and that was accredited by the RCN (2002; 2008). We responded to feedback from students, graduates, managers and organisations and with patient feedback used to provide service-user input. This all helped amend the original programme, updating it in line with the evolving nature of advanced nursing, patient and service need. With developments in advanced nursing, since programme validation four years previously, it was pertinent to review and amend contents to reflect current thinking and working.

The resultant programme used DH advanced level nursing criteria (DH 2010) as its benchmarking tool, linking learning outcomes for individual units of learning with competencies within this document (Appendix 2.4). This would support development of theory and practice elements of advanced nursing, facilitating students to achieve the appropriate level of practice in their clinical roles, in line with DH competencies, alongside a robust academic programme of education at Masters level. The programme was successfully validated and delivery commenced. It is proving popular, as was its predecessor. It is well-evaluated by graduates and their practice organisations; considered fit for purpose and practice, in meeting needs of individual nurses and organisations, and supporting academic and practice development. Undertaking PD1 in the hospital was pivotal to capturing requirements and identifying gaps that could be filled through developing and delivering the new curriculum for advanced practice education.

### **3.5.1 Reflection on PD Project 2**

(7/2015) "I was well-prepared and knowledgeable about current advanced nursing roles, practice and development, when embarking on this curriculum development project ('unquestioning questioning'). Although involved with previous programme validations, I had not led on such an event. It was an opportunity to reflect on and enhance my leadership and management skills, linked to the leadership pillar of advanced practice. It involved working with stakeholders internal to the university and externally, and required me to be conversant with local, regional and national perspectives on advanced nursing. It was a huge learning curve (unquestioning questioning'), working through complex, sometimes frustrating processes, within rules and regulations of the university. Building understanding of all aspects of designing and delivering an academic programme strengthened my skills as educator and programme leader, as I became more knowledgeable with academic and administrative processes, and aligning this with clinical practice. I embraced this challenging process with confidence, competence and vigour, with successful validation and delivery of the new programme commencing soon after.

This resulted in my 'certain certainty' in relation to achieving requirements of this project. Having undertaken PD1 within the hospital, had benefitted the education programme development. The hospital framework helped outline what advanced nurses did, what education they needed and where deficits were. This played a role in building the curriculum based on the reality of practice and in line with service and patient need. "

### **3.6 Writing a book chapter on advanced practice career development**

(12/2015) "Involvement with the PD projects gave me confidence to accept the invitation to co-author a book chapter on careers and career development for advanced practice (Walsgrove and Griffith 2015). This also informed the research study, as the topic of advanced nursing was the core theme of the publication. Much like the first stage literature review, the literature review for the chapter highlighted potential for investigating experiences of advanced nurses and their contribution to patient care.

Informal interviews were used as profiles within the chapter, as personal narratives of advanced nurses and practitioners' ('serious playfulness'). This process helped develop interview skills and generally enhanced my researcher skills, towards 'certain

certainty' with understanding and capabilities in this capacity. The interviews helped build the interview schedule for my research study, as I had experience of interviewing, albeit not for formal research. This provided impetus for finding out more about the real life-world of advanced nurses. I wanted to replicate some of this, more formally, and inform the knowledge-base of advanced nursing, through qualitative research ('unquestioning questioning'). Publication of this chapter and recognition received, in writing and using the profiles as part of this process, gave me confidence and the feeling that I was now a 'researcher' who could competently undertake research using similar skills, building on this less formal work, as a foundation on which to build. This was definitely a reflexive stance, not merely reflection on an achievement."

With completion of the PD, there was a solid basis for pursuit of the research in parallel to it, which was already unfolding. This is found in the next chapters, starting with the second stage literature review.

## Chapter 4 Literature review for the exploration of advanced nursing

The first stage literature review provided a basis for the PD and set the scene for the research study. This second stage built on the first, but with more focus specifically related to answering the research study questions. The aim was to outline relevant aspects of advanced nursing, identifying gaps in literature, through analysis and synthesis of findings, from mainly qualitative studies, a few quantitative studies, systematic and literature reviews. This helped to contextualise the research aims, focusing on characteristics and models and contributions of advanced nursing to patient care. The purpose of a critical narrative review, such as this one, is to integrate and summarise a range of appropriate literature, not to look for new perspectives or challenge theory (Pope and May 2006), nor to direct the research. This review does not claim to have identified *all* research in the field, as it is not designed to be extensive or exhaustive, rather an informative snapshot of relevant studies to inform the research, sensitising the researcher to what is known already about the topic (Holloway and Galvin 2016). A third stage enabled ongoing dialogue with literature linked to research findings, keeping updated and providing theoretical support for data analysis.

### 4.1 Literature search and review strategy

The literature search started with identification of a two-stage question, aimed at yielding appropriate literature, in line with the step-by-step approach, outlined by Aveyard (2014).

*"Are there common characteristics of advanced nursing roles and practice that can form the foundation of an advanced nursing framework and do advanced nurses make a positive contribution to patient care and service delivery?"*

The question was formulated, supported by the PEO (Population, Exposure, Outcome) model, described by Bettany-Saltikov (2012), to simplify, target and structure the search process. This helped formulate focused questions and to concentrate searching on relevant evidence, particularly targeting qualitative studies (Table 5). Extraction of key words was used to search relevant papers, with medical subject heading (MeSH) terms added for advanced nursing and qualitative research. This was added after initial searching using *Advanc\* nurs\* AND Practice OR role* had captured a plethora of publications that did not appear relevant. For quantitative studies, the PICO (Population, Intervention, Comparison, Outcome) model is more appropriate, including **I**ntervention and **C**omparison, for search focus.

<b>PEO for qualitative studies</b>
<p><b>Population</b> - Advanced nurses (including plethora of titles, descriptions), patients and or staff in acute or primary healthcare settings, across range of specialist areas</p> <p><b>Exposure</b> - Identification / description / exploration of characteristics / features / attributes of advanced nursing / nurses / practice, skills / knowledge / competence, elements / aspects / criteria, role / practice. Models / frameworks advanced nursing - definition/s, nature of. Benefits, impact, care, treatment, effects, effectiveness, contribution, perspectives, experiences, added value</p> <p><b>Outcome</b> - Structure / foundation of advanced nursing; Contribution of advanced nursing to patient care / service delivery</p>
<b>PICO for quantitative studies</b>
<p><b>Population</b> - as for PEO</p> <p><b>Intervention</b> - Identification, description, introduction of care / treatment / tasks / skills / criteria Service addition / substitution to existing service</p> <p><b>Comparison</b> - other services, staff, costs</p> <p><b>Outcome</b> - Effectiveness / efficiency / impact of advanced nursing care / treatment Patient, staff or service outcome</p>

Table 5 PEO and PICO for qualitative and quantitative studies

Main data sources were limited to CINAHL, British Nursing Index and Cochrane library, accessed through the university's EBSCOhost electronic platform. This was because these databases contain most relevant papers related to advanced nursing and healthcare generally. Flemming and Briggs (2007) cite CINAHL as the most important resource for qualitative evidence, a useful premise for searching studies for this review. There were some overlaps between databases, as well as different results from different ones. The inclusion criteria were publications on advanced nursing, not limited to geographical location or practice setting. A number of preferences limited the search - peer reviewed to increase quality of studies, in English or translated, to make appraisal easier and less likely to lead to incorrect interpretation of findings and date range to maintain reasonable publication currency. Commentary, editorials and anecdotal articles were excluded to maintain quality and rigour of studies used, according to established assessment criteria, such as that outlined by Aveyard (2014).

A summary of the search process is found in Figure 2. identification of more than 200 records was reduced to a more manageable number through the screening process, reducing screened records to 67. These were screened for eligibility by reading titles and abstracts and then accessing the full article or discarded but kept on file, to use as reference. The start date for searching was around the time of the first advanced nurse

practitioner education programme, along with publication of competencies in the UK by the RCN (2002). This marked a period of considerable expansion in advanced nursing in the UK, influenced by key policy documents, including *'Making a difference'* (DH 1999), and *'The NHS Plan'* (NHS 2000), which advocated expanding nursing roles, including advanced nurses. This was followed by much research activity and publications on advanced nursing. Thus, it seemed appropriate to target the search on literature from 2000 to the present (2012). It is suggested five to ten years ensures currency of research findings, with seminal or influential works being an exception to the rule. A further literature search using the same strategy, covering 2012 to 2016 was conducted, with records added later. This addition brought the review up-to-date, ensuring currency of papers, as the initial review took place on starting the research, some years previously.

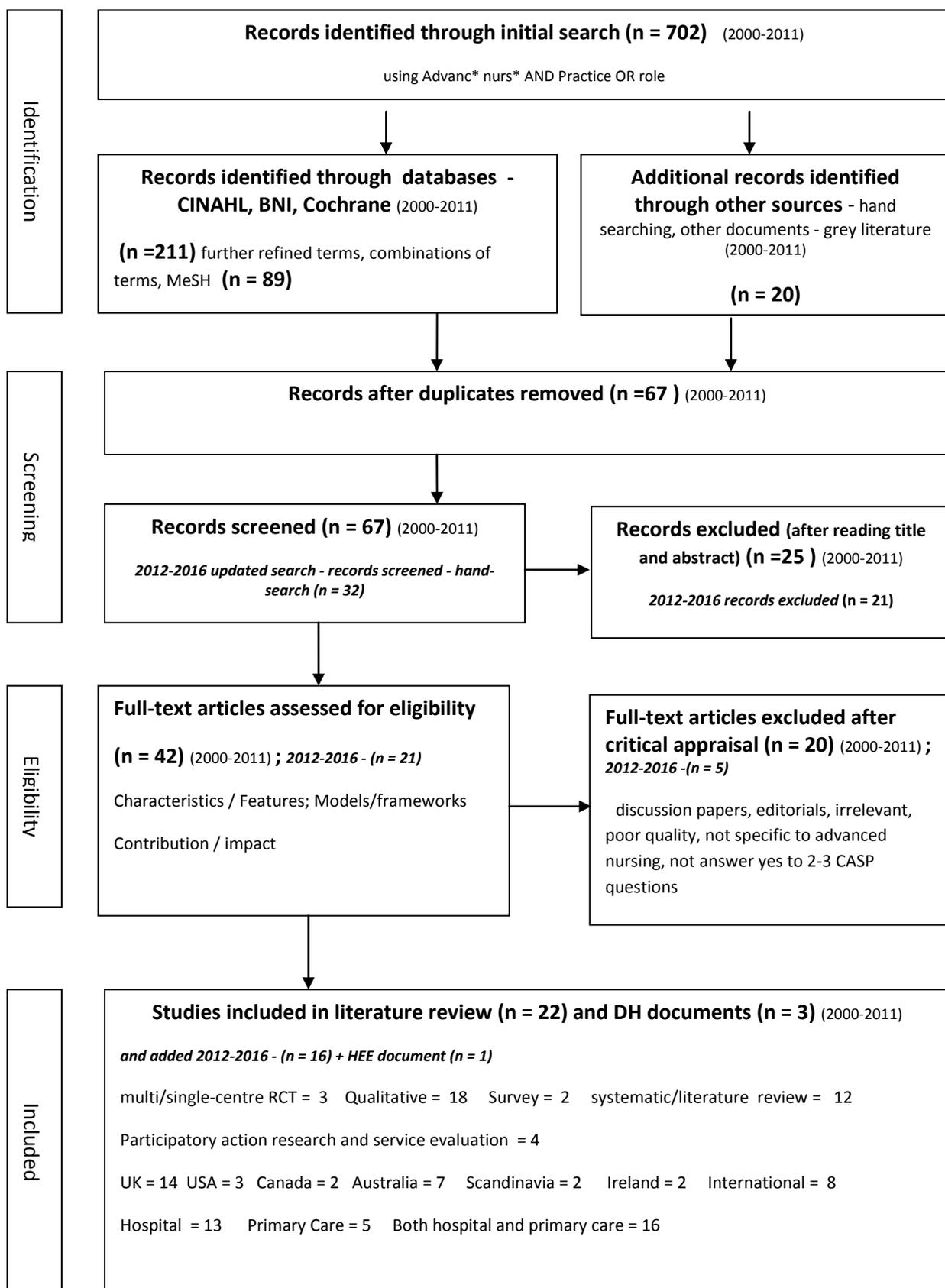


Figure 2 Flowchart for literature search process - 2nd stage literature review

The selected studies were appraised with support of relevant critical appraisal tools; (Critical appraisal skills programme [CASP] 2017) for most papers, as relevant to the particular study design. An adapted version of Crombie's (2008) critical appraisal tool was drawn on for surveys (Appendix 3). This aided structured critical reading and enabled informed judgements on research presented. According to Aveyard (2014) such tools are used to guide processes of exploration and interpretation rather than being a rigid application of sets of rules. Kuper et al (2008) argue this is particularly important with assessment of qualitative research, which requires reflective thought, as opposed to utilisation of a scoring system. Broadly speaking, the aim is to highlight results of studies and whether they are valid and to assess whether results would help inform the research. Thus, all studies selected met most criteria for assessing quality and validity and reliability and/or trustworthiness and were relevant to the research, in some way, even where quality was limited.

## **4.2 Themes from findings of the literature review**

Analysis involved reading and re-reading papers, highlighting pertinent points and drawing themes from findings related to advanced nursing, to answer the literature review question, with details added to tables (Appendix 4), including process, methodology, methods, authors and participants. This helped capture main points and identified themes. The main themes were separated into distinguishing features, characteristics and frameworks/models for advanced nursing and contribution to patient care and service delivery (Appendix 4.1). For characteristics, sub-themes were sub-divided into four pillars of advanced practice. At the next level of analysis, themes were collated from across studies and similarities and differences highlighted. A review of findings is detailed in the next sections, which, when read in conjunction with reference to the literature review tables, provides a collective overview, along with discussion and implications, related to meeting the two-stage literature review question.

### **4.2.1 Distinguishing features of an advanced nurse**

Recurring themes portray distinguishing features of advanced nursing, including professional autonomy, highly developed knowledge and skills, managing complexity, nurse-patient relationships, holistic care and multi-professional teamworking. Professional autonomy in this context, relates to assuming sole responsibility for and freedom to make and act on discretionary and binding decisions made within the

practitioner's scope of practice (Dolan 2000), as opposed to professional practice requiring direct referral to other disciplines. For nursing, this is most often doctors, traditionally seen to hold dominance over nurses' decision-making, particularly when related to patient management (Clark et al 2009). This echoes Stilwell's (1985) earlier definition of autonomy for advanced nurses, in assessing patients with undifferentiated, undiagnosed clinical problems.

Autonomy is a consistent feature reported, aligned with high levels of decision-making and independent, directly accountable practice. An example is seen in Dalton (2013), who highlights decisions made in initiation and administration of evidence-based therapeutic interventions. This was a key finding from this grounded theory study undertaken by an experienced ANP, that extracted data from six doctors, six nurses and six ANPs in a single hospital setting, through focus groups and semi-structured interviews. This provided a range of perceptions of the ANP role, through an appropriate, rigorous methodological approach that is clearly described, resulting in interpretation of ANP roles in this specific context. Caution needs to be exercised as this is specific to this individual setting and the author may have been influenced by his own professional role. However, critical appraisal revealed key points relating to characteristics of ANPs that could be considered elsewhere in similar settings.

Although a single setting study, it offers a detailed profile of what the ANP does, but perhaps lacks depth in exploring experiences of being an ANP. Considering autonomy in relation to other nurses, advanced nurses are seen to display extended scope and a higher level of practice, compared to entry-level registered nurses, with their professional autonomy relative to this. Other larger-scale studies, including Marsden et al (2003) and Gardner et al (2007) also report similar findings. These two latter studies offer superficial exploration of advanced nurses' autonomy but this is related to significantly larger groups of participants. Autonomy is included as an underpinning principle of advanced practice in the UK's advanced practice framework documents published in 2010, which drew on the extant evidence-base of advanced practice, such as some of the studies included in this review, alongside experiential and opinion data from relevant experts.

A recurring theme throughout the literature reviewed is professional autonomy and independent practice enabled through relevant expertise, usually related to the specialist practice setting of advanced nurses. This tends to be largely generalist in

nature, in primary care settings and emergency departments (Carnwell and Daly 2003; Norris and Melby 2006) or targeted towards distinct specialist areas (Yeager et al 2006; Jackson and Carberry 2014). Also, most papers referred to specific expertise related to knowledge and skills encompassing a broader remit than the specialist area. This enhanced knowledge and skill-base is accompanied by advanced levels of clinical and diagnostic reasoning. A systematic review by Mantzoukas and Watkinson (2006, p. 32) asserts that ability to make judgements is inherent to decision-making for response-based clinical practice, arguing that,

*"The relevance of knowledge is that it provides a building block for developing the skills required of an advanced nurse practitioner."*

Linked here is a recurrent feature of advanced nurses developing innovative, creative roles, developed through experience, knowledge and skills, referred to as pioneering and usually initiated from patient need. This includes Williamson et al's (2012) ethnographic study conducted by experienced qualitative researchers, who explored, in depth, ward-based ANPs roles in a single hospital in England, similar to the setting for my study. Participants included patients, ANPs and ward nurses, which provided a reasonably well-balanced perception of the role, how it functions and benefits it brings. Jackson and Carberry (2014) reported similar findings with focus on newly developed advanced nursing roles in a specific critical care setting, with evaluation of activities undertaken, providing comparative data with medical tasks. Lloyd-Jones (2004) previously suggested such diversity tends to cause ambiguity for specific roles, with confusion around what advanced nursing is, perhaps curtailing developments in some areas. Certainly these two studies provide detail of what advanced nurses do, but lacks depth of exploration of 'how' and 'why' aspects.

The ability of advanced nurses to critically appraise and interpret practice, draws on phronesis or clinical wisdom developed through experience. Flaming (2004, page 251) asserts that

*"using phronesis instead of 'research-based practice' is the guiding light for nursing practice."*

This is alluded to in Mantzoukas and Watkinson's (2006) and Hutchinson et al's (2014) literature reviews. This latter paper reported on meta-analysis of more than two decades of research, concluding that there is more consistency across examples of advanced nursing than previously thought but that there is a paucity of qualitative data to get at the deeper understanding of such elements of advanced nursing. Implications

in the literature are that advanced nurses use a range of different knowledge, such as intuitive, ethical and personal, alongside discriminate use of research-based knowledge.

With their considered higher level of expertise than their entry-level registered nurse colleagues, advanced nurses are reported as assuming a mix of responsibilities, drawing on traditionally medical and their own nursing expertise, highlighted in Rosenfeld et al's (2003) and Gardner et al's (2010)'s descriptive work sampling studies; these reported smoothly blending of nursing and patient management activities, using extended scope, advanced practice skills. This more recent Australian study's findings are equally applicable to the UK, with established sets of work categories clearly described and drawn from International literature on advanced nursing functions and research studies conducted by the primary researcher. The study covered observation of the work of 144 advanced nurses across a significant number and range of different clinical settings, but mainly focused on what advanced nurses do rather than in-depth focus on experiences of being advanced nurses.

Application of significant clinical expertise is seen with advanced nurses managing complex care situations and managing risk, accompanied by autonomous decision-making. This is identified in a number of studies reviewed, including Kucera et al's (2010) narrative analysis of 59 nurses' stories from across a range of settings. Drawing on collective cases studies to evaluate impact of ANP roles on patient, staff and organisational outcomes, McDonnell et al (2015), reported similar findings. This was achieved through interviews and non-participant observation, yielding good quality, in-depth data analysed and interpreted by a number of appropriate expert researchers. O'Connell et al (2014), focused on capabilities, whilst continuing to emphasise advanced nurses dealing with complexity as a mode of practice, applying competence in unfamiliar and familiar situations.

O'Connell et al (2014) argue, through their large-scale systematic review, that advanced nursing is moving beyond characterisation by a set of core competencies towards advancement, in terms of capabilities underpinning their practice. Most studies reviewed demonstrate advanced nurses using advanced assessment skills to achieve a more holistic approach to patient care, which is not a new finding but further supported through more recent research. Similar features were outlined within a holistic framework by Bryant-Lukosius and DiCenso (2004) through participatory action

research in Canada and other qualitative studies (Donnelly 2006; McNamara et al 2009; Williamson et al 2012). Another feature linked with holistic care, is building and maintaining relationships with patients. The advanced nurse is seen working closely and in partnership, building therapeutic relationships with patients, with contributing factors relating to empathy, advocacy and enabling emotional and psychological support for patients (Sandhu et al 2009; Nieminen et al 2011; Jokiniemi et al 2012).

Such factors are not unique to advanced nursing, but fit with the central premise of caring, at the heart of nursing and integral to nurse-patient relationships. This is drawn from work of eminent nurse theorists, including Watson (1985) and Parse (1987). Bradshaw (2000) suggests there was a move away from these core nursing roots, with development of advanced nursing focusing on a medical, task-driven approach. However, as advanced nurses developed more autonomy and healthcare changes arose needing emphasis on more social aspects of patient care and management, there appears to have been re-direction of advanced nursing, cognisant with caring. Examples of this shift are reported in qualitative studies that analyse data related to in-depth exploration of experiences and perspectives of advanced nurses themselves, including Donnelly (2006) and Williamson et al (2012).

Working collaboratively with multi-disciplinary teams is reported as a feature of advanced nurses. They are seen working closely with all levels of health and social care staff, as part of multidisciplinary teams, often as team leaders, providing input characterised by high standards of patient management. This is reported in Fleming and Carberry (2011), Nieminen et al (2011) and McDonnell et al (2015) as a pivotal contribution to quality patient care. These researchers used appropriate methods (focus groups, non-participant observation and interviews) to gather a wealth of in-depth, qualitative data from advanced nurses, their managers and doctors to provide a balanced perspective from lived experiences. This supported rigour and quality assessment of the studies. Multi-professional working and close collaborative relationships are viewed positively and as necessary to achieve high standards of quality care and support holistic, person-centred approaches. The advanced nurse is referred to, in a number of papers, including Fleming and Carberry (2011) and Williamson et al (2012), as a 'lynchpin'; at the centre of patient care, pulling all aspects together, through multi-faceted, adaptable, dynamic approaches and as key players in co-ordination of care and treatment. This multi-professional element is not always seen positively, with Jakimowicz et al (2017)'s systematic review reporting on

advanced nurses experiencing difficulties establishing and maintaining value of advanced nursing in general practice settings, focusing on relationships with doctors.

#### **4.2.2 Characteristics of advanced nursing**

Characteristics of advanced nursing were identified, related to the four pillars of advanced practice, with predominant focus on direct patient care. McNamara et al (2009) reported 60-75% of the multi-faceted advanced nursing role mostly involved in direct patient care and clinical support. This is a theme in other studies, including Barton and Mashlan (2011) and Neville and Swift (2012). Jackson and Carberry's (2014) UK study, although only based on one week's data, reported half the advanced nurse's role was direct patient care, independently assessing patients and prescribing. The authority to prescribe was a ground-breaking addition to the advanced nurse's repertoire of skills. Gardner et al (2007; 2010) identified direct and indirect patient care activities in similar work sampling studies in Australia, to Jackson and Carberry (2014).

These characteristics run alongside best qualities of nursing care, drawing advanced nurses back into their nursing practice sphere. The literature asserts that it is about medically-orientated skills or 'tasks' as additions to care provision within a nursing framework, for holistic assessment and management of patients. It is purported that advanced nurses do not consult with a patient as a doctor would, but interact with patients whilst maintaining nursing orientation (Bryant-Lukosius and DiCenso 2004). Even within this snapshot of literature, nursing care function is a consistent theme, with addressing health needs, assessing psycho-social status, optimising care, health education and supportive aspects, seen as characteristic. Jakimowicz et al (2017) indicate possible tensions arising for advanced nurses being able to offer quality care of this nature in time-limited consultations. In contrast, other researchers report on roles that embrace all aspects of an advanced nursing role, including Fagerstrom and Glasberg (2011) and McDonnell et al (2015).

A strong focus on leadership is reported in papers, including Dowling et al (2013), who undertook a large-scale review of a wide range of literature, describing and analysing advanced nursing. They concluded that leadership and autonomy as central to effective performance of advanced nurses. Yeager et al (2006) and Nieminen et al (2011) found advanced nurses making a strong visible leadership contribution in organisations where they worked. The primacy of leadership function remains closely

related to patient management for advanced nurses. Daly and Carnwell (2003) continue this theme, referring to direct patient care perspective running alongside the strategic role. Barton and Mashlan (2011) outlined leadership function of ANPs for their patient caseload within the specific service where this evaluation took place, as opposed to this only being the domain of medical consultants.

Service-specific aspects, such as practice development and at a more strategic level, influences on clinical and policy decisions and clinical developments, are outlined by Donnelly (2006) and Nieminen et al (2011). Also, Fagerstrom and Glasberg (2011) undertook an exploratory study reviewing seven new ANP roles across a range of settings, through interviews with their nursing managers. They reported on ANPs' contributions to the organisations' learning and caring cultures. Part of the advanced nurse's leadership capacity is insider knowledge of healthcare to facilitate patient care and initiate improvements (Williamson et al 2012). Barton and Mashlan's (2011) service evaluation identified that, despite the advanced nurses being able to develop their roles and shape services, this was hindered by the organisation's inflexible structures, which was contrary to effective use of advanced nurses. More recently a shift to transforming such cultures, is seen with implementation of new ways of working and models of care, proposed by NHS England, such as '*NHS five year forward view*' (NHS 2014), proposing advanced nurses as a means to help meet healthcare needs.

The educator role of advanced nurse is seen as a core function, in relation to educating patients and staff. With patients, a significant element revolves around condition-based information-giving, health education and promotion and a resource for information and advice. Fleming and Carberry's (2011) experiential findings from perspectives of participants outlined experiences of advanced nurses, as educators and role models, who shared a wide knowledge-base with nurses and other staff. Perhaps with pioneering and relatively innovative perspectives of advanced nursing, the role model aspect is important, for sharing 'what', 'how' and 'why' aspects, taking roles forward to meet patient and service needs. Advanced nurses are reported as having an informal educative role for nurses and other staff, including junior doctors, and in a more formal capacity, teaching, clinical skill development and competence assessment (Sheer and Wong 2008; Hutchinson et al 2014).

This all links with their research function, reported as key to sharing knowledge and development of the evidence-base of nursing, more specifically advanced nursing

(McNamara et al 2009). Characteristics related to research are not strongly represented in the papers reviewed. Bryant-Lukosius et al (2004) assert that advanced nurses lack skills, knowledge and experience and resources to participate in research activities. They suggest this may adversely affect opportunities for developing roles and development of knowledge associated with advanced nursing. Gardner et al (2010) reported only one to six percent of activities of advanced nurses in their study included research. Several authors, including Fagerstrom and Glasberg (2011) comment on research, in relation to working to and being part of development of an evidence-base and critically appraising and applying research findings into practice. Although not specifically related to traditional research function, the advanced nurse is viewed as a change agent, evaluating practice, identifying and leading on improving practice (Begley et al 2013).

#### **4.2.3 Models and frameworks for advanced nursing**

Randomised controlled trials (RCTs) by Venning et al (2000) and Kinnersley et al (2000), both of which appear to have been rigorously conducted and Horrocks et al's (2002) systematic review of RCTs in primary care, reported on advanced nursing, with emphasis on doctor replacement models. Disappointingly, this review did not cover UK papers, as evidence was limited at the time. Sandhu et al (2009) demonstrated a similar focus comparing advanced nurses and doctors consulting with patients in an emergency department. Consensus on a number of models relates to the primary focus of clinical practice. This includes Ackerman et al's (1996) '*Strong model of advanced practice*', characterised by a blend of extended clinical practice with standard nursing functions, which largely mirror the four pillars of advanced practice. This model has been used as a template for other models, including Gardner et al (2010).

There continue to be a number of advanced nursing models developed, whose drivers constitute a medical substitution approach. Barton and Mashlan (2011) refer to a functional substitution service model where advanced nurses directly replaced doctors, however, this was also characterised by best qualities of nursing practice. Jackson and Carberry (2014) reported on a model with emphasis on specific roles traditionally associated with doctors, with more than fifty percent of the role being independent patient assessment and prescribing, usually performed by trainee anaesthetists.

Bryant-Lukosius and Di Censo's (2004) participatory, evidence-based, patient-focused process for advanced nursing role development, implementation and evaluation (PEPPA) framework was created through a participatory action research process. It was developed from adaptation of two existing frameworks, as a multi-functional model firmly embedded in a nursing, as opposed to a medical model of care. The focus was on addressing patient needs through delivering coordinated care and collaborative relationships, using the broad range of advanced nursing skills, knowledge and expertise across all role domains and scope of practice. This has continued to be used extensively in Canada, where it originated as a model for developing advanced nursing roles, an example of which is reported in McNamara et al's (2009) service evaluation, testing use of the PEPPA model to develop advanced nursing roles.

For the UK, this progression towards providing services with a complementary approach, rather than purely a replacement model is described in the RCN's framework for advanced nursing practice and education introduced from 1996, published in 2002 and updated 2008 (RCN 2008). Nursing expertise is the cornerstone for developing advanced nursing roles, with opportunities to combine the art of nursing with clinical tasks, traditionally considered the remit of doctors. It is arguable that emergence of advanced nursing beyond doctor substitution, is influenced by nursing's values-base of care and desire to keep the person at the core of practice. This is underpinned by a caring, holistic nursing philosophy, which echoes throughout many papers reviewed. Mantzoukas and Watkinson (2006) identified an integrated nursing-medical model, with provision of holistic patient care and treatment. Strongly portrayed in this systematic literature review is embedding of advanced nursing values and holistic practice.

Donnelly (2006), Yeager et al (2006) and Norris and Melby (2006) refer to blending caring and curing, with addition of medical functions within a nursing framework, blurring boundaries between medicine and nursing. However, this came with traditional boundaries being tested, with introduction of advanced nurses facing challenges that this potentially brought. It is argued that implementation of advanced nursing models, requires pre-empting and resolution of areas of resistance and an organisational culture that enables innovation, according to Barton et al (2012). Kucera et al (2010) mirror previous studies, with similarities relating to merging medical and nursing aspects. Fleming and Carberry (2011) continue this theme, demonstrating synthesis of expert nursing practice with traditional medical elements and provision of continuity of care for patients.

Another theme relating to frameworks and models for advanced nursing, reflects its multi-dimensional nature, centred on the patient, as seen in McNamara et al's (2009) service evaluation of advanced nurses in Canada. This was similar to Kucera et al (2010) who present a model of advanced nursing practice, with a patient-centred approach, using a full repertoire of skills at a higher level.

Hutchinson et al's (2014) systematic review summarised more than two decades of research on characteristics of advanced nursing, with data ranging across a large number of participants. They reported greater consistency across practice categories, that had previously been reported. They identified seven domains of advanced nursing practice, which include autonomous advanced clinical practice and care planning, improving care, educational activities, research, leadership within and outside organisations and management activity. These domains are congruent with the four pillars of advanced practice and continue with similar themes, confirming an overall picture of advanced nursing, ranging from 1990s to the present. A theme supporting consistency for advanced nursing frameworks can be seen in Gardner et al (2016) and Bryant-Lukosius et al (2016) who drew on the conceptual model developed previously as Bryant Lukosius and Dicenso's (2004) 'PEPPA model', discussed earlier. Also, Ackerman et al's (1996) 'Strong model of advanced practice' has been used more recently as a template for other models, such as Carryer et al (2017).

Concurrently, in line with multi-dimensional models that have emerged, there appears to be flexibility and adaptability around advanced nursing, as it responds to the ever-changing picture of healthcare globally. This has continued through to the current picture explored in more recent research. Perhaps this adds to ongoing debate and difficulties trying to pinpoint a rigid, static structure for advanced nursing that might be considered as a single framework, despite examples of a number of evidence-based models and frameworks that were emerging to conceptualise advanced nursing. To add to the debate, maybe there is no need to try to achieve consensus, as this could stifle innovation and creativity in development of advanced nursing to meet patient needs and changing service delivery models.

#### **4.2.4 Contribution of advanced nursing to patient care and healthcare service delivery**

Using quantitative approaches, Venning et al (2000), Kinnersley et al (2000) and Horrocks et al's (2002) compared aspects, such as cost-effectiveness, length of consultations, patient satisfaction and consultation processes. Generally, findings supported efficacy of advanced nurses, from a 'task-based' approach, rather than all-round experiential one. Sandhu et al (2009) continued similarly by comparing doctors and advanced nurses, but with a focus on behavioural elements. Outcome measures in this study covered relationship-building, education and counselling within consultations. The researchers identified a need for further research with regards to impact, which perhaps suggests a less comparative, more experiential methodology would have yielded greater depth of data on contributions of advanced nurses to patient care.

Fleming and Carberry (2011) and Barton and Mashlan (2011) reported on delivery of more timely interventions and improved continuity of care. Neville and Swift (2012) produced a suite of case studies to evaluate 400 ANP roles introduced to improve quality of care and reduce costs, reporting on improvements in quality of care, reduced costs, increases in capacity and extension to the range of services for patients and reduction in medical workloads. Similar findings were reported by McDonnell et al (2015) on advanced nurses in an acute hospital setting, identifying positive impact on patient experiences, outcomes and safety. Martin-Misener et al (2015), in their systematic review of RCTs, focused on cost-effectiveness compared to doctors, concluding that advanced nurses have equivalent to better outcomes and potential cost-savings.

Most papers reviewed referred to positive contributions' of advanced nurses to patient care and service delivery. The themes extracted related to positively influencing patient outcomes, consistently demonstrating high quality, effective clinical practice and patient care delivery. In Australia, Jennings et al (2014) reported, in their systematic review and Jennings et al (2015) in their RCT, both exploring positive impact of advanced nurses working in emergency care settings. Donald et al (2013) and Martin-Misener et al (2015), highlighted, in systematic reviews, key aspects of impact of advanced nurses in care delivery, but concluded that further exploration was required.

Patient satisfaction with care delivery and service provision was reported as high in studies, including McDonnell et al (2015). Fleming and Carberry (2011) previously reported advanced nurses perceived as providing a unique contribution to care delivery. Similarly, Williamson et al's (2012) study reported on the pioneering element of the role, considered pivotal to facilitating the patient journey, with provision of quality, holistic care. These three studies were conducted in similar settings to PD1's hospital and my research study, providing insight into the impact of advanced nursing within acute hospital settings. This may have implications for practice locally.

With more focus on education and leadership, McDonnell et al (2015) reported on the impact of advanced nurses in improvements in staff knowledge, skills and competence and contributions to meeting organisational priorities and policy developments. Begley et al (2013) and Elliott et al (2014) particularly noted the visible leadership contribution of advanced nurses, from a clinical and wider professional perspective, which to date, had been under-represented in research. These two papers reported on different elements of a large national study conducted over several years in Ireland, which drew data from a wide range of participants, including advanced nurses and midwives and specialist nurses, using a range of appropriate methods, such as non-participant observation, focus groups and interviews. The in-depth, qualitative data was supported through secondary data analysis using documentary evidence and literature review.

A small selection of papers has been reviewed, focusing on the impact of advanced nurses on patient care and service delivery. The literature reviewed constitutes a snapshot that highlights the innovative contribution advanced nurses have made in improving access to and quality of care, using a range of quantitative and qualitative approaches.

#### **4.3 Discussion and implications from literature review findings**

A number of relevant research papers were reviewed, covering a range of dates (first stage review of papers from 1990s-early 2000s and second stage papers from 2000-2012, followed by 2012-2016). The review consisted of qualitative, quantitative and systematic and narrative literature reviews, service evaluations and other forms of professional enquiry. From this narrative review, it would appear that there remain gaps in the literature with particular focus on experiences and perceptions of advanced nurses in the UK. However, this review adds to the knowledge-base, through appraisal

of research, with emphasis on features and characteristics of advanced nursing, models and frameworks and contributions to patient care.

Quality of the evidence was variable from a methodological perspective, related to its rigour. In terms of qualitative research, there has been value added from the studies reviewed, even where the quality of the research methodology and processes is limited. A number of studies did not clearly describe what was meant by advanced nurse and advanced nursing practice and there was some confusion around definitions of different roles explored and elements, such as educational standards and qualifications, scope of practice and titles. This makes it difficult to clearly relate findings to other areas, such as the context of this study, and its research and PD.

There appear to be more studies on new roles and their implementation, as opposed to evaluating well-established ones. This is potentially a deficit in the research, as experiences of established advanced nurses are likely to provide depth of insight into roles and services that have grown and developed during the course of the evolution of advanced nursing. It is anticipated that through my own research and preceding PD, that there will be more focus on ANP and CN roles and services that have existed for some considerable time, as well as more recent examples. This may redress the balance, to a small extent, in terms of available literature from the perspective of advanced nursing in the UK.

Although it could be argued that, as this work is focused on advanced nursing in the UK, International studies are not relevant. However, what emerges is a significant world view of advanced nursing, which further strengthens the UK evidence-base. Additionally, it might have been pertinent to review studies only from an acute hospital perspective as this is the setting for PD1 and my research study. However, anecdotal evidence and personal experience indicates that the generic nature of advanced nursing is equivalent within primary and secondary care and across specialist clinical areas. The similar distinguishing features, characteristics and frameworks across settings are reported in studies including Ball (2005) (primary and secondary care); Gardner et al (2007; 2010; Gardner et al 2016) (acute hospitals) and McNamara et al (2009) (neonatology, cardiology, nephrology). Pulling together themes from findings in the papers and considering these within the wider body of knowledge of advanced

nursing, reveals a fairly consistent picture reported as broad, defining elements of advanced nursing.

From this literature review, a number of distinguishing features were identified that underpin practice of advanced nurses and relate to how they function. This is followed by detailed descriptions of characteristics of advanced nurses that relate more to activities comprising their practice. These can be categorised into the four pillars of advanced practice, with direct patient care most dominant but the other pillars evident. Referring to earlier studies reviewed, characteristics were depicted that appear to have been enhanced and built on and are included in more recent research. This strengthens the case for these being well-established, relevant characteristics of advanced nursing, across the UK and other countries, including USA, Canada, Ireland, Australia and New Zealand. Interestingly, despite nordic countries only just coming to the fore with advanced nursing, the two studies from Finland, Fagerstrom and Glasberg (2011) and Nieminen et al (2011), identified similar characteristics, as elsewhere.

At the forefront of advanced nursing, appearing as a thread through the papers, is improving practice, using various approaches, such as service development and research. The tendency within more dated papers, was comparing advanced nursing practice with that of doctors. At this time, they were establishing their identity and challenging traditional medical models of care. Findings were variable and although, in some areas, advanced nurses had a more positive impact than doctors, in other areas they were equivalent to or there was no positive impact, in comparison with medical colleagues. There is also limited description of levels of practice and education of participants investigated, compounding findings and potentially causing confusion.

The more recent papers revealed positive contribution to patient care and service delivery, with moves away from comparative studies towards consideration of roles with a strong nursing orientation, as key to advanced nursing's contribution to patient care. This includes more qualitative studies, exploring experiences and perspectives of participants and focusing on what added value advanced nurses offer patients and services. This is encouraging as part of my rationale for undertaking the research is based around focusing on participants' voices to demonstrate what positive contributions they can make. There continue to be quantitative studies, mixed methods and service evaluations that add data to consider, in relation to positive contributions of

advanced nurses. However, a significant number yield findings that are fairly superficial, focusing on tasks rather than behaviours.

From reviewing literature, the evolving nature of advanced nursing continues to be shaped by visionary thinking, planning and anticipatory adaptation, as complex lifestyles and a rapidly expanding global healthcare environment creates significant challenges. Advanced nursing is and continues to be shaped to address complex and dynamic healthcare system needs and meet demands for flexibility in service delivery. However, this is also seen as fraught with continued confusion and misconceptions and difficulties in establishing a unique professional identity that strengthens and supports the over all concept of advanced nursing and its practice.

Some of the challenges and barriers to implementation and maintenance of roles range from lack of awareness and understanding of the concept and lack of support. In some cases, organisational and professional challenges that restrict adoption of new models of care and ways of working offered by advanced nursing and its practice. Hence, the need to continue to build the evidence-base of advanced nursing from qualitative and quantitative perspectives and through good quality PD and service development initiatives. The literature highlights that, although there continues to remain diversity and lack of consensus around advanced nursing, what emerges, are commonly occurring themes. This includes distinguishing features, characteristics and frameworks, which are briefly described in this literature review.

This review critically appraised a selection of evidence, which contributes to understanding advanced nursing from a number of perspectives and strengthened thoughts around the value of using a qualitative approach, listening to voices of participants and adding an interpretative element. There appears to be limited reporting on distinguishing features of 'how' and 'why' associated with advanced nurses, but more focus on 'what' they do. The literature reviewed reports largely positive influences of advanced nursing on patient care. This is mainly from a qualitative viewpoint but not specifically from advanced nurses themselves, which is an approach worthy of further exploration.

With this small-scale literature review, what came to light was a plethora of peer-reviewed research papers, with the scale of this evidence-base confirming the significance of advanced nursing within today's healthcare services and its potential

influence on improving patient care and service delivery. This further confirms the need to continue to build on this, providing ingredients that highlight implications for practice that exploring advanced nursing can have. It keeps advanced nursing at the forefront of healthcare practice, with my own research and PD adding a meaningful, positive contribution to this knowledge-base of advanced nursing through a synthesised approach and synergy of these two core approaches for this enquiry.

#### **4.4 Reflection on Literature Review**

(2016/2018) "The literature review was undertaken using a rigorous searching and review process. Having informed the PD and started to set the scene for the research with the first stage review, I was not starting from scratch and was acutely aware of previous omissions and mistakes, from the first stage. I approached this review from a better-informed position. Consequently, I was able to gather and appraise a plethora of relevant research papers, useful for informing the research study and supporting thoughts around where gaps in advanced nursing research were, that I felt might be filled, to an extent, through my research and PD. Having to update the review after a period away from studying was difficult as I ended up with too many papers, and found it hard to be selective and reduce the volume.

However, the end result and themes from papers, have been valuable in meeting the aims of the literature review and appropriately informing the research and enhancing the PD. I have built on my search strategies and critical appraisal skills, which are now of a high standard, as I have deeper understanding of processes, as well as knowledge of research methodologies and processes that have been developing during my DProf journey. The review has been beneficial as I have now undertaken a second PD project mirroring PD1, in another hospital and further validation of curriculum at the university. I have been able to use the literature review to inform both projects and greatly enhance content of the advanced practice education programme. However, it also made me realise that there remains a dearth of literature to draw on to continue to drive forward advanced nursing. This is the drive I need to ensure that I share synergy of the PD and research. through publication, beyond the thesis."

The background and context for the research have been established through the PD and literature review, setting the scene for the research, which is captured in the next chapters.

## Chapter 5 Research design and methodology for knowledge creation

"An Interpretative phenomenological analysis exploring what it means to be advanced nurses in an acute hospital and their views on their contributions to patient care"

### 5.1 Background to and rationale for the research study

The ultimate goal from fusion of the PD and research was to create new knowledge of advanced nursing, with the research focusing on more in-depth exploration that lends itself to a qualitative approach. This should add to the extant body of knowledge, with a quest to enhance and improve patient care and service delivery, within a framework that keeps the person at the centre of practice. Moule and Hek (2011) assert that excellence in practice depends on the professional group's research and evidence-base and that there is a responsibility to contribute to one's own professional knowledge-base through research activities, in this case advanced nursing, which subsequently has been achieved.

Reflection on the rationale for undertaking the research is summarised in personal narrative recorded in my researcher diary. " For a nurse undertaking research, like myself, the value of this type of practice-orientated research is that findings are aligned with topics usefully explored in practice. This can support concomitant developments and enable translation of research into practice, as argued by Curtis et al (2017). This is also in line with the DProf research requirement of building on practice-based knowledge, offering understanding of aspects of advanced nursing, locally and generally."

As Curtis et al (2017, page 862) purport, that really resonates with my personal viewpoint,

*"Translating best research evidence can make a more transparent and sustainable healthcare service, to which nurses are central."*

Motivation to pursue the research study, fused with the preceding PD, was fuelled by reflection on current available knowledge, from three levels, conceptualised by Klein and Kozlowski (2000):

- Macro - general concept of advanced nursing;
- Meso - advanced nurses in the UK;
- Micro - individual advanced nurses in an acute hospital setting

As the research focused on a particular group of nurses in one setting, as did PD project 1, publication of the study adds to existing macro and meso level evidence, building on the general concept of advanced nursing and focusing on the UK model, thus supporting currency and context of the evidence-base. At micro-level, PD1, was initiated because little was known about advanced nurses or what they did in this particular hospital. The project culminated in development of a framework for advanced nursing, from the PD. Continued exploration of advanced nursing, at a deeper, more personal level than was possible or required by the PD was anticipated to enhance this synthesised study, through the research element. Knowledge generation from the research, using the PD as its foundation, expected to reveal detailed, individual and shared experiences of advanced nurses within this specific hospital setting. This can be a valuable addition to the knowledge-base, as it is steeped in the reality of practice. Depth of description and interpretation should enable readers themselves to critically reflect and appraise the study, considering implications for their own practice, in their own settings and in relation to its fusion with the PD.

The research study aimed to explore experiences of being advanced nurses in this specific hospital setting and to find out what their views were on their contribution to patient care and service delivery. Although invaluable, informative and key to advanced nursing at the hospital, the PD can be strengthened by inclusion of research findings from this study, as it continues on the ongoing cyclical pathway, which McNiff (2013) outlines as characteristic of PD. Sharing this work through publication and other dissemination methods will further provide a way of contributing meaningfully and openly to the knowledge-base and will ensure it is more widely accessible.

## **5.2 Research questions and aims of the research study**

Consideration of goals for the research is captured in personal narrative, in my researcher diary that set the scene to developing the research questions and aims of the research study. "After deliberation and discussion with colleagues, my student group and supervisors, two preliminary, broad research questions were created, which concentrate on participants' experiences and encourage exploration of what it is really like to be an advanced nurse and what their contribution to patient care is, from their own perspectives. Having completed most of the PD and literature review, I had refined thoughts of what I wanted to achieve by pursuing the research, merging it with these other two elements that provided a strong foundation. This is illustrated in the

research questions and subsequent aims and objectives that arose. In selecting the approach and framework to use, I considered the research question from my axiological, epistemological, ontological and methodological perspective as a constructivist nurse researcher and practice developer, wishing to explore individuals' constructions of reality (Mertens 2015). Such consideration should support quality and rigour, in accordance with a qualitative approach, and more specifically IPA, and drawing on Yardley's (2008) principles."

Two broad research questions were created from preliminary reflection on the topic of advanced nurses' experiences and perspectives, refined following the literature review.

- 1: What does it mean to be an advanced nurse in this acute hospital setting?
- 2: What contribution do the advanced nurses believe they bring to their patients' care and related service delivery?

Reflected in these questions is development of an interpretive element for data analysis, and putting personal experiences explored within a wider social (healthcare practice), cultural (advanced nurses in a hospital setting) and theoretical (advanced nursing) context. Denzin and Lincoln (2017) view this type of approach as congruent with the epistemological stance of an interpretive qualitative inquiry that is context-specific and uses a data-driven (bottom-up) methodology, which prioritises participants' own personal accounts. Seeking to explore how individual participants make sense of their experiences, engaging with the meaning their experiences hold, and what they think and feel about them, requires interpretative, contextual methodology, that needs capturing within the questions and aims.

The research questions, aligned to the aims of the study, provided guidance for its pursuit. The aims were:

1. To undertake a small-scale research study, using an IPA approach to enable the research questions to be answered, using the broader-based PD undertaken in parallel to this study, as a sound foundation.
2. To explore the life world experience of being an advanced nurse within the specified hospital setting, from the participant's own viewpoint, through IPA-orientated interviews.
3. To understand what the advanced nurses' perceptions are, of the contribution and added value they bring to patient care and service delivery, through interviews.

4. To investigate, using phenomenological, hermeneutic and idiographic elements implicit within an Interpretative Phenomenological Analysis (IPA) approach, both individual and collective perspectives of the advanced nurses, exploring similarities and differences.

Drawing all the different elements together and considering the overarching goal for the research, supported creation of its title:

"An Interpretative phenomenological analysis exploring what it means to be advanced nurses in an acute hospital setting and their views on their contribution to patient care."

### **5.3 Selecting an appropriate research approach**

Reflecting on the background and rationale for the research led to consideration of the best approach. Lavery (2003) suggests that the decision to undertake research of a particular experience, starts with the researcher engaging in a process of self-reflection, during the preparatory stage. Larkin et al (2006 p. 108) argue that approaches particularly responsive to the subject under investigation are likely to generate the best outcomes, which lends itself here, to considering a qualitative approach. Qualitative research tends towards post-positivist or constructivist beliefs, drawing on environmental and individual differences of people. It also considers that there is not a single reality but that the researcher elicits participants' perspectives as multiple realities. There are a number of qualitative approaches that can provide a framework for investigating phenomena within such a milieu, to shape and support the research question/s and methods of data collection and analysis. With this in mind, alignment between the underlying belief system, research question/s and methodological approach helps underpin the rigour and quality of the research, according to Denzin and Lincoln (2017).

Thus, the study was based within a qualitative approach, referred to by Denzin and Lincoln (2017, p.10) as:

*"an interpretive, naturalistic approach to the world...(and) qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of their meanings people bring to them."*

This resonated with me, in terms of conducting the research, taking account of the everyday real-life settings and total context of participants' lives, with consideration of development over time for them, rather than a static moment in time. It could, therefore, provide a means of exploring in-depth, rich, valuable experiences of participants, and hence, discover knowledge through subjective perspectives on their

experiences, in their own words. Qualitative inquiry does not imply a homogenous field; there are a number of epistemological positions that can be employed. This needs to not be taken lightly, requiring depth of contemplation and reflection and detailed exploration, before deciding on the best approach. This includes reflection on the ontological and epistemological underpinning philosophical stance of researchers themselves, which is captured in my researcher diary (Appendix 5).

Qualitative researchers are immersed in the setting of people whose experiences are being explored and there is a close relationship between them. The researcher focuses on the '*emic*' or insider view and delves into perceptions, meanings and interpretations of their lived world and characteristics, as outlined by Holloway and Galvin (2016, p. 3). This approach inevitably requires a non-judgemental perspective from the researcher, as they have access to inner most thoughts and feelings of participants, demanding a good rapport and mutually trusting relationship. This aligned with my personal, professional experiences in clinical and education practice, immersed in advanced nursing. As Willig (2013) purports, the approach needs to support rather than negate the researcher's professional and personal interests and links, therefore, with their axiological positioning, in terms of processes, involvement, inclinations and pre-dispositions. For me, this was bound up with my philosophical underpinning as a nurse, supported by my ethically-driven professional code of conduct (NMC 2015) and 6Cs nursing values. Qualitative research is generally considered value-bound, as opposed to what may be considered the more objectivist, value-free model of quantitative research. With qualitative inquiry the aim is to investigate the nature of participants' realities, usually with some influence of the researcher.

This involves adoption of an approach that carefully guides the inquiry, the context and selection of the processes for data gathering and analysis. These points support the ethical position underlying the conduct of a qualitative research study, such as this one, explored in more detail later in this thesis. Qualitative research, considered in terms of a number of exploratory and interpretive activities, does not favour one single methodological approach over another, according to Denzin and Lincoln (2017). It is more about researchers using their own judgement to decide the best approach.

A range of qualitative approaches was considered, in order to ensure the most appropriate method for the research intention, aimed at obtaining the desired results. This included grounded theory and ethnography. Both these approaches, amongst

others, have been used successfully for exploring advanced nursing, such as studies by Griffith (2004) and Madrean et al (2016) respectively. Grounded theory focuses on building theory around social processes and interactions, tends to use larger sample sizes and is directed towards more macro-level of analysis, according to Achora and Matua (2016). It develops codes and categories from qualitative data to construct theories about the topic (Corbin and Strauss 2008). These aspects of grounded theory were not particularly congruent with meeting the aims of my study. Similarly, ethnography was discounted. Although a specific community of participants was being investigated and likely to bring to the fore certain culture and custom elements, the focus was more on individual experiences and similarities and divergence between them, as opposed to targeting their cultural aspects. Ethnographic studies are designed to explore cultural phenomena where the researcher observes society from the viewpoint of the subject of the study, as outlined by Hammersley and Atkinson (2007). Again, whilst this could have offered a means of studying a homogenous sample of participants like the advanced nurses, a culturally-focused approach was not what I intended for this group.

These methodological approaches, amongst others, have their own unique traits but do share some common features under the umbrella of qualitative inquiry, including the central position of the humanistic, personal voice of participants. A fairly significant number of qualitative studies have been undertaken related to various aspects of advanced nursing, including Griffith (2004), Nieminen et al (2011) and Madrean et al (2016). They have taken different methodological approaches from the one surfacing for my study. Although the core subject matter is similar, a different approach and differently focused research questions would enable concentration on creating new, potentially innovative strands of knowledge, alongside other studies' findings. Thus this could broaden and strengthen the overall knowledge-base and enable individual life-world stories of participants to be heard, when similar findings result. Conversely, the potential risk of using the same approach could result in an element of duplication rather than new knowledge creation. In contrast, my interests swayed towards the two traditions of phenomenology and hermeneutic phenomenology, within which similarities and differences exist, based on their philosophical bases.

Husserl's (1970) conceptualisation of phenomenology focuses largely on description of a phenomenon and the life-world of people and the structure of their experiences. This appeared congruent with how I was looking to proceed. Adding an interpretive element

moved this towards a more hermeneutic phenomenological approach, with consideration of writings of Heidegger (1962/1927) and Gadamer (1990/1960). This includes taking into account meanings that arise from the interpretive interaction between historically produced texts and the reader. With an additional component of idiography considered in the context of my study, this seemed to err towards a third methodological approach, of interpretative phenomenological analysis (IPA) as particularly relevant, and which became the final selected approach. What the alternative methodologies would not necessarily provide was equal merging of three components of phenomenology, hermeneutics and idiography, detailed by key proponents of IPA.

IPA could provide a supportive methodological framework, with the whole focus on experiences and perspectives, for investigating and attempting to decipher multiple subjectivities. This was with the aim of understanding advanced nursing in the hospital setting. Additionally, this echoes with adherence to principles of humanisation that feature throughout this thesis. These principles are at the heart of my own and participants' professional practice, helping this study maintain a values-based approach, in line with ethical research practice. Todres et al (2009, p. 55) refer to the individual as the subject and the world they inhabit and experience as the object, that are mutually co-created, but it is a world that is not objective, rather a *"humanly relational world."*

#### **5.4 The qualitative research framework for the study**

Using macro, meso and micro categories helped identify an appropriate methodology. At macro-level is overarching qualitative inquiry, outlined by authors who, like myself, have strong nursing backgrounds, including Holloway and Wheeler (2010), who are key proponents of qualitative research, particularly applied to nursing and healthcare research. At meso-level, a broad stance of phenomenology, with its philosophical approach to exploring lived experiences. Balls (2009) observes that, increasingly, nurse researchers have been using phenomenology, due to its similarities to nursing, with involvement of the whole person and valuing personal experiences.

Nursing concerns itself with understanding, being perceptive to and empathising with people, which maintains commitment to humanising principles. It recognises validity of personal experiences, respecting individuals, listening to and believing them, and being

able create a good rapport quickly. Such skills are valuable for phenomenological inquiry and as such, nurses may feel they are already adept at carrying out a good interview when gathering data for this type of research. From a personal perspective, I would concur with this train of thought, as a nurse, and now embarking on the pathway of being a nurse researcher, by using this type of approach for my research. Considering phenomenology in more detail, it provides the means of exploring the 'how' rather than only the 'what' of the phenomena. Giorgi (2005, p.76) makes a general statement about phenomenology's evolution as

*"a shift away from the thing and nature toward human beings and their worlds."*

The transcendental phase of phenomenology that emerged from the philosophical perspectives of Husserl (1970) was concerned with the world as it manifests itself to individuals. This is within an epistemology that carefully examines experiences, seeking out lived experience, as consciously experienced by individuals. This tends to focus more on description, but does not rule out some level of interpretation. When based within a Husserlian tradition, personal assumptions are suspended, with bracketing what is known already about a phenomenon. This is an approach that influenced more descriptive phenomenological researchers, such as Giorgi (1997; 2009). He conceptualised a modified Husserlian approach to phenomenology and the framework he used was based on reduction, description and searching for essences.

The emphasis of phenomenology, within this type of framework tends towards uncovering common elements shared across a range of individual experiences, with third person accounts outlining general aspects of phenomena. If only participants' experiences were being captured, this descriptive nature would be suitable. Phenomenology, along with other non-quantitative research that fits within a more qualitative approach, does not necessarily deviate from employing processes and methods that make analysis of its data both rigorous and in line with models of human science historically rooted in scientific methodologies. When there is intention of understanding more about real-life experience of participants, an approach to investigation, drawing on phenomenology as an underpinning theoretical basis, should provide *"vivid and accurate renderings of...experience, rather than measurements, ratings or scores."* (Moustakas 1994, p.105), whilst also ensuring a rigorous process.

A move by Heidegger (1962/1927) towards an existential emphasis that was shared by Gadamer (1960/1989), albeit with some differences in philosophical orientation, viewed

the person as a being within the particular context of their own world. This was with a belief that it is not possible to be objective and to not interpret, as experience and pre-conceptions can not be suspended. Heidegger (1962, p. 37) surmises that,

*"The meaning of phenomenological description as a method lies in interpretation"* and continues with

*"Interpretation is not an additional procedure: it constitutes an inevitable and basic structure of 'our being-in-the-world.' "*

He coined the term *Dasein*, '*there-being*,' to mean the uniquely situated quality of being human. It is this interpretive engagement, with the research participant's account becoming the phenomenon with which the researcher thus engages. Interpretive phenomenology, in contrast to the more descriptive tradition, continued through works of other hermeneutic philosophers, such as Gadamer and Ricoeur, who purport that '*our being-in-the-world*' is tied up with language, social relationships and the historicity of understanding. McManus Holroyd (2007) argues that Gadamer's perspective of hermeneutic experience is a learning experience leading to a significant shift in consciousness, rather than merely a collection of experiences.

Adopting a largely Heideggerian approach acknowledges the ever-changing nature of lived experiences and appears congruent with the underpinning care philosophy and elements of humanisation related to nursing and other healthcare experiential exploration. Langridge (2008) argues for moving beyond philosophising into practice, to considering that there are not really any boundaries between description and interpretation. Perhaps this suggests keeping an open mind and adopting a flexible approach, rather than trying to rigidly adhere to a framework firmly embedded in a specific philosophical approach. He contends,

*"such boundaries would be antithetical to the spirit of the phenomenological tradition that prizes individuality and creativity"* (Langridge 2008, p.1131).

As the research progresses, a regard for writings of these eminent philosophers, researchers and authors will be maintained and drawn on as an underpinning basis. Currently the desire to deepen understanding of participants' experiences, appears to sit best within an interpretative framework, exploring how participants make sense of their experiences. The focus on behavioural aspects in context, as will be the case, is particularly relevant for nurse researchers, according to Matua and Van der Wal (2015). They maintain that nurse researchers are increasingly using hermeneutics to inform their research. Benner's (1984) seminal research on expertise related to nursing practice used qualitative methodology with an interpretive approach. However,

she did not appear to acknowledge the part played by the researcher, nor were participants' views described, both points proposed for inclusion in my study. Benner and Wrubel (1989) continued this type of approach, using hermeneutic phenomenology, in relation to specific aspects of practice development in nursing. Again this resonated for my research, as it was intertwined with the PD, which had provided the context for my research.

Fusing the PD and research strengthened consideration of the best framework for the study, to ensure a quality, ethically-sound piece of research undertaken using a rigorous process. Mercer (2007) undertook an interpretive phenomenological study of nurse practitioners (advanced nurses) with a view to understanding the personal narratives of their lived experiences. This demonstrates an example of such an approach's efficacy and its affinity to nursing. This perhaps accounts for part of the rationale for why nurses, like myself, are drawn to such approaches to shape their evidence-base. An interpretive approach appears to be particularly relevant for exploring the nature of human experience related to nursing, with it being holistic, complex and contextual, as opposed to studying more empiricist aspects of nursing, that might err towards a more positivist approach. It also can support the establishment of a theoretical basis for a particular element of the discipline, in this case, advanced nursing.

At micro-level, the final selected methodological framework, based on Smith et al's (2009) IPA, can enable descriptive, interpretative and idiographic elements of the topic to be explored. Mjosund et al (2016) highlight interpretive phenomenology using an IPA process as a valuable qualitative approach that has been used across a range of disciplines, including nursing research. This is seen utilised by a number of researchers, including Anstey (2012). In addition, IPA is recommended in nursing and related disciplines, as an effective way to explore and understand healthcare. It has also been employed to explore illness from the service user perspective (Biggerstaff and Thompson 2008; Mapplebeck et al 2013). With IPA, the researcher explores how participants describe and make sense of their own personal and social world. It is seen as a popular approach for healthcare because of its focus on subjective lived experiences of participants, merging phenomenology, hermeneutics and idiography. IPA may be used for health-orientated research because people working in the field are interested in hearing narratives related to illness and have an innate need to learn about others' experiences. Perhaps this is tied to engagement and interest of

healthcare professionals in relation to people generally, in their professional lives, and one of the reasons for taking such a career pathway, which is certainly true of myself.

As an established, now respected methodology used in health, social care and educational psychology, with detailed, structured guidance to assist researchers in analysis, this reinforced the argument for using IPA. With the combination of phenomenology and hermeneutics providing the theoretical foundations of IPA, it uses interpretation of phenomena under investigation, as a means to develop knowledge and understanding. This is in contrast to more positivist approaches to obtaining knowledge from experiences. Having now established the methodology of choice, a more detailed overview of IPA is now presented.

### **5.5 Interpretative phenomenological analysis as research methodology**

Interpretative Phenomenological Analysis (IPA) is a qualitative, experiential research methodology, which Smith (1996) describes as a different, albeit complementary approach, to others. It sits under the general umbrella of phenomenology, the tradition from which it emanates. IPA consists of phenomenology, hermeneutics and idiography. It is inductive in nature, moving from the particular to the general, and being open-minded and flexible, rather than predictable or theory-led. Tomkins and Spiers (2014) argue that good quality IPA work is informed by theory, not driven by it, with the rationale and interpretative elements set in the context of existing theory. With a sound background of advanced nursing and synergy of the research and PD adding greater breadth of knowledge to draw from, at a local (micro) level. This would provide the theoretical aspects to inform my research, rather than the theory leading the research.

IPA draws on theoretical perspectives of three hermeneutic theorists, namely Heidegger and Gadamer, previously mentioned, and Schleiermacher. Eatough and Smith (2008) discuss IPA in terms of exploring experiences, focusing on Heideggerian interpretive phenomenology. This puts experiences of individuals as the central facet, with interest focused on how things are in their world. This includes culture, history and language, as perceived in a conscious way, which is the notion of intentionality. Then, what happens between the person and world around them, is considered as intersubjectivity. Ashworth (2006) makes a number of key points relating to the Heideggerian view of phenomenology that are key to IPA. This includes consideration of the individual at the centre of an inquiry being self-interpreting and making

interpretations of knowledge, with their understanding being part of the self. This leads to embodiment as the way of experiencing how they function in that world. Added to this is the concept of temporality, that is perception of meanings, in relation to time, past, present and future. This has an important part to play in how the individual views their own world as it is closely tied to what has happened in their past, what is currently happening and, as a result of this, what they see as part of their lifeworld in the future.

With a different emphasis, but similar school of thought related to hermeneutics, Schleiermacher was concerned with interpreting and understanding the context of text and how authors understood biblical texts. For Schleiermacher, interpretation was tied in with analysing linguistic, as well as psychological interpretation of texts. IPA, similarly, focuses on language as an important element of interpreting participant experiences, as it is key to reflecting the experience and may support shared understanding, together with exploration of how to make sense of their experiences. Gadamer (1976) built on Schleiermacher's work by fusing phenomenology with hermeneutics, integrating individuals within the world of people, objects, language, culture and relationships. He theorised that there can not be disconnection from these facets, and considered that enquiry always starts from the enquirer's perspective.

Shineborne (2011) amongst other authors, argues that IPA is influenced by symbolic interactionism, which relates to individual meanings being uncovered through interpretation of participants' complex, personal life-worlds. With research participants being drawn from the very specific context of the PD Project hospital and under the umbrella of advanced nursing, these facets bind them together as a social group, albeit with an individual element to each one. With this particular study, this selection of the research participants is another element of synergy, from a 'people' perspective, as the same broad group of advanced nurses were the PD participants, as well as the group from which the research participants, were drawn.

Adherence to underpinning of symbolic interactionism through overarching IPA methodology, will emanate throughout this study, and influence findings. Smith and Eatough (2006, p. 325) continue this focus, referring to a central analytic concern of IPA as one of social cognition, linking back to underlying principles of symbolic interactionism as,

*"a concern with unravelling the relationship between what people think (cognition), say (account), and do (behaviour)."*

From a general perspective, this is aligned to what may be considered the most applicable philosophical view, what Guba (1990, p. 17) describes as a basic set of beliefs that guide action. The three key features of IPA, namely phenomenology, hermeneutics and idiography are not unique to IPA but Cassidy et al (2011), concur with Smith et al's (2009) argument that the way they work together and techniques used, make IPA an associated but distinct approach to phenomenological enquiry. Smith et al (2009, p. 37) summarise co-dependency of phenomenology and interpretation,

*"Without the phenomenology, there would be nothing to interpret, without the hermeneutics, the phenomenon would not be seen."*

Implicit to formulating a question for an IPA study, is consideration about what the data can tell us about participants' understanding of and sense-making related to their experiences within their specific context. This focuses on meanings, as opposed to differences or causation, as would be the case with a hypothesis, and more in keeping with other methodologies, such as grounded theory. Larkin and Thompson (2012) continue this argument by advocating that IPA does not test hypotheses, neither does it tend to build theory. However, its outcomes can be considered in relation to existing theory and can inform new theory construction, in this case, advanced nursing.

IPA aims for detailed accounts and to make sense of participants' experiences by systematically exploring and interpreting individuals' lived experiences, as context-specific, within their own settings, focusing on the emic perspective and using rich, personally-focused descriptions. This tends to consider the individual case, capturing rich data from each one, as well as divergence and convergence across cases. To support illustration of this approach, participants' own narratives are pertinent, with direct quotations used to engage with the participant-orientated approach. According to Smith and Eatough (2006, p. 323) IPA enables exploration of

*"reality as it appears and is made meaningful for the individuals."*

This illustrates the idiographic nature of IPA, as opposed to a nomothetic approach to knowledge creation that establishes generalisations from more objective methods.

In IPA, semi-structured, one-to-one interviews have generally been the preferred data collection method, being well-suited to in-depth, personal discussion and the close relationship between researcher and participants. This facilitates engagement in flexible dialogue, with questions modified dependent on participant responses.

Detailed analysis of a single case study has constituted a preferred method used for some IPA research studies, as a means of enabling rich and meaningful data to be gathered. Other methods, such as focus groups have been used effectively. However, Newhouse et al (2011) suggest that focus groups may compromise detailed exploration of personal experiences by being over-ridden by generic, social elements of sense-making by the focus group itself.

Using interviews can enable the researcher, to work jointly with each participant through a person-centred approach to the data collection and subsequent analysis. This resonates with the idiographic requirement of IPA that concentrates on specific individuals as they recount and deal with their own experiences and maintains congruence with principles of humanisation. Review of Alvesson's (2003) critique of the research interview and reflection on the most suitable type of interview method for this study led to consideration of the neo-positivist view of studying facts, that lends itself more to structured interviews. Conversely, the romanticist view of focusing on meanings, combined with the local perspective, taking into account the social construction of situated accounts, made a semi-structured through to minimally-structured interview more applicable for this IPA-orientated study.

Phenomenologically, IPA supports production of individuals' subjective accounts of their experiences, with examination of the life-world of participants and concentrating on their personal perceptions of the phenomena. Participants are encouraged to share their own stories, in their own words, as also features in other phenomenological approaches. These accounts are subsequently interpreted and reflected on by the participants and the researcher. Within IPA, the researcher assumes an active role in the exploratory, interpretative process. Shaw (2010) purports that adopting an IPA approach, with the researcher being proactively involved with participants, requires recognition of the delicate balance between detachment and attachment in the researcher/participant relationship, their personal worlds and individual experiences.

Use of reflexivity enables formal acknowledgement of this interpreter role, with Shaw (2010) stressing the important role of reflexivity for the researcher, involving explicit self-evaluation. Although not exclusive to IPA, Pope and May (2006) consider exploration of different dimensions of the participants' life-worlds as acting like a lens through which to view and interpret data. The participants are facilitated by the researcher to clarify their thoughts and feelings through reflection and analysis, aiding

their understanding of their experiences and perspectives and making them meaningful (Dahlberg et al 2008). With IPA, individual participants actively interpret their experiences and their world and it can be argued, in line with Heideggeran theory, that it is impossible to *not* interpret; Indeed, Rose and Webb (1998) suggest that text may be meaningless, without interpretation. However, Holloway and Galvin (2016) assert that multiple interpretations of texts can be made because of the reflective nature of researchers involved in their own relationships with the world and with others.

IPA employs in-depth qualitative analysis, that always involves interpretation. Engagement in the interpretation proceeds in a cyclical manner, which Smith (2007, p. 27) refers to as the '*Hermeneutic circle*', using detailed individual parts and the synthesised whole, to make sense of the phenomenon explored. The research participant's experience becomes the phenomenon with which both the participant and the researcher engages. Examples particularly relevant to an IPA study might be that each interview is part of the whole study and each experience is part of the whole life. Working around the hermeneutic circle involves moving back and forth between these positions, enabling the interpretation to become dynamic, iterative and cyclical. The researcher then further explains and interprets meanings of participants' accounts as they progress with analysis and discussion within the study.

Smith et al (2009, p. 3) indicate that there is not a single, prescribed way of doing IPA, but it does involve two-part interpretation or '*double hermeneutic*'. Smith and Osborn (2003, p. 51) summarise double hermeneutic as the process through which,

*"participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world."*

Further explanation of the *hermeneutic circle*, is of questioning, uncovering meaning and further questioning enabling interpretation and understanding of the phenomenon, through this *double hermeneutic* approach, characterised with two inter-linked layers. The hermeneutic of empathy focuses on rebuilding the original experience in its own right, while the hermeneutic of suspicion uses external theoretical elements to explore the meaning of the phenomenon. Larkin et al (2006) suggest that there is another layer of hermeneutics in IPA, with the reader making sense of the researcher's attempt to understand the participant's experience. This reminds one of the importance of accurate, comprehensive, clear writing up of the research to enable this interpretative element by readers, making sure findings are valuable for wider audiences.

The idiographic nature of IPA involves close investigation of the individual, with extracts from participants' commentary strengthening this part. Biggerstaff and Thompson (2008) discuss how IPA enables idiographic examination of experiences that is rigorous, albeit within a flexible, inductive approach. Reid et al (2005) allude to flexibility, as not only acceptable, but a strength. Small sample sizes are appropriate for IPA because of the single case or case-by-case, idiographic approach to analysis. The researcher and participants work together in an IPA study, as partners and co-researchers, with participants acting as first hand experts in relation to their knowledge of concepts, exploring these through focused, engaged conversations between researcher and participant. Kvale (1996, p.32) views these conversations as knowledge-constructing, characterising everyday life, suggesting such research interviews are

*"an enriching experience for interviewees, through dyadic interplay with the interviewer, obtain new insights into their life world and the research theme."*

This chapter has provided a background and rationale for the study and refined research questions and aims, with review of methodological approaches helping with the final selection. "Unpicking key elements of IPA was helping me consider how I was going to approach the data gathering and analysis, and how this would sit within the underlying philosophical and theoretical framework that was emerging and that is articulated in this chapter." With decisions made through critical appraisal and reflection on the context and relevance and application to the study, this paved the way to planning the process and conducting the study, outlined next.

## **Chapter 6 The process for gathering and analysing the data**

### **6.1 IPA process for gathering and analysing data**

The systematic process of IPA's framework offers structure but not necessarily completely prescriptive adherence. As a first time researcher, I felt this provided a supportive structure to work within, albeit one that I could adapt to suit the uniqueness of my study. My thoughts around its uniqueness were grounded in the fact that the PD Projects undertaken in parallel with the research (Chapter 3) were inextricably intertwined with it. PD1 provided data on the advanced nurses job profiles, describing what they did, and knowledge and skills and education to support their roles. This was practical, objective data that supported development of resultant job descriptions and the framework for advanced nursing for the hospital. Fusing this with findings from the research would provide synergy of the research and PD, culminating in a synthesised whole exploratory piece of professional enquiry.

However, this left a gap, in my opinion, with regards to how these nurses did what they did and why. Having reviewed literature, this strengthened my opinion on limited research for these specific elements. There was no indication from the PD project of their personal qualities or their thoughts on being advanced nurses or how and why their professional development had taken them on this pathway. I hoped to address this through this study, using depth of exploration of their subjective experiences and perspectives that IPA offers, building on the PD, which provided a strong, informative, key foundation.. With reference to PD Project 2: advanced practice education curriculum development, pursuing this study, would add value to the programme, sharing advanced nurse participants' stories with students and drawing on findings from the study to shape the ongoing curriculum.

Support for using the IPA framework is borne out by reference to growing numbers of studies that have successfully utilised IPA. This is demonstrated within Smith's (2010) paper that reviewed 293 empirical studies from three major databases that used IPA, published between 1996 and 2008. With this significant number of studies reviewed, this provided an opportunity to learn from researchers' reports, drawing on their ideas and giving me confidence for my own methodology and process. This took into account phenomenological (lived experience of advanced nurse participants), hermeneutic (making sense of the advanced nurses' experiences and perspectives on their care delivery) and idiographic (small purposive sample of advanced nurse

participants within a specific hospital) aspects to explore. From a contextual basis, interpretation of lived experiences of being advanced nurses, from their own perspectives and exploring their perceptions of their contribution and added value, in terms of patient care and service delivery, was to be the focus. This is similar to approaches that Edwall et al (2007) and Davenport (2012), amongst other researchers, used with good outcomes in outlining lived experiences.

## **6.2 Quality and rigour for this IPA research study**

All research raises issues related to its trustworthiness and rigour. With qualitative approaches being subjective and considering meanings in context and active involvement between the researcher and data, this contrasts with neutrality and objectivity characterising more quantitative research. In the preliminary stages of my research, it was crucial to plan and implement strategies for research conduct to ensure quality and rigour. As Robson and McCarten (2015) assert, all research, regardless of approach, needs to be open to judgement of its credibility and ethical integrity, with researchers striving for a high level of quality and rigour. Thus, it was important to consider soundness and adequacy of methodology and quality and rigour of processes throughout.

Consideration of relevant and effective criteria will differ from those used to assess quantitative research. This is an area that generates continued controversy and debate, with scholars not able to reach consensus. A number of diverse perspectives on assessing the credibility of qualitative research, discussed by Rolfe (2006), requires researchers to justify and readers to make judgements on whether the credibility of the research is sound, based on a range of different criteria. The typically subjective nature of qualitative research lends itself more to an open-ended and flexible way of assessing its quality that can be applied to the diversity of approaches used, rather than rigid rules more applicable to quantitative research. This does not detract from using robust, systematic and well-organised approaches, seen to be more consistent with a quantitative approach.

Although there are a number of schools of thought on judging qualitative research, what is important is to be able to explain why my study is credible and for readers to be able to make their own judgements. A range of quality criteria was considered, leading to an appropriate strategy to demonstrate quality and rigour for my study. Some more

conventional criteria that characterise qualitative research are of trustworthiness and authenticity, which are used as an alternative to the concepts of validity and reliability, typically associated with quantitative research. This is particularly relevant when used within the context of healthcare research, due to the subjective nature, involving human beings' thoughts, feelings and behaviour.

A combined approach was adopted, using qualitative research criteria for trustworthiness (Holloway and Galvin (2016) and Yardley's (2000; 2008), quality and rigour criteria for assessing the study's credibility. IPA favours the guidelines for assessment conceptualised by Yardley, as essential qualities that characterise good quality qualitative research. These are sensitivity to context, commitment and rigour, transparency and coherence and impact and importance. IPA's creative process requires a degree of flexibility to be applied, rather than following a prescriptive route, whilst still adhering to requirements for quality and rigour. Thus, this strategy demonstrates commitment to the broad, flexible remit of IPA. Noble and Smith (2015, p.34-35) and Holloway and Galvin (2016, p.310) list a number of common strategies for ensuring trustworthiness in qualitative research, against which I checked my research (Table 6a). This was blended with Yardley's (2000, 2008) broad-based principles for assessment (Table 6b). This provided confidence that the required breadth and depth, related to my research conduct was presented, without adherence to rigid criteria and this was transparently and openly highlighted. Table 6 captures this, cross-referencing between sections a and b, where relevant, with further detail offered in the next section.

<p>6a) Trustworthiness strategies for qualitative research  (adapted Noble and Smith (2015, page 34-35 &amp; Holloway and Galvin (2016, page 310) - four core elements of trustworthiness - credibility, transferability, confirmability, dependability as opposed to key terms used for quantitative research - validity, reliability, generalisability</p>	
A1) Member checking	<p>Summarised, repeated, paraphrased participants' words, checked my understanding of their experiences. Returned to participants, themes identified to check agreement with my interpretation of their realities, made changes. Am I on right track? Did I understand this same way you meant it? Helped verify plausability.  Trustworthiness through approval of participants, supports negotiated process of meaning making between researcher and participants</p>
A2) Searching for negative cases and alternative explanations	<p>Open to themes and patterns emerging and looking for challenges and alternative cases that don't fit into the emerging model - viewing all cases as individuals in their own right, as well as moving into looking for similarities and convergence (B1)</p>
A3) Peer review / debriefing	<p>Supervisor review transcripts to ensure IPA approach and check 1st layer analysis. Colleague review transcripts and analysis to confirm if I am staying as close as possible to reality of experiences of participants and to challenge themes emerging</p>
A4) Triangulation	<p>Only limited element of this in terms of investigator triangulation and with data triangulation - not use of single case study but 7 participants for data source</p>
A5) Audit or decision trail	<p>Maintaining detailed record of process and decisions before and during study, from contextual, methodological, analytical, personal response perspective.</p>
A6) Thick description	<p>Detailed description of phenomenon being investigated and the process</p>
A7) Prolonged engagement	<p>Immersion in setting, engage with participants throughout</p>
A8) Reflexivity	<p>Critical reflection on my own preconceptions and discussion of this throughout with supervisors and colleague who peer reviewed my data (B3). My researcher role and relationship with participants. Excerpts researcher diary, personal narrative as tool for engaging in reflexivity - recording thoughts, feelings uncertainties, values, beliefs, assumptions that surfaced throughout research</p>

6b) Characteristics of good qualitative research using Yardley's (2000, 2008) assessment criteria favoured by IPA research	
B1) Sensitivity to context	Evidence-base of advanced nursing; literature review; specific setting of acute hospital trust for PD Project 1 where all participants work. Research questions cover participants' personal experiences of being advanced nurses in hospital and views on their contribution to patient care/service delivery
B2) Commitment and rigour	In-depth engagement with topic (A7) - researcher advanced nurse, engaged advanced nursing, practice and education perspective, immersion in topic, literature review of topic, PD focus advanced nursing. reading, methodology, Masterclass by experts IPA support skills. Good consultation/communication skills in clinical role, transferable to interviews. Interviews audio-taped, transcribed verbatim (A6). IPA process to ensure rigorous approach to data collection and analysis in steps. Immersion in data, support with analysis - colleague / supervisors adds depth and breadth (A1, A7)
B3) Transparency and coherence	All steps in research process described, adherence to participants' own voices, returned to participants to check, direct quotes from participants' transcripts, themes, excerpts from layers of analysis included. Findings presented in-depth, discussion around findings analysed using knowledge-base to support arguments, strengthen descriptions (A5, A6) Reflexivity, role of researcher honestly and openly portrayed (A8).
B4) Impact and importance	Consideration for how the study can add to the body of knowledge of advanced nursing. Transferability to other similar settings, propose model advanced nursing in hospital. Consider model in relation to knowledge-base and other examples from practice

Table 6 Checklist for quality and rigour for research study

Lincoln and Guba (1985) view confirmability and authenticity as key considerations, with strategies used for findings and conclusions to meet aims and enable participants' true perspectives to be recounted. Findings should be consistent and accurate, in terms of dependability, as opposed to the more positivist approach of reliability, which I was mindful of striving to achieve during design and implementation of the study. Silverman (2017) deliberates that data generation and analysis should be relevant to the research questions, as well as comprehensive, careful, honest and accurate, thus enhancing trustworthiness of the research. This is distinct from terms more congruent with quantitative research, such as '*true*' and '*correct*', that many qualitative researchers, including myself, would not consider relevant to apply to their research. Mason (2012, p. 188) adds useful advice for trustworthiness when he purports,

*"At the very least this means that you must satisfy yourself and others that you have not invented or misrepresented your data, or been careless and slipshod in your recording and analysis of data."*

Credibility appears more appropriate for qualitative research than reliability that characterises more quantitative approaches. Credibility is of particular importance, especially in relation to internal validity, with participants understanding the true meaning they give to situations in their personal, social contexts and researchers' findings being compatible with perspectives of participants. This formed part of the rationale for undertaking this study with the aim of getting as close as possible to participants' experiences. It was anticipated that answering the research questions was an opportunity to learn from the insider perspective of advanced nurse participants themselves, offering understandings of the phenomena under examination, through their own stories. For this study, it was participants' experiences and their perspectives that become the phenomena explored, by these insider experts who were participants themselves and myself, to a lesser extent. This has been seen in other IPA studies, with Reid et al (2005, p.20), referring to opportunities for "*learning from the insights of the experts.*" This would really add to more superficial and objective data from the PD.

The detailed account of the sampling strategy supported adherence to sensitivity to context with participants as individuals and their own personal contextual elements, homogeneity of this participant group and the contextual setting of the specific hospital. In keeping with qualitative research as the overarching paradigm and IPA specifically, dependability and confirmability, along with sensitivity to context, were acknowledged through purposive, homogenous sampling of participants. Transparency was apparent

in description of sample selection and inclusion of main demographic and contextual details of participants, with some concealments, to maintain anonymity of individuals.

Transferability is more relevant to the contextual nature of qualitative research than demonstrating elements of generalisability, seen as a hallmark of quantitative research. Generalisability does not tend to be a qualitative research goal, but there may be consideration of patterns, even when exploring individual cases, but this may be irrelevant for single case investigations. For this research, I expected to find patterns of similarities between some concepts related to participants. The research findings need to resonate with readers, with them discovering meanings in the findings and able to relate to them in relation to personal experiences, in their own settings (Kuper et al 2008). This links with Sandelowski's (1993) assertion of trustworthiness and visibility of research to an extent that makes it auditable, leaving a decision trail, enabling the reader to follow and verify the process. All these elements support the conduct of the research from a rigorous perspective.

The idiographic nature of IPA may raise questions of generalisability and replication of study findings elsewhere. In fact, it could be argued that the synergy of the PD and research would add more strength to such aspects. However, IPA is not necessarily averse to making general claims, as long as a careful, step-by-step approach has been adopted. This can be achieved through detailed exploration of each case prior to moving forward and making more general claims. Yardley (2008) differentiates horizontal from vertical generalisability; horizontal relating to applicability across settings and vertical relating to building interpretative theory. It is this latter type of generalisability that's more akin to IPA. With vertical generalisability, the reader can gain understanding of and insight into the subject matter and consider existing theories and generation of new theory from the research. They can interrogate findings, with consideration of their own experiences and make judgements themselves about the relevance and significance of the research within their own and wider contexts.

Choosing the structured IPA framework, utilised to good effect by IPA researchers, such as Cassidy (2012) and Anstey (2012), helped guide the process for this study and supported its rigour. This included conducting the study in line with the phenomenological and idiographic nature of IPA, focusing on participants' accounts of their experiences and what these meant to them. This was alongside the hermeneutic analysis, which maintained commitment to IPA methodology and a qualitative research

paradigm, in a broader context, which fits with sensitivity to context (Yardley 2008). Ensuring rigour can be achieved through a systematic and carefully considered research design, data collection, interpretation and communication.

Rigour for qualitative research that is congruent with IPA's framework, is more in line with achieving completeness of data collection and analysis. For my own study this included the depth of each individual case, with each participant's own life story, and the multiple layers of analysis and interpretation, which demonstrated achievement of rigour, in this sense. Transparency and coherence, from Yardley's (2008) principles, relate to clarity and openness, recounting details of data collection and analysis, with comprehensive, transparent detail of processes, which is apparent throughout the study, and captured in the relevant sections of the thesis.

Once interviews were written up and anonymised, I returned to participants to check with them that veracity, privacy, confidentiality and fidelity, related to transcripts and emerging themes from their data, were apparent. I reflected on this, concluding that this might be construed as possibly working outside the double hermeneutic of IPA. The interpretation of the IPA researcher may not be one that their participants are aware of or able and/or willing to acknowledge. However, with the flexible nature of IPA, I felt it was acceptable and I could justify my reasons for employing this strategy, contrary to the fact that member-checking does not tend to be a feature of IPA. This felt important from a personal perspective, particularly due to my level of immersion in the phenomenon under investigation and novice researcher status. Without it, I felt this may have potentially led to inadvertently moving away from individual personal voices of participants, which I wanted to avoid, and which would have been a greater move away from the IPA framework.

The collaborative approach, related to data, was firstly evident with the participants who I worked alongside in the interviews, in a co-researcher, co-creation of knowledge approach, in line with the double hermeneutic (Smith et al 2009) and through member-checking, after the first stage data analysis. Collaboration was also apparent as I asked participants for consent for my supervisory team and a healthcare professional colleague to read the anonymised transcripts, themes and some of the analysis narrative, to support the analytical process. This permission was duly gained from all participants. This helped increase trustworthiness of data analysis, facilitating a rigorous and transparent approach, and supporting me, as a new, single-handed

researcher. Involvement of researcher colleagues in IPA is encouraged, as a means of ensuring rigorous, analytical trustworthiness. Rodham et al (2013) argue that more comprehensive understanding of experiences of participants results if others contribute empathic or critical interpretation to data, which was evident. Wagstaff and Williams (2014) suggest that any help with reflective and analytical processes adds depth to findings and supports quality and rigour.

Thorough, accurate records of interviews and data analysis were documented, in detail. Rich data resulted from ensuring depth of description and interpretation of participants' experiences and perspectives. This should enable readers to consider findings within a wider context and the research to be disseminated with a view to applicability elsewhere. This meets Yardley's (2008) criteria of transparency and coherence, and commitment to IPA's rigorous process; impact and importance, results from sharing and dissemination of findings locally and beyond, with consideration of the study, adding to the body of knowledge of advanced nursing.

IPA research processes are strengthened through a critically reflective and reflexive approach that can support rigour. Clarke (2009) asserts that understanding a participant's life-world or experience is influenced by the researcher's own experiences and pre-suppositions. It is argued by Smith et al (2009) that the researcher takes on the same sense-making skills as the participant, but in a more conscious and systematic manner. Drawing on their reflexive skills, the researcher attempts to stand in the participant's shoes, metaphorically speaking, assuming an insider perspective. This is whilst also coming from a researcher viewpoint, consciously and systematically exploring participants' experiences and perspectives, standing alongside the participant, in their own shoes. Finlay (2002) refers to requirement for this integration of such a high degree of reflexivity on the part of the researcher, as a means of ensuring integrity and trustworthiness, fitting Yardley's (2008) criteria of transparency.

### **6.3 Research governance and ethics for this research study**

Closely aligned to quality and rigour of research, are the ethical principles that guide its practice and which must be adhered to throughout any study, regardless of approach and thus, were a key focus throughout the research study. The biomedical ethical principles detailed by Beauchamp and Childress (2013, p.13) are equally applicable to research practice, as to healthcare practice. They encompass the moral principles of

*beneficence* (doing good), *non-maleficence* (avoiding causation of harm), *respect for autonomy* (respecting and supporting autonomous decisions) and *justice* (fair distribution of benefits, risks and costs). As the researcher, I was required to adhere to these ethical principles, with regards to over all research strategy and in relation to research participants. At the level of research design and methodology, ethical principles needed consideration for the approach taken, ensuring consistency with the research strategy.

With the research participants, the ethical principles required their fully informed consent, and to minimise any risk of harm to them; protect their anonymity and confidentiality, give them the right to withdraw from the research at any time and avoid using deceptive practices. Selection of the research design, methods, sampling and analysis strategies was considered from an ethical standpoint, with IPA characterised by its approach that values individuals' experiences. An overview of published IPA studies, undertaken within health and social care settings, confirmed this perspective. Part of the rationale for IPA is that it can help understanding experiences of a specific group of people, according to Reid et al (2005), which makes the sampling strategy ethically sound. The analysis of data should provide a means of recording findings that support development and evaluation of services and roles and improvement of patient care, leading on from the PD, which was running in parallel to this research study. This demonstrates that the rationale for undertaking the research was ethically sound, in terms of beneficence, and as a potentially valuable contribution to the evidence-base of advanced nursing. This was already starting to happen from the PD perspective, through local dissemination of findings from the locally-based PD. Synergy of the PD and research using the synthesised whole of the study, would strengthen this contribution as the two elements were not undertaken in isolation.

The theory informing this study includes the current evidence-base of advanced nursing, from a general perspective and locally, including what was emerging from the PD and that was further scrutinised and appraised through the staged literature review. I explored and interpreted associated findings from other studies and re-evaluated existing theory of advanced nursing, in relation to understanding my participants, in their own social and cultural context. As the research participants were from the same participant group as the PD, I already had a reasonable level of knowledge of them, albeit at a superficial basis. This is an approach used in the context of IPA methodology, as purported by Smith et al (2009). As the research progressed and to

support readers' interpretations, findings were presented and discussed further, supported by critical review of literature, exploring similarities, differences and associations between study findings and evidence. This was considered within the context of the PD findings, bringing both elements together, as a synergistic whole.

Prior to starting the study, and following ethical guidelines, a study proposal was written and approval gained for access to participants, from the hospital's research department. As this did not include patient involvement, as outlined within Department of Health's (2006a) *Research Governance Framework for Health and Community Care*, the university's research governance and ethical review processes were followed and relevant ethics approval gained, with the study being part of the university's doctoral programme (Appendix 6). Submission of an online application, along with the research proposal and supporting documents, including interview schedule questions, participant information sheet and consent form was made (Appendix 7). Part of the university's process included ongoing compliance to standards required for data recording, research material storage and disposal. Annual monitoring reporting by the university as part of the D.Prof. process, ensured continued governance elements, from a personal perspective. Also, regular supervisory meetings with my supervisory team, throughout my doctoral journey, helped ensure I worked in an ethical and appropriate way, advocated by Polit and Beck (2017) as essential to such enquiry.

I am always required to work within my professional code of conduct as a registered nurse, in relation to standards of practice and behaviour. Holloway and Galvin (2016) advise on the particular importance of health researchers applying principles that protect research participants from harm and risk, following professional rules set in their codes of conduct and research guidelines, such as that encompassed in the Department of Health (2006a) standard. This is similar to conduct expected in professional practice, so was not difficult to grasp from a researcher perspective, as it is similar to a registered nurse working in a healthcare setting, a familiar setting for me.

Consideration of the potential impact of the research was assurance that my intentions were based on beneficence, with regards to research participants as individuals, as well as for the wider world of advanced nursing and healthcare generally. The potential benefits outweighed potential risks to participants and the wider population, which was confirmed through the research ethical approval process. With justice, the approval process had confirmed that the proposed research strategies and processes were fair

and just. Adding to this are ethical rules put forward by Beauchamp and Childress (2013) that need to be applied to conduct of research and its participants, namely veracity, privacy, confidentiality and fidelity. These principles are not without their critics, with Huxtable (2013), suggesting these elements may be inapplicable, inconsistent and inadequate in healthcare research. He believes they have merit but should be viewed only as a starting point to moral deliberation, rather than an end point and with respect, the authors did suggest they offer a framework for identification and reflection on moral issues. According to Huxtable (2013) there needs to be a degree of judgement in working with the principles, to ensure they are robust and fit for purpose with their application to research participants, in my case, the advanced nurses. This suggests a note of caution in using these principles as an absolute to ensuring the research is conducted ethically.

The possible implications of the research study for participants were considered, and the value of the research itself, both essential considerations for ensuring research is conducted in an ethical manner. The participants' dignity, rights, safety and well-being were taken into account and in line with respect for their autonomy, they needed to participate voluntarily, not through coercion and from an informed position (Department of Health 2006a). As such, they had expressed interest themselves in telling their stories, and this was from a well-informed position, with their expertise in the subject matter, and having been part of PD1. The details of the study were discussed with each participant, including methodological approach and methods, before inviting them to join the cohort. This was reinforced with written information and confirmation of written informed consent. The participants had my contact details and were encouraged to contact me to discuss anything about the study, or if they decided at any time, to withdraw from participation. Thankfully all participants were in agreement with what was proposed and in fact, appeared really enthusiastic at being involved. Throughout the research process, I kept them informed of what I was doing and returned to them regularly to check that they wanted to continue.

Mcilpatrick et al (2006) suggest that an ethical consideration in qualitative research is that interviews can stimulate reflection, appraisal, and substantial self-disclosure. Such outcomes can result in sensitive and emotive issues being elicited by participant interviews. Thus I took this into account, in relation to the potential impact discussing personal experiences might have on participants, focusing on non-maleficence. I needed to be prepared to deal appropriately with any issues, with provisions being

made for participants' well-being and identification of appropriate support, if required. This was discussed with participants during data collection, with no-one indicating they felt they did not have adequate support mechanisms, if required. They were advised they could pause their interview at any time and terminate it, should they feel unable to continue, ensuring they felt in no way coerced to proceed if they did not want to. Interestingly several participants suggested the interview process had been an opportunity to reflect on experiences, which they rarely had the opportunity to do amidst their busy lives, and that this had been a positive, empowering experience. One of them referred to their interview as akin to 'a therapy session' and thanked me for helping them articulate their advanced nurse journey.

As researcher and interviewer I was honest and open about the research process and findings, maintaining a stance of veracity and fidelity, in accordance with Beauchamp and Childress' (2013) ethical rules. Returning to my professional integrity and strict adherence to my professional code of conduct, I maintained the same honest, open approach to the research practice, as I do with my nursing practice. I maintained confidentiality and anonymity, giving participants' pseudonyms for their personal identities and also changing gender of two participants to ensure the only male participant could not be identified. Their specific area of practice was altered to ensure they could not be identified through their practice setting, as all participants were from one single hospital setting. The Declaration of Helsinki (WMA 2008, p.3) asserts that *"every precaution must be taken to protect the privacy of research subjects"*.

Every effort was made to ensure all interactions with participants were wholly ethical, throughout the process and when writing up findings and disseminating the study. I explained to participants that data collected would be kept confidential, which was achieved for all electronic materials, by storage on a password protected secure system. All hard copies of materials through which they could be identified, were kept in a locked cupboard along with the digital voice recorder used for interview recordings. It was also important, particularly within the bounds of my professional code of conduct and duty of candour (GMC/NMC 2015), and that of participants, who are all registered nurses, and in line with good research practice, to inform participants of limits of confidentiality. If they shared anything that questioned their capability to practice or their professional integrity, or if there appeared to be patient protection issues, then information would need to be shared with the study supervisors and other relevant

personnel, and any issues dealt with appropriately. As it happened there were no issues that needed to be dealt with.

Findings from the study, once completed, needed to be open for discussion and review and ready for dissemination in a wider forum, to be beneficial to the wider community. This enhances the possibility of transferability and maintains the research within ethical principles, ensuring an open, transparent approach. The rationale for conducting the study was ethically sound, in terms of doing good rather than harm, with the study adding a potentially valuable contribution to the evidence-base. However, it is crucial to ensure the setting and context are described in detail, honestly and transparently, as the onus is on readers to assess transferability, according to Kuper et al (2008). Thus, in writing up the research, I endeavoured to achieve this whilst discussing findings in different contexts, locally and within my wider professional network.

## **6.4 Data gathering and analysis and people involved**

### **6.4.1 Advanced nurse participant sample**

Smith and Eatough (2006) purport that, to a certain extent within IPA, the sample selects itself, within the boundaries of the subject matter, which echoed my own experience. Sampling was directed by my involvement with PD1 and knowledge of participants themselves. All participants had expressed interest in being involved in the research during the PD project at the hospital, which they were participants in, as they were in roles that met criteria for the hospital's advanced nursing framework. I was keen to use this group to select from, as I felt this would add to the PD outcomes, with more in-depth exploration of advanced nurses' experiences. Van Manen (1997) argues that with qualitative research, particularly when employing a hermeneutic phenomenological approach, the sampling strategy needs to start with assurance that participants are willing and able to recount personal experiences. The nature of IPA requires a high degree of active involvement and emotional engagement with the subject, from participants, which I had discussed with them.

Thus they needed to be aware of and committed to this level of involvement and in a position to put in the time and effort required. I wanted to be confident they would be able and willing to share and reflect on deep, personal experiences and perspectives that underpin their day-to-day lives as advanced nurses. I needed to be comfortable

interacting with participants, feeling they could work with me, on an equal footing. They needed to not feel intimidated or threatened by me and confident to share very personal experiences, without feeling judged or feeling they needed to not disclose particularly sensitive issues that may cause any compromising situations. Holloway and Galvin (2016) refer to this as implicit or subtle coercion, which employment of reflexivity can help avoid.

The sample was from different departments, with other factors being time since qualification as registered nurse, in post as an advanced nurse, education, training and gender. This was not a rigid categorisation but, having some diversity, in variables between participants, provided a broader picture of this relatively homogenous group within the specific setting. Jenkins (2002) suggests that how people interpret and make sense of the worlds they inhabit is influenced by specific elements that make them individual, including gender, class, age and professional structures. Supporting some diversity with variables was likely to result in a range of different experiences, despite being in the same hospital and similar roles, as was apparent on a more superficial level, during PD1. Seven advanced nurses were approached, through contacting them personally, then formally through written invitation. IPA is said to work well with small sample sizes of six to ten, in order for the depth of meanings to be uncovered. Larger numbers may lead to themes being too broad and descriptive and goes against IPA's idiographic nature. A purposive, relatively homogenous sample offers a focus on exploration of a specific group within the local setting, characteristically likely to share common experiences in a particular situation. This is a feature of IPA, identifying a group who give insight into particular experiences.

The participant group was drawn from the specific hospital, for whom the research questions were significant and contingent upon the phenomenon being investigated. Knowledge of individuals, as participants in the PD, gave me confidence that this would materialise through the study, as I collected their data. Smith and Eatough (2006) comment on how this shows a close link between IPA and ethnographic researchers investigating within specific contexts and focusing on exploring cultural aspects. The similarities echoed here are from IPA's context-specific epistemological basis and ontologically, in terms of knowledge being developed from a local and situational basis. This differs from other approaches, such as grounded theory, whereby theoretical sampling and saturation methods are used to broaden applicability of findings, according to Charmaz (2006).

Table 7 details criteria used to select participants and their main variables, highlighting advanced nurses from a range of areas, with different professional backgrounds and experiences, albeit in a similar context. The starting point for selection lay with nurses themselves' expressing interest to participate, during the PD project. With a number of potential participants to choose from, some variables were scrutinised, to ensure a reasonably representative range of experiences, with consideration of exclusion criteria detailed previously. Although not an exact representative sample, it provided a degree of representation for the community of advanced nurses at the hospital.

Criteria for selection of participants
<ul style="list-style-type: none"> <li>• Employed at PD project hospital in role, fits hospital's advanced nursing framework</li> <li>• In posts fit Job descriptions ANP or CN</li> <li>• Education pathway appropriate to post, in line with hospital framework</li> <li>• Meet competency frameworks, in line with RCN competencies for nurse practitioners (RCN 2008) / Department of Health Advanced Level Nursing (DH 2010) / Nurse consultants (Gerrish et al 2011)</li> <li>• Willing and able to participate</li> </ul>
Selection based on above criteria and using representative elements
<p>PD Project 1 project group- ANPs &amp; CNs participated in project</p> <ul style="list-style-type: none"> <li>• CN - 7 in post, all female, age range 36-58, Medicine, oncology, surgery, ophthalmology</li> <li>• ANP - 60 in post, 50 female, 10 male, age range 32-57, Medicine, oncology, surgery, emergency/acute areas, out-patient &amp; in-patient services</li> </ul>
Selection from above project group as study participants - (n = 7)
<ul style="list-style-type: none"> <li>• 1 CN, age 40-45, female, medicine (n = 1) specialist modules different university, non-medical prescriber</li> <li>• 6 ANP, age range 38-53, 5 female, 1 male; medicine 2, surgery 3, emergency/acute - 2 (n = 6), all undertaken ANP programme of education local university, all non-medical prescribers</li> <li>•</li> </ul>

Table 7 Selection of research participants and their main variables

#### 6.4.2 The IPA Researcher role: people

Smith et al (2009, p. 55) assert that underlying qualities of an IPA researcher include being open-minded, flexible, patient, empathetic and with a desire to be part of the participant's world, alongside determination, persistence and curiosity. As a novice researcher, I had limited experience of whether these qualities related to me, for

research, but felt confident they were transferable skills from my practice-based roles, as advanced nurse and educator. Additionally, passion and enthusiasm for the enquiry I was pursuing, was heightening my determination and persistence, and curiosity was at the heart of the desire to explore the phenomenon of advanced nursing, using IPA. This gave me confidence that I fitted criteria for an IPA researcher, able to conduct the research, in line with its epistemological, ontological and axiological basis. "As I immersed myself in IPA methodology and processes, I considered my personal qualities, relevant to being the researcher, reflecting on my skills and then applying them to the context of the research and selected approach."

From a reflexive perspective, I aligned qualities proposed by Smith et al (2009) as underlying tenets of my professional persona, along with dimensions of humanisation and 6Cs nursing values. This informs my philosophy of care and education delivery and now, relates to me, as a researcher. With this latter point in mind, Todres et al (2009) purport that dimensions of humanisation create a value framework for qualitative research; thus these are applicable to expectations for an IPA researcher engaging with participants.

Table 8 illustrates dimensions related to myself as the IPA researcher, congruent with the philosophical underpinning of my personal, professional practice and working within the four pillars of advanced practice, humanising care and 6Cs nursing values, as provider of direct patient care, leader/manager, educator and now, researcher.

Spectrum of dimensions from <u>H</u> umanisation to <u>D</u> ehumanisation ↓ <b>H</b> ↓ <b>D</b>	Reflection on my researcher role within the context of dimensions of humanisation, focusing on ensuring a humanising approach
Insiderness ↓ Objectification	Emic view, subjective, personal experiences, perspectives of participants. For readers, transparent approach, invites reader into research, experiences, of participants & researcher
Agency ↓ Passivity	Ensure participants on equal footing with researcher, empowering them to tell their stories, awareness of, conduct of research within ethical framework
Uniqueness ↓ Homogenisation	Idiographic nature of IPA, participant's unique life-world story. Unique approach to research study, based on flexible, adaptable nature of IPA to retell a unique study
Togetherness ↓ Isolation	Co-researcher, co-creator of knowledge with participants. Interviews - working together. Ensuring writing up research, reader feels part of research, relating to what's being said and make own judgements alongside participants and researcher
Sense making ↓ Loss of meaning	Facilitating participants to make sense of own experience, researcher making sense of participant's experience and sense making. Ensuring in writing up, reader can make sense of findings and in position to decide on application to own practice
Personal journey ↓ Loss of personal journey	Capturing personal journey of participants, letting them direct data, reflexivity - participant and researcher. Personal journey - researcher using IPA approach flexibly to meet personal journey of being researcher
Sense of place ↓ Dislocation	Context-specific approach, selection of purposive sample of participants based on context, encourage participants to tell stories in relevant aspects of context. Record findings ensuring sense of place is focus
Embodiment ↓ Reductionist body	Depth of data collection & analysis, reflexive approach to participants and researcher understanding resultant embodied experience of what means to them to be advanced nurses

Table 8 Humanisation dimensions and my IPA researcher approach

In planning the research and using a reflective and reflexive stance, a personal narrative from my researcher diary summarises my thoughts. "Immersed in the setting, there was already professional closeness and familiarity between myself and potential participants. This was useful for understanding the world they inhabited and their previous education pathway. However, it was also to be viewed with caution, ensuring I did not take this world view for granted, making assumptions, which would require a questioning approach, synonymous with being a stranger, displaying sensitivity to what was being investigated. Delamont and Atkinson (1995, page 149) refer to this *'making what is familiar strange.'* As the researcher 'inquirer', I already had a depth of knowledge and understanding of advanced nursing. This was already part of my life-world experience and it would be difficult and unnecessary to separate myself from this world, but rather to use this as a positive element to enhance the study."

Taking a reflective stance and visualising how potential participants might react in a negative or reserved way to me interviewing them, also led to exclusion criteria. By the time interviews were undertaken, PD project 1 was complete and I was working at another hospital, so their involvement in the study was not affected by my position in the project team. Whilst working at the project hospital, I had line managed a number of advanced nurses and, therefore, avoided recruiting them as potential participants. The majority of the advanced nurses had undertaken or were undertaking advanced practice education courses at the university, where PD project 2 was conducted. As programme leader for these courses, I excluded any current students as participants. Thus, the focus before starting the study was grounded in reflexivity, which emanates throughout. Shaw (2010, p. 234) describes reflexivity as *"an explicit evaluation of the self"*, which is what I was doing as the research progressed. Horsburgh (2003, p. 209) refers to reflexivity in the context of doing research using IPA, as

*"acknowledgement by the researcher that his/her own actions and decisions will inevitably impact on the meaning and context of the experience under investigation."*

Maintaining a reflexive approach throughout a study enhances transparency, in line with Yardley's (2008) principles of quality and rigour. Ensuring transparency around the multi-faceted role of interviewer and researcher, was a constant consideration, demanding constant engagement with self-awareness and analysis of my influence on every aspect of the research. "With an already heightened level of reflexivity, through the DProf, I was starting on a well-informed, self-aware footing that provided

opportunity to constantly review and adapt my researcher role throughout the study. However, I needed to not be complacent or make assumptions around this and to continue to be vigilant about how I proceeded." This was captured in my reflective diary, which was helping chart my learning and development and was a tool for capturing and critically analysing the whole experience. Moving it's main focus to the research supported description, sense-making and interpretation of the entirety of the study, strengthening synergy of the PD and research, which became core to the study as a whole. This used a depth of reflection and reflexivity; perhaps rather abstractly considering a similar way to gathering and analysing data from participants. Some extracts from this diary are in Appendix 5.

IPA's inductive and idiographic approach assumes a different stance from that of Husserl's phenomenological reduction by bracketing and Giorgi's empirical phenomenological focus of lived experience, both of which attempt to try and minimise the influence of the researcher. In contrast, Smith et al (2009) advocate for the central role of the researcher as interpreter, who uses their pre-conceptions as a valuable, supportive element helping make sense of participants' individual worlds and the knowledge of the researcher enabling and supporting better understanding. They believe it is not possible to reach a value-free understanding of participants' worlds. Finlay and Gough (2003) suggest it is not easy to set aside one's own beliefs so as not to influence the research, consciously or subconsciously. This requires a high degree of personal, professional self-awareness that underlies the reflexive approach needed.

Berger (2013, p. 220) purports that the researcher should engage in reflexivity and

*"...carefully self-monitor the impact of their biases, beliefs and personal experiences on their research."*

The researcher must acknowledge their own influence on the research and recognise they can not be an objective investigator, and in fact, with IPA, this is not expected of the researcher role.

Utilising reflective and reflexive skills remained an important element to support the IPA research process, as data were gathered and analysed. The IPA researcher assumes a prominent position, deliberately being part of and affecting data gathering, analysis and interpretation, which requires great depth of awareness of how this might bias findings. This is more difficult to manage than with other methods of data gathering, such as surveys with fixed responses, due to the personal interactions between the

researcher and participants. In the same way that participants were being investigated as individuals within the specific context, as the researcher, I was also a similar person in context, balancing emic and etic perspectives, from a phenomenological and interpretative position (Larkin et al 2006, p.106). According to Finlay (2002), this invariably has an effect on participants' responses and is likely to influence findings. For qualitative research, this is not viewed negatively, in fact this can have a positive effect. Shaw (2011) adds that the IPA researcher's conceptions are necessary and inseparable from the research process, rather than a source of bias.

Returning to identified qualities of an IPA researcher, required consideration of the recommended '*curiosity*' element that needs to be prominent at all stages of working back and forth within the hermeneutic circle, assuming such a stance from the start of the research. This also supports the requirement to try and bracket preconceptions and how this can be pursued. Le Vasseur (2003) argues that adopting a stance of curiosity, assuming lack of knowledge and understanding of phenomena being explored, enables the researcher to question their prior knowledge and experience and to develop a new perception of it. Le Vasseur's (2003, p. 419) approach

*"involves getting beyond the ordinary assumptions of understanding and stay persistently curious about a new phenomenon."*

#### **6.4.3 Data gathering - interviews with advanced nurse participants**

Between four and ten interviews is advised for IPA studies, to allow for some cross-case analysis, without becoming overwhelming and for close, in-depth analysis of each participant and understandings of particular experiences by a particular person or group. The commitment achievable for case study level of analysis, richness of individual cases and depth of data, comparisons and contrasts between cases and pragmatic restrictions, was considered in relation to being a single, novice researcher undertaking a study within the confines of a doctorate. Opting for a focus group may have compromised detailed investigation of personal experiences, especially as this was not a method I had experience of. Individual interviews would offer a better opportunity to compare experiences and shared meanings, more in keeping with an idiographic focus, congruent with IPA, as reported by Reid et al (2005). The seven participants comfortably fitted recommendations for sample size and one-to-one interviews. This was not overwhelming and enabled engagement in a meaningful, sustained way, with participants, their texts and the overall process of interpretation.

The IPA framework and interviews provided a structured tool to gather data, supporting inquiry through two interlinked features, outlined by Larkin et al (2006, p.102). Firstly, meeting the phenomenological aspect, by '*giving voice*' to the life experience of being an advanced nurse and considering what they offer their patients. Secondly, to meet interpretative requirements by contextualising and '*making sense*' of what they said about their experiences and perspectives of the care they deliver. This is from an individual and group perspective, as I selected a fairly homogenous group of advanced nurses from one hospital setting. Larkin et al (2006) argue that one-to-one interviews allow rapport to develop so participants can think, speak and be heard, facilitating in-depth, personal discussion. According to Polgar and Thomas (2008), a face-to-face approach will help heighten interpretations and relationships and enables active, reflective participation in meanings embedded within the dialogue. This makes interviews a powerful tool for reflecting participants' experiences and enables flexibility in facilitating exploration of their unique elements. IPA research should aim to follow participants in novel, unanticipated directions as the story unfolds, according to Smith and Osborn (2008), which lends itself to interviews for my research participants.

Thus, I became a travelling companion rather than tour guide, on their journey of exploration of their experiences and perspectives of being advanced nurses. An extract of personal narrative illustrates my reflective thoughts. "Consideration of what I was proposing to achieve seemed to lend itself better to interviews, with the researcher facilitating the participant to explain and interpret their own experiences, encouraging explanation through questioning, whilst the researcher takes an interpretive stance. With good grounding in the knowledge-base of advanced nursing and from detailed data from the PD, I anticipated drawing on these theoretical elements during interviews, supporting exploration of participants' experiences, using the hermeneutic levels." It is worthy noting that engagement with the group from which the research participants were selected (the advanced nurses from PD1's hospital), had already furnished me with a plethora of experiences and perspectives, from an informal basis, to add to the more formal theoretical aspects. This is another contributory factor related to the building synergy of the research and PD.

Review of questions used in a number of IPA research reports helped construct a suitable questioning strategy, in preparing for the interviews. An Inductive approach facilitated by using open-ended questions was planned, in order to help gain rich, detailed descriptions of the phenomenon. An advanced nurse educator colleague

reviewed questions on the interview schedule. She had herself undertaken a study with advanced nurses as participants. She felt the schedule would yield appropriate data, giving me confidence to start with a 'test' interview. This 'test' interview used prompt questions from the schedule that had been through university ethics approval. The participant was aware that questions were being tested to see if the right sort of data was emerging to help answer the research questions.

(Before test interview) "This helped familiarise me with the interview schedule to ensure that during 'real' interviews, I give participants my full attention rather than keep referring to it. (After test interview) The interview seemed to go quite well, although I was nervous and conscious of saying too much and decided for final interviews I would trust participants to tell their stories, with less prompts. I tended to rush the participant, rather than letting her take time to think and talk freely. I adapted my interviewing technique and talked more slowly and clearly, which, Smith et al (2009) suggest helps set the tone for both participant and researcher, in terms of being reflective and in a position to make sense of what is being said and start interpreting. There was a tendency to focus on gathering information on her role, rather than more experiential and interpretive aspects. Having shared the transcript with my supervisors, they advised that I needed to adapt my approach, to align better with the research questions and ensure subsequent interviews were IPA-orientated, rather than largely descriptive, in nature. This interviewee became one of my participants, Belinda, who was subsequently re-interviewed, once I refined and focused the interview schedule and was more knowledgeable in applying an IPA-orientated approach. Rather than discard Belinda's test interview, parts of this transcript were built on, for her final interview, so as not to lose data from the test interview. This was also the advice of my supervisors who reviewed the transcript, giving constructive feedback for the 'real' interviews."

A safe, comfortable, confidential but familiar environment, with an attempt at minimising interruptions was selected for each interview, to facilitate good rapport and aid the information-gathering process. I approached participants to check where they would feel most comfortable and what environment would be most conducive to conducting their interviews. Two participants opted to be interviewed in the hospital in meeting rooms away from their busy clinical areas. This was not ideal, as one of them was called away on a couple of occasions, disturbing the flow of the interview. Also, for both interviews, there was a feeling of needing to not take up too much time so they could return to their clinical duties.

The others chose to be interviewed at the university, in an interview room, which allowed breathing space before the start of each interview and enabled them to take their time in reading the participant information. This also allowed flexibility with the length of the interview, as I did not want to stifle them with regards to sharing their experiences. Choice as to whether they participated or not, followed by them taking a lead on the environment for the interview, showed commitment to ensuring they were co-creating the knowledge from data they were generating, in collaboration with myself and taking a lead in the interviews, rather than passively following the researcher's lead. Greenhalgh et al (2016) argue that co-creation of knowledge through collaboration, supports the achievement of research impact, which can also be considered a resultant factor for an IPA study, such as this one.

A semi-structured, tending towards fairly minimally-structured interview allowed focus and structure around topics and questions to explore, whilst allowing flexibility and adaptation as interviews progressed. "I made sure participants felt at ease and showed interest in what they said, encouraging them to give as much detail as they wanted about topics explored and reassuring them that there were no right or wrong answers, as it was about their personal experiences. Although there is preference for semi-structured interviews in IPA, for these interviews, the fairly minimally-structured approach enabled unique experiences of participants to be portrayed and sense made of them." This is reported to create more of a platform for interviews to be pursued through exploratory rather than explanatory purposeful conversations. Van Manen (1997) asserts that understanding a phenomenon can be facilitated through exploration of narrative materials, such as that manifested from conversation.

"Planning the interviews started with consideration of my role as researcher and interviewer and the participant as interviewee, embarking on a professional conversation between the two of us, as advanced nurses, first and foremost. Taking this stance for proceeding with interviews is what Kvale (1996, p. 5) referred to as a '*professional conversation*.' What I spent time and reflective contemplation doing and then executing, was to conduct in-depth interviews described by Smith et al (2009, p. 57) as '*a conversation with a purpose*,' which is informed by the research question."

The interview schedule was a guide and prompt, to help keep dialogue focused on participants' experiences and perspectives and kept things moving in a meaningful and interpretative way, in line with an IPA framework. The questions were first-tier

questions covering main topic areas related to their personal experiences of becoming and being advanced nurses and their contributions to patient care. They were designed to encourage participants to take more of a lead during the interview, whilst offering the opportunity to facilitate exploration through reflection and interpretation of key areas, as we progressed. "It was also a supportive tool, as I wanted to ensure that if participants struggled to recount aspects of their life-world experiences, this might potentially lead to superficial and inadequate data. Instead I could prompt them to continue their dialogue with main topic areas listed on the schedule."

"Each interview was prepared in advance, focusing on the individual participant and using the interview schedule to visualise where and how I might influence responses to questions or my interpretation of how they might make sense of things. This involved reflective and reflexive skills as I was acutely aware of needing to pre-empt my preconceptions, attempting to bracket these, in order to ensure data generation was as honest and accurate as possible. This ensured I was self-monitoring my researcher role, being attuned to the potential impact of my beliefs, biases and own experiences, on the research. This was first and foremost from the participant perspective, with acknowledgement of the possibly unavoidable, potential impact I might have on them, as they knew me as an advanced nurse and educator and member of the PD project team." Smith et al (2009) suggest that one may not know which preconceptions might come to the fore and thus it is difficult to bracket preconceptions until engaging with data. I felt this was an opportunity to consider this beforehand and acknowledge it.

Prior to starting, the steps of the interview were explained, interviewees confirmed they had read and understood the information sheet and their informed consent double-checked, using the consent form. As part of this preparation, I briefly explained the IPA process of data collection, involving their description and sense-making in relation to being an advanced nurse. I also described the active researcher role and involvement in helping make sense of and further interpreting their life-world stories. I made sure they were aware of the process and were not expecting me to be a passive data collector, asking a set of direct questions, without depth of engagement or involvement, as might be the case, using a different approach. "I wanted to ensure they didn't feel I didn't need to know something they felt was relevant as they had made assumptions of my expertise and knowledge of advanced nursing and their personal life-world stories."

The interviews were approximately one hour long, which had been discussed at the start and were audio-taped using a small, relatively un-intrusive digital recorder, with participants made aware of this. Although acknowledged that audio-taping of interviews can be invasive and affect participant responses, audio-taping and transcribing interviews is considered as necessary for IPA studies, according to Smith et al (2009). This process ensures accuracy and the ability to capture and recall salient points made using participants' own words and thus outweighs potential negative aspects. Verbatim records of data collection are not possible without having audio-taped interviews. Another advantage of audio-taping is that it enables a free-flowing, open approach, encouraging collection of rich, detailed data, rather than the interviewer having to pause proceedings to write notes and lose eye contact with the participant.

The interviews were self-transcribed, allowing accuracy of transcription and enabling deep immersion in the data, helping make sense of it and aiding interpretation. The transcripts ranged from 10,000 to 15,000 words, indicative of the large volume of data. Accurate transcription is seen as essential to trustworthiness and authenticity of qualitative research, as interviews can be listened to many times, to ensure accuracy as the transcription is written and checked until as word-perfect as possible.

The specific feature of IPA for participant and researcher is the double hermeneutic within the interview, for collection and concurrent first stage analysis of data. Larkin et al (2006) discuss how the researcher, through questioning and prompting, facilitates the participant to make sense of their experiences. Ricoeur (1981) purports that the double hermeneutic makes a distinction between hermeneutic of empathy, which focuses on interpreting the reconstruction of an experience in its own terms, from hermeneutic of suspicion, which makes an interpretation based on outside, theoretical perspectives. This is expanded in IPA, which takes a middle ground by extracting meanings from experiences, combining the two hermeneutic positions, with hermeneutic of questioning. Shaw (2010) argues, that reflexivity is integral to experiential qualitative research, such as IPA, for data generation and interpretative analysis and asserts that it is an essential element of the double hermeneutic.

Layers of analysis	Details in each layer of data analysis
<p>1st layer analysis</p> <p>Audio-taped Interviews 1. Ann 2. Belinda 3. Charles 4. Diana 5. Emily 6. Fiona 7. Gina</p>	<p>Hermeneutic circle &amp; double hermeneutic - participant &amp; researcher</p> <p>Case by case, not influenced by previous interview</p> <p>Brief notes during and after interview and reflected on process and data gathered - Appendix 8.1 - Ann</p>
<p>2nd layer analysis</p> <p>Transcription of interviews - read, re-read</p> <p>Re-listen to audio-tapes - amendments, accuracy, notes made</p>	<p>Self-transcribed interview</p> <p>Reflected on, jotted down semantic content, exploratory notes</p> <p>Checked audio-tapes x2-3 against transcription</p> <p>Read transcripts x2-3, familiarise interviewee data, sense making, interpretation based on 1st layer by interviewer, adding 2nd layer</p> <p>Appendix 8.2 - extract 1 Fiona and 2 Gina</p> <p>Appendix 8.2 extract 3 Emily</p> <p>Appendix 8.3 Extract 4 Ann</p>
<p>3rd layer analysis</p> <p>Transcript divided into 3 columns</p> <p>Hermeneutic circle - Left column = researcher; questions, summary points, right-hand = participant - developing themes, quotations</p> <p>Middle column = phenomenological &amp; idiographic = original transcript, including semantic points</p> <p>Supervisors / researcher - review</p> <p>3 super-ordinate themes; sub-ordinate themes</p>	<p>Key words, non-words, symbols, sense-making, interpretation Appendix 8.4 Extract 5 Diana</p> <p>Supervisors - discussion on themes, IPA-orientation</p> <p>Amendments on supervisor feedback of preliminary narrative - Appendix 8.5 sample of supervisors' commentary</p> <p>Appendix 8.6 Member-checking - review and amendments</p> <p>Appendix 8.7 analyst comments on transcript, interpretation</p> <p>key words / phrases, grouped together similar categories = themes, direct quotations detail of participant dialogue, narrative account - Appendix 8.8 extract 6 Gina</p>
<p>4th layer analysis</p> <p>Cross-case analysis and individual, unique themes</p> <p>dimensions &amp; 6Cs nursing values,</p> <p>Table 10 - 4 pillars of advanced practice</p> <p>5th layer analysis</p>	<p>Themes categorised - shared, unique. Moving idiographic to nomothetic level interpretation.</p> <p>Appendix 8.9 - 4th layer shared and unique themes</p> <p>Appendix 9 comprehensive list of themes</p> <p>Linking findings with theory, literature, findings fit local context, implications for research adds to knowledge</p> <p>Table 10: Final super-ordinate &amp; sub-ordinate themes,</p> <p>Appendix 10 and Table 12 - Holistic lifeworld constituents</p> <p>Appendix 11 - 6Cs nursing values-base - words/phrases,</p> <p>Table 13 Humanisation dimensions - participants</p>

Table 9 Layers of data analysis

#### 6.4.4 Data analysis of advanced nurse participant interviews

Analysis of data was undertaken using Smith et al's (2009) IPA framework as a structured, multiple layered approach, with some flexibility. Table 9 outlines the process, showing steps within and after each interview, from an individual and collective perspective.

##### First layer of analysis

The first layer of analysis was conducted concurrently with data collection, using a non-directive, albeit prompting style that enabled collection of detailed, reflective, first person accounts. This was not restricted by a rigid set of questions, but questions were adapted to focus on salient points, as the participant described and made sense of their experiences, as they arose. This allowed the participant to take a lead, whilst acting as primary expert, in relation to the phenomenon, in line with the primary point of the hermeneutic circle and with the participant initiating the double hermeneutic, describing and attempting to make sense of aspects of their own experience.

The opening questions of each interview were first tier, which feature in all IPA studies. Each interview commenced with a broad invitation to share the individual's experiences and was aligned to answering the first research question, *"I want to know about your experiences, thinking about what sense you make of being an advanced nurse in the hospital, what that means to you."* (All participants). This provided the opportunity to start engaging in inquiring dialogue through questioning that was not leading, but open and fairly broad-based. Use of open questions is advocated by Larkin and Thompson (2012) for an IPA study, helping elicit data on experiences and understandings of people in specific contexts, with an exploratory purpose. To cover the second research question, about participants' perspectives of their contribution to patient care, later in interviews, I moved the interviewee on to explore this. *"If I was to ask you what you think your unique contribution is to your patients, your added value?"* (All participants).

Other exploratory questions helped maintain an individually-based, exploratory questioning approach throughout, such as "So was there a point that you got to where you thought, yes, I can call myself an ANP? Was it a conscious thing or just reflecting on other people?" (Charles) and, "You talked about unique abilities...is it that you've got a consistent presence through the pathway, that you're available, what is it?" (Diana) and "...you also talked about

being quite autonomous. Are those the sort of things that are at the heart of your experiences?" (Emily)

With a key emergent theme for all interviewees being to maintain their professional nursing identity, questions were drawn from their narratives focused on this, *"Do you reflect on that, because you don't want to lose your nursing skills? Talking about you as a nurse and it's obviously important to you?"* (Ann)

These later questions remained fairly broad in nature, but offered a foundation for allowing uniqueness of participant stories to emerge, using the interview schedule to probe and prompt. I worked between hermeneutic of empathy and questioning, with hermeneutic of suspicion coming into play at a later stage of analysis, largely after the interviews. Guided by the IPA framework, involved taking an active, concurrently reflexive approach by exploring participants' experiences and perspectives with them, showing a critical consciousness of what they were sharing with me (hermeneutic of empathy).

This level of reflexivity enabled consideration of how the participant was working through and making sense of their own experiences, drawing on their own reflective and reflexive skills, further encouraging interpretive elements of their accounts (hermeneutic of questioning). Working around the hermeneutic circle, from my researcher world to the participant's world, moving back and forth between these two points ensued. This created a balance between gaining an emic and etic perspective related to exploring the participant's experiences and views and the researcher starting to interpret. This was not easy and may have been better executed by a more experienced IPA interviewer, particularly in the earlier interviews, as I was learning how to adopt this IPA approach, having to think on my feet, consciously working with the hermeneutic circle and double hermeneutic (Appendix 8-8.3).

Some IPA studies, have second tier questions, which generally engage with relevant theory. Extant theory of advanced nursing was drawn on, as familiar territory for me from a practice perspective, as well as an up-to-date viewpoint, through the PD projects and literature review. This enabled me to think on my feet and explore points made by participants that linked with relevant theoretical aspects. An example is the four pillars of advanced practice within current frameworks of advanced practice, which were referred to by participants during their interviews.

The same process was adopted for each interview, with adaptations made, dependent on the individual's ongoing dialogue. This resulted in collection of a significant volume of deep, meaningful data, congruent with answering the research questions. I worked collaboratively and in partnership with each participant, to identify and start to interpret meanings that would help make sense of the phenomenon. The first layer of analysis in IPA was enabled through interpretative aspects forming part of the interview process. "I acknowledged my personal perspectives, as best I could, with regards to meanings drawn from the participant, being aware these were personal and contestable and not necessarily in line with my participant. I continued with each interview, mindful of minimising my influence as I employed a more interpretative stance, rather than making assumptions based on my prior knowledge and experiences." The researcher needs to be open and see the world from a new perspective based on that of the participant. However, Moran (2000) argues that IPA researchers are only able to be party to an incomplete version of a participant's experience as they make sense of it through their own narrative, with explorative and interpretative work required to understand meaning from part disclosure.

From an idiographic standpoint, and case by case, I wrote notes immediately after each interview, utilising a reflective and reflexive approach (Appendix 8.1). According to Larkin et al (2006) this helps to ensure that initial thoughts are captured as part of this first layer of analysis. I made reflective notes of the interview process and content, as a way of engaging in reflexivity in relation to the research. This strategy helped me put aside each participant's interview, in order to start the next one afresh, to help illuminate particularities of the individual participant; an idiographic method involving bracketing emergent ideas from the first case, whilst working on the second and subsequent ones. This is an illustration of working across the hermeneutic circle, in line with Smith et al's (2009) process, moving between the whole single case interview as part, then moving across all participant interviews, as a collective whole.

### **Second layer of analysis**

The second layer of analysis for each interview was self-transcription, case by case, paying attention to the way participants talked and shared their experiences (Appendix 8.2-8.4). Easton et al (2000) purport that self-transcription enables the researcher to revisit the actual interviews to ensure everything is captured as accurately as possible, as it happened. This included recording semantic content, such as hesitations, pauses, overemphasised words, laughter and tone of voice. Transparency and

credibility of a study are enhanced by self-transcription of interviews and analysis, in a timely manner and in line with an IPA approach.

At this stage, my first two interviews (Ann and Belinda) had been completed and transcribed. On reflection, I felt their interviews were less IPA-orientated than they could have been, making me acutely aware of needing to pay particular attention to further analysis, to attempt to decipher sense-making features from their narrative accounts. Whilst in subsequent interviews, such aspects were more clearly portrayed from prompt questions and commentary, seeming to more obviously work across the hermeneutic circle and double hermeneutic during interviews.

Having transcribed an interview, data analysis was enhanced through constant engagement with the transcript and listening to the recorded interview to help understanding, aiding interpretation and encouraging reflection on key objects of interest. This was accompanied by note-taking to capture these points and comments and particular phrases, linguistic characteristics and interpretative aspects, where I was asking questions of the transcript and looking for hidden meanings (Appendix 8.3, 8.4). This supported capture, not only of the verbatim dialogue, but the conduct of the interview. An important element of this process, according to Rodham et al (2013) was ensuring that I was listening actively to the recorded interviews, engaging with data, as opposed to just reading written transcripts. Brocki and Wearden (2006) purport that there needs to be close interaction between analyst (researcher) and transcript, with the researcher employing their interpretive resources, as part of analysis. The original dialogue was highlighted in different colours, to illustrate where the interviewee moved from a superficial and general perspective to a more personal, sensitive level; where they made sense of their own experiences or interpreted points from a general advanced nursing, theoretical viewpoint, reflective of the hermeneutic of suspicion. Non-word semantic elements were highlighted in bold (Appendix 8.2).

Listening to the audio-taped interview, whilst transcribing it, immersed in the data on a continuous basis, helped me further bracket, being curious and reflexive about my own perspective. Thus, data was recorded as it happened, rather than being open to interpretation afterwards or in written notes, during an interview. Audio-taped recording offers a cue to make one aware of one's pre-conceptions and possible biases, and to articulate and manage these. This does not mean that elements of personal reflection and interpretations, drawing on one's own experiential and professional knowledge,

should be disregarded. This can usefully support emerging understandings of the participant's world, considered as Gadamerian type dialogue between one's pre-understandings and the participant's experiences, according to Smith et al (2009).

### **Third layer of analysis**

On reaching this next layer of analysis, the middle column was verbatim narrative of the interviewee's transcript. The left-hand column of the transcript, was the left hermeneutic or researcher side of the hermeneutic circle. This included the interviewer's first-tier questions, from a phenomenological and idiographic view, asking the interviewee to describe their individual experiences, from a hermeneutic of empathy. Further prompt and exploratory questions were added that helped the participant make sense of their experiences and the interviewer to start to interpret, in line with hermeneutic of questioning. A third level of hermeneutic drew on some initial theoretical aspects, drawn from literature and findings from the PD, as hermeneutic of suspicion. Also, in this column were summary points and commentary on semantic aspects (Appendix 8.4, 8.8).

The right-hand margin was used to document key words and phrases for developing into themes, from the participant side of the hermeneutic circle, along with consideration of language use and metaphors aligned to themes. Moving away from the transcript to reflect on notes and comments made helped develop themes, enabling a focus on the most important and interesting data, whilst reducing the volume of text. Pringle et al (2011) argue that main themes are illuminated and informed through anchoring findings in direct quotes, which was the next stage of the right-hand hermeneutic, with significant quotes highlighted from participants, that correlated with emergent themes. This supported grounding of the research in the reality and individual life-world of each participant. From a personal perspective this showed me working with participants according to dimensions of humanisation, as an underpinning of my researcher role and allowed participants to reveal their life-world experiences and perspectives, within this context.

I progressed through the second and third layers of analysis for the first interview transcript, which was analysed fully, before proceeding similarly, with subsequent interviews (Table 9). Each transcript was explored and analysed, descriptively, conceptually and linguistically, leading to understanding of the first case in depth (Appendix 8-8.8), through this layered process, before moving to the next case.

My supervisors reviewed several transcripts, emergent themes and analysis of data, up to this level of analysis (Appendix 8.5). They checked themes were actually represented in transcripts and not just my personal interpretation and that the preliminary narrative was as close as possible to the reality of participants, and represented IPA-orientation.

Each transcript, emergent themes and key quotations were shared with individual participants, to gauge veracity and accuracy and to check if I had misinterpreted or misunderstood anything. A few minor adjustments were made, based on their feedback (Appendix 8.6). "This gave me confidence that I was making sense of their experiences, based on their life-world realities rather than my own perspective on their experiences. Ann and Emily felt my interpretation of one or two points, in terms of what the tone of their voices portrayed was misrepresenting what they were saying. Ensuring I worked within an ongoing ethical framework, particularly respect for autonomy of my participants, I acknowledged this and amended the analysis accordingly." Noble and Smith (2015) state that capturing data via audio-taping and verbatim transcription allows an audit trail for checking data with others, which enhances trustworthiness of the research. This was particularly important for me, as a novice researcher, providing a mechanism for sharing data and checking data analysis closely reflected the reality of the interviews, staying close to participants' voices.

The next part of the third layer of analysis for each participant, involved pulling together lists of key words and phrases, creating themes, grouping these together into similar categories of wider subject areas, which became three overarching super-ordinate themes. Direct quotations illustrated key pieces of dialogue categorised into these theme groupings. A final individual narrative for each participant was created from the layered analysis, with the phenomenological, descriptive level including an understanding of the experience and subsequent exploration (Appendix 8.8). There was then more critical analysis based on deeper interpretative work, which consisted of detailed, interpretative, reflexive, idiographic accounts from the researcher's interpretations, as was the case.

At this point, an objective overview of narrative accounts of the participants' original transcripts and themes extracted was sought from a healthcare professional who works in a hospital distant from where the study was conducted. She therefore has limited knowledge of the actual setting involved and is not a nurse. This meant she did not

have any pre-conceived ideas about advanced nursing or potential bias or conflicts of interest that might have clouded her view of experiences being recounted by participants. Larkin and Thompson (2012, p.101) suggest that achieving a balance between '*giving voice*' to participants and '*making sense*' through an interpretative process takes time and effort and involvement of peer support can facilitate development through discussion of these components. A difficulty related to unconscious bias is that it is hard to eliminate through reflexivity, according to Finlay (2008). However, it is thought that this can be uncovered through discussion, hence my involvement of others during these analytical phases. This resulted in useful points to consider from a different viewpoint and a few amendments ensued for several participants. Overall, there was good consensus between us, with my colleague feeling I was staying close to participants' voices and sense-making from the data and was not led astray by my researcher pre-conceptions (Appendix 8.7).

#### **Forth layer of analysis**

The next stage is cross-case analysis, without losing touch with individual life-worlds of participants or detracting from capturing individual, idiographic experiences and unique themes. The focus moves to also eliciting shared experiences, comparing and contrasting across participants and looking for patterns and connections, highlighting general themes and combining them across cases, where apparent. On working through each transcript, the super-ordinate themes were the same and sub-ordinate themes were the same or similar, but others were unique to individuals (Appendix 8.9). Once individual and cross-interview themes were detected, resultant themes were pulled together into a preliminary, comprehensive list (Appendix 9). This demonstrated a move from idiographic to nomothetic level of interpretation between and across cases, from particular to shared, descriptive to interpretative, on an individual and group basis. This is another aspect of working across the hermeneutic circle from individual to collective, idiographic to nomothetic elements.

Abstraction, described by Smith et al (2009), identified patterns between emergent themes that led to clustering sub-ordinate themes under three distinct concepts that emerged at the highest level, as super-ordinate themes, shared by all participants. Their titles reflect the psychological essence embedded within each. 'Becoming an advanced nurse' demonstrates the importance of development elements related to participants' experiences, and acknowledges inter-related temporal aspects. 'Being an advanced nurse' illustrates embodiment of all constituents of their holistic lifeworld.

The third super-ordinate theme, 'contribution to patient care and service delivery' captures spatiality aspects, with meanings of events, characterising what they do, reflecting humanising, caring underpinning, adding value by being an advanced nurse. The next level of analysis involved what Smith et al (2009) describe as subsumption, whereby emergent themes were considered in relation to the super-ordinate status, which brought together the series of related sub-ordinate themes. The sub-ordinate themes were shared by two or more participants or were unique to individual participants, if they appeared to be of particular importance. A process of numeration that considered frequency with which certain themes appeared, was another indication of the relative importance of some themes, giving weight to whether or not it was worthy of inclusion.

A constellation of sub-ordinate themes for each participant was then clustered under the most relevant super-ordinate theme, with titles using descriptive words that had emanated from analysis and interpretation of participants' narratives. This supports the capture and reflection on an understanding of the meaning of each theme. The sub-ordinate and lower order themes within sub-ordinate themes reflected participants' own words and phrases to maintain the idiographic element of the analytical process, keeping data close to unique individual participants and drawing out unique, idiosyncratic elements.

### **Fifth layer of analysis**

Whilst writing up findings, a fifth layer of analysis was added, as analysis and interpretation continued during this phase, which had not been anticipated during previous layers of analysis. This included re-organisation and changed priorities of some themes, along with refinement of theme titles, to better reflect the findings. This analytical layer was pursued in the context of cross-case analysis. A return to re-reading interview transcripts and close reference and critical evaluation of the full narrative accounts led to less important themes being discarded, others re-prioritised and some re-labelled. This tended to be where there was repetition of points or when, on re-reading as a whole, some aspects were not relevant or did not fit with themes. This appears congruent with another element of double hermeneutic with narratives as the whole and themes being the part/s, with the result being synthesis into a revised 'whole' interpretation.

Table 10 represents final super-ordinate and main shared sub-ordinate themes. Super-ordinate theme 1: Becoming an advanced nurse started as 'Developing as an advanced nurse' but with further analysis and interpretation of this main theme and its related sub-ordinate themes ensued and, 'becoming' appeared more congruent with development aspects being completely inherent to embodiment of being an advanced nurse. For 'Being an advanced nurse', sub-ordinate themes under this overarching super-ordinate theme's descriptors were amended to more closely reflect lifeworld constituents of being an advanced nurse. The order of these themes altered, in line with priorities and importance placed on particular aspects by participants, from a spatiality perspective. An example of this is strong emphasis on nursing identity and clinical focus that emanated once findings were being written up.

<p>Super-ordinate theme 1 Becoming an advanced nurse</p>	<p>Super-ordinate theme 2 Being an advanced nurse</p>	<p>Super-ordinate theme 3 Contribution to patient care and service delivery</p>
<ul style="list-style-type: none"> <li>•Sub-ordinate themes</li> <li>• 1.1 Starting on journey</li> <li>• 1.2 Questioning approach</li> <li>• 1.3 Education, skills knowledge</li> <li>• 1.4 Temporal aspects</li> <li>• 1.5 Nursing experience as foundation</li> <li>• 1.6 Meeting an advanced level of competence</li> </ul>	<ul style="list-style-type: none"> <li>•Sub-ordinate themes</li> <li>• 2.1 Nursing identity and clinical nursing focus</li> <li>• 2.2 Blending nursing and medical aspects</li> <li>• 2.3 Education and support</li> <li>• 2.4 Leadership, team working, improving care</li> <li>• 2.5 Autonomy, responsibility, safe practice</li> <li>• 2.6 Comparison with other people's roles</li> <li>• 2.7 Other people's perceptions</li> </ul>	<ul style="list-style-type: none"> <li>•Themes</li> <li>• Continuity of care</li> <li>• Being there for patients</li> <li>• Improved patient outcomes</li> <li>• Communication and therapeutic relationship building</li> </ul>

Table 10 Final super-ordinate and main sub-ordinate themes

## Chapter 7 Findings from research study

The findings maintain focus on phenomenological, hermeneutic and idiographic elements of IPA, together with my preliminary analysis and interpretations of meanings of different concepts extracted through a critically reflective approach. This also acknowledges three main areas of four pillars of advanced practice, dimensions of humanisation and 6Cs nursing values that emerged and that are discussed in more depth in the discussion section, later in the thesis. Due to the focus on the interpretative element, IPA research does not look for definitive analysis, but presentation of data should support what the researcher is claiming. This is the stance taken for the findings, which are based on my personal context and experiences and from synergy with the PD. This is supported by input from others, to strengthen and provide more collaborative, resultant interpretations. A further hermeneutic level will be adopted as readers make sense of what they are reading, adding their own interpretation of the participants' experiences. As the reader of this thesis, you are the next interpreter, alongside the participants and researcher and, as such, provide another analytical layer, through your own interpretations.

The three super-ordinate themes from the data, *'Becoming an advanced nurse'*, *'Being an advanced nurse'* and *'Contribution to patient care and service delivery'* are congruent with answering the research questions, a reminder of which is useful, in keeping on track with answering them:

- 1: What does it mean to be an advanced nurse in this acute hospital setting?
- 2: What contribution do the advanced nurses believe they bring to their patients' care and related service delivery?

Figure 3 illustrates super-ordinate and main sub-ordinate themes, within the context of constituents of the holistic lifeworld and four pillars of advanced practice. These themes are detailed in this chapter; the reader is guided to the main body of text and accompanying appendices 8 to 12. This captures building experiences of participants phenomenologically, hermeneutically and idiographically, focusing on language (words and phrases) that particularly connects with underpinning humanisation dimensions and 6Cs nursing values. Further in-depth exploration and a coherent overview and critical review and discussion and conclusions are continued in chapter 8.

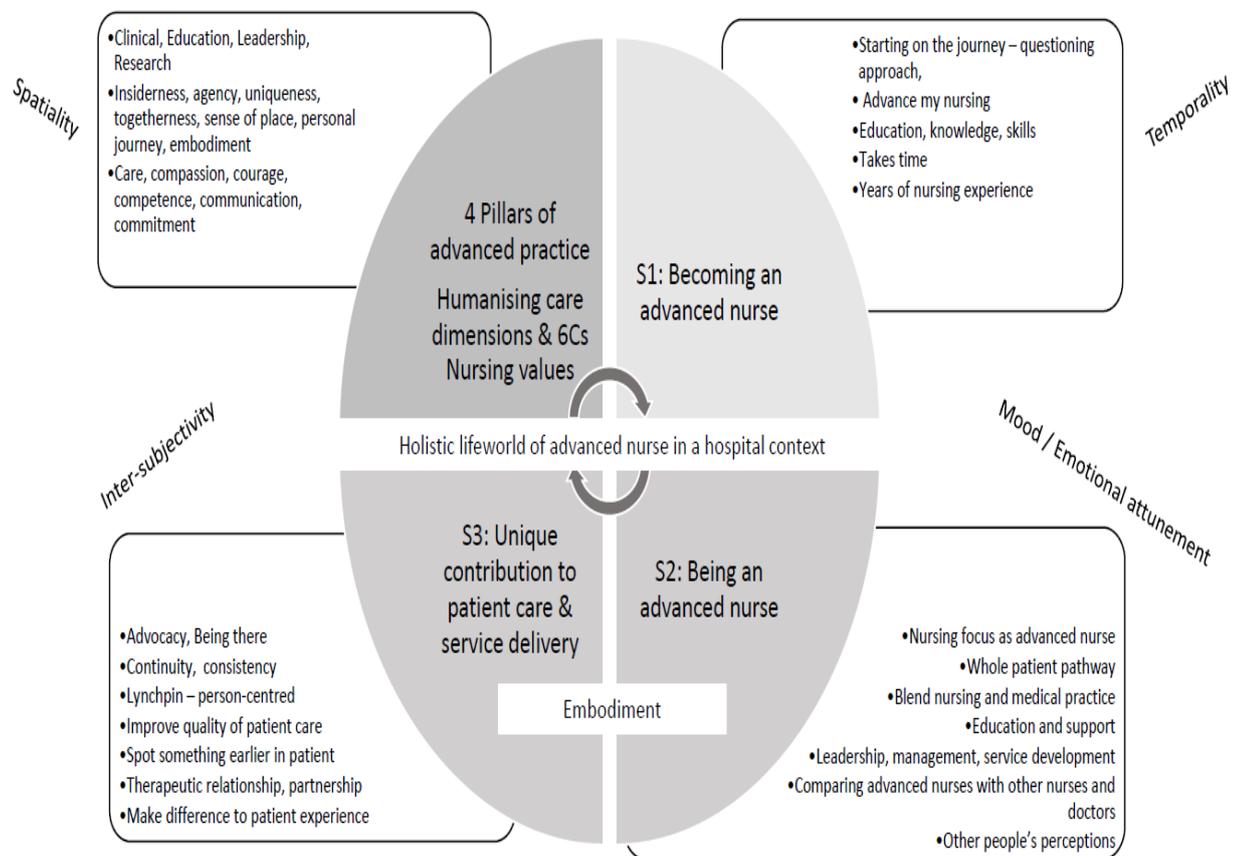


Figure 3 Super-ordinate and main sub-ordinate themes and holistic lifeworld constituents of the advanced nurses

## 7.1 Introducing the participants: Ann, Belinda, Charles, Diana, Emily, Fiona, Gina

Table 11 contains relevant demographic details of the participants. To maintain confidentiality and anonymity, pseudonyms are used, with first letters of names representing the order of interviews, A to G; age range, not actual age is included and gender not revealed, with two cases swapped for gender anonymity. My profile maintains reflexivity as researcher, considering similarities and differences with participants, acknowledging pre-conceptions and conceptions, based on my professional status, helping set aside and highlight any influences this could have. This provides openness and transparency, enabling readers to judge my potential impact on the research.

<p>Pseudonyms - 1st letter name = order of interviews. Age range not actual age. Gender not revealed - 2 cases swapped gender for further anonymity.</p> <p>ANP = advanced nurse practitioner -job description title CN - consultant nurse - job description title; RN = Registered nurse</p>
<p><b>Ann:</b> Age 50-55. RN 33 years; ANP 1 surgical speciality, ANP programme university after RN qualified 20 years. Moved different speciality after 1 year as ANP. Current ANP role 10 years. Completed education over 5 years, prescribing 5 years ago.</p>
<p><b>Belinda:</b> 35-40. RN 18 years, specialist nurse to CN. Education - specialist, advanced assessment, prescribing M level modules. Trainee CN to CN different hospital, current CN post 13 years specific medical speciality.</p>
<p><b>Charles:</b> 40-45. RN 20 years; advanced nurse developed after qualified 10 years. ANP surgical speciality 10+ years. ANP education university while developing ANP role 10 years ago, prescribing 8 years ago</p>
<p><b>Diana:</b> 35-40. RN 13 years; advanced nurse after qualified 8 years, whilst senior staff nurse on ward. ANP programme - ward role to ANP. ANP medicine on completion of programme university, included prescribing. ANP post 5 years.</p>
<p><b>Emily:</b> 45-49. RN 18 years, employed as trainee ANP acute setting after qualified 15 years., undertook ANP programme whilst trainee, completed 1 year. Prescribing 6 months. critical care background prior to acute care.</p>
<p><b>Fiona:</b> 50-55. RN 23 years; advanced nurse development after RN qualified 7 years. ANP emergency/acute setting 18 years. Mainly in-house, some modules relevant ANP, then ANP programme university, builds on previous, completed 12 years ago, prescribing 9 years ago. Now further targeted study.</p>
<p><b>Gina:</b> 50-55. RN 28 years. ANP surgical speciality 20 years, in-house development, couple of <i>modules</i> relevant to ANP practice, included prescribing . Full ANP programme university, building on previous studies, completed this year.</p>
<p><b>Researcher</b> 50-55. RN 14 years, before ANP programme same university as 6 ANPs, ANP surgery same hospital as participants. Progress role leadership / service development. 3 hospitals lead ANP role. Joint role - programme leader 15 years. MA PD / education PGDiP 12 /10 years ago.</p>

Table 11 Advanced nurse participants - individual cases

With demographic information noted, final super-ordinate and sub-ordinate themes are explored and interpreted. This is captured through unique, idiographic narrative accounts of participants' views of becoming and being advanced nurses. A selection of these individual accounts of the ANPs, is included within section 7.2 (Ann, Diana, Fiona). The accounts of the remaining ANPs perceptions of their contributions to patient care and service delivery are presented in section 7.2.1 (Charles, Emily, Fiona). The samples were selected on the basis of variability between participants - age, area of practice, length of time as advanced nurses and job profiles (Table 11).

An acceptable IPA study paper (in this case, my thesis) should include sufficient sampling to demonstrate depth of evidence for each theme. For studies between four and eight participants, Smith's (2011) IPA quality evaluation guide recommends inclusion of extracts from at least half the participants. This provides a combination of idiographic 'case study' type data, as well as indications of convergence and divergence, representativeness and variability. As Belinda was the only CN, her individual account of becoming and being an advanced nurse, as a CN, and her unique contribution to patient care and service delivery, is presented within section 7.3. Other accounts are available for reference (Charles, Emily, Gina - becoming and being an advanced nurse, as an ANP; Ann, Diana, Fiona - unique contribution to patient care and healthcare service delivery), as abridged versions, ensuring transparency (appendix 12.1 and 12.2).

## **7.2 Individual accounts: Ann, Diana, Gina becoming and being ANPs**

(The following are used within narrative accounts in section 7.2 to 7.4 - In speech marks and using "*italicised text*" = participants direct quotes. [ ] = words omitted from quotes. (speciality) = anonymised specific medical or surgical area. ANP = advanced nurse practitioner, CN = Consultant nurse - both considered under umbrella of advanced nurse)

**Ann** explored development from being 'just a nurse'. "General nurse background with extended training [ ] as a normal nurse I would have never have questioned it. I would just have said, 'yes, OK'" She reflects on starting in a different clinical area as a, "huge leap, like starting all over again [ ] like doing my ANP training all over again..[.] so much of it is transferable because it's quite generic." She centred on familiarity with scope and different boundaries of practice and felt comfortable and confident with these and working autonomously, helped by advanced nurse training. This is her evolving life-

world experience from being an 'ordinary' nurse to advanced nurse. She made sense of being more questioning, analytical and empowered to think for herself and to challenge. "Happy to learn but I'm not going to make that decision, not my role.[ ] I'm not doing it. I understand why I'm doing this and why I'm stopping or starting [medication]. You have to be true to your knowledge-base and your area of expertise." She has courage now to speak out. "To stand up, literally stand up and be there and don't just say 'I'm going home now' ". She explored an experiential knowledge-base and its importance, only in patients' best interests, demonstrating human-centred practices, particularly related to dimensions of uniqueness, agency and togetherness and competence and commitment 6Cs nursing values.

She is open to change, if there is rationale, but with caution, perhaps suggesting a certain lack of adaptability, with a tendency towards objectification and passivity on the spectrum of humanisation, for certain situations. Ann implied that she has clinical leadership skills, albeit more organiser than leader and not keen to delegate and admitting she likes to be in control. Team-working enables her to give patients time when they need it, reflecting her humanising, caring approach, with uniqueness and togetherness. *"I can go back, I can leave the ward round and actually put the curtains round and sit, [ ] whilst they go and do the ward round."* Ann explored diversity of being an advanced nurse, ranging from traditional ward-based nursing up to the higher level of an advanced nurse. *"It can be as basic as giving a patient a commode to actually organising something that is quite invasive for a patient, off my own back."*

Ann is keen to point out how important being part of the team is for her, without losing sight of the nursing and caring elements that define her and that are the key to why she loves her job, reflecting a compassionate, strongly humanising approach. *"I am still classed as a nurse. [ ]. So we've got patients, working in teams [ ] I don't know, I just love doing what I do."* She likes the caring side, *"it was always bedside caring, helping somebody through something"* but there are tensions as she has to maintain acceptance with the medical team, to be part of it. This appears to involve a less demonstrably caring, compassionate persona, which she seems uncomfortable with; perhaps as it pushes her towards the more reductionist body and objectification dimensions. Her experience of supporting junior doctors, she talked about quite maternalistically. *"To literally be there, think on your feet, like a mum with all your kids at home, you have to know exactly what they're doing and plan what they're doing."*

She likes association with higher level practice associated with being an advanced nurse and professional identity rather than 'normal level' nurse. *"Because you are there as a nurse, you know..it's almost like we're filling the middle ground between medicine and nursing..[ ] people who know you in your advanced role."* She seemed to struggle with a dichotomy between acceptance as part of the medical team and staying true to her nursing, caring values-base. There seemed to be underlying tension between her nursing and advanced nursing role, with *"Super-nurse, common term you want someone to understand,"* perhaps implying being superior to 'normal level' nurses. She is proud of being a nurse but in the environment she works in, kudos is from medical elements, so perhaps she has to assert herself as more aligned to medical rather than nursing colleagues. She reflected on diversity of ANPs and doesn't think a clinic-based role would suit her. *"it's so diverse and why it's so hard to say what is an ANP. There are so many different types of potato! They're all different."* She was keen to point out she does not view advanced nurses as subservient to doctors, implying this was the perception previously; but now this has changed, in her opinion. *"Looked at differently, expectations of you are greater, not like traditional handmaidens to the doctors [ ] over the years has changed [ ] accepted as somebody who can actually make a proper clinical decision, not just take orders."*

**Diana's** (Speciality) skills were key to starting to develop as an advanced nurse and she repeated several times that learning from experience is not all from a book. An example is given of the direct approach when leading on a clinical emergency in her area and the level of experience and expertise required. She had a determination and commitment to take her career forward with desire to improve patient care, reflecting her humanising approach. This shows her acknowledgement that in such situations, it is necessary to adopt an approach erring towards the more dehumanising end of the spectrum, particularly objectification and passivity. Diana did not have much support from medical colleagues at first, until the ANPs started to make changes in their practice and then consultants started to acknowledge their value. She continues to progress and was now aware of wider perspectives. She had built a level of credibility with medical consultants as she now 'knew their language' and they had trust in her. She acknowledged her communication skills, with a patient on their level, as well as professional conversations with consultants, believing this came from experience within the clinical setting. She referred to this as *"worldly knowledge you get from experience."* She described and made sense of her experience, firmly rooted in all

dimensions of humanising care, particularly sense of agency and place, personal journey, insiderness and togetherness.

Diana analysed being an advanced nurse as assuming aspects of the medical role, but with her philosophical underpinning as a nurse, immersed in the humanising dimensions. *"So that uniqueness of the ANP, that you've got the interaction with patients already on board..[ ], so it's a lot of the nursing bit there as well as all the doctor bits."* She reflected on her experience involving a *"different kind of care, a different type of medicine"* combined. She belongs to a group of nurses, empowered to proactively change practice and who look to the evidence-base that underpins their practice. She asserted a powerful position developing through her advanced nursing identity and proactive approach to changing practice, which has challenged medical colleagues. Diana interpreted being an advanced nurse as part of her personality, with caring and compassion at the heart, person-centred and making sure patients get best care, from an altruistic perspective, but embedded in humanising care and nursing values.

She was confident about the way she and her ANP colleagues practice. Maybe there was an arrogant undertone here of 'my way is the best way' but this may just have been confidence in her approach and experience, moving towards the dehumanising end of the spectrum. This should be considered in the context of her particularly complex patient caseload, as this may be a more appropriate approach for managing aspects of such patients' care and treatment. Counteracting this is also an open, sharing manner, and is always accessible to patients and staff. Embodiment as an advanced nurse is through being specialist in her field, an educator, support for others and subscribing to evidence-based practice. She showed professional integrity and passion to make things better, showing a strong sense of commitment to patients.

Diana was pleased that being an ANP had enabled her to share knowledge and experience with colleagues, because she had to do this for herself. This showed her humanising approach to colleagues, particularly focused on togetherness and personal journey. She questioned advanced nursing's possible effect on doctors, with concern that an ANP-focused service may de-skill doctors. She saw herself in a senior role with responsibility to take forward practice. She wants to maintain her nursing identity and philosophy of caring and helping people, and talked passionately about this, as her embodied advanced nurse, not as a doctor substitute but advanced nurse. This had

been challenging and continued to be, but she shows resilience and drive to continue with nursing at the heart of what advanced nursing means to her. *"You know you can make a massive difference to somebody's pathway and you've literally been stopped because you're not a doctor, can be really frustrating."* Being an ANP is newer in her speciality and challenging to get accepted as a 'nursing', not 'doctor's role.' For Diana, patients' perceptions are that when you say you are a nurse, they view interactional elements this implies and feel they can talk to you. Then, as you *"do clinical tasks"* associated with medicine, their perceptions changes and they think you are a doctor. This perception is seen in medical staff, which she finds frustrating.

**Gina's** journey started not as replacement but to complement the doctor's role, focusing on meeting medical deficits. She wanted to progress and needed a challenge. She felt the doctors saw value in ANP practice and something that helped improve services, when they were experiencing problems and were not meeting targets. She reflected on when it started to change from expansion of her staff nurse role, evolving gradually, not consciously noticing when it changed. This had not been easy as they were dealing with unknown territory when it started, so it was quite innovative and pioneering and they had to deal with obstacles along the way; however it now is a reputable role within a well-established service.

Being an advanced nurse *"...is a big role"* managing care, making decisions, being responsible for a team, working as part of a bigger team, and having input with all teams. She saw it as a bit of everybody else's role, *"a foot in every camp"* whilst also sitting outside, not fitting neatly into any one camp. She described this as an outsider and insider. She could not pinpoint when things changed but felt it had become more advanced, commenting that it tended towards being medically-orientated and then swung back to more nursing-orientated *"don't know when it became more nursing."* This suggested it is not necessarily medical elements that make it more complex but a mixture of medical and nursing aspects. She felt she is not restricted and knows what is happening all round because of being part of each aspect of the pathway, supporting patients on their personal journeys.

Gina demonstrated clinical leadership and team leadership skills, implying others around her look to her for leadership, to make decisions and guide them. Being an advanced nurse had always been *"[ ] definitely, definitely a nursing role."* but medically-led by consultants. She used patient feedback to demonstrate how they saw her and

this was poignant, as what she does needs to be meaningful. This was also about her professional integrity and humanising aspect of her experience, across all dimensions. She discussed some good outcomes, realised through being able to work independently, seeing her own patients. She explored her position in the team, her professional integrity and that consultants listen to her. She seemed surprised about this as maybe she did not realise how much power she has, as this developed with her. Her level of responsibility had increased recently now she had responsibility for junior ANPs, needing to carefully guide and support them, mindful of not expecting too much. Gina reiterated that people come to them (ANPs) first to sort problems out or for information, which shows that others see them as knowledgeable and approachable, *"the first port of call, troubleshoot for them."* The perceptions of the ANPs, when they came into post was not always complimentary, from other people, such as ward sisters, and she talked of being perceived as moving into the doctors' territory.

### **7.2.1 Individual accounts: Charles, Emily, and Fiona's unique contributions to patient care and service delivery**

**Charles** focused on collective contributions; he did not realise what had been achieved by himself and his team from a wider perspective, until he saw what other areas were doing. Then he realised how much more they offered patients. He described an emergency clinic run by the ANPs with consultant support, having a positive impact on service delivery and patient care. This shows commitment, in line with 6Cs values. When prompted to explore a personal perspective, he referred to his common sense, which he defined as being on the same wavelength as the patient. He used his experience to inform, educate, reassure and support patients through their experience because he is there, knowing how it is for them. His communication skills are a key element of this, in line with communication of the 6Cs and particular focus on humanising dimensions of agency, uniqueness and sense making at a high end of the spectrum. He felt that he shows empathy and is able to be open and honest with his patients. He believed that his confident approach helped patients to feel better, linking to competence 6C value. *"To show empathy and be kind and answer any of the little questions they have, just to answer them, be honest with them. [ ]. I think if they see that you're confident then they feel much better."* By sharing his deep understanding with patients, drawing on his own experience helps achieve good quality patient care, drawing in commitment to communication and competence 6Cs values. *"I'm thinking about pre-assessment [ ] really explain to them what's going to happen and because we are there and part of it we can really explain to them."*

He reflected on a patient encounter that showed the difference he made, helping her make informed choices about care and treatment, supporting her in making sense of her personal journey. He illustrated the impact he made through reassurance, information-giving, and knowing exactly what she needed to help her understand the condition. "[ ] .talked to her for 6 weeks, spent time with her and now she understands and feels a lot calmer." He focused on balancing explanations with ensuring patients understand implications of something without frightening them. He saw the philosophical underpinning of this practice as being added value he offers, which is conceptualised through all humanising dimensions and 6Cs together, underpinning his practice. "You have an understanding that you can share with your patient and I would say that's something, for me, that helps."

**Emily's** experience is an opportunity to turn manic, busy situations into something that is still busy but human-centred, showing her compassionate, caring approach, in line with the 6Cs and specifically sense of place and personal journey. She felt able to just spend a few minutes with a patient who looks bewildered or upset, explaining things to them, which makes things better for them, stopping them feeling scared. Patients' experience loss of meaning and personal journey and dislocation, which Emily feels she helps to regain back towards humanising end of the spectrum and linking to communication and competence 6Cs values. Being able to share knowledge "*but actually..by providing that explanation, it can make a huge difference to the patients.*" The more she understands and can rationalise in words to patients so they understand, and make sense, the more compliant patients are. She used an example to show where something could have had a different outcome if she had not intervened and listened to the patient and supported her and used team members to support, as well. "*We moved on to the next patient and I said to the team I'm just going back to that patient.*" She feels she picks up when a patient is upset but doesn't think everyone would have done so. Emily is able to sort out many problems through an approach focused on holistic care, with all 6Cs underpinning her practice and humanising dimensions of agency, togetherness, personal journey and sense making.

She felt the unique contribution of being an advanced nurse is that she fill gaps, make things flow, and is a buffer for diffusing difficult situations, in line with caring and commitment of 6Cs and agency and personal journey humanising dimensions. "*I'm a person that can make things seem better for the person when they're going through a pretty grotty time.*" Emily saw patients who were not well-managed and felt she made

a difference for them, as well as creating a service that was cost-effective for the organisation, considering both quality and cost-effectiveness. This created a streamlined service, using expert members of the multi-disciplinary team to support developments. In this service, ANPs filtered patients to correct pathways, helping support good patient outcomes not only by doing things but by appropriate referrals. *"Things are working well, time is saved, it's a good outcome for the patient and it's just giving good quality care that you know in your heart is what should be happening and so for all the efficiency you can put into your job and being effective, it's human factors, having compassion, having time to listen."*

**Fiona:** ANPs had demonstrated a positive impact of their service through audit and patient satisfaction surveys, showing commitment and caring, in keeping with 6Cs values-base. The benefit to patients was not necessarily only high level clinical skills, but being able to communicate, reassure, support and share information with them. This shows embedding in humanising dimensions, particularly insidersness, uniqueness, sense making and sense of place. She explored an example of patients on medications with no knowledge of what they are for; what makes a difference is the ANP taking the time to tell them about their medications so they understand, giving patients ownership of their own conditions, and thus more challenging of their own care. Another positive impact was that she picks things up at an earlier stage with patients and deal with them. Her uniqueness is her sense of humour, she is cheerful at work and supportive, all part of her caring role to colleagues and patients. Staff come to her because they know they can talk to her, so her approachability is key to her contributing to staff well-being. Thus, in relation to her human-centred approach to staff, Fiona was describing dimensions of agency and togetherness, albeit using different language for these elements.

A poignant example illustrated Fiona's delivery of human-centred care, across all humanisation dimensions, high on the spectrum. This was the case of a father, whose 6 week old baby died and how she was involved with him from when he came into the department until he left. This was a challenging experience but one she dealt with using compassion and a humanising approach. She gave him her whole attention and was there for him throughout the traumatic experience. He fed back positively that she had been honest and thanked her. Her communication skills were key to this difficult situation and being with the father; a sense of togetherness, sense of place and agency being key humanising dimensions related to her involvement with him. No-one else

wanted to get involved as he was difficult; so she took responsibility at an advanced level, showing courage, as an underlying 6C, directed at a difficult situation, as well as compassion and caring. *"He hadn't let anyone else near, and he'd entrusted me to make sure his daughter got safely to the mortuary and, you know, to come back and let him know that, he entrusted his child into my hands. and I just felt that really difficult situation. I felt I had made a difference. I couldn't change the outcome but I do really think I made a difference to him."*

She recalled a second scenario involving a small child who died, where she made some, perhaps courageous, potentially controversial decisions about managing his parents, which some colleagues, at the time, criticised her for. However, she stuck to her decisions and continued with what she saw as the right strategy to manage the situation. The parents sent a thank you card, captured in the quote. She had seen things from their perspective, thinking outside the box, showing her compassion and strongly humanising care approach across all dimensions. *"They said that one consideration was the kindest thing ever, you know, you actually noticed that despite in all that chaos and our tragic situation, you were understanding, you thought, it was almost like I had thought outside the box and seen things from their perspective and they said, all those little things made such a difference but I went with my gut .. and yeah so that definitely it made a difference you know and whilst I questioned myself over it actually it was the right thing to have done for them."*

### **7.3 Individual account: Belinda becoming and being a CN**

**Belinda** has passion for her speciality, apparent even from early in her nursing career. Providing good quality nursing care and getting essential nursing care right and good patient experiences, is very important. One immediately gets a sense of what is at the heart of her experience, that shaped her in becoming an advanced nurse, showing an overarching humanising approach, underpinned by 6Cs nursing values. She made sense of becoming an advanced nurse, as using her intellect to its full potential for clinical skills and having high level nursing skills as a foundation. Belinda sees advanced level nursing in terms of critical thinking and looking at *"new emerging evidence coming through and looking at how you can integrate that into your practice."* She wants to make a difference to patient care and service delivery by adding to knowledge in her speciality and to nursing, showing commitment and competence.

She started having her own patient beds, along the same model as a medical consultant, working alongside them, with the same workload and predominant clinical focus. She saw her role as *"being able to spend time making lots of different decisions and gathering lots of information to inform your management plan, be that medical, be that nursing."* She reflected on the ground-breaking nature of the CN role, discussing her professional responsibility to take forward nursing, quite courageously, it would seem, particularly in her speciality, which is *"my passion."* She summed up being an advanced nurse as a package of things, characterised by higher level thinking and decision-making, leadership, drive to develop services to improve patient care and a facilitative element of bringing colleagues along with her. This is alongside acting as a key facilitator of care delivered through nursing and other healthcare colleagues.

Being part of the national agenda from both a nursing and speciality perspective is important and shows advanced nursing from an outward, wider context. Maintaining safe practice is important, ensuring she is confident in making safe decisions and she clearly has confidence in her own ability, seeing these facets as core to advanced nursing. She is cautious, in relation to functioning safely, particularly as she is in an isolating position, which makes her consider need for support mechanisms, particularly from a nursing perspective. Belinda appeared to struggle with maintaining her nursing focus, but is keen to ensure she is true to nursing rather than a *"mini-doctor and selling her soul to medicine."* She reflected on the very medical model where she works, which she is determined to challenge, putting forward the essence of nursing at the core of her practice and underpinning values of 6Cs and humanising care dimensions. Togetherness and agency were two dimensions that were particularly relevant to Belinda's experience of being an advanced nurse.

**Belinda** found it difficult to quantify her personal contribution and saw herself as working as part of a team, bringing the whole team along with her. She referred to feedback from staff, who highlighted her patient-centred approach. She saw multi-disciplinary team working as making a real difference, having a positive impact on patient care. She used an example of when she felt she did make a unique contribution to patient care, which was very poignant and clearly showed her underlying philosophy of care embedded in 6Cs and humanising care dimensions as her values-base. Of particular note here, were uniqueness and togetherness, on the highest level of the spectrum of the dimensions. This involved working with the whole patient pathway and thinking holistically about all aspects of a specific patient's care,

based on the family's feedback; very much echoing embodiment dimension. This showed a clear example of added value of her involvement in patient care. *"There's something about information giving and also being able to bring not just support them emotionally but being able to give them concrete information about their care, being able to give them time you know if it is something about their diagnosis, their recovery or even just they need to be on certain types of medication."*

She talked about being in a team, facilitating others to provide good quality nursing care, which she saw as part of her unique contribution. She pulled together what her contribution is, through what she sees an advanced nurse should be. Although one assumes this is personal, she was, again, not putting herself forward personally, but as the model of care provided by a CN working at an advanced level of practice, with authority to make decisions, which the role gives. *"Just the odd occasion when it's just me, and a patient and relative and yes I could say for that individual, personally I made a unique contribution but I hope most of the time, the vast majority of the time, I bring my whole team along with me."*

## **7.4 Cross-case analysis and interpretation of participants' experiences**

### **7.4.1 Super-ordinate theme 1: Becoming an advanced nurse**

#### **Sub-ordinate theme 1.1: Starting on the journey**

##### ***When you're passionate about something, it's easier*** (Belinda)

The participants were experienced nurses when starting their advanced nursing journeys, at crossroads in their careers. Shared themes intimated the main rationale for becoming an advanced nurse was remaining in a nursing role involving patient care, with intersubjectivity related to patients. This is encapsulated by Gina. *"I want to expand my role, I want to develop, I want to get promotion, but I want to do it still staying close to the patient and so becoming an ANP I was able to meet those needs."* For several participants, the pathway was not clear, at first. For Fiona and Gina the service was new, albeit at a time when evidence of such developments emerging in hospital settings, similar to theirs; reported by Rolfe and Phillips (1997), Manley (1997) and Hicks and Hennessy (1998). These two participants were clear they did not want to

move to management posts, but to stay close to patients and such a move, was in line with the school of thought at the time, was clear motivation.

Belinda made sense of starting with the specialist area rather than a general position, from a spatiality perspective. *"I wanted to go into (speciality), that was my great passion."* Her drive was clearer but similar to Gina and Fiona, remaining with desire to be involved primarily with a strong patient-focus and the specialist area. When she saw how other CNs worked she saw where she wanted to take her own role. *"I knew I didn't want to be management [ ]. What I need to do is become a nurse specialist, then get on and become a CN."* Charles reflected, *"I haven't made a conscious decision to become an ANP; it's just something in me I would always want to do. [ ] So nothing conscious just that I can help people and if I can help other nurses in (speciality), in my time that I am on this planet, then it's something I would like to do now, there's no other reason than that."* This showed his strong desire to maintain his clinical role and supporting other nurses, primarily in his speciality, comparable to Belinda.

An individual sub-ordinate theme for Ann was the drive that came from reflecting on being a staff nurse on the ward. *"I think the approach to it initially was, 'I'm just coming to work and I'm doing my bedside care and I'm going home and that suits me fine and patients are happy with me."* However, she wanted to be challenged, which was borne out through starting her journey. *"But having done it (advanced nurse training and education), it's actually made me better at doing things.[ ] When I worked as a normal nurse you just did stuff and hopefully knew it was important so you reported it. Now I know what's important as far as I know!"* This was similar for Diana who made a conscious decision, with her desire for hands-on patient care. She reflected *"I was asking a lot of questions. [ ] I think it was [ ] because I wanted to know more about (speciality), about advanced practice, 'why is it only doctors doing that role? why can't it be a nurse? OK what else can I do that is advanced, that can take me forward.' "*

Emily's motivation was also related to being close to patients. She insightfully reflected that, *"I had an increasingly management-orientated role. I missed my clinical [ ]. But if I was going to do clinical I wanted it to be..in a proactive, innovative, fulfilling role where you fully use your resources."* She asserted a different perspective related to her drive for learning, *"One of my reasons for wanting to be an ANP was that I felt that there was potential to develop my scope of practice and to develop my capabilities and also to test myself personally to see what I was capable of.."* By this time, expectation for

advanced nurses was academic preparation at Masters level. This had not been the case for Ann, Fiona and Gina, who studied to degree level, although increasing, through more recent study to Masters level.

### **Sub-ordinate theme 1.2: A questioning approach**

#### ***Questioning that led me to become an ANP*** (Diana)

A shared underlying characteristic was an inherently questioning nature that helped drive them to becoming advanced nurses. Charles referred to himself as "*questioning, challenging why people are doing things*" Diana referred to her "*.inquisitive nature. I wanted to know more, I wanted to be better..nosey devil!*" And Ann's experience included "*questioning critically,*" which denotes not only the questioning but critical approach, associated with advanced nursing, reiterated by other participants. This is reported in literature on advanced nurses and linked with problem-solving and decision-making (Mantzoukas and Watkinson 2006).

### **Sub-ordinate theme 1.3: Education, knowledge, skills**

#### ***All your courses and things that back it up*** (Charles)

The advanced nurses focused on education and developing different types of knowledge and skills. All ANPs had undertaken an advanced practice education programme and all referred to the important part it played for them in becoming advanced nurses. "*All the courses and everything falling into place*" (Gina). This perhaps was meeting enquiring elements that they felt they met, through combining practice-based and university education. Fiona, reflecting on, "*potentially I can spot something a lot earlier in a patient.*" Charles recounted a patient consultation, where he "*picked that up as an ANP and prevented a heart attack*", making sense of this as, "*its advanced practice.*" This fits with the shared theme of significant clinical focus of being an advanced nurse, participants illustrating higher level knowledge working clinically, at the medical-nursing interface, reported similarly by researchers including Knowles et al (2006) and Duffield et al (2009; 2010).

The start for Fiona and Gina was hospital-based development, when it was a relatively new concept, respectively, eighteen and twenty years previously. This was when emergence of advanced nursing within secondary care was relatively slow to develop.

Barton and East (2015) argue that this was hampered by lack of understanding, alongside desire for cheap, 'quick-fix' solutions to healthcare problems, that did not acknowledge particular educational support for role developments. Gina reflected *"When we first started the service, there weren't really many people being called NPs, there wasn't a set format for it."* Similarly, Fiona purported *"From ground-level, it was very new, we never had ANPs working in the area, it was very much trial and error"* She continued to explore their preparation with *"An introduction to 'nurse practitioner', brought that back to where we were working."* This referred to courses offered by other hospitals, to prepare nurses to work differently to meet service requirements, which emphasised more medical 'task-based' skills, as reported by Marsden et al (2003). Currie et al (2007) argued that such restricted education can limit advanced nursing roles, and undermine its advanced practice element. This perhaps explains continuation of these participants' educational pathway, making sense of comments, *"Yes, I am in an advanced role, but I see it as an advancing role because it's never-ending,"* a theme from Fiona reflecting on her experiences.

Rushforth (2015) argues that there was lack of clarity, around this time, with regards to the best preparation for advanced nursing practice. This was despite a number of studies pointing towards limited educational preparation contributing to sub-optimal patient care and benefits of evidence-based education for advanced nurses in the UK (Barton 2006). This appeared to be changing and a shared theme from Diana and Emily, both who did the ANP programme more recently, was more clarity around their goals, from a practice and education perspective. *"To develop existing skill sets and learn new skills sets by doing the ANP course and then think how you best use your capabilities. The 1st year focused on skill-set and how to deepen decision-making. Part of it was questioning, part of it was being on the ANP course"* (Emily). She continued, *"doing the ANP course was pivotal, developing my vision, working out my identity."* This showed a different perspective to Gina and Fiona, whose roles started to develop prior to formal education input. Ann also had a clearer perspective from her education pathway, undertaken whilst developing her role. She described and made sense of this, as enabling her to practise differently to a ward nurse, highlighting a hierarchical position from higher level practice and the knowledge-base she was implying. *"Having had training in advanced practice and knowing what that means from an education point of view, gives you more (than a ward nurse)."*

Charles' strategy stemmed from depth of reflective practice, based on training and education. It is suggested critical reflection-in-action, which appears to be what Charles was referring to, is an inherent process for advanced nurses to achieve critical thinking and analytical skills (Mantzoukas and Watkinson 2006). He showed self-awareness of learning and development needs and how to meet deficits, on an on-going basis. This involved *"reflecting on other people [ ] use your own autonomy to learn"*, which Belinda (the only CN), echoed with *"very driven, sorted out what I needed and asked for it."* Emily talks of *"learning from others"*. Reflexively, Charles continued with a focus on spatiality and intersubjective elements, *"constantly improving yourself to improve services and for patients."*

***Become a CN...forward nursing with passion and be a ground-breaker (Belinda)***

Belinda undertook speciality-specific education and training, followed by advanced assessment and prescribing modules at Masters level and was now doing a PhD. An individual theme was not to have followed a formal or structured pathway, partly due to CNs only being introduced in the UK around 2000 (McSherry et al 2007). Belinda's route to CN, started shortly after this, when the concept was less defined, with acknowledgement of its diverse and complex nature (Kennedy et al 2011). This seemed an appropriate pathway, with the different focus for her CN role on specialist, rather than generalist skills and expertise, more aligned with ANPs (Manley and Titchen 2012).

Another theme was Belinda's knowledge and skills under the same umbrella of advanced nursing as the ANPs, fitting with spatiality and inter-subjective elements. This aligns with literature on the nature and characteristics of CNs, with concept analyses considering a broad-base of roles under the overarching definition of advanced nursing (Dowling et al 2013). Belinda reflected on reaching *"a level with my advanced practice that is challenging me with critical thinking academically."* Manley and Titchen (2012) explored greater emphasis of CNs on being research-practitioners, reflected in Belinda's experience, as she pursues a PhD, and in line with the emergent definition of the CN concept. *"Now I'm doing my PhD I feel I am at the right level now."* Sharing and creating knowledge appeared as a unique theme for Belinda. This is an element that sets her apart from ANP participants, suggesting key differences between the two categories of advanced nurse. This element of being a CN, embedded in Belinda's experience, fits with Gerrish et al's (2011) mixed-methods study of comprehensive systematic review and series of case studies. A key finding related to

organisational significance of CNs, with a specific element for Belinda, of the impact of new knowledge generation, through involvement in research (Gerrish et al 2011).

***Working at advanced level you have to underpin it with knowledge*** (Fiona)

A shared theme involved development of higher level knowledge and skills, usually considered the remit of medical doctors, combined with nursing knowledge and expertise; this accounted for spatiality and intersubjective constituents. This is similarly highlighted in studies, such as Kucera et al (2010) and Fleming and Carberry (2011), as key characteristics of advanced nursing. Gina reflected on starting her advanced nurse journey, when she *"didn't have advanced skills,"* progressing to being an advanced nurse who uses *"medical knowledge and nursing skills together and knowledge borrowed from all different angles and disciplines."* Fiona asserted that *"to work at an advanced level, you have to have advanced skills, advanced knowledge but you are still a nurse, a nurse with advanced skills."* Although a general comment, it was made in the context of reflecting on her own lifeworld. This shared theme of knowledge and skill-base moves from knowing how to do something, such as practical, clinical skills, to knowing why something is done, with depth of understanding and application to practice. This appeared to integrate knowledge in all arenas of knowing underpinning advanced nursing practice, in line with Carper's (1978) essential ways of knowing and Roach's (1987) notion of nursing competence. Engagement with these ways of knowing and its application supports the notion of the advanced nurses being aware and pursuing an approach of both humanising and nursing 'know how', as well as scientific 'know that'. This spans all eight dimensions of humanisation, at the higher end of the spectrum.

A shared theme depicted higher level practice beyond entry-level registrant nurses, distinguishing them as advanced nurses. This is mirrored in previous research, including Gardner et al (2010) and highlighted as a key trait of advanced nursing (DH 2010). Ann used a patient encounter to illustrate this, *"more knowledge than the ward nurse. I could explain to them, because I can understand. I know what he's had done and that's the difference. I just feel it saves you waiting or the patient waiting or even nurses waiting for a decision to be made [ ]. That sort of huge gap between being a ward nurse and having to wait desperately for a doctor to do something has gone. You don't if you've got ANPs there."* These accounts illustrate participants making minute by minute judgements about what should be done and what is right and responsible, congruent with Carper's (1978) ethical way of knowing within an underlying humanising

care and 6Cs nursing values approach, with competence, courage and commitment at the forefront.

Fiona linked development of advanced knowledge, in terms of benefitting patients.

*"The knowledge we were building on, we were utilising experience and the knowledge we had and actually it made you realise how much you did know, but you weren't actually aware you knew it until you put it into practice. I mean it was scary, but it was also very satisfying, and we could see a benefit to the patient."* In addition to highlighting advanced level knowledge, this showed philosophical underpinning of human-centred care and 6Cs values. Emily reflected on when her advanced level knowledge was instrumental in enabling her to provide a patient who was upset, with an explanation of her condition. *"My imparting knowledge, an explanation and for me the more I understand and the more I rationalise in words that the patient can understand, this can make things better for the person."*

#### **Sub-ordinate theme 1.4: Temporal aspects**

##### ***Taken time...developed over years*** (Charles)

The relevance of temporal aspects is seen with each participant working chronologically through their journey. This became embodiment of being an advanced nurse, with, *"doing it for so long,"* where Gina recounted her experience and changing environment, as advanced nursing changed and she reflected, *"I don't know when it became more advanced."* Charles referred to taking time and education to support developments. *"The advanced part came over the years, it's going to be a couple of years yet."* He acknowledged, *"It's not just because you've been here a long time,.."* The shared theme suggests advanced nursing should not be considered as a quick-fix solution to developing roles and services but built over time, experience and education, also reported by McConnell et al (2012).

#### **Sub-ordinate theme 1.5: Nursing experience as the foundation**

##### ***Years of nursing experience...prior to my journey of advanced nursing*** (Diana)

Diana's quote, the sub-title here, was echoed by all participants, including *".25 years in my career"* (Emily) and *"staff nurse E grade on the ward for years"* (Fiona). This highlighted the lengthy period of time the advanced nurses had been qualified RNs,

with this temporal element a shared theme. This indicates the considerable level of experience, knowledge and skills they possessed as nurses, reflective of spatiality and intersubjectivity, before embarking on advanced nursing pathways. *"Not something if you've been a nurse for a year, you can suddenly go into."* (Gina). Diana stated *"it comes from experience, couldn't do it as a junior nurse without full experience."* Gina interpreted nursing experience as the background to developing. *"You really have to use experience of being a nurse and dealing with patients, relatives, carers and so on."*

### **Sub-ordinate theme 1.6: Meeting advanced level of nursing competence**

#### ***What your capabilities are and how best to use them*** (Emily)

The participants made sense of their experience, education and skills that led them towards embodiment of becoming advanced nurses, cognisant with Mantzoukas and Watkinson's (2006, p.33) review of literature that reports that

*"advanced nurse practitioners are expected to demonstrate expertise in clinical judgement and decision-making."*

These elements appeared key to the advanced nurses meeting the level of competence required. Inter-subjectivity focuses on being nurses as foundational to becoming embodied advanced nurses. They made sense of their experiences through specific language, such as *'higher level', extended skills but a lot more'* and *'advanced practice'* sending a clear message of significance of what they do and where they are situated, in terms of levels of practice, embodied in becoming and being an advanced nurse. This echoes the higher end of the spectrum of the humanisation dimensions, particularly focusing on sense-making and embodiment.

For Ann, being an advanced nurse is *"knowing why you do something - the bit advanced nurses have."* reflecting on her embodiment through reaching a competent level of practice as an advanced nurse. A sub-ordinate theme for Gina was progression to *"making decisions I can justify from all angles."* Gina and Emily referred to *"a more lateral perspective* (Gina), *being able to think outside the box."* (Emily), as part of their lifeworld experiences. Another shared theme interpreted by Belinda introduced critical thinking as contributing to being an advanced nurse. *"I am at a level with my advanced practice that is challenging me with critical thinking."* She referred to her *"higher level thinking and decision-making skills"* that characterise advanced nursing generally. This is mirrored in research, including McNamara et al's (2009)

service evaluation. O'Connell et al (2014) focused on capabilities of advanced nurses, which drew out similar elements to these participants. This spatiality focus on critical thinking and questioning was a recurring theme, with Ann's example of working with the consultant, "*discussing things with the consultant and saying 'why am I doing this rather than that?' Sometimes I'll be there and think, 'why have I done that for this one and yet the patient seems to be presenting the same?' [ ] Once you start questioning them and everything, sometimes they will revert back and think, 'no actually you're right, we'll go with that' And I think, 'OK, so I have actually influenced a consultant's decision-making!' "*

An individual theme for Charles was protocols, making sense of differences between non-advanced and advanced nurses, commenting that nurses follow protocols but doctors don't tend to. He continued to explore how advanced nurses deviate from protocols, with critical questioning and thinking beyond their prescriptive, restrictive remit. "*You may examine a patient and if you get it completely wrong then they could lose a leg, it's that serious [ ] need to be educated and follow pathways, don't just follow them, you need to know why and then I would actually say you're doing an advanced role. I think it's really important that, rather than following 1 to 10, you know exactly why you are doing 1 to 10 because nothing ever goes quite plain sailing. You need to be aware of what can happen, recognise something that can come in as part of that protocol [ ] awareness and being alert that something could change, deviate from that. It's often what starts as A doesn't end up as C. but something different.*" Working outside strict adherence to protocols is seen to indicate a more experienced, advanced nurse, better able to respond to patients as individuals, similarly reported by Marsden et al (2003). Dreyfus and Dreyfus (2005) argued that autonomous decision-making and freedom to act as an accountable practitioner, rather than rule-based performance, is associated with expertise, again congruent with the advanced nurses' experiences.

Diana reflected, "*It's not until you are actually exposed to it on a daily basis, do you really start to understand what medicine is and how you interact with patients and actually develop your skills [ ] It's because you're an ANP that you know what's going to happen, you know their treatment, the case, the medications, the procedures, you know the outcome almost.*" Emily pulls together different aspects, commensurate with phronesis to make sense of her experience that is underpinned by humanising care dimensions and 6Cs nursing values. "*(We) have tasks and skillsets that we do, but it's*

*not what we do, it's the way we do it and, for me, the way you do it can actually make a huge difference to whether it works as well as it could for the patient."*

Charles' experience culminated in interpretation of embodiment, capturing the shared theme of phronesis. *"It's taken time and experience to become an ANP [ ] you actually need to be doing it and established doing it and really become quite wise at what you need to do [ ] experience and common sense."*

For Emily, embodiment of the status of being an advanced nurse, was interpreted by drawing on other people's perspectives. *"You've done time, you've demonstrated competence so there is a certain amount of respect and rapport from your colleagues [ ] he (consultant) said I 'would always be very thorough and, you know, I never found an additional clinical sign that she hadn't picked up on her clinical assessment'..and I was able to question the diagnosis. I get a lot more satisfaction from knowing that I am capable but I'm not just a robot that does clinical tasks."* This highlights temporality of becoming an advanced nurse, closely inter-related with development of requisite knowledge, understanding and expertise to function at this advanced level. Currie and Grundy (2011) discussed this, in relation to workforce development and succession planning, reporting significant time for developing individuals with the right knowledge, skills, abilities and values for advanced nursing practice; also articulated through this study's participant dialogues.

Fiona discussed how progressing as an advanced nurse *"changed my scope of practice"* through *"extended skills and knowledge."* There is consensus in literature of advanced nursing characterised by expansion of the traditional scope of nursing practice, asserted by Callaghan (2008) and McConnell et al (2012); this study's participants interpreted these features of being an advanced nurse, from their personal perspectives. Shared sub-ordinate themes can be interpreted as demonstrating they had described and made sense of becoming advanced nurses, benchmarking the point they reached beyond entry-level registrant nurses, suggestive of advanced level nursing practice. Ann summed this theme up succinctly when she argued, *"If you haven't got the information and knowledge-base, no advanced nurse will work,"* implying this is what she now has. She emphasised her *"decisions based on evidence and experience,"* implying a key characteristic for advanced nurses, functioning at advanced level practice.

An individual theme for Emily drew in another thread, interpreting becoming an advanced nurse, with intuitive practice developing from merging knowledge, skills and practice, as conceptualised by Benner (1984) for expert nursing practice. *"Experience and intuition, even with my differential diagnosis. There are times when I have thought 'surely not?' and then you'll go back and look at the information, you'll look at the clinical presentation and history, you'll look at comparative data and you'll think, no, I think this is and actually. I still think it's this and actually it was!"*

#### **7.4.2 Super-ordinate theme 2: Being an advanced nurse**

##### **Sub-ordinate theme 2.1: Nursing identity and clinical nursing focus**

###### ***Professional identity and philosophical underpinning*** (Emily/Gina)

Synthesis of shared themes portrayed participants' professional identity as nurses, philosophically underpinned by humanising dimensions and 6Cs values-base. They reinforced this whenever they referred to elements construed as taking them outside parameters of this nursing identity. Interpretation of this key theme is 'hot data' that appears to define the lifeworld of these participants. This nursing identity, aligned with spatiality and intersubjectivity, maintains immersion in the profession, and is core to embodiment of being an advanced nurse. All participants were enthusiastic and passionate about what they do, with satisfaction derived from being advanced nurses, with the heart of this emanating from enhancing and building on their established nursing practice. This is embedded in compassionate care and the significance of this for them, as a spatiality constituent. This was real embodiment of being advanced nurses for them, high on the spectrum of dimensions of humanisation. Emily reflected on her identity. *"For me one of the key things about being an ANP from a nursing perspective, I feel it creates an identity within myself as a person and also within my professional role as a nurse."* Diana commented, *"It's the identity [ ] because of my nursing background."*

Professional identity linked with job satisfaction and maintaining nursing focus, in keeping with 6Cs, particularly courage and commitment. Ann commented several times that *"I love my job"* and Gina said *"I still do the job I love."* Similarly, satisfaction of being an advanced nurse is echoed by Fiona, *"..advancing has given me passion for my nursing."* Charles, Diana and Belinda discussed their passion more specifically for

their specialist area and improving patient care. *"I love it, you know, I'm passionate, I still am about [speciality]"* (Charles); [speciality], *that was my passion, my great passion*" (Belinda), *"because of my passion"* (Diana). This is evident through the positive language they all used and enthusiastic, animated way they told their stories. Their strong feelings around nursing identity, linking with emotional attunement, were illustrated through their use of language, which portrayed a powerful message and confirmation of meanings, through repeated words and tone of voices. They used words and phrases cognisant with humanising and 6Cs values, with these values being how they practice as advanced nurses.

A shared theme was stressing words *'nursing'* and *'care / caring'* when they explored this element. Ann reported her experience in a direct, clear and passionate way. *"What I think my role is, sort of what I am..[ ]. Because you are there as a nurse you know. I am still classed as a nurse [ ], very much the nursing, yes, yes."* Belinda reflected, *"The heart of what you are doing, immersed in the nursing role."* and *"being able to be a true nurse and not just a mini-doctor."* She was particularly emphasising nursing as the key focus, using terms such as *'heart'*, *'immersed'* and *'true to'*. She stressed her nursing identity, related to responsibility for supporting staff, portaying humanising factors, in caring for nursing colleagues, particularly togetherness and agency. *"Doing my bit for the nursing profession, developing up the next lot of nurse specialists."*

Diana became angry and frustrated when she recalled an occasion when she was praised by a consultant for her 'medical' consultation skills, with the consultant suggesting she should have trained as a doctor, without acknowledgement of nursing aspects of the consultation. *"Why can't I be an ANP and still have that level of expertise? Maybe I came across more 'doctory' than as a nurse, I don't know, but I'm a nurse, an ANP."* This fits with inter-subjectivity as the relationship between the doctor and herself as the nurse. Spatiality relates to the significance of this is to her lifeworld, embodied in being an advanced nurse, not as doctor, but advanced nurse.

Fiona reflected on becoming and being an advanced nurse, within the context of her professional nursing identity, with underpinning dimensions of humanisation and 6Cs values-base. *"I am a very hands-on nurse. I didn't want to lose that, it was important for me not to lose the foundation of being a nurse, it had to be the core of it actually."* She thoughtfully continued, making sense of her experience as *"the core of that is I*

*want to be a good nurse working with extended skills, I guess.*" Gina, explored her role starting as a medical replacement, progressing towards being more nursing-orientated, with an individual sub-ordinate theme that, *"It sort of went medical and it's come back nursing again."* Interestingly, this is not necessarily a result of commencing her role in the 1990s. Earlier research reports on examples of advanced nurses working in hospitals, whose primary focus was their expert nursing practice (Rolfe and Phillips 1997; Brown 1998). This is in contrast to stronger focus on advanced nursing characterised predominantly by skills more traditionally associated as medical 'tasks', as others studies focused on at the time, such as Sakr et al's (1999) randomised controlled trial that compared care of advanced nurses with junior doctors in a minor injury unit in the UK.

Ann's poignant comment encapsulates how she felt about being an advanced nurse, with embodiment echoing a combination of humanisation dimensions and 6Cs values-base. *"You have to really feel it, you can have such extensive knowledge, do hundreds of courses..it's all learnt stuff but, yes, yes, it's understanding it and feeling it and having the compassion, all that is still there in an advanced role."* Other participants interpreted their experiences, with shared themes that considered positive contributing factors at the core of their practice that concomitantly added value to patient care and service delivery.

With care provision, shared themes were synthesised and interpreted for all participants making sense of their person-centred approach, aligned to a humanising care and 6Cs values framework. Charles considered it important for an advanced nurse to *"need to learn to achieve best patient care."* For Emily, having time to spend with a patient was congruent with humanising dimensions; especially high on the spectrum, were togetherness, sense of agency, sense of place, sense making and personal journey, which strongly underpinned such an element of her practice. *"Spending five or six minutes with someone, you just make it better."* Diana continued this theme, reflecting on these underlying human elements, with *"it's always been about the patient and their experience."* Like other participants, she referred to being an advanced nurse enabling her to have time for patients, *"experience and consistency, there every day, there every single day."* This caring approach, with practice steeped in nursing values, advocacy and patient partnerships is reported in research, including Donnelly (2006) who undertook a similar hermeneutic phenomenological study exploring the essence of advanced nursing practice.

### ***Nursing practice*** (Diana)

A shared theme for all participants was emphasis on core nursing skills, with compassionate care and communication at the forefront, echoing theorists, most notably Benner (1984), Watson (1985) and Parse (1987). The phenomenological research of Roach (1987) conceptualised professional caring values for nursing, with emergence of five attributes for caring; elements that appear to have been further developed in the UK, to become the 6Cs nursing values. Charles reflected on advanced nursing for him. *"It encompasses lots of nursing skills."* Belinda, reflected on her own experience, interpreting this in relation to a nursing focus, but at higher level. *"Nurses dip in and out and the luxury they have is they have real crossover of skills with tendrils into all different elements."* Belinda reflected on *"combination of essential nursing care and very dependent patients [ ] makes you advanced in your nursing, a package of things."* Fiona explored nursing aspects of her role, *"..caring role, that's where the nurse comes in."*

Diana reflected on a patient interaction when interpreting her nursing focus. *"It was all about finding out about the patient and who was there for them, so there was a lot of nursing there as well as all the doctor bits."* She continued by interpreting this, echoing a humanising, caring approach, mirrored by other participants, as embodiment of being an advanced nurse. *"It's us, and it's the nurse, and I thoroughly believe the ANP has those unique abilities to take the patient, the minute they come into hospital, and say 'Hi, I am Diana, this is what is going to happen, this is where we are going to go with this, how we are going to take you to the next stage [ ]'. You have to want to help that person, but that to me is who I am, my role."* Ann remarked *"I haven't lost my ward nurse skills, I've added to them."* Supporting this analysis, a thread running through the literature is found, including studies by Nieminen et al (2011) and Fleming and Carbery's (2011). This is with the foundation of advanced nursing as a high level of nursing practice that is part of being an advanced nurse; participants were intent on articulating this.

### ***We are specialists in our field*** (Diana)

Spatiality, as meaningful, significant world of places and things is reflected, as participants made sense of immersion, now embodied for them as advanced nurses, in the particular hospital and clinical setting. Interpretation of findings revealed length of time participants had worked within their specific areas of practice, with the greatest time being Gina's twenty years, with *"five or six years experience in [speciality] care,"*

prior to starting her advanced nursing journey, in that area. Fiona reflected on her specialist knowledge-base, referring to the *"multi-functional and specialist"* nature of her role. Diana made sense of the importance of specialist knowledge and experience in her setting, *"especially in [speciality], we get lots of junior nurses who don't know how to manage it because it's quite rare, so you have to have that experience [ ] and I think being advanced, and I have got the years behind me, of experience, to know how to deal with such situations and manage these things and to think on my feet."*

### ***Continuity, knowing the patients on my ward*** (Gina)

The speciality experience and knowledge and familiarity with particularities of patient care and treatment within the same organisation and patient management by consistent multi-disciplinary teams, were highlighted. This stressed continuity and knowing patients, which participants felt characterised advanced nursing, congruent with humanising dimensions particularly insiderness and uniqueness. Gina purported to *"knowing everybody in the hospital"* and Diana reflected on working with medical consultants and familiarity with patient care in her area. *"You've worked with your consultants for this length of time [ ]. They look for your response [ ]. You automatically know they're going to refer for a procedure.. [ ] you know what is needed, you know what's going to happen."* Gina referred to continuity of care management, viewing this as a positive contribution to her patients' care. *"You've had that continuity, you've seen them from the start because you've pre-assessed them, seen them on the ward and then normally, if they've got any problems, they know they can ring you or if they're coming back for treatment, you're going to see them again anyway."*

A shared theme for a number of participants was the transient nature of doctors, who may only stay in one area and specific hospital for short periods, as opposed to the more permanent and consistent nature of advanced nurses. Ann explained that *"you get the registrars start every year and it's (pauses) sort of a testing period."* Gina reflected on when she first started and part of the rationale for adopting the ANP model in her area was due to *"no continuity on the medical side because your house officer would go, every three months."* Such factors are reported in research, such as a small-scale, ethnographic study of ANPs in an acute hospital setting (Williamson et al (2012), and McDonnell et al 's (2015) collective case study of ANPs, also in an acute hospital setting. Although in single-sites in the UK, both were comparable to where the participants are based, with findings seeming to correlate with those emerging here.

### ***Holistic patient care and communication skills*** (Ann/Emily)

Emanating from interpreting themes from all participants was holistic care across the whole patient pathway within the hospital, humanising the personal journey and sense making for the patient. Spatiality and inter-subjectivity related to emphasis on patients and comparing advanced nurses to doctors. Fiona interpreted how she works across the whole patient pathway, as a constant in the patient's journey. *"It might be because you're there, taking a segment of that whole role, whereas I am actually working from A to Z."* Ann continued, expanding slightly on this.. *"Meeting and greeting a patient and you're starting everything off..taking it right the way through..[ ]*. *And that takes you right back to your history-taking, finding out, you know, what's wrong with the patient, what they presented with, it goes from the very beginning and so, to where you end up."* Charles' experience was illustrated by describing a clinic he runs independently. *"Holistically manage a patient from beginning to endpoint and all that goes in between, [ ] an emergency clinic, as an ANP. I will see a patient, assess them, perhaps send them for a scan, bring them back, do their dressings, then speak to the consultant if I need to.."* Gina reflected, *" we join the bits together. If you went through the notes, you would see us all the way through a complete episode [ ]*. *It's about looking at the bigger picture and looking at the patient and what they need, you just see outside the box."* This theme links with findings from studies, including Williamson et al (2012) who refer to advanced nurses as a 'lynchpin' in the middle of patient pathways.

Shared themes focused on therapeutic elements and holistic care enabled by the advanced nurse role, correlating with findings in Nieminen et al (2011) and Williamson et al (2012) and other studies. This reflects humanising, caring elements of participants, linked to intersubjective and spatiality constituents and embodiment within their lifeworld experiences. Diana reflected that *"we're looking after you, we're with you, it's more of a health promotion, holistic view."* She interpreted this, *"We think a lot more about the patient experience because we're nurses, that's what we do day to day, we ask them about who is at home with them, doctors don't tend to do that."* Fiona, similarly, made sense of this reflexively, *"We (ANPs) do the whole patient pathway (sense of place and personal journey high on the spectrum of humanising dimensions here). We see them, take a history, examine them, request and interpret investigations, the plan of care we decide that, so it's a much more holistic approach. We're with that patient the whole time, talking to the patient, [ ] all the treatments and we can be explaining to them while doing the treatments, so they actually see that one person the whole of their journey."*

Emily continued from a more problem-based perspective, perhaps more closely associated with a biomedical approach, linked with the nursing and medical interface of her experience, albeit maintaining 6Cs values-base. *" You pick up if there is something not right. [ ] you can sort out a whole load of problems and we want to give holistic care, not just sort out the bit that's not great and just walk away, things go wrong when there's not been joined-up thinking. We fill the gap for joined-up thinking, to make things flow."* Gina reflexively interpreted this theme, from a broader perspective. *"You'd do the ward round and be the person who would chip in and say that so and so lives on her own at home and needs this and this, you can't just chuck her out! Putting those extra bits that they (doctor) don't think about..[ ] it's a broader picture, looking at all aspects, not just from a medical point of view but I'd look at it from a ward and home point of view. [ ] It's not just about doing it, doing it. It's about the bigger picture and looking at the patient and looking at what they need."* These narratives touch on potential dichotomous aspects of participants' experiences. In situations where risks must be minimised or patient safety is threatened, a less humanising approach may be required, erring towards objectification and passivity. However, this acknowledges that care and treatment then needs to proceed, from an over all humanising perspective, supporting patients on their personal journeys that are safe and effective.

Belinda intertwined holistic care and communication skills embedded in a humanising approach. *"It wasn't just looking at the patient, it was looking wider, something about information-giving, being able to not just support them emotionally but able to give them concrete information about their care, being able to give them time. If it's something about their diagnosis, their recovery or even just they need to be on certain types of medication, drawing it all together, the whole interaction."* Diana similarly made sense of communication within the sphere of providing holistic care, as core to being an advanced nurse in her clinical setting. *"I ran the entire consultation, exam, took a history and the management plan..[ ]. I want to find out about their social history, who looks after them, how are they going to get home, do they have a dog who needs to be looked after and does that all impact on their health needs?..we think a lot more about the patient..[ ] The doctors say 'you've had an event, you're going to have this procedure and you'll have these tablets, that's the plan' [ ] I will also be 'right', OK, how are you going to get home? Who's going to look after you? You need to stop smoking, it's not going to be easy, you kind of go through the whole health promotion as well."*

Holistic care throughout the patient pathway is facilitated through human-centred practice, supported by effective communication and building therapeutic relationships with patients, similarly reported in Nieminen et al (2011). Communication, in the context of being a 6C nursing value, is considered central to successful caring relationships and effective teamwork, which is reflected by participants and summed up by Fiona. *"It's communication with the patient and building up relationships with your patients, being able to talk to a patient, reassure them and that is just as important as being able to perform invasive skills. The clinical skills and knowledge are important but the actual foundation of talking to patients, building a relationship with them, gaining their trust, making them feel comfortable, knowing that you've actually cared for someone, is really important; working at an advanced level that is even more paramount because you're going to be performing invasive procedures on them."*

A similar theme is explored by Emily. *"The ward round rips through. I see various reactions on people's faces, bewilderment, people upset and I'd go back and say 'Do you want to have a little chat about that, shall I just explain things, did it make sense?'. They were suddenly not scared. And you can go back and talk about the differentials.. 'we're thinking this, but we have to rule out other things'.. There is a way of describing it that makes it...speculation of someone is far worse than being given a perspective. By providing that explanation, it makes a huge difference to patients."* She continued to interpret this experience. *"It doesn't have to be a long conversation but it might be a really pivotal piece of information they are divulging or a fear they have that means they can't take their medication or they won't do certain things."*

Gina explored and interpreted advanced nurses' communication capability, in comparison to doctors, drawing on intersubjectivity of her lifeworld. *"We read patient's verbal communication more than a doctor who will just come in and blanket cover things, [ ] not just be task-orientated."* Diana keenly pointed out *"that's the uniqueness of ANPs that they've got the interaction with patients already on board."* She continued by interpreting this shared theme in a simple, straightforward manner. *"Another benefit to being an ANP is you can still have that rapport with patients. You know how to have a conversation with a patient, you know that just sitting down with them."*

## Sub-ordinate theme 2.2: Blending nursing and medical aspects

### ***Nursing skills blended and merged with those technical skills*** (Fiona)

Ann sets the scene for blending nursing and medicine, as part of being an advanced nurse reflecting, *"It's because you have your bedside nurse, you have your doctor and there is nothing really in between. [ ] nothing that bridged that gap and I think that is definitely there now (ANP role)"* She goes on to interpret this *"If you've got ANPs there, because you do suddenly, you do slide between both bits, kind of like moving your little cursor up and down."* For Belinda advanced nursing is having *"a nursing focus rather than a medical focus."* The sense made of this reflects a firm foundation of nursing, rather than being a substitute to medicine. This is also reported in findings from studies, including Gardner et al (2007) and Williamson et al (2012). Gina mirrored the other participants, making sense of her experience as merging medical and nursing skills. *"I use medical knowledge and nursing skills together [ ]"* and goes on by expanding on the source of *"knowledge borrowed from all different angles and disciplines."* Belinda remarked *"being able to spend time making lots of different decisions and gathering lots of information to inform your management plan, be that medical, be that nursing."*

Fiona made sense of being an advanced nurse as *"working as a medic but still remaining a nurse."* The implication here is that these technical skills are tantamount to traditional skills associated with medical practice, and this is reiterated by all other participants. Jackson and Carberry (2014) previously reported on this skillset in the same way as the participants. Fiona also reflected on *"not working with the medical team, not replacing them but we were taking on their roles [ ]. We were having to learn a completely different way of nursing because we were working in a medical role, like with our history taking."* Charles commented about how he works at the medical-nursing interface. *"Seeing a patient, assessing, diagnosing, investigating and treating the patient and then following them up. I would say it encompasses all of that and managing it in a timely way and reassuring the patient and giving them confidence. So we do this all ourselves as an ANP."*

Ann explored her experience. *"You might do something very basic, right up to the real extreme, where you're asking for something that even a registrar can't even ask for."* She continued by describing a range of skills more closely aligned to medicine that enabled her to do this including medically-orientated history taking, physical

examination, diagnostic decision-making and prescribing. Fiona explored the wide range of patient presentations she dealt with "*doing something simple one minute and then resuscitating someone the next.*" She also alluded to the unpredictable nature of her role, coupled with her ability to deal with simple and complex patient cases. This was a theme shared by Belinda and other participants. Fiona discussed the unpredictable nature of being an advanced nurse, alongside dealing with complexity, which had become the norm for Gina as an advanced nurse. These findings are similar to studies, including Gardner et al (2007; 2010), Barton and Mashlan (2011), McDonnell et al (2015). Belinda indicates what she believes to be more important as an advanced nurse, than clinical skills more traditionally associated with medical practice, which is echoed by all participants. "*It's around emotional support and information and the actual doing side, the clinical stuff, in a way, anybody could do, rather it's the way you do it that's the crux.*"

### **Sub-ordinate theme 2.3: Autonomy, responsibility, safe practice**

#### ***Comes with a lot of responsibility to be an advanced nurse / a certain kind of beast..quite autonomous*** (Diana / Emily)

This theme extracted 'courage' 6Cs value for all participants, enabling them to do the right thing for people for whom they care, with agency and togetherness coming to the fore. Ann and Belinda felt they were sometimes stretching to the edges of their knowledge and abilities, which articulated the higher level of practice of an advanced nurse. Belinda made sense of this. "*So you're working at the limits of your practice and your knowledge.*" Ann continued similarly with, "*I'm not over-reaching anything, that gives me confidence to do what I actually do, it gives me boundaries so I know where I can go. I feel comfortable and I know.*" This is suggestive of broader complexity of being an advanced nurse, evidenced in their advanced decision-making skills, also reported elsewhere, including McConnell et al (2012).

All participants incorporated autonomy as a defining element, recounting examples from a range of aspects of their practice. Their autonomy mainly related to advanced decision-making within the context of their clinical roles and was associated with advanced levels of knowledge and skills, which Diana attempted to make sense of. "*Shouldn't you, as an ANP, consider some of the other options and if you are taking on extra responsibilities, you've got to have a little bit more knowledge?*" Prescribing was

significant to several participants, setting them apart from non-advanced nurses. Charles discussed *"autonomy practised with my prescribing."* However, Ann remarked that she also knew when to seek assistance from someone more senior, invariably the consultant, as she tended to work to a level sometimes higher than the registrar. *"I can sort out to a certain level and then, when I don't know, I can get assistance."*

A unique theme for Belinda was *"what I enjoy the most about being an advanced nurse but also one of the hardest things is being autonomous and being able to make decisions about patient management of care without necessarily having to consult your colleagues."* She had worried about decisions she had made about patients, having been given responsibility for her own beds before she felt ready for such high level responsibilities. *"Your scope of practice and what you are actually doing..that made me feel quite vulnerable.. meetings with the legal lead for the organisation just..to double-check from an indemnity point of view, they knew exactly what kind of decisions I was making."* This reflects her depth of self-awareness and ability to critically reflect as a method of self-regulatory judgement, which was explored by other participants, including Fiona. *"You are an ANP but to make a difference, from my own legality point of view, professional point of view and to actually continue working, maintaining those high standards ..[ ] and that's only through being able to look at yourself..[ ] look reflectively."* This links to active thinking in practice, according to Benner et al (1999) and maintaining safety for patient care, indicative of advanced nursing.

A shared theme for all participants was working independently and autonomously but also safely, and within the scope of their practice, which is summed up by Emily and Diana. Emily stated that it is *"autonomously assessing patients independently..you are reaching differential diagnoses, you are discussing it with the consultant, it is very autonomous and although you had support, it makes you think autonomously."* Diana made sense of her experience, *"It's not about you thinking you are the be all and end all..it's that you know your limitations. There is a certain point that you can get to. I think before you get there, you say, 'OK, I need to stop here and think, this could just be out of my scope, I just want to make sure."* Fiona focused on safety and needing to become assertive and resilient, to ensure both patient and advanced nurse are safe. Within such a sphere, vocabulary used here denotes a more dehumanising approach, but one that is appropriate to safety and working within one's scope of practice. *"Whilst working at an advanced level there needs to be safety as well for yourself and your patient. [ ] another component of your role is to say, 'no I'm not happy to do that..[ ] you*

*have to be able to be quite assertive..and 'no, I'm not comfortable with that'." When asked whether her level of responsibility had increased, Gina answered "Oh yes, totally now, yes!" a theme shared by all participants.*

#### **Sub-ordinate theme 2.4 : Education and support and being a role model**

##### ***A huge part is sharing your knowledge / a role model as an ANP*** (Charles / Fiona)

All participants explored education with patients and staff. Ann made sense of educating and supporting junior doctors, as an important embodied part of her experience. *"Yes, I love the F1 development part. I think they're great, and yes, it's brilliant. It's nice to be there for them"* She reflected and interpreted that *"when you get them (F1 doctors) coming from medicine into surgery, ohh!, its like learning things, it's so different, [ ] polar opposites [ ] work so differently [ ] and trying to get them to understand."* What also came through was the relationship between junior doctors and herself, which can be interpreted in a maternalistic manner. *"I can be confident they know what they are doing about things and making decisions. [ ]. But I let them off"* This confident attitude is in response to her constancy, with speciality knowledge and clinical setting-based presence appearing to put her on a higher standing, hierarchically. However, she added a different view, when making sense of the inter-subjective nature of this relationship more generally, where she was on more equal footing with them. *"They don't have to go to a senior doctor, they can come to somebody, not lesser than them or more than them, it's almost like a buddy to be able to bounce off and say 'what do you think?' And give them that little bit of confidence."*

This is a similar theme for Belinda, who reflected on her expert level of knowledge and skills for the condition-specific patient caseload she is responsible for. She implied a higher level than doctors, although the level of doctor she referred to wasn't clarified. *"I train the medics up so they can safely do all their bit"*. With other staff who she provides education and support for, this seemed to encompass all of the multi-disciplinary team, although mainly focused on nurses, where she was *"supporting the other staff giving good quality care.[ ] empowering and facilitating others to impact positively on patient care."* This came across as a significant aspect of being a CN, with a *"huge amount of time training and developing all the other staff in their (condition-specific) expertise because this was lacking, was detrimental to patient care."* A key aim of her role is facilitating high standards of care through practice of

other nursing staff and the multi-disciplinary team, coming from a strong sense of agency and togetherness in her humanising framework for practice. The main focus of her role with nursing staff is to *"advise them, give them that extra push that they need to go off, do their own thing..they want advice from me. I enable, I open doors for people."* She continued to discuss the role model element. *"I suppose as a role model and people looking at you and role modelling themselves on you."*

Gina explored education, reflecting on junior members of the ANP team, as she was *"responsible for their development, training, and appraisals."* Emily took a more collective, inter-subjective approach, *"nurturing skills and learning within the nursing and medical team to improve service provision."* Diana felt she had moved to a position where she could provide education and this was now embodied in being an advanced nurse, using her higher level knowledge and skills. This was more formal, through delivery of study days. *" We put on study days for nurses because I think it is important for nurses...I never got that when I was training. I had to go and find out the information for myself, but now I am in a position to say, 'OK, let's do a study day.' I think that is part of us..to educate our colleagues, and that's nurses, physios, doctors. That's who we are. We are ANPs, we are specialists in our field, we should be able to provide that education and support to everybody."* She discussed her role as educator and support for junior doctors and nurses. *"They'll often come to me and say what does that mean? What does that terminology mean? What about this, do I prescribe that?"* Mantzoukas and Watkinson (2006) also report on such multi-dimensional aspects of advanced nursing that incorporate a similar type of educator role.

### **Sub-ordinate theme 2.5: Leadership, team working, improving practice**

#### ***Being a leader, being driven to develop services for your patients / work as a team..really important part*** (Belinda/Fiona)

All participants reflected on being part of a team, considering this from an intersubjective perspective, with make up of teams they are aligned to, varying. Ann is keen to point out the importance of being part of a good team, which for her was the medical team, not nursing team, despite being ward-based. *"Part of a team although I practice autonomously [ ], make decisions together as a team."* Belinda, Charles, Emily, Fiona and Gina focused very much on working as part of *"a multi-disciplinary team"* and referred to being part of nursing teams too.

Belinda linked her leadership as aligned to the consultant body as part of this multidisciplinary team, which was a unique theme for her as a CN. *"When there are other leaders within the team as well, my other consultant colleagues, finding your own niche and...how you all fit together."* Emily saw herself as *"one small cog in a big wheel but you are part of one big wheel..[ ] if everybody made a little bit of difference, it would have a really big impact."* Similarly, Fiona referred to working as part of the multi-disciplinary team and focused on the specific team of ANPs she works with and other nurses in the department. Charles discussed multi-disciplinary team-working, with ANPs he works with all contributing with shared passion for improving practice in order to improve care. This acknowledged shared philosophical underpinning of being advanced nurses, rooted in dimensions of humanising care and 6Cs values, particularly commitment and courage.

As the most senior and experienced member of this ANP team, Charles had taken on a leadership role, having worked on his own for many years. He saw his leadership function as leading on patient care, which is reported in other studies, such as Kennedy et al (2015). *"In my ANP role, I am a good advocate for that, patient care comes first."* He remarked on people coming to him because they knew what his capabilities were, so this brings his leadership function together with a support and educator role. Diana had responsibility, in her leadership role, to take forward practice and provide the best possible care, mirrored in other studies (Nieminen et al 2011; Hutchinson et al 2014). She was keen to promote *"challenging the norms, [ ] let's do something different, .let's change practice,"* working with a group of like-minded ANP colleagues. *".. that's how we as nurses were able to stand and say, we should change this, should we not? We can go down that road, we can make those decisions."* These advanced nurses were demonstrating humanising care through person-centred leadership and service development, congruent with all 6Cs values, strongly focused on commitment.

### **Sub-ordinate theme 2.6: Comparison with other nurses and doctors**

#### ***Very different role to what I do*** (Charles)

A recurring theme related to the level of practice they worked at being higher than non-advanced registered nurses. Several of them compared themselves with non-advanced nurses, with the advanced nurses able to spend more time with patients, due to the nature of the way they worked. *"It's not easy for a ward-based nurse, [ ] they*

*literally haven't got the time."* (Ann). The advanced nurses saw themselves as hierarchically above non-advanced nurses due to enhanced knowledge and skills and the position they assumed in their roles. *"Not everyone can work at an advanced practice level, ..are not encouraged to and in some ways not even allowed,..if you're a jobbing staff nurse, it is quite hard to be autonomous."* (Belinda). *"They haven't got the confidence or the training and everything behind them to make those clinical decisions, whereas I have got that."* (Ann).

Gina explored differences between ANPs in her speciality and specialist nurses they work alongside. Gina made sense of the difference, *"they (specialist nurses) don't really have acute patient contact like we do..definitely less hands-on than we are...just work differently..not so autonomous[..]. They are not making any big decisions..but may change decisions if they need to be changed."* This is an interesting reflection, with Gina seeing significant differences between the two roles, as she has expertise in the speciality and more generalist knowledge and skills, characteristic of her advanced nursing role. A similar observation was made by Belinda, of her own condition-specific area. *"Some people do have the knowledge and skills but because they are not at an advanced practice level they don't feel they have the authority. [ ] Specialist nurses are very knowledgeable but reluctant to take that last step and make decisions, even though they come and check things out with me."*

Belinda and Gina's reflections are indicative of ongoing debates between specialist and advanced nursing. Interestingly, Charles and Belinda had moved from being specialist nurses to being advanced nurses. It could be deemed their roles resemble 'hybrid' specialist/advanced roles. This is slightly different to Gina and Diana who also worked in specialist areas of practice, as they seemed to present their roles predominantly focused on generalist skills and knowledge across a broader remit, with specialist aspects being important but not to the same degree as they were for Charles and Belinda.

When making sense of being advanced nurses, participants all made comparisons with doctors, concluding that they incorporated skills and knowledge from medicine, but not as the most major elements of their roles. Fiona made sense of her experience, *"whereas the medic would take parts of that..so we kept out nurse basis..but utilising extended skills and knowledge[..] I think medics are more black and white whereas nurses add in a few more colours to the palate and just fill in some of the gaps."* She

continued to interpret her experience, *"not replacing them but we were taking on their roles and it was a very autonomous role..working as one but still remaining a nurse."* Interpreting where they positioned themselves in relation to the level of medical knowledge and skills, all ANP participants saw themselves aligned to junior doctors and with some elements, registrar level. These reflections on comparative elements with doctors, link with considering legal aspects of their practice, as advanced nurses, judged against that of equivalent practice of medical colleagues (Dimond 2015). Ann interpreted *"a broader spectrum than a doctor, because they expect them to do the bit that I am going up to but they don't do all the other stuff, so our role is so vast, especially if you are ward-based."* Diana took a different approach comparing ANPs with doctors, with ANPs *"maybe a bit more considerate about long term effects of their health needs..rather than the right now."*

Belinda, as the only CN, was *"more aligned with how senior medics work."* This was the expectation of her role and contained within her medically-orientated 'consultant nurse' title. This had caused Belinda some concern as she struggled to maintain nursing focus within such a medically-dominated environment. Similar to the ANPs, Belinda also saw differences with CN colleagues in the hospital. *"Other CNs are all so very different in their remits..in different specialities. So having a group that has the same speciality, often with a very similar role than from nurses in a different speciality."*

Another recurring theme for all ANP participants was different models of ANP they had experience of. For Ann *"it's (advanced nursing) such a vast area, that you can't pigeon-hole it."* This perhaps acknowledged the concept of advanced nursing as *"multi-dimensional in nature..multi-faceted,..flexible..adaptable"* (Fiona). Although Ann rationalised this, *"the majority of all advanced nursing roles, you slot together, one way or another, it's not easy though."* For Charles, Diana and Fiona, differences were highlighted even between ANPs within their own areas, interpreted as being due to backgrounds and individual focus of each ANP. This perhaps indicates flexibility and adaptability of advanced nursing, dependent on patient and service needs. This utilises strengths of individual advanced nurses within a team, whilst acknowledging shared professional identity as advanced nurses. Language used and experiences shared around this theme indicate affinity for the advanced nurses' identity embedded in an overarching humanising care approach.

## **Sub-ordinate theme 2.7: Lack of understanding and expectations of advanced nurses**

### ***I wasn't expecting to see a nurse / people's perceptions of a nurse*** (Gina / Fiona)

Several participants felt people did not really understand what advanced nurses do, although Ann believed this had improved over the years. *"Hard to put a description on, people don't understand what the role is. [ ] I think people are a lot more aware now of what we do."* Diana explored general public perception with lack of understanding of blurring medical and nursing roles. She reflected on patient reactions to consulting with her, often concluding with them saying *"Thank you doctor!"* despite having explained who she was. Diana and Emily felt medical colleagues and managers still weren't sure what the expectation was of advanced nurses, but felt they were supportive of developing the concept in their areas. *"We don't really know what an ANP does, so we need you to guide us..it really was hard because no-one really understood what an ANP was."*

Belinda made sense of other people's perceptions,, *"..in CN practice and because there are so few of us, then people don't necessarily realise the level of decision-making and responsibility you are taking and therefore there isn't the support structures there to help you."* Fiona and Gina explored perceptions from other staff, of their roles, particularly when first setting up services, which proved a challenging time for both of them. Gina reflected on the image she felt was portrayed aligned with being a doctor, *".yeah, completely nobody knew. I mean we didn't even have a uniform, we had a white coat!"*

### 7.4.3 Super-ordinate theme 3: Contribution to patient care and service delivery

***That's the difference that we make, it's a difference in the quality / the whole interaction is worthwhile*** (Gina / Belinda)

All participants viewed their unique contributions from a collective perspective, as part of the teams they were part of. Despite often working in quite independent and autonomous ways, they all saw themselves centred within multi-disciplinary teams; concomitantly developing aspects of their roles, according to where they saw sub-optimal care or deficits in services. This fits with 6Cs values of care, compassion communication and commitment. *"What can we do to add value?"* (Diana), *"we have made a big difference [ ] that improved quality all the way through."* (Gina) This lack of an egotistical approach was apparent for them all, with reasons for becoming an advanced nurse primarily focused on improving patient pathways and ensuring every patient experience of being in hospital is the best it could be. *"It's the patient [ ] they actually had a really good journey.."* (Ann).

This collective perspective is deeply rooted in a framework of humanising care, with patients at the centre, *"..remain focused on patient care, an excellent standard of patient care, that's always been my focus"* (Charles). Linked with insidership, they cite examples of working holistically across patient pathways, focusing on the individual person, empowering and supporting them, building a shared vision of care with the patient (togetherness and agency). Diana reflected, *"we're looking after you, we're with you [ ], holistic view, [ ] finding out about the patient [ ]."* This echoes embodiment for patients, as a core contribution participants make. Watson's theory of nursing views holistic care as central to caring (Watson 1985) and Benner and Wrubel (1989) highlight primacy of caring in nursing, close to the patient. This is reiterated by Cummings and Bennett (2012) within the 6Cs nursing values. Participants maintain patients' sense of agency through sharing knowledge and information, giving them time, facilitating them to make their own choices and empowering them to take control of their own health and well-being. *"Explaining a lot more [ ] gives them more ownership."* (Fiona). In some instances, there appears to be a tendency towards directing information at patients, moving up and down the spectrum of humanising dimensions, erring towards passivity and some objectification.

Participants know their patients and are a presence throughout their journeys, which is a crucial contribution, drawing in compassion and communication 6Cs. This maintains congruence with philosophical concepts of nursing theorists, including Carper (1978), Roach (1987; 2002) and Parse (1987) and continued through 6Cs nursing values (Cummings and Bennett 2012). This links with insidership and uniqueness of patients, from the focus of the advanced nurse contribution, through togetherness with patients, which emanates through patient scenarios. Fiona discussed working closely with parents of a child who died, *"entrusted me to make sure his daughter got safely to the mortuary."* Belinda explored an interaction with a patient's family. *"We had a younger patient [ ] I was the only one who asked about his children and I was just trying to imagine what turmoil they were going through [ ]"* These examples show Fiona and Belinda connecting to patients and their families, aligned to sense of place, outlining how they lessened dislocation of situations individuals found themselves in.

A shared theme was communication combined with therapeutic relationships with patients, interacting on their wavelength. Emily discussed how crucial this is, with enhancement through becoming an advanced nurse. *"It's because it's not actually been explained so if you can address that from the outset [ ], suddenly everybody's happy, things are working well, time is saved, it's a good outcome for the patient and it's just giving quality care that you know in your heart should be happening, [ ] having compassion, having time to listen."* This supports patients, helping them make sense of situations, within contexts of health and well-being and threats to this through illness. Other participants focus on similar situations, with contributions to patient care through sense making and supporting meaningfulness of their personal journeys.

Gestalt of findings captured phenomenological, hermeneutic and idiographic elements from individuals; nomothetically, differences and similarities between cases are outlined, through cross-case analysis. Interpretation ensued through reflection and first-order meaning-making by participants and sense-making by the researcher, during and following interviews, as second-order (Smith et al 2009, p. 35). Further depth and breadth of discussion, supported by literature and drawing on theoretical connections and the PD, followed by conclusions (notably creation of the conceptual model of advanced nurse in the hospital context) are presented in chapter 8. This is in keeping with the flexible, creative process of IPA.

*"First, IPA is a creative process. It is not a matter of following a rule book."* Smith et al (2009, p. 184).

## **Chapter 8    Advanced nurses' lifeworld experiences: discussion and conclusions from synergy of the research and PD, with creation of the conceptual model of advanced nurse in a hospital context**

Although some analysis is included within the findings, this discussion and conclusions section takes exploration to a deeper level. Relevant theoretical connections for key themes that emerged, are made; namely humanisation dimensions, 6Cs nursing values and four pillars of advanced practice. Support from the literature, including nursing and more targeted advanced nursing theory and research is drawn upon. Additionally, the DProf PD provides a foundation for informing and fusing with the research, resulting in a synergistic whole exploratory study. This PD / research exploration culminated in creation of the new, unique model of advanced nurse in a hospital context, which is presented later.

Up to now, analysis has largely stayed close to participants, moving back and forth at an interpretive level, between hermeneutic of empathy and hermeneutic of questioning, across and around the hermeneutic circle (Smith et al 2009). This has run alongside the PD, so closely aligned to the research, from an insider perspective for participant (PD and research participants) and researcher/practice developer (myself), with immersion of all these individuals within both elements. A further hermeneutic, akin to Ricouer's hermeneutic of suspicion (1970) and seen in some IPA studies, is woven into discussion on findings, drawing from a more formal, outsider perspective through theoretical aspects. This supports the balance between insider and outsider interpretations.

### **8.1    Exploring advanced nursing in a hospital context through fusion of the DProf elements, it's people, processes and frameworks**

As the research study progressed, findings were analysed and interpreted, using a reflective and reflexive, personal narrative approach, supported by the literature review; with conclusions drawn, mostly from fusing the PD and research. It is difficult to separate conclusions, as distinct and exclusive to the research, as the other elements were inherent to over all exploration of advanced nursing. This is illustrated in Figure 4, which helps set the scene for discussions, showing exploratory activities that resulted in development of the conceptual model of advanced nurse, as the main conclusion and final key product of the whole exploratory study.

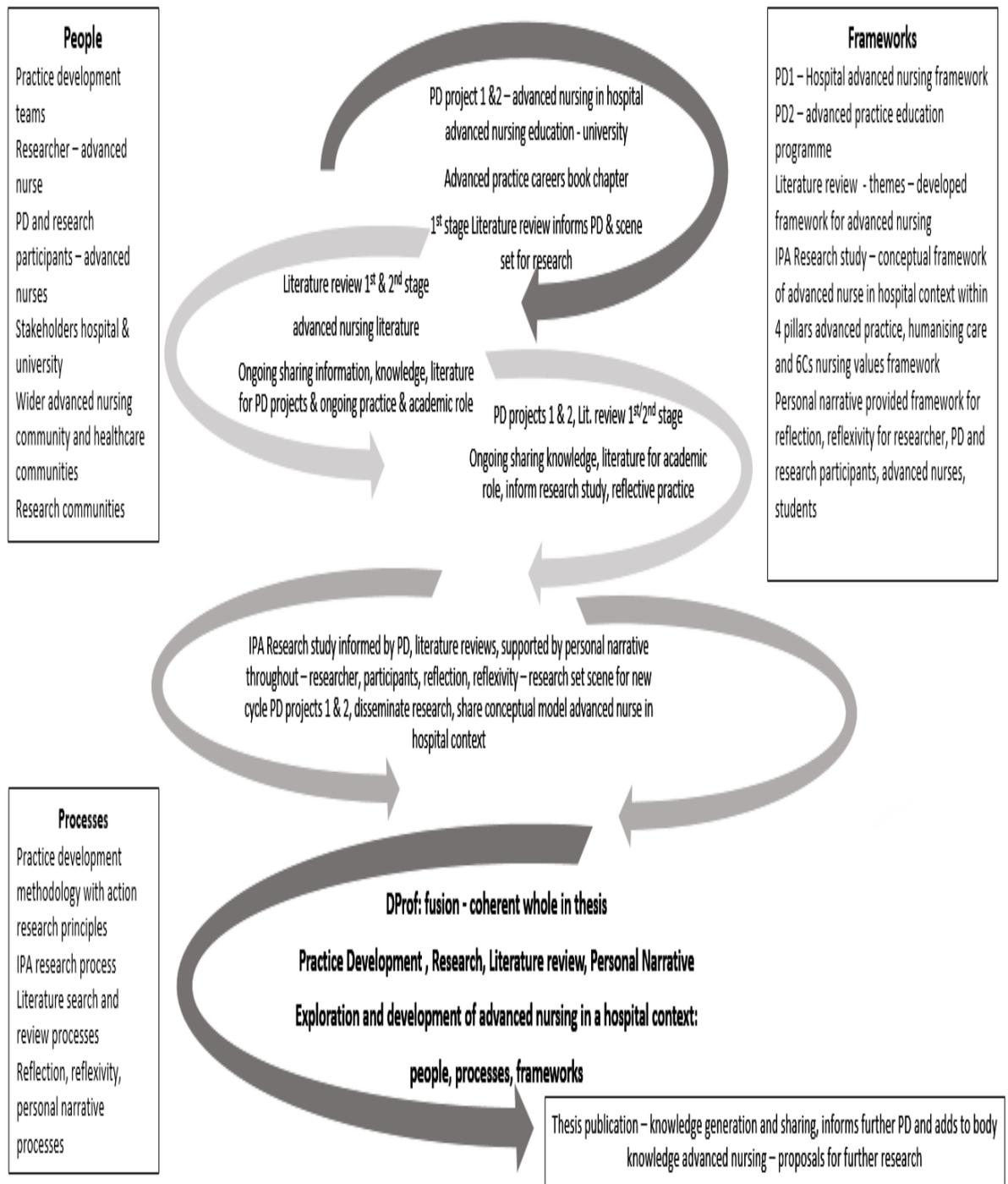


Figure 4 Fusion of the DProf elements for exploring advanced nursing in a hospital context: people, processes, frameworks

## 8.2 Listening to participants' voices and sharing lifeworld constituents

The narrative accounts are supported by reality of participant voices through, often poignant, direct quotes that link with constituent parts of the holistic lifeworlds of participants. The real voices powerfully illuminate the bipolarity spectrum of dimensions of humanisation, along with the 6Cs nursing values-base. These concepts emerged as philosophically underpinning holistic lifeworld experiences of being advanced nurses in this hospital context, individually and collectively. Smith et al (2009, p.110) recommend inclusion of plenty of quotes for each new theme of the data, helping capture lived experiences and supporting creation of an IPA narrative that is

*"a dialogue between participant and researcher and that is reflected in the interweaving of analytic commentary and raw extracts."*

The authors also refer to IPA as *"a dynamic and a holistic entity."* (p.203), which fits well here, using the concept of holism, bringing themes together into an overall journey through each individual and the collective lifeworld of the advanced nurses.

Interpretation of findings, enhanced by both PD projects, painted a comprehensive picture of the advanced nurses, conceptualised within the context of holistic lifeworld constituents. This draws on Galvin and Todres' (2013) framework from a caring and well-being perspective that was relevant to the healthcare environment of participants. This supported interpretation from a broad perspective with connection to different contexts and situations, collectively comprising holistic lifeworlds, through inter-linked constituents. Holism of lifeworld and constituent parts comes from philosophical, phenomenological writings of Husserl, further developed by Heidegger (1962/1927) and Merleau-Ponty (1945/1962), which have informed qualitative research approaches, including IPA. This resonates with Galvin and Todres' (2013, p. 155) *"embodied interpretation of their life-world experiences,"* which they argue, facilitates the researcher *"to slow down and be with the communicated phenomena in an embodied way"* (p. 166).

From a researcher perspective, this helped conceptualise the plethora of themes and to make sense of meanings, along with drawing strongly on the PD, particularly PD Project 1. This was perhaps inevitable and certainly desirable, as all research participants had also been part of the PD project participant group.

Constituent	Brief description
Temporality  Shared themes of participants	Time aspects, past, present and future, moments of people's experiences as a part of their lifeworld story and gaining a sense of the significance of these temporal elements for the individual. Links with IPA and working across hermeneutic circle, moving between the part (moment in time) and the whole (whole story experienced in time)  Time related to developing and education, in post, length of experience, time with patients
Spatiality  Shared themes of- participants	Context of individual's lifeworld of places and objects, with closeness or distance being indicative of importance of each 'object' in whole lifeworld experience. Synergy with IPA and hermeneutics, as significance of object (the part) in relation to experience (the whole)  Skills, knowledge, competence, job role, 4 pillars of advanced practice, nursing, medicine, patient pathway, care, treatment, autonomy, responsibility, boundaries, model
Intersubjectivity  Shared themes of- participants	Lifeworld as takes place in social context, in a world with others, relationships, language  Relationships, communication, Patients, doctors, advanced nurses, nurses, specialist nurses, CN, ANP, public
Mood / emotional attunement  Shared themes of participants	Lifeworld is affected and integral to mood and feelings, in relation to all other constituents. See world differently depending how one feels and vice versa. Reflective of meaning of situations. perceptual, interactive  Passion, passionate, love my job, enthusiasm, compassionate, caring,
Embodiment  Shared themes of participants	Emodiment of oneself in context of all other constituents together - holistically, includes other people, things, places, embodied in relation to past, present future. How one interacts with world around, intuition  I am an ANP, Being an ANP/CN, what I am, identity, as a person, values, nursing philosophy

Table 12 Constituents of holistic lifeworld of participants and key words

Within the findings and discussion, constituents have been referred to where they connect with key themes that emerged. A brief description of each one is illustrated in Table 12, showing associations between constituents and key shared themes, focusing on words and/or phrases. Additionally, appendix 10 details constituents in relation to individual themes, from an idiographic perspective of participants.

### **8.3 Dimensions of humanisation, 6Cs nursing values and pillars of advanced practice**

It was not until the study progressed to the analytical and interpretative stages that 6Cs nursing values-base (DH 2012) and dimensions of humanisation (Todres et al 2009) emerged, as significant defining themes to describe the *'how'* and *'why'* of being advanced nurses. With nursing and caring at the heart of participants' lifeworlds, it became apparent that these themes could help describe more hidden, less concrete aspects of their experiences and perspectives. The advanced nursing framework for the hospital, built through PD project 1, outlined component parts that fitted each individual role profile, from a practice perspective. These identified activities collectively fit a particular job role, representing what the nurses *do*, within the four pillars of advanced practice. For example, for the ANP, comprehensive patient assessment, history taking, physical examination, prescribing, ordering and interpreting investigations, were core clinical pillar skills.

What is not included in the hospital framework is *how*, and *why*, the nurses deliver care and treatment in the way that they do, as this was not expected of the project. However, it did lay a foundation of the 6Cs and dimensions of humanisation, on a superficial level, as PD participants shared snippets of experiences throughout interactive elements of the project. Impetus for exploring the advanced nurses' experiences more deeply through the research, came from hearing PD project participants' informal narratives, sharing a little more of the *'how'* and *'why'* of their lifeworlds.

Thus, this combined framework, along with the four pillars, emerged as an appropriate mechanism for enabling a clearer, comprehensive view of practice-based, *'what they do'* elements, along with more hidden aspects that philosophically influence, inform and shape the lifeworld of an advanced nurse. In DH (2012), the CNO summed up that by focusing on 6Cs as values of every aspect of nursing practice, the aims of improving patient care and strengthening the profession, can be achieved. This resonated with the picture painted by the advanced nurses, helping articulate and cement the meaning of being an advanced nurse, in terms of their values and meeting the CNO declaration of immersion in these values, as a vehicle for supporting improvements in patient care.

Patient care	Advanced nurse
<b>Insiderness:</b> on patient cues, read patient body language, how to have conversation with patient; availability, consistency; sort whole lots of problems	Comfortable in my role, I am a nurse, I am an ANP; nursing identity; caring, compassionate, understanding it, feeling it; my flexibility; don't have close patient contact, not ANP
<b>Agency:</b> share information; patient better informed – more confident; really explain because we are there, not scaring them; empowered; making sure patient gets best treatment & care	Confidence in own ability whilst safe; brave, people come straight to you for an answer; passion to change things; let's make it better; courage, compassionate motivation is to achieve good outcome for patients
<b>Uniqueness:</b> know patient, build trusting relationships, add in some gaps, something additional; picked that up as an ANP, prevented a heart attack;	Learning best patient care; managing things through patients; in timely manner, reassuring, giving them confidence – then can call self ANP; ANP softens clinical efficiency of medicine; human factors, compassion, time to listen
<b>Togetherness:</b> on same wavelength as patient; being there for patient; have an understanding can share with patient; explain what's happening, ensure patient understands situation ; time for patient; empowerment; MDT makes difference to patient care	team dynamics – fantastic; you're an ANP to make a difference; empowering, facilitating others to positively impact patient care; supporting others, advise them, give them extra push for giving quality patient care; nurturing skills and learning in medical and nursing teams – improved service provision; can we make it slightly better; role model as ANP;
<b>Sense making:</b> important essential nursing care spot-on; complex/simple merged through nursing / medical skills, knowledge for individual care; becoming advanced nurse takes time, experience, education	Knowing why you do something – bit ANPs have; now I know what's important; knowing you have actually cared for someone; evolved for needs of service / patients; when passionate about something its easier; always about patient and their experience; for me personal human element important; what's point if not make difference
<b>Personal journey:</b> Whole patient pathway, holistic care; patient-centered, move through time in meaningful way, past, present, future, patients in unfamiliar contexts, life interrupted – value for concerns, help adapt; can spot something earlier in a patient	Kept nurse basis; knowledge and skills at higher level; always about patient and their experience; constantly improving self to improve service and for patients; keep a nursing voice, championing things;
<b>Sense of place:</b> Put patient at ease, reassure, knowledge, answer questions, being there; people scared, being there	Having the time to actually do what I do; support other staff giving quality patient care; preventing admissions that don't need to happen;
<b>Embodiment:</b> How experience world, perceptions contexts, possibilities, limits Recognition individual in social context, everyone unique & valuable; whole pathway	Remain focused on patient-care, on excellent standard of care always my focus, where it all comes from; I'm passionate about improving services

Table 13 Dimensions of humanisation and 6Cs nursing values framework

During analysis and interpretation, as part of hermeneutic of suspicion, this overarching, combined framework helped categorise and label and give meaning to key research themes, from a collective perspective. A selection of key words and phrases that particularly resonate with the 6Cs (**highlighted and in bold**) combined with humanisation dimensions (non-highlighted, normal text) (Table 13) and snapshot of words and phrases related to 6Cs values (Appendix 11).

All participants made sense of lived experiences, within the four pillars of advanced practice, adding a deeper interpretative layer to the hermeneutic of suspicion. This aligned with practice of the advanced nurses, *what they do*. This had already been core to PD1 with the four pillars implicit to the hospital framework, and job descriptions structured around these pillars. The education curriculum, developed as PD2, focused on delivering education aligned with meeting competencies within the four pillars. Also, they were extracted as a theme from the literature review, confirming their relevance and importance for shaping advanced nursing practice.

The research offered an opportunity to explore aspects of the advanced nurses' lifeworlds, from a deeper, more analytical and interpretative way than was possible for the PD. Findings identified approximate percentages of time for each pillar (Table 14) by considering the amount of dialogue and number of words and phrases specifically related to each one. Although not exact representation, this offered insight into significance of each pillar, as part of each participant's whole lifeworld experience. PD1's data, extracted from electronic activity diaries and other methods, had revealed broadly similar trends. This suggests research participants were reasonably representative as a sample of the wider PD participant cohort of ANPs and CNs.

Participant	Clinical	Education	Leadership	Research
Ann	70%	20%	5%	5%
Belinda	50%	20%	20%, includes consultancy, internal & external	10%
Charles	70%	15%	10%	5%
Diana	75%	15%	10%	
Emily	70%	20%	5%	5%
Fiona	65%	20% uni. LP 15% in practice	10% (now 15%),	5%
Gina	70%	20%	10%	
Researcher	30% 20%- 2017	40 %	20% mainly education - 2017	10% 20% - 2017

Table 14 Percentage for participants within each pillar of advanced practice

This all provided a key building block for developing the pillars within the conceptual model that resulted. As a consequence of this synthesised exploratory study, they were established as practice domains of the conceptual model of advanced nurse in the hospital context, alongside the dimensions of humanisation and 6Cs nursing values, detailed later in this chapter - Figure 5 (ANP), Section 8.6.1 and Figure 6 (CN), Section 8.6.2. This was in line with what was happening across the UK, prompted by guiding documents published not long before commencing the study, including NES (2010), NLIAH (2010) and DH (2010).

#### **8.4 Becoming an advanced nurse**

At this point reviewing Figure 3 and Table 11 (Chapter 7) and Table 12 (Section 8.2) and Table 13 (Section 8.3) is a reminder of key themes and constituents pertinent to this discussion, within the context of the study as a whole. Progression towards becoming an advanced nurse was the first of the super-ordinate themes that emerged as vital to the lifeworld experiences of the advanced nurses (Figure 3). Literature supporting such progression is reported by Wiseman (2007), with advanced nursing enabling experienced nurses to remain clinically-based. This is reflected in the significant focus within the clinical pillar for participants and their primary motivation of direct patient care.

This was previously acknowledged by the UK government strategy for nursing that supported advanced nursing roles, with the intention of achieving better patient outcomes by improving quality and services. This is whilst enabling experienced nurses to stay in clinical roles, rather than moving into management (DH 1999). This was further emphasised in the more recent *6Cs vision and strategy for nursing* (DH 2012). This indicates governmental level guidance and support for advanced nursing, albeit without policy drivers that would have been more directive, if advanced nursing had secured some form of central regulation, which has not been the case, to date in the UK. This national guidance, which also includes the advanced level nursing position statement (DH 2010) published shortly before initiation of PD1 and PD2, and other key documents, were pertinent influences, instrumental for guiding these local initiatives, similar to cases in other organisations across the UK.

The participants explored knowledge and skills required to enable them to move towards being advanced nurses, congruent with demonstrating relevance of Masters

level preparation, considered key to development of informed autonomous decision-making. Inman (2003) asserts that the complexity and level of responsibility of advanced nursing roles requires this level of education. This was portrayed by the research participants as core to their development towards functioning at advanced level. In conjunction with this, PD1's job descriptions included essential criteria of Masters level education for ANPs and CNs. Similarly, PD2 acknowledged this requirement for Masters level, as well as key areas for development, such as autonomous decision-making.

This links with stepping outside traditional nursing boundaries and enhanced clinical practice, similarly reported by McConnell et al (2012). The journey of becoming advanced nurses culminated in indication of competence, distinguished by discretionary decision-making. This is argued as being fundamental to autonomous practice and higher levels of practice (NLIAH 2010). This was previously conceptualised through work of nursing theorists, most notably, Benner (1984) in her level of expert practice and aligned more specifically to advanced nursing, in literature, including Mantzoukas and Watkinson (2006). Although continuing to be situated mainly within the clinical arena, participants also referred to developmental aspects within education and leadership/management function. For Belinda, the only CN, this also focused particularly strongly on research. The PD projects had been cognisant of such development, embedding nursing practice predominantly within the clinical pillar but also ensuring ANPs and CNs work across all four pillars of advanced practice.

Types of knowledge that participants referred to, in becoming advanced nurses, echoed Carper's (1978) essential ways of knowing, such as empirics, scientific knowledge or 'knowing that' and personal knowledge, and tacit knowledge or 'knowing how.' Benner et al (1999) also report this combination of ways of knowing, asserting that good nursing practice draws on best available scientific evidence that supports clinical judgement and decision-making. These authors argue that such facets enhance reasoning skills for clinical situations, which appears particularly applicable to the participants. This is where a certain dichotomy may arise from a humanising care perspective and that may be uncomfortable for advanced nurses, who sit more firmly within the context of more humanising care dimensions. Clinical demands are likely to move up and down the humanisation/dehumanisation spectrum, according to specific situations that may require a less humanising approach, due to risk or safety issues.

The participants appeared to use these ways of knowing, drawing on critical reflection, often under uncertain circumstances, depicting this as advanced nursing and highlighting this as indication of levels of competence they had reached. Inman (2003) argues that advanced practitioners engage in critical and reflective practice to support them in providing clinical and professional leadership and they engage in scholarly activity to advance their nursing knowledge and skills, for patient benefit, as well as the nursing profession. This was reflected in the advanced nurses' narratives. Concurrently, a focus on supporting development of critically reflective skills, critical appraisal skills and facilitating application of these facets within practice, was built into the curriculum developed in PD2, supporting such development.

Pearson and Peels (2002) argue that advanced nursing practice is characterised by experiential and theoretical knowledge with combined application resulting in high standards of clinical performance; for the participants, this signified advanced level nursing, embodied in being an advanced nurse. Engagement with these ways of knowing and its application to patient care supports the notion of advanced nurses being acutely aware and pursuing an approach indicative of both humanising '*know how*' (Hemingway et al 2012) and scientific '*know that*', required for more empirical, and perhaps more medically-orientated aspects of advanced nursing. This appears to be more closely situated at the medical-nursing interface, which resonates in other studies, including Jackson and Carberry (2014). Again, this could be where tension could arise across the spectrum of humanising dimensions, where more objectification and passivity may predominate and where the advanced nurses struggle to maintain their embedded values of nursing and humanising care. Some of this 'discomfort' is hinted at within some of the advanced nurses' narratives.

Through shared themes, all participants described becoming advanced nurses involving development of clinical competence, not only more advanced assessment and patient management skills, but actions related to the way they do things and knowing why and how. It is apparent that when the advanced nurses describe human-centred aspects of their practice, they become animated in their story-telling. This notion of overarching competence rather than only technical knowledge, was described as one of Roach's (1987) attributes of caring in nursing; this was more recently developed as 'competence' of 6Cs values. Such competence is reflective of an emergent advanced nursing knowledge-base that demonstrates underlying scientific

understanding, application to practice, and phronesis, combined as knowledge interlinked with experience and practice.

The nature of practical wisdom or phronesis, tied with ethics and action is alluded to in participants' narratives, as they described the point of embodiment of being an advanced nurse. An interpretation of several participants' use of 'wise' and 'wiser' fits with phronesis, as part of this embodiment. Other studies, including Nieminen et al (2011), used a theoretical framework to explore advanced nursing roles, based on these facets of knowledge. O'Connell et al (2014) reported on a capability framework encompassing broader, deeper functional knowledge, building on competencies that fits with these advanced nurses' experiences. This perhaps moves advanced nursing to further depth and breadth of nursing competence and one embedded in humanising care and 6Cs nursing values, which became a core theme in the conceptual model of advanced nurse in a hospital context (Figure 5 and 6). This is in addition to participants describing and interpreting human factors from a capability perspective, indicative of advanced nursing.

The participants reflected on embodiment of being advanced nurses, including their education and competence development, demonstrably beyond NMC entry-level registered nurses. This required immersion in practice and a range of diverse experiences, with blending expert nursing and development of more traditional medically-focused clinical skills. This is similar to Neville and Swift (2012) and Gardner's (2013) findings. O'Connell et al's (2014) literature review supports capability associated with practitioners who are creative, have high level self-efficacy and apply competencies in different, often complex situations. This is mirrored in this study's findings and within PD1. Dalton (2013) similarly refers to highly complex role elements and diversity of advanced nursing roles, in his qualitative study in a hospital setting in the UK, similar to this study's participants. All these authors reported on appropriateness of the clinical environment of healthcare, as the basis for supporting education and development of advanced nurses, portrayed as crucial for the advanced nurses' development.

This was mirrored in PD1, as expectations of advanced nursing were of clinical practice development strongly rooted in practice settings; with ANPs and CNs being key members of multidisciplinary teams, usually aligned predominantly to medical teams, but with a basis of expert nursing practice. The ANP and CN job profiles portrayed

higher level of practice and freedom to act than entry-level registered nurses working in traditional nursing roles.

### **8.5 Being an advanced nurse**

Participants' professional identity as nurses was strongly portrayed, with underpinning dimensions of humanisation and 6Cs nursing values. This humanising care, nursing focus is prominent in previous research across recent decades, including Brown in 1998 and Ramis et al in 2013; also echoed in the model of caring, compassionate, relationship-centred care, conceptualised by Dewar (2012). Although the medical-nursing interface was part of being an advanced nurse, participants articulated more multi-dimensional aspects as important, within their defining nursing focus and values (Table 9 (Section 6.4.3); Appendix 11). Advanced nursing is similarly reported in research, including Manley (1997) and McConnell et al (2012).

It could be argued, at a superficial level, that PD1's framework helped to establish the start of a shared identity for advanced nurses at the hospital. Previously there was little understanding or consensus on what constituted advanced nursing at the organisation. Also, development of PD2's education curriculum included more philosophical underpinning focus of advanced nursing, alongside more practical, practice-based learning. This has all helped to cement these elements as part of a model for advanced nurses, enabling them to articulate the strongly nursing and humanising care identity, that appears at the heart of being an advanced nurse in such a context.

Interpretation of the theme of merging nursing with medical skills particularly emphasised spatiality, intersubjectivity, mood and embodiment lifeworld constituents. With spatiality, this combination appeared particularly meaningful, embodied as part of being advanced nurses, which they made sense of. They showed how they incorporate these merged elements into everyday practice, through recalling examples from daily encounters with patients and staff with whom they work. Language used when exploring this theme highlights emotional attunement, with confident dialogue confirming the significance of this theme for them. There is no doubt or hesitation in how they explored this, suggesting its particular significance. Weight is added to this argument of advanced nurses working predominantly with a nursing focus and functioning at the interface between medicine and nursing, through numerous studies spanning developments of advanced nursing, including Mantzoukas and Watkinson

(2006) and McDonnell et al (2015). Now, this is further articulated as a key aspect in the conceptual model of advanced nurse that resulted from this study (Figure 5 and 6, Section 8.6.1 and 8.6.2).

Deeper interpretation of more technical and clinical skills associated with traditional medical practice suggests these were not what defined or drove their practice as advanced nurses. They appear more as useful tools for assessment and diagnosis, rather than the essence of what they do. This was also seen in PD1, with these aspects being essential criteria in the job descriptions produced within the hospital framework developed. They are also included within the education curriculum developed in PD2. However, the research participants tended to focus little on the significance of these skills, probably as they were now largely proficient in having mastered them. They seemed to refer to them more as a list of '*tasks*' that add to the full repertoire of elements comprising the whole of what they do.

In contrast, when discussing more abstract elements of being advanced nurses and more nursing-orientated aspects, they delve much deeper and focus on significance of these aspects, to a greater degree, coming alive in their narratives. This is suggestive of participants in roles perceived as more than junior doctor substitution roles, with a higher degree of expert nursing practice that is the essence of being an advanced nurse. This mirrors findings in a similar hospital setting reported in Williamson et al's (2012) ethnographic study exploring ANPs in an acute hospital setting and seemed to prevail within PD1. Previously, drawing on Benner's (1984) seminal work, Manley (1997) argued that expert nursing practice is aligned to advanced nursing more than the medical/nursing interface, reported more recently by researchers, including McNamara et al (2009). This is embedded in the conceptual model of advanced nurse created through this study.

Sheer and Wong (2008) argue that emergence of advanced nursing in hospital settings focused initially on a tendency towards the medical/nursing interface, with greater autonomy and independent practice. This is similar to developments experienced by participants in this study and articulated through PD1. Conversely, specialist nurses erred towards more supportive, patient education roles that were medically-directed, with less autonomy and independent practice. This was considered in terms of where specialist and advanced practice were positioned on the novice to expert practice continuum (Benner 1984); specialist assuming a lower position on the continuum than

advanced practice. For PD1, this was similar to the advanced and specialist nurse roles reviewed and conceptualised within the hospital framework.

A different view is of two concepts as distinct entities of equal standing on this continuum, with a different overarching remit, but with some overlap (Pulcini et al 2010). This appears as a feature of CNs in the UK, who are invariably seen to possess expert levels of nursing practice within a specialist area, as was the case with Belinda (the CN) and other CNs at the PD1 hospital, who fitted a similar profile. Although advanced nursing is characterised as predominantly in a generalist field, examples in the literature outline *specialist* advanced nurses. Certainly this is the case for most participants in this research study and was seen as a feature of a number of PD participants within PD1. This is reflected in other studies, including Yeager et al's (2006) case study evaluation in a neuro-surgical speciality, Fleming and Carberry's (2011) exploration in critical care and Nieminen et al (2011)'s qualitative study that explored roles in paediatrics, medical and surgical units in Finland.

Provision of holistic care, usually across whole patient pathways within the hospital constituted a hallmark and embodiment of participants' lifeworlds, which became a key component of the conceptual model of advanced nurse (Figure 5 and 6). Williamson et al (2012) reported ANPs as pro-active in providing holistic care and McDonnell et al (2015), in their collective case study, reported holistic assessments by ANPs as highly valued. This is not a recent concept, with Brown (1998) outlining similar aspects. There is also a key link here with advanced nursing models, including Bryant-Lukosius and DiCenso's model (2004, p. 535) where

*"The primary focus of the role (advanced nurse) should be on promoting continuous, coordinated care designed to improve patient health."*

This shared theme for participants intertwines holistic care across the whole patient pathway, therapeutic relationship-building and concomitant communication skills; elements that emerged as an overarching facet of being an advanced nurse and incorporated into the conceptual model of advanced nurse. This is closely aligned with all dimensions of humanisation, positioned high on the spectrum and 6Cs nursing values. The participants discussed capabilities, referring to additional advanced clinical skills enabling them to function within such a joined-up approach. Interpretation draws on Carper's (1978) ways of knowing again; although difficult to categorise, empirical knowledge driving their practice, does not appear as the most defining component.

What appears to define them as advanced nurses is interconnected, interdependent, overlapping aesthetic knowledge, with personal and ethical knowing, focusing on the value and significance of knowing the patient. Ethical knowing aligns with higher levels of decision-making and judgement components of being an advanced nurse, valuing and advocating with and on behalf of patients. Inman (2003) comments on advanced nurses using ethical reasoning in dealing with dilemmas in patient care. For the participants, this is reflected through a strong, ethically-driven, person-centric approach embedded in humanising care dimensions and 6Cs values. This is also pertinent to NMC's (2017, p. 3) '*Enabling professionalism in nursing and midwifery practice*,' which mirrors the professional approach of the advanced nurses, with guiding principles advocating,

*"The ultimate purpose of professionalism in nursing and midwifery is to ensure the consistent provision of safe, effective, person-centred outcomes that support people and their families and carers to achieve an optimal status of health and well-being."*

This also brings to mind the art of nursing reflected at the heart of the advanced nurses' lifeworlds, captured in their direct quotations, with recurrent, powerful emphasis on knowing the patient, with overarching sense of insiderness and uniqueness. Referring to nursing theorists to make sense of this, draws Carper's (1978) ways of knowing together with Parse's (1987) description of value of human presence of the nurse, connecting with patients and respecting their beliefs and opinions. Tanner et al (1993) purport that knowing the patient is not only related to empirical knowledge, but to the other ways of knowing, and is core to clinical judgements. Additionally, Benner and Wrubel's (1999) interpretation of the art of nursing, focused on nursing interactions with expert nursing practice, adds weight to the other theories. This resulted in an emergent picture of the meaning of knowledge, related to embodiment of being an advanced nurse, philosophically-informed and embedded in extant nursing theory.

For the advanced nurses, a greater level of responsibility and concomitant autonomy are accompanied by a maintaining safety and working within their scope of practice, but not beyond their limitations. This is another area where a dehumanising approach may emanate through advanced nurses' practice, in a quest to maintain safe practice, protecting themselves and patients. There is consensus in literature that advanced nursing extends the traditional scope of practice, according to Callaghan (2008). Barton (2006) asserts that advanced nursing is distinguished by high degrees of autonomy, authority and accountability, in comparison with non-advanced nurses. This

is also reported in more recent literature, including O'Shea (2013). The level of responsibility now exercised by participants is invariably linked to complexity. Most of them started by assessing and managing more simple cases, but progressed to where complexity and uncertainty and management of patients with undifferentiated, undiagnosed problems is now an everyday part of being an advanced nurse. Kucera et al (2010) refer to complex care situations dealt with by advanced nurses, adding support to findings here, and reflected in the conceptual model of advanced nurse.

All participants appeared acutely aware of accountability and responsibility and adherence to working within the limits of their practice (NMC 2015), particularly relevant to being advanced nurses. At the same time their role boundaries appeared quite fluid and flexible, adapting and extending to meet requirements of patients and service needs, a finding explored in research, including Kennedy et al (2015). This is within a safe, legal framework, which they referred to using examples to highlight experiences, accentuating understanding of their responsibilities.

Dimond (2015) explores standards of practice applicable to advanced nurses working more independently than non-advanced nursing colleagues, with reference to well-established principles of law. This includes the Bolam test of reasonable standards of practice used to determine negligence and usually involves reference to national guidelines and employers' policies. Where advanced nurses are adopting activities usually seen as the domain of doctors, standards of their practice would be judged against medical staff who would formerly have undertaken those activities. This may be why they reflect on their practice, in comparison to medical colleagues. This links to initiating PD1, with acknowledgement that local governance elements were lacking with nurses who had advanced their practice, outwith a whole system-based approach, which needed to be addressed.

The advanced nurses' articulated levels of autonomy, responsibility and decision-making exercised, aligning with Mantzoukas and Watkinson's (2006) report on critical thinking, reasoning and analysis that characterise higher level practice of advanced nursing. Dowling et al (2013) add to this, arguing that this is central to effective performance of advanced nurses. Autonomy is a shared theme, with participants discussing what it means in terms of having capacity and freedom to make decisions, and power and responsibility to do so. Thus, this became a core component of the conceptual model (Figure 5 and 6).

Concurrently, this implies constant evaluation and integration of knowledge and experience referred to as part of their lifeworld. Several of them explored prescribing and specific patients for whom they made significant decisions about care and management, without direct involvement of medical teams. Prescribing is now an accepted component of advanced nursing, with independent nurse prescribing enabling prescription of medicines in the same way as doctors (NMC 2018). It is an essential criteria within PD1 hospital's job descriptions for ANPs and CNs and core taught element of the curriculum developed through PD2. This aligns with the current national picture of advanced nursing and its practice (DH 2010; NES 2010). Ward and Armstrong (2015) purport that nurses' prescribing authority in the UK is the most comprehensive in the world and linked with benefitting patients. For these participants, prescribing is a particularly defining element of being an advanced nurse and key component of the new conceptual model. It also links with higher level autonomy and responsibility. Thus, this needs weighing up in relation to maintaining safety and avoiding risks for patients. This may be another area where dehumanising dimensions are more appropriate, albeit within an overall humanising care approach.

All participants described being an advanced nurse within the education pillar for patients and staff and education of self. There is evidence of this as a key aspect for advanced nurses throughout the literature and it is a major component of PD1's hospital framework and incorporated in the conceptual model (Figure 5 and 6). Elliott et al (2014) observed this in relation to capability-building within multi-disciplinary teams and McDonnell et al (2015) reported on improved staff knowledge, skills and competencies facilitated by ANPs in the hospital setting. Participants allude to this being facilitated by higher level knowledge and skills, which enhances care delivery. Their competence and capabilities as educators and support roles for staff and patients are cognisant with togetherness and agency. Fleming and Carberry (2011) similarly report on advanced nurses sharing their wide knowledge-base with other nurses in a critical care setting.

Part of PD1's framework was an education and training strategy, with core aspects added to job descriptions. This strategy used DH (2010) criteria for advanced nursing practice, as the benchmarking tool for the advanced nurses to map their development needs and competence against. This also linked with PD2, with the new education curriculum using the same benchmarking tool. This fits well with and strengthens the

education pillar, from the PD and how the hospital education and training strategy and university education curriculum are committed to the same overarching framework.

Most research participants referred to active involvement in education and support of junior doctors, particularly related to specialist knowledge and familiarity with patient caseload management in their specific settings. They showed commitment to sharing knowledge related to more medically-orientated care and treatment, but also implications that doctors are being exposed to core nursing elements, such as relationship-building and communication skills. Additionally, participants discussed patient advocacy, with significant contributions to multi-disciplinary ward-rounds; they ensure all aspects are considered as part of holistic packages of care, not only medical factors. This implies an educative element for junior doctors who observe the advanced nurses managing care from this all-round, holistic, perspective; sharing best practice and guiding and supporting them to adopt similar practices, as part of the multidisciplinary approach to delivery of care. This is similar to findings from Yeager et al (2006) and Hutchinson et al (2014).

Most participants discussed education and support for nurses, seeing their responsibilities as instrumental to facilitating quality patient care for patients, supporting other nurses in this quest. They discussed education and support aspects as implicit to being an advanced nurse; linked to portraying professional standards of what they do (NMC 2015) and how they provide patient care, using humankind care and 6Cs values, alongside professionalism guiding principles (NMC 2017). Donnelly (2006) argues that a framework of holistic care, strong advocacy and nursing experience are characteristic of advanced nursing and the vehicle through which they maintain their nursing values. This is mirrored in other research, including Fleming and Carberry (2011) and Williamson et al (2012). All these studies, along with this current one, refer to a key aspect of supporting professional development of others, by advanced nurses; this is through role modelling, aligned to promoting the image of advanced nursing portrayed here. The NMC's (2017) *'Enabling professionalism'* is pertinent to advanced nurses and fits with leadership, as well as the education pillar. NMC (2017, p.5) highlights that nurses and midwives should strive to be

*"an inspiring role model working in the best interests of people in your care,[ ] is what really brings practice and behaviour together in harmony."*

This is first and foremost a role model of advanced nurse, with expert nursing practice being the primary concern; with the essence of nursing being at the heart of this. Similarly, Manley (1997), outlined the role model for advanced nurse conceptualised through a model of practice based on patient-centred care and advocacy, expert nursing practice, change agency, clinical leadership and collaborative practice. This was apparent with participants in this study and translated into the conceptual model of advanced nurse (Figure 5 and 6).

Sheer and Wong (2008) focus on the advanced nurse in relation to patient education with particular reference to health education and health promotion. This is mirrored in most participants' experiences and thus incorporated into the conceptual model. Nieminen et al (2011) reported advanced nurses playing key roles in the learning culture of their organisations, which was alluded to by Belinda and Charles as part of their educator function, within their hospital setting and a wider stance. This was especially apparent with Belinda, as a more significant aspect of her role than the ANPs, relates to education and staff support, particularly for nurses. She describes facilitating quality patient care delivered by others, with her support. Coster et al (2006) found that part of the way CNs work is through influencing the practice of other staff and Gerrish et al (2007) purport that CNs empower front-line staff to deliver evidence-based care. This is mirrored in Belinda's experience as CN, setting her aside as different from the ANPs. This comes across in the two versions of the conceptual model - Figure 5 (ANP), Figure 6 (CN).

With leadership, the advanced nurses' particularly related this to clinical care, specifically assessment and management of patients, which is reflected in the leadership pillar of the conceptual model. This is similar to Dalton (2013) who reported ANP roles in a hospital setting who had clinical and managerial leadership functions, characterised (like these participants) by autonomous practice, complexity and diversity. The participants viewed their leadership function linked to working as key members of multi-disciplinary teams, with collaborative relationships leading to more co-ordinated approaches to care. They all provided illustrative examples of leading on patient care, from working alongside senior medical staff on wards or in clinics, whilst demonstrating the invariably autonomous and independent nature of advanced nurses in their clinical settings. This is reported in research across decades from 1990s and more recently (Hicks and Hennessy 1998; Yeager et al 2006; McDonnell et al 2015).

The advanced nurses' leadership experience appeared to err towards 'transformational' leadership style and aligned with '*engaging leadership*', conceptualised by Alimo-Metcalfe and Alban-Metcalfe (2008). It is maintained that this type of leadership approach is pivotal to success of healthcare organisations at all levels, and suggests why this tendency was seen in the advanced nurses. Govier and Nash (2009) report on leadership as a key skill for all levels of nursing, purporting that this provides means of influencing all aspects of care delivery, taking forward the contribution that good nursing care makes to patient outcomes and cost efficiency. They continue by asserting that nurses can be central to health leadership and policy development, whilst maintaining traditional nursing skills, characterised by compassionate care, also reflected in the advanced nurses' narratives.

More recently, Anderson (2018) remarked on how advanced nurses are reported as positively influencing clinical outcomes and improving cost-efficiency, and seen as a potential solution to some leadership challenges identified from inquiries, including the Francis Report (Mid Staffordshire NHS Foundation Trust Public Inquiry 2013). This mirrors the perspective of the advanced nurses on their own contributions to patient care and service delivery. However, Anderson (2018) also comments that advanced nurses are not necessarily adequately prepared to undertake a leadership role beyond immediate patient management, which is what Charles was alluding to, in acknowledging his need to undertake leadership training. The less prominent place of leadership in the ANP model, perhaps bears out this commentary and may be an area worthy of development and should be considered in relation to further professional development of these ANPs and in planning education of future advanced nurses.

Belinda, Charles, Diana, Emily and Gina discussed leading on improving patient pathways and care, and referred to good patients outcomes that resulted. This tends to not be outlined from a personal, but a wider multi-disciplinary team stance, working collaboratively with the aim to realise good quality care. This echoes previous research, including Elliott et al (2014) who report on visible leadership contribution of advanced nurses, seen as pivotal to initiation of new initiatives for patient care delivery. McDonnell et al (2015) evaluated ANP roles in an acute hospital setting, demonstrating their contribution to achievement of organisational priorities and meeting targets and policy development. This was correspondingly captured in Diana, Emily, Fiona and Gina's experiences, with Fiona making specific reference to positive audit results and patient satisfaction in service development, through their advanced nursing roles.

Adding external consultancy strengthened significance of the leadership pillar, for Belinda, the CN, differentiating her from the ANPs, in this regard, to a certain extent. This is seen as a core difference between the two versions of the ANP and CN conceptual model. This focus on leadership and consultancy is implicit to *'leading change adding value'* nursing strategy document (NHS 2016) and NMC (2017) *'Enabling professionalism in nursing and midwifery practice.'* Both documents guide nurses at all levels to take on leadership functionality, to facilitate person-centred, caring, compassionate care, and are therefore pertinent to the ANPs and CN. Belinda's portrayal of being a CN, is of a strategic consultancy and leadership profile and clinical consultancy. This echoes through literature, with CNs expected to be at the forefront of nursing developments (Clegg and Mansfield 2003). Professional leadership is cited as a key feature of CN roles, characteristic of a transformational and democratic leadership style (Hutchinson and Jackson 2013), which is how Belinda described herself. This ranges across clinical contexts with CNs possessing expertise in nursing practice, education and knowledge-brokering, amongst key features. From a strategic perspective, this is linked to their field of practice, with presence within and outside organisations where they work (Manley et al 2008; Gerrish et al 2011); this is demonstrated as Belinda's lifeworld experience.

Research was not discussed to any great extent by participants, other than the ANPs using evidence-based practice and being able to appraise and apply findings into practice. The ANP participants interpreted research from service and practice development perspectives, and evaluation and audit, rather than empirical research. They focus on working to evidence-based practice, aimed at maintenance of high standards of care, in line with guidelines and standards, which they are very conversant with. Despite this lack of experience with empirical research, they show commitment and competence to sharing knowledge and experience to improve patient care and courage to challenge sub-optimal care, in pursuit of compassionate, person-centred care. This is reported elsewhere, with practice and service development considered as key aspects of advanced nursing roles (Manley 1997; Barton and Mashlan 2011); this is implicit to the ANP version of the conceptual model (Figure 5). With the research pillar less prominent for the ANP model, this suggests that this is perhaps an area for further development, to fully embrace advanced nursing within the four pillars of advanced practice. A commitment within *'Leading change, adding value'* (NHS 2016, p.13) is *"to lead and drive research to evidence the impact of what we do."*

This supports the view that there perhaps needs to be more focus for ANPs on working towards meeting this commitment, within their nursing profession's strategy. The insight gained particularly from the research study suggests a need to enhance and enable research capability and support a more clinical academic element. The advanced nurses demonstrate a wealth of experience and expertise within their respective fields of practice, worthy of being harnessed. This could be valuable to advanced nursing locally and more widely. Promoting an advanced nursing workforce who are better trained and more actively engaged in research should help shape its evidence-base, thus informing and potentially further improving patient care. Such engagement can influence the wider agenda of advanced nursing research that can contribute to high quality patient care and healthcare services.

Donnelly (2006) reports on development of nursing practice and influencing clinical and policy development as part of the essence of advanced nursing, viewing research in its wider sense. Hutchinson et al (2014) report research and scholarly activity as part of the advanced nurse role, referring to this across categories of advanced nurses, including ANPs and CNs. This was not robustly reflected in the participants' lived experiences. Probably, the peripheral place research appears to maintain, is a consequence of predominant clinical input, particularly of the ANPs, curtailing them from fully embracing such aspects, to any great degree. Although Diana alludes to this when she recalls discussing improving patient care with her ANP team colleagues when she says, "*let's do some research*" but this is not discussed further and she does not give examples of taking this further. Contrary to the ANPs experiences, research was where Belinda as CN, differed. Her focus was more prominently based within a research perspective, with expectation of CNs involved and leading on research in their fields of practice, according to Dyson et al (2014). This is incorporated into the CN version of the conceptual model (Figure 6).

The CN had faced challenges with lack of understanding of her role, which resulted in limited senior nursing support in her organisation. Lack of adequate support mechanisms is reported in other studies, such as Bloomer and Cross (2010), and perhaps, this study can provide a small glimmer of hope for improving this situation for CNs in the future, with increased understanding of what being a CN means. Gerrish et al (2011) argue that CN roles are diverse in nature but often span both organisational and professional boundaries, which is certainly what is evident in the CN model. The CN role was introduced in England in 2000, to achieve improved outcomes for patients

through improving quality and services. It is reported by Hutchinson et al (2014) to differ from that of an ANP in terms of the expert knowledge-base more likely to be applied to education and development of practice in others and through involvement in leading practice change and research. This certainly is apparent in the conceptual model of ANP and CN (Figure 5 and 6).

Throughout discussion on findings from synergy of the research and PD, the newly created conceptual model of advanced nurse has been alluded to, at key points in the text, signposting the reader to Figure 5 (ANP) and Figure 6 (CN). This facilitates understanding of how the model was built from synthesised exploration of advanced nurse in the hospital context, which came to represent the main conclusion and key product of the whole study.

### **8.6 The conceptual model of advanced nurse in the hospital context**

There are two versions of the model, ANP and CN, with distinction necessary due to prominence within the four pillars and different focus of the ANP and CN roles, despite all participants classed as advanced nurses. This emerged from findings discussed earlier and details of building the conceptual model (Figure 5 and 6). In the figures, the greater height of each pillar represents the main focus of that pillar for the advanced nurse's practice elements. The shading of pillars represents the following: **darkest shading** for the most prominent pillar; **lighter shading** for less prominent and **light shading** for least prominent pillar/s. The difference between the ANP and CN model is related to the main focus of each one and merging of the four pillars is shown by how closely positioned each pillar is to the others. The largely clinical nature of the advanced nurse (ANP and CN) is the principal pillar, followed by education and leadership/management less prominent, but remaining important. Research was least significant for ANPs but more so for the CN. The model can be seen to encapsulate 6Cs nursing values and dimensions of humanisation as *how/why* of being an advanced nurse, underpinning practice embedded within the four pillars, as '*what they do.*'

## 8.6.1 Model of advanced nurse within the hospital context: Advanced Nurse Practitioner

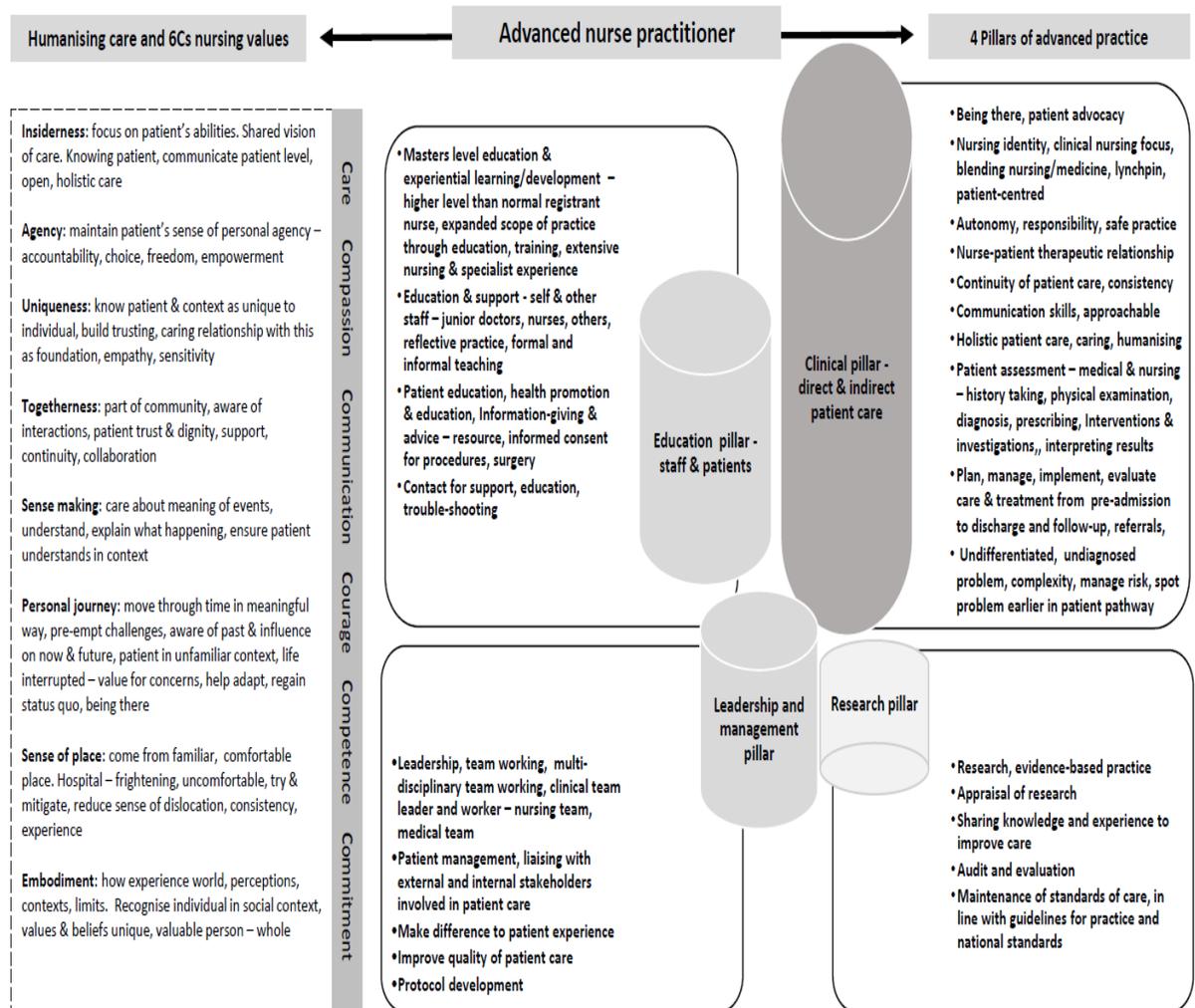


Figure 5 Conceptual model of advanced nurse in the hospital context: ANP

For ANPs, the clinical pillar represented approximately seventy percent of their practice, blending expert nursing practice with advanced assessment skills, more usually considered the remit of medical practice. This includes patient assessment incorporating history taking, physical examination, initiation and interpretation of investigations and undertaking interventions. This leads on to clinical reasoning and medical diagnostic decision-making for often complex issues and undifferentiated, undiagnosed problems. Patient care management invariably involves autonomous decision-making albeit within a multi-disciplinary team approach. This includes undertaking interventions, prescribing pharmacological and other therapeutic treatments, admission and discharge and referral of patients from and to health and social care services. This requires additional professional responsibility and

accountability and higher levels of autonomy and independent practice than normal level registered nurses. This is all merged with expert nursing practice, with communication and building therapeutic relationships, nursing, social and psychological care, core to this; with practice predominantly within 6Cs nursing values and high on the spectrum of dimensions of humanisation. Combination with more traditional medically-focused elements brings practice together into whole packages of person-centred, holistic care throughout patients pathways. Central to their practice are consistency and continuity of care, '*knowing their patients*' and '*being there*' for them, ensuring good patient outcomes and experience for patients. Specialist knowledge is a key part of their practice, embedded in the clinical pillar.

The education pillar involves patients, self and staff, all inter-related and undertaken within a multidisciplinary approach. Masters level education and experiential learning/development is core to the ANPs practice. Expanded scope of practice is facilitated through education, training and extensive nursing and specialist experience. The education pillar includes supporting staff, including doctors and nurses and trainee advanced nurses, with flexibility to meet individual needs and organisational requirements in order to facilitate quality patient care. Reflective practice, formal and informal teaching and role modelling are amongst key aspects. Informal, opportunistic patient education, health promotion, information-giving and advice to support patients on their pathways and gaining consent for procedures, are integral to direct and indirect patient care. This includes trouble-shooting and problem-solving and being a contact for support to patients and their families.

The leadership pillar was less prominent, amounting to approximately ten percent of the ANPs' practice. The ANP version of the model depicts leadership with particular emphasis on clinical leadership, related to patient care and management, including liaison with external and internal stakeholders. This is also with particular reference to being both a member of a multi-disciplinary team and team leadership. The leadership aspect is also characterised by commitment to making a difference to patient experience and improving quality of patient care and service delivery for their patients. Protocol and policy development at local level shows ANPs working in a leadership capacity, with change agency and promoting best practice.

The research pillar was least significant for ANPs, amounting to less than ten percent, although it does include recognition of and adherence to current, best evidence. The

ANPs appraise research and work to evidence-based practice, aimed at maintenance of high standards of care, in line with guidelines for practice and national standards. With a philosophical foundation of humanising care and 6Cs values, they show commitment and competence, in relation to sharing knowledge and experience to improve patient care. They demonstrate courage to challenge sub-optimal care, in pursuit of delivery of compassionate care. They view research in a rather general sense, with engagement in monitoring and evaluating practice, through non-empirical research, using audit and evaluation and methodologies based in practice and service development. However, they explore exploratory and evaluative elements related to patient care and service delivery within the context of a humanising and compassionate caring philosophy.

## 8.6.2 Model of advanced nurse within the hospital context: Consultant Nurse

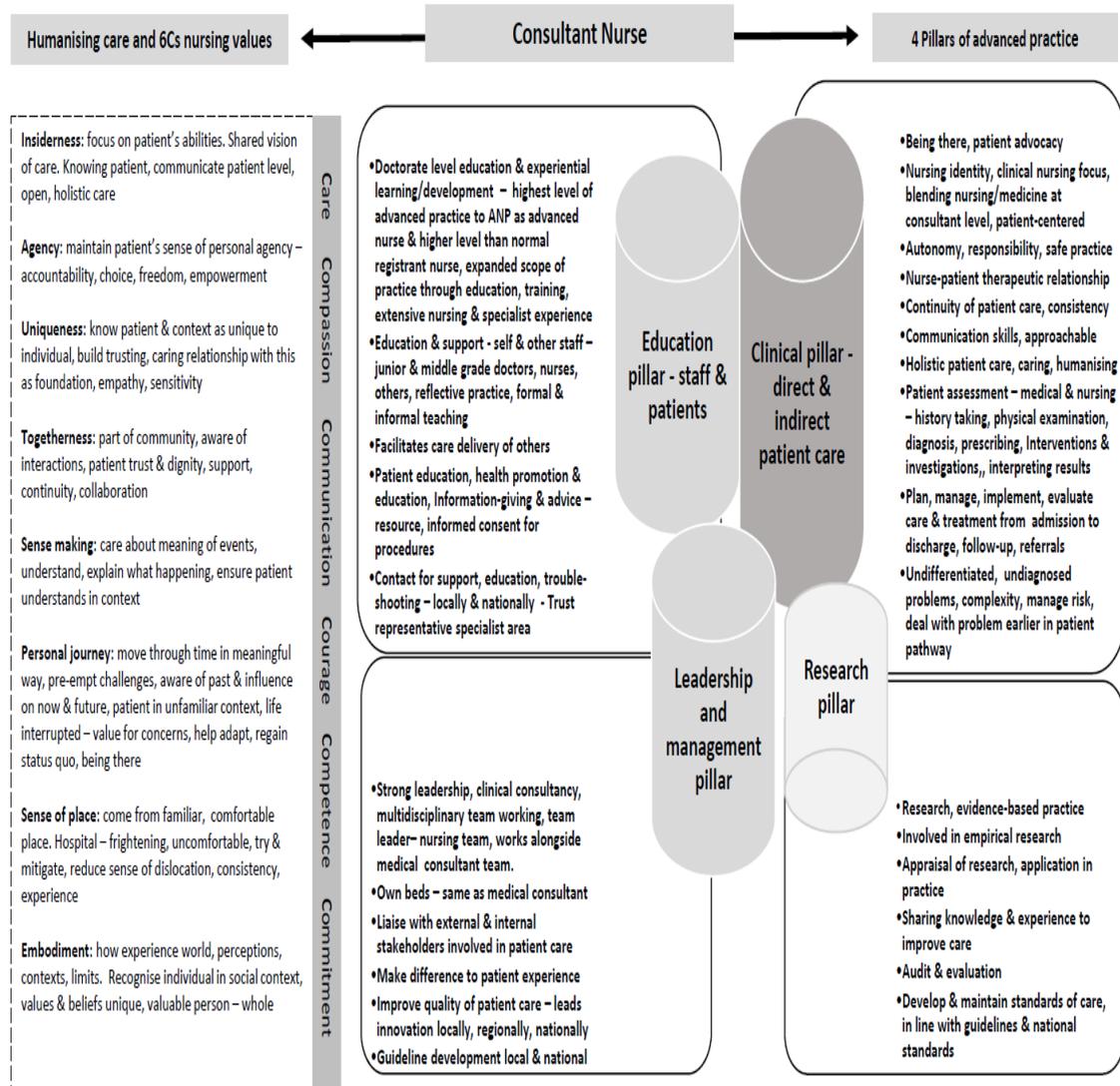


Figure 6 Model of advanced nurse within the hospital context: CN

The CN model is a more closely fused model between the four pillars, particularly with clinical and leadership pillars, whereas the ANP model is more linear in nature across pillars. The CN model is similar to that of the ANPs, for the clinical pillar, but approximately fifty percent and with a higher level of clinical practice more comparable to medical consultant level. This is evident with the CN having responsibility for her own patient beds and working alongside, on a more equal standing, with medical consultants. The CN appears to have a higher level of autonomy and responsibility for patient care, with greater freedom to act and more independently-based practice and decision-making for her own patient caseload. The ANPs tend to work clinically, more on a par with the junior doctors, albeit with a 'care management', rather than 'illness

management' perspective, more akin to medical practice. This is the essence of the uniqueness of the nursing element of being an advanced nurse, which differentiates them from being under the auspices of doctors, whether CN or ANP.

With greater fusion between pillars for the CN, education and leadership amounted to approximately twenty percent for each. The expectation for the CN is doctoral level rather than Masters level. This is in keeping with the CN being viewed as at the highest level of advanced practice, with a more external-facing role than ANPs, and more extensive nursing and specialist experience. With the education pillar, the same themes are evident for the CN and ANP model; however, for the CN, there is more involvement in education of middle grade doctors, as well as junior doctors and other CN and ANPs. The CN is more of a facilitator of care delivery for others, most notably nurses on the ward and support staff, junior doctors and other healthcare professionals. For the CN, the leadership pillar includes additional consultancy function, with a greater degree of strategic perspective for the organisation. There is representation for the specialist area and nursing, locally, regionally and nationally, with involvement in activities and initiatives at all these levels.

The research pillar amounts to approximately ten percent for the CN, likely to increase as Belinda continues her doctorate, building on her research function and enhancing her education and leadership capabilities. Gerrish et al (2011) report on the knowledge-brokering function of advanced practice nurses, in relation to promoting evidence-based practice among clinical nurses. The supposition is that CNs are at the forefront of advanced nursing, actively problem-solving and facilitating change, through sharing knowledge, teaching and role modelling. This is evident in the CN model and exhibits some subtle differences between CN and ANP model. This may be due to tendency for CN roles to have indirect impact on patient outcomes, reported as difficult to evaluate, according to Dowling et al (2013). This emanates from the CN whose lifeworld experience is captured as consistently exploring her contribution to patient care and service delivery from a largely collective perspective.

The conceptual model for CN and ANP represents advanced nursing within this specific hospital context. This is focused mainly on the clinical pillar, but with the other three advanced practice pillars playing an important part. This seems to really define them, illustrating what it means to be an advanced nurse, embodied in the values framework of the 6Cs and humanisation dimensions.

## 8.7 Strengths and limitations of the study and implications for practice

### 8.7.1 Strengths and limitations

This study has offered an interesting, informative glimpse into the holistic life-worlds of the advanced nurse participants in the specific hospital setting, which was previously all but unknown. This is despite entirety of experiences not being fully captured due to time and resource constraints of undertaking this study as part of a DProf.

Conceptualisation of findings is made, with reference to three main themes of four pillars of advanced practice, humanisation dimensions and 6Cs values. Further exploration and interpretation, through deeper interrogation, has drawn on relevant, contemporary and longer standing literature, along with experiential understandings, particularly the PD. This has all supported the building picture of advanced nursing in this hospital context. This meets with the combined approach from Yardley (2000; 2008) and Noble and Smith's (2015) quality and rigour assessment (Table 6, section 6.2) and Smith's (2011) quality principles for assessing IPA. Synthesis of findings thus adheres to quality assessment, consistent with qualitative research generally and specifically to IPA, with alignment to theoretical transferability.

Immersion in individual and shared lifeworld experiences of the advanced nurses is a particular strength of this study. The findings conceptualise some emergent core characteristics that represent embodiment of being an advanced nurse in this hospital context. The research was instrumental in bringing to the fore factors indicative of the '*how*' and '*why*' that underpin the '*what*' of their embodied life-worlds. These are often not outwardly obvious, nor easy to describe or interpret. However, the framework provided by the four pillars, dimensions of humanisation and 6Cs values, enabled greater clarity for detailed, informative description and interpretation of experiences, helped by language and vocabulary this framework offered. PD project 1 was hugely valuable for confirming that PD participants shared similar characteristics and philosophical underpinning, subsequently uncovered as key features of lifeworld experiences of research participants. Although there are studies reporting similar aspects, including Fagerstrom and Glasberg (2011) and Williamson et al (2012), more attention tends to be paid to what advanced nurses do (Neville and Swift 2012).

Thus, further strength of this study lies in the lifeworld of advanced nurses from a deeper cognitive perspective, and with specificity to these participants. Articulation of comprehensive details of real-life experiences that are close and true to participants' descriptions and interpretations, has resulted in constructing practice-orientated

evidence that pays heed to perspectives and judgements of the advanced nurses themselves. This is focused on the humanly qualitative nature of their caring practices. Although more practical facets were illustrated through the PD, the research added depth and breadth to the overall depiction of advanced nursing, within the hospital.

The study enhances and supports findings from aforementioned and other research, and the PD, adding to advanced nursing's evidence-base, with some new empirical weight. This culminates in a view of the essence of nursing embedded in research participants' experiences, in keeping with humanising care and 6Cs nursing values. This builds on more superficial data gathered from the 160 participants of PD1, further substantiating findings from the research. This is a unique contribution that adds value to the knowledge-base, offering a new and different perspective on advanced nursing. To date, there are no other published research reports focusing on the '*how*' and '*why*' of advanced nurses within a hospital context, embedded in humanisation dimensions and 6Cs nursing values. Thus, this distinctive addition fills a gap in the literature with regards to more hidden elements of advanced nursing that emerged and that are invariably difficult to describe. This enhances and strengthens the gestalt of qualitative evidence, which can inform and be translated into practice and education, for advanced nursing at practice and policy levels, through research-based exploration and interpretation of lifeworld experiences built on closely aligned PD.

Further strength comes from detailed, meaningful descriptions and interpretations of experiences and perspectives of participants, captured and analysed using a structured, systematic process of an IPA framework. Every attempt is made to maintain transparency and thoroughness in descriptions of process and content of the study, which has been achieved. This has hopefully resulted in presentation of good insight for readers, into the advanced nurses' experiences and sense they made of them, always with the essence of nursing strongly articulated through their accounts. This is as close as possible a representation of their actual lived experiences, enabling new, deep and meaningful insights into advanced nursing, from participants themselves. "This was definitely not anticipated; reflection on my pre-conceptions prior to gathering and analysing data and pro-active involvement in PD1, was that substitution for doctors' roles would be the predominant focus of their experiences. At the start of data gathering, I had not even considered that such essence of nursing and caring would materialise from their narrative accounts; although there was a glimmer of this from PD1."

A further strength of this study is that readers can refer to details of PD1, with the hospital framework created as part of this (Chapter 3, Appendix 2.1 and 2.2). This enables greater transparency and credibility, as the PD provided a solid foundation, informing the research and fusing the two elements as a synthesised whole study. It is not routine for qualitative research to draw on such a plethora of findings from a fairly large cohort of PD participants, from which the research participants were selected, as was the case here. Thus, reference to PD1 and 2, for supporting and enhancing interpretation and judgement of the research findings, is a key aspect. This is part of the interpretative position, conceptualised by Ricoeur (1981) as hermeneutic of suspicion, which is a valuable addition strengthening this study. Readers are better able to scrutinise how convincing evidence is, in terms of thoroughness and competence, alongside judging its trustworthiness and authenticity, as quality and rigour criteria of qualitative research and IPA specifically (Holloway and Wheeler 2010; Smith et al 2011).

Humanisation dimensions, conceptualised by Todres et al (2009), were not particularly familiar to healthcare practice nor embedded within nursing, when commencing this study. It was once data was being gathered and analysed from research participants, building on PD participants' experiences, that alignment with a humanising care approach started emerging. Thus, humanisation dimensions and 6Cs values became a means of articulating, labelling and categorising how and why the advanced nurses function as they do. All the dimensions seemed to strongly resonate with nursing and caring aspects of advanced nursing, adding this outwardly defining notion of the '*doing*' and '*being*' that adds a different view of advanced nursing. This is in contrast to prior perspectives more akin to medical technicians undertaking a skill-set, more usually seen as medical doctors' practice. The humanising care framework provided insight into and sense-making of the lived experience of being an advanced nurse. This includes a keen desire to facilitate improvements in patient care and service delivery, whilst upholding and promoting humanising care values. "I believe my synthesised PD/research study has enabled me to establish and articulate this; this is with the model of advanced nurse in a hospital context: (Figure 5 and 6) providing an illustration that can be shared locally and widely. This all provides a strong, credible basis on which to continue to develop advanced nursing that can support improvements to patient care and service delivery."

In addition, drawing on Galvin and Todres' (2013) work, qualitative research findings may also be viewed as congruent with the humanising values framework, guiding and supporting the humanly textured focus. Thus, within the context of undertaking the IPA study, the process and findings could be situated within this appropriate values framework, which in turn, acted to demonstrate a rigorous, credible platform for the new knowledge creation that ensued.

Interpretation from data analysis is substantiated by inclusion of extracts from interviews, words, phrases and full direct quotes, adding further strength to findings, from an idiographic and real-life perspective, demonstrating further commitment to qualitative research and an IPA approach. Aligning these extracts to humanisation dimensions and 6Cs added another layer of poignancy and transcendence of this values framework, as core to lifeworlds of the advanced nurses. Adopting the double hermeneutic and constructivist theoretical framework, analysis and interpretation by another researcher may have developed similar or different themes. Content validity of themes and ensuring closeness to participants' voices, was strengthened through member-checking and review by my supervisory team and analyst colleague.

"Utilising such an approach has not been easy, particularly as I had no previous IPA researcher experience. I am sure there are deficits and omissions that more experienced IPA researchers would not have made. However, I have progressed my researcher skills, enabling me to produce a strong piece of research whose findings can be used in the context of new knowledge of advanced nursing. Additionally, I believe this has shone a light on me, as a researcher and practice developer, whose identity focuses greatly on promotion of essence of nursing and humanising care within advanced nursing; perhaps this is now my personal *unique selling point* within the world of advanced nursing, from perspectives of both research and practice development. My strong belief is now established as immersion of advanced nursing within this humanising and compassionate care philosophical underpinning that gives it a unique professional identity, with practice undertaken within the four pillars of advanced practice."

Undertaking the PD and building the conceptual model from the synthesised PD and research, is already starting to be of value, as findings are shared. Interested parties are introduced to and encouraged to consider a different view of advanced nursing and its potential added value, with quality-focused benefits for patient care and service

delivery. Crucial to this, is derivation directly from the reality of the hospital setting within which the PD and research were undertaken, ensuring a high level of credibility and authenticity for the whole synthesised study. The PD and research, supported by the literature review, uncovered foundations for and embodiment of being an advanced nurse in this hospital context. This now offers a defining, valuable contribution to the evidence-base, from creation of the new, unique conceptual model as a strong base on which to expand and develop similar roles in the same and other settings.

It has not been possible to present all experiences and perspectives of participants, due to depth of analysis required of IPA and restriction on word count for the thesis. This may have resulted in omissions that could have added further depth and breadth to the interpreted lifeworlds of participants. Additionally, my lack of experience as a researcher may have led to deficits and errors that I am not aware of and that may or may not come to light after publication and dissemination. Also, as a small-scale study, only a snapshot has been possible, maybe leaving readers with questions unanswered. Although this can be seen as limiting, suggesting further enquiry is required, this may inspire others to pursue similar studies, through research and/or PD or as a fused whole exploration, such as this one. This would then add further weight to findings and evolving knowledge of advanced nursing, along similar lines, using this creative and innovative approach to the professional enquiry undertaken. The full individual narrative accounts of participants were hugely insightful but there has not been opportunity, within this DProf, to do them full justice. "However, I plan to use them as the basis for journal publication, conference presentation and to add to the content of advanced practice education, in order to make best use of this rich, valuable data, with its unique insight into advanced nursing within this hospital context."

Other potential limitations are my position, as novice researcher and as a professional immersed in advanced nursing, through my joint practice and education role, within the same setting as participants.

"As a novice IPA researcher, I needed to explore and to aim to be true to the methodological approach, ensuring a robust process was undertaken according to quality and rigour criteria. I believe this was achieved to a reasonable extent, through extensive reading, discussion with colleagues around methodology and masterclasses, which helped construct my study. I needed to be conscious of my need to develop my researcher skills as I went along and to consider potential biases, pre-conceptions and conceptions that I may or may not have been aware of, from my professional standing.

At all times I have and continue to be mindful that I am likely to have been unaware of some of these elements. I did and will continue taking into account other people's opinions on my conduct, learning from experience and being open to change and making every effort not to be inappropriately influenced. What I did achieve was that I did not lose touch with the value of my own lifeworld of being an advanced nurse, where this was used appropriately, as a positive addition.

Becoming familiar with methodology and processes, considering double hermeneutic and the hermeneutic circle and other elements of IPA and working within a qualitative approach, my reflective skills deepened. I maintained a researcher diary (Appendix 5 - extracts from researcher diary), where I was honest and open and weighed up potential biases, considering ways of minimising influence on participants during interviews and through data analysis and writing up findings. I reflected deeply on every aspect of interviews, which was enhanced by reference to the PD, literature and reflective and reflexive immersion in transcripts. I needed experience of actually being a researcher to embody what I was doing, as the researcher. In retrospect, I could have been more IPA-orientated in interviewing but feel the data gathered was adequate to meet a first-time researcher's level of performance. Reflexivity became more apparent as I continued the interviews and subsequent analysis, helping me to improve techniques as I progressed. Thus, latter interviews were more in line with the requirements of a qualitative and IPA approach. Enough detail of the interviews is included in the thesis to enable readers to use their own interpretative skills and make judgements as to the value of the data gathering and analysis and subsequent interpretations.

This was all helped by inclusion of others, at various stages. I returned on occasions to seek input of participants to check I was being true to their real-life experiences, making it clear that I was researcher, first and foremost, not advanced nurse and educator they knew me as. The input of my supervisory team and analyst colleague supported data gathering, analysis and interpretations, minimising the insider element that could have altered perception of participants' lifeworlds from my pre-conceptions and conceptions. This was further strengthened from informal dissemination of aspects of findings with other colleagues, as I proceeded. I shared aspects and sought opinions that I reflected on, which helped me remain balanced from insider and outsider perspectives, with the advanced nurses' lifeworld experiences. This led to deepening of reflexivity inherent and important to the IPA approach, from the researcher's perspective, and enhanced and enriched by being a co-creator of

knowledge and co-researcher with participants. Colleagues' support helped to confirm or refute my thoughts and interpretations on experiences and perspectives of participants."

The IPA approach does not suggest findings should be generalisable or transferable, rather that they offer additional knowledge within the context of the phenomenon of advanced nursing. The strong idiographic and interpretive commitment, according to Smith (2011), may raise questions about study generalisability and utility within practice. However, clarity and detail of the specific context of participants and situational settings should provide enough detail for readers to consider findings in relation to their own contexts; which is certainly my experience of reviewing similar studies. The findings do not make claims representative of *the* truth or *the* meaning of lived experiences of participants. "Instead I have responded to different ways participants invited me into their worlds as they see and live them, and have thus made my own interpretations based on looking through such a lens. It is hoped that this provides insight into and understanding of meanings of being an advanced nurse in the specific context, with IPA providing a practical and appropriate means of answering the research questions, focusing on understanding lived experiences. Thus, I believe this has added a small, unique, valuable contribution to advanced nursing's body of knowledge through answering the research questions, building on and fusing with the PD."

### **8.7.2 Implications for practice**

PD project 1: SNR was undertaken partly due to lack of understanding of advanced nursing at the hospital and concerns linked to governance. As a result of the project, better understanding of the meaning of advanced nursing resulted, as well as interest in further developing advanced nurses and ensuring this is done in a systematic and safe way, adhering to principles for good local governance. The research added greater awareness and depth of understanding, with further insight into being an advanced nurse within this context, with consideration of people, processes and frameworks, throughout all the activities.

"There is scope for further awareness raising and enhanced understanding to be shared within the hospital, bringing the organisation up-to-date, since PD1 was completed several years ago. This has been discussed between myself and the executive nursing team, with a more formal presentation planned shortly."

A gap that emerged from the PD, that became more apparent from the IPA research, indicates that the hospital may not be making best use of potential capabilities of advanced nurse participants, in leadership, education and research. Involvement in more formal education activities and support mechanisms for staff, building leadership, research and practice development skills, would further enhance the practice of these advanced nurses. This would offer a broader remit to being an advanced nurse and support contributions to improving care. Gray (2016) argues that important elements of advanced practice, including innovation, education, research and leadership are not strongly evident, which came across to some extent, in this study. He advocates that actively encouraging these key features of roles can enrich advanced nursing and its practice, which supports this as an element to take forward at the hospital.

Creation of the conceptual model (Figure 5 and 6) illustrates advanced nursing as an entity in its own right with practice embedded in the four pillars of advanced practice and the essence of nursing, and underpinned by 6Cs values and humanising care framework. It appears to offer what was missing from the hospital framework developed in PD1 and drawn from fusion of findings from across the DProf elements. This is further corroborated through recent documents in the UK; notably, NHS *Guide to nursing, midwifery and care staffing capacity and capability's* proposal, ensuring "*the right people, with the right skills, in the right place at the right time*" (NHS 2013) and *NHS Five Year Forward View* (NHS 2014). Also pivotal is '*vision and strategy for nursing*' (DH 2012) and NHS England's (2016) '*Leading change, adding value.*' Such publications and initiatives proposed within them, support roles, including advanced nurses, along with relevant research and PD, such as this study. This provides a foundation to build advanced nursing further, with more clarity in defining characteristics and potential contributions that advanced nurses can bring, without losing touch with nursing and a strongly humanising care focus. This broadens the implications for practice of this study from the local to a wider, national context, in terms of its contribution.

Using the conceptual model as a template, sharing findings related to differences between ANPs and CNs, can support the specific hospital and influence and inform other organisations, in exploring workforce solutions to meet service and patient needs. At individual level, aspiring CNs and ANPs have been considering career pathways, utilising the model as a tool to support development planning, personally and with their managers and teams. This is helping them to be visionary in progressing practice,

whilst remaining person-centred and embedded in nursing and humanising care values. Thus, this model offers a template for the advanced nursing community, with a flexible approach to practice for different categories of advanced nurse (ANP and CN), as depicted in the two version model. Further dissemination of the benefits of this beyond the immediate hospital broadens its contribution as a positive implication for practice of advanced nursing generally. This is being realised from a regional context, as I work from a consultancy basis with other organisations, sharing these experiences."

This synthesised PD/research study has made a small addition to the body of knowledge of advanced nursing, with breadth and depth of insight into the lifeworld of an advanced nurse in this hospital context. Disseminating findings is providing a forum for sharing ideas related to advanced nursing generally and more specifically, at local, regional and national levels. This offers a unique view into this setting and meanings of becoming and being an advanced nurse, with perspectives on contributions to patient care and service delivery. The setting and type of practice are fairly generic and therefore there is scope for using findings as the basis for supporting developments of roles and practice and for improving care and service delivery.

The potential for ensuring nursing and caring elements are at the heart of introducing and developing advanced nursing roles is anticipated as a key message to take from this study. The participants articulated how it was these elements that were embodiment for them as advanced nurses and the overall added value of their roles. This was demonstrated through their narratives, often using examples from practice, to illustrate value of this embodied advanced nurse as a crucial enabling factor for good patient experiences and outcomes. High quality care and treatment is outlined, as delivered through their safe and effective advanced level skills, within the overarching humanising care, 6Cs values framework. This appears to be a sound basis on which other healthcare staff can base best practice, with these advanced nurses acting as inspirational role models, captured through their interpreted narratives and enabled through sharing this study.

At a time when there is a need to develop different ways of working and new roles are needed to fill gaps in healthcare provision, Barton et al (2012a) argue that advanced nurses provide a good alternative to meeting some of the deficits. However, Rolfe (2014) asserts that this argument seems to emphasise extension into the medical

domain and compensation for doctor shortages, which may prove detrimental to the core of nursing. Gray (2016) adds that due to this emphasis on development of medical skills, advanced nursing practice development has taken second place. It is anticipated that this study can counteract these views, helping to promote an advanced nursing identity that sits firmly at the forefront of the nursing profession, rather than being driven by adopted medical skills, as more important and influential elements.

England's chief nursing officer's '*vision for nursing*' (DH 2012) introduced the 6Cs for nursing, during the time of undertaking this research. This has proved instrumental in further supporting and strengthening nursing aspects of participants' practice identified through this study. This was not a conscious factor for participants, nor influenced by myself as the researcher, as this had not, at this stage, been a consideration as a framework, incorporating 6Cs and humanising dimensions. It was not until the study's analytical stages that similarities between participants became apparent with embodiment of being an advanced nurse immersed to such a great extent, in this framework. This suggests potential for sharing how closely aligned the advanced nurses lifeworlds are, with this values base, and proposes such a notion as defining elements.

Prior to this study, little was known about how these advanced nurses functioned or the potential for contributing to patient care and service delivery, outside their immediate departments. Dissemination of this study is anticipated as a means of enabling these unique stories to be shared, giving these advanced nurses a strong, articulate voice in the advanced nursing and wider healthcare community, locally and more widely.

### **8.8 Reflection on undertaking the study**

(2014) "Initial reflection on advanced nurses in the hospital (PD Project 1), suggested new knowledge creation would materialise from close scrutiny of their experiences. PD1 was valuable for providing the background for the research. Adding exploration and interpretation to not only 'what' they do, but also 'how' and 'why' could offer the opportunity to make visible elements that I believe relate to the essence of nursing, hidden by an identity focusing largely on clinical skills. Some of this had been articulated by PD project participants, with snippets of information related to their experiences of being advanced nurses, emerging from interactions with them. This left

me feeling inquisitive, as I wanted to know more, believing this could only enhance the professional enquiry and strengthen the building of a framework of advanced nursing for the hospital. This was lending itself to enquiry focused on qualitative research but, initially, I was not familiar with the range of approaches available."

(2016/2018) "Undertaking the first (PD) and second stage (research) of the literature review helped meet this deficit in knowledge, as I discovered studies using different approaches, research methodology literature and published research. I attended relevant workshops and masterclasses (Chapter 5 and Appendix 5). I became aware of personal involvement as researcher, acknowledged and reflected on, in my diary. As a novice researcher, I relied heavily on input from colleagues to ensure I was pursuing the research appropriately, reflecting on every aspect, as it unfolded. The process of IPA usefully provided structure and kept me focused on working within this framework. I am sure there are errors and if I came to repeat a similar study, I would approach things differently and from a better prepared and informed position, with some good experience to draw on. I feel I achieved what I set out to do and answered my research questions. Merging research, literature review and PD resulted in the advanced nurse conceptual model, steeped in 6Cs values and humanising care dimensions."

(2018) "I feel privileged to have worked in collaboration with my participants, uncovering their holistic lifeworld stories. The PD informed and ran parallel to the research. The fused research and PD has now been instrumental in supporting further PD related to advanced nursing and further development of advanced nursing education curriculum, supported by the literature review and enhanced by personal narrative and reflection and reflexivity. This is where all elements of the DProf really fuse together in a cyclical, spiralling of knowledge creation to support ongoing development of advanced nursing. It now starts to be difficult to unpick where one element finishes and another starts, with the result being one of a cohesive, synergistic whole, adding a significant contribution to the body of knowledge of advanced nursing."

## **Chapter 9 Making an original contribution to knowledge and practice of advanced nursing, reaching my final destination and meeting DProf aims and objectives**

This chapter illustrates and summarises synthesis of the four DProf elements and outcomes that resulted (Figure 7), which represent my original contribution to the knowledge base and professional practice of advanced nursing. Continuation of personal narrative towards reaching my final destination is captured, including my own version of the conceptual model of advanced nurse (Figure 8, Section 9.2). A summary of meeting DProf aims and objectives, detailed in this thesis and defended through the subsequent *viva voce*, concludes this synthesised whole piece of work in section 9.3.

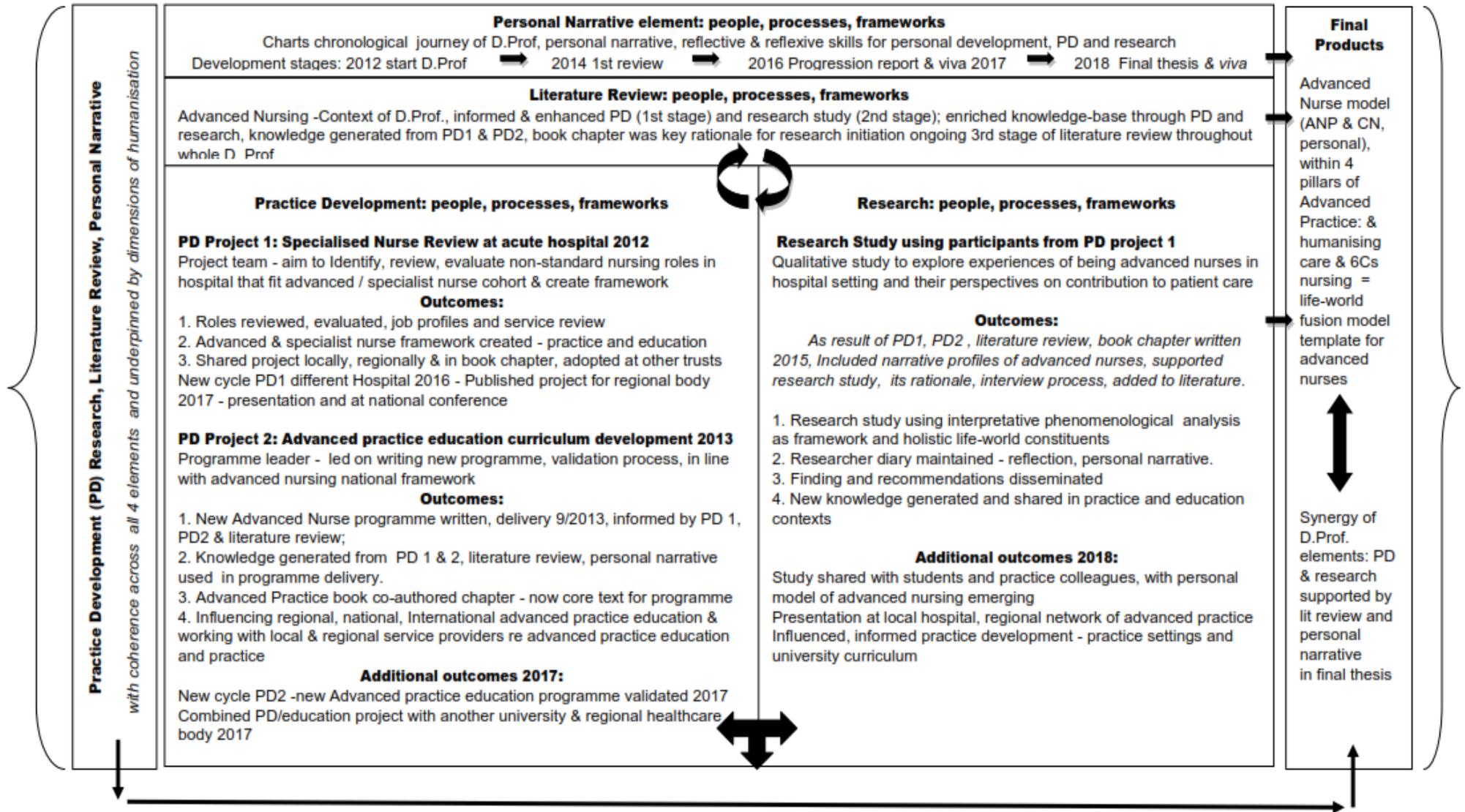


Figure 7 Synthesis of the four DProf elements and outcomes

## **9.1 Making an original contribution to knowledge of advanced nursing**

The synergy of all four elements that characterises this DProf has resulted in a well-balanced professional enquiry that has led to a unique contribution of advanced nursing knowledge creation and professional practice development. This work commenced with PD, which merged with, drove and informed the research.

"This whole piece of work thus represents my contribution to the knowledge base and professional practice of advanced nursing. However, in line with the strongly collaborative, participatory nature of PD (Boomer and McCormack 2010 and IPA research (Smith et al 2009), the whole study does not represent solely my own contribution to advanced nursing. My role was one of the main player and narrator, along with all other participants throughout the whole process, who were co-creators and co-researchers and practice developers. Both PD projects were pivotal to advanced nursing practice and education development in the local area, in line with the national picture and currency of the evidence-base. Further PD projects, carried out four years later, had the merged research and original PD projects at their core, forming a solid, well-informed basis, within largely the same contexts.

My personal contribution for PD1 was as an expert advisor and key, pro-active player in the creation and implementation of the advanced and specialist nurse framework for the hospital and elements linked with this, such as the job descriptions and education and training strategy. For PD2, I led on development and subsequent delivery of the new advanced nursing education curriculum at the university. The programme was monitored and the first cohorts who graduated, evaluated the programme well, with subsequent delivery based on this positive evaluation (Appendix 2.3). This PD project was disseminated regionally, nationally and internationally with advanced nursing educators, sharing this good education practice example.

Although beyond the scope of this thesis, the PD initiatives that followed the two initial projects, mirrored PD1 and PD2, broadening the knowledge base and professional practice and progressing with the ongoing evolution of advanced nursing and its practice. They also benefitted from my increased expertise and experience gained through the doctoral studies. This has subsequently broadened my unique contribution for PD for advanced nursing and its practice locally and nationally.

Towards the end stages of this doctoral journey, I was offered the opportunity to lead on a PD project similar to PD1, within a hospital in the same area. This arose from involvement in PD1 and reputation of the positive and practice-based advanced nursing education programme at the university (PD2), now in its second year of successful delivery. I confidently and enthusiastically seized this opportunity, using enhanced researcher and practice development skills, alongside a sound knowledge-base from the previous fused PD/research and literature review. This drew together the people, processes and frameworks related to exploring and developing advanced nursing that provided a sound foundation. An additional element was that funding for this project and my employment as project leader, came from the regional branch of Health Education England [HEE], within the remit of developing advanced practice at national and regional level. This was through local initiatives and development of a new national multi-professional advanced practice framework (HEE 2017). The project resulted in an advanced practice framework for this second hospital, representing further personal contribution to advanced nursing (Appendix 13).

Similarly, a second cycle of PD has subsequently been undertaken at the university, with further programme development, building on the success of the first. This new programme was written, in line with the new advanced clinical practice framework (HEE 2017), with demand now for a broader-based advanced nurse programme and parallel programme for allied health professionals. This culminated in my leadership in validation and delivery of the revised and new programmes. This programme development was better-informed and drew on my enhanced skills and knowledge-base, developed as a result of undertaking the DProf.

I was better able to take a strong leadership role, with my expertise in terms of the people, processes and frameworks being instrumental, in successful development and delivery. The literature review and research elements contributed hugely to this new programme. This relates to supporting education provision, paying more attention to nursing-orientated aspects, such as advanced communication skills, building therapeutic relationships and developing personal, aesthetic and ethical knowledge-base of advanced nursing. A curriculum that focuses on celebrating the essence of nursing and encouraging a humanising care approach is being encouraged, alongside development of requisite clinical skills. This demonstrates another element that illustrates my unique, personal contribution to advanced nursing's knowledge base and practice.

The research demonstrates a more unique, personal contribution, but still one that has been co-created and co-produced with participants, in line with IPA (Smith et al 2009). The conceptual model of advanced nurse in the hospital context (Figure 5 and 6, Section 8.6.1 and 8.6.2, and my own personal version (Section 9.2)), adds a new, innovative view of advanced nursing as a significant addition to the knowledge-base and one fused with findings from the PD. This is all supported by the literature review, collectively supplementing the current, ever-expanding, knowledge-base of advanced nursing.

Dissemination of findings from the PD, literature review and research, and more recently, the second hospital-based PD project (Appendix 13, Appendix 14), is starting to be shared widely, through my involvement in wider regional and national advanced practice networks. I have shared findings informally and formally through verbal and poster presentations at conferences. I have also been sharing this work with students on the advanced practice education programme at the university, which has generated significant interest and inspired students, in a variety of ways, related to their own practice and development of their roles and services within their own organisations. This has also influenced the practice of work colleagues within both the hospital and university settings.

This has involved consideration of how the PD and research findings can influence and support role and service development within hospital settings, as well as other healthcare contexts. There is acknowledgement of advanced nursing roles that are complementary to other health care professionals and as advanced nursing roles in their own right. This is helping to inform employers and support current advancing and advanced nurses in their development. This is encouraging and inspiring other aspiring advanced nurses to confidently and, through a better informed position, embark on initiation of roles, enabling pursuit of appropriate career and relevant education pathways. They are enabled to follow the lead of the inspirational participants and myself, in the PD and research from a local perspective and with reference to a broader scope, through considering findings from other research studies highlighted through the literature review. With completion of the fused work presented in this thesis, I am now planning to write for publication, to enable sharing this significant piece of work, with an even wider audience, as a valuable and unique contribution to the body of published evidence of advanced nursing."

## 9.2 My personal journey of academic and professional development

"The focus of my learning and development journey has required adoption of more critically reflective and reflexive skills that encouraged critical examination of practice and other concepts and widening of perspectives. Reflective practice is important for professional practice and academic development and thus was vital to this doctoral journey. It had a strong presence throughout each element, building contemplative practice, as a researcher, practice developer and developing scholar, as explored by Owen-Smith (2018), empowering and supporting me in pursuit of my goals. This was supported by adoption of personal narrative writing that enabled articulation of my DProf lived experience, as well as the lifeworld experiences of the PD and research participants. Reflecting on achievements I have made from the fused PD and research and ongoing work that resulted from recognition of my contributions, has highlighted how far I have come during this doctoral journey. This has been in developing professionally and academically, alongside making pivotal contributions, through my work, to advanced nursing from a practice, education and now research perspective.

Creating my own version of the conceptual model of advanced nurse (Figure 8) has enabled me to articulate my own role and practice, reflecting on what I do, as well as how and why I do it and supporting me in confidently articulating what I can offer, through fusion of the four pillars of advanced practice, embedded in the essence of nursing and caring, within my own embodiment of advanced nurse. My own model, with more educator, leader and researcher elements than the other two versions, came from including myself in exploratory, reflective and reflexive processes, inherent to undertaking this work, commensurate with the DProf process. This is a framework for my own professional practice (as is the case for the other two versions for ANPs and CNs), with embodiment now for me, as both '*reflexive scholarly professional*' and significant movement towards being a '*reflexive professional scholar*' (Fenge 2009; Barnard 2011), as my career takes a turn towards more academic and researcher focus."

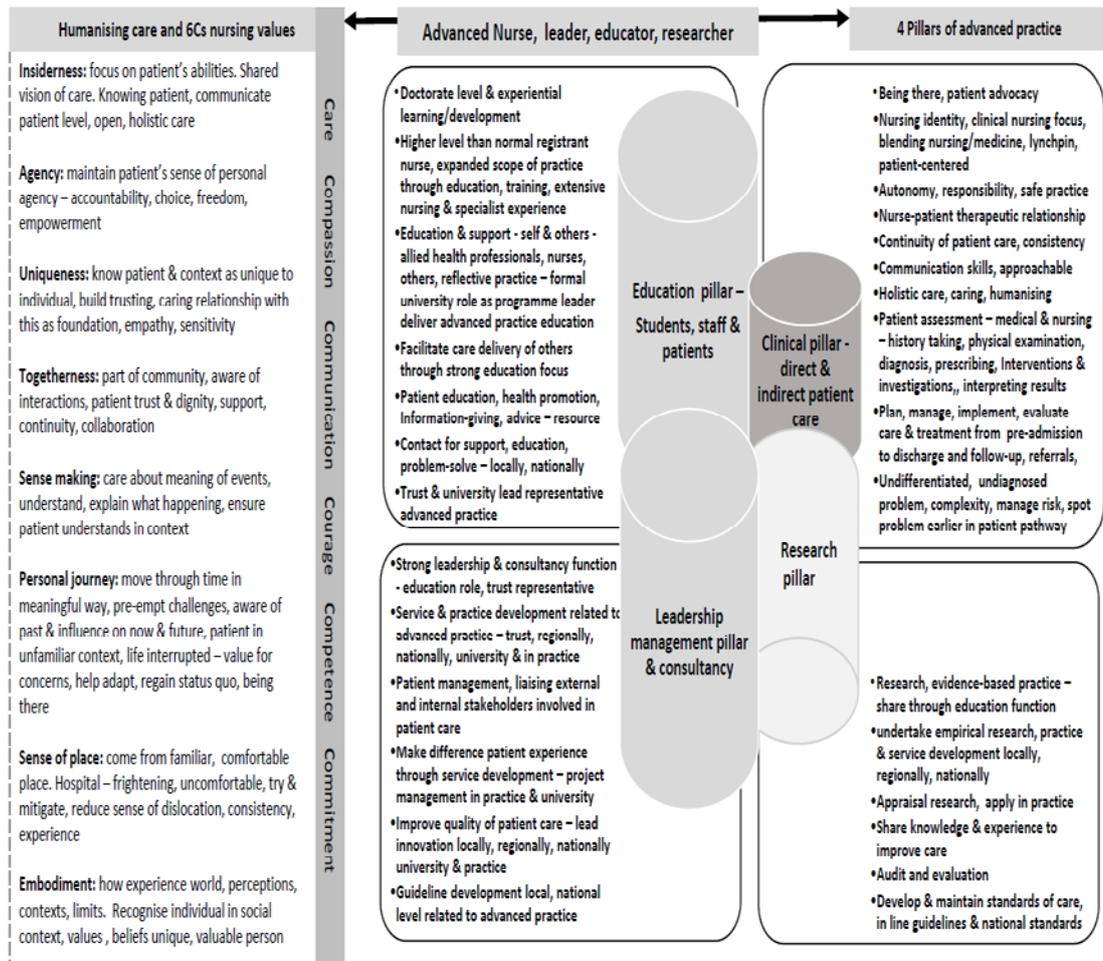


Figure 8 My personal model of advanced nurse

"As I head towards the 'finish line' I am reflecting on where I was on 'the start line' and how far I have progressed during this journey of personal, professional and academic development (my own Olympic games). Most importantly for me and closely aligned to the personal philosophy underpinning my practice, rooted in 6Cs values and humanising care dimensions is that what I achieve is meaningful. This was never merely a personal triumph and individual achievement, but fuelled by desire to achieve positive outcomes from this work that influence and make a difference to my nursing profession, particularly focusing on advanced nursing. The ultimate aim is that the synergistic whole of this work contributes to enhancing patient experience and improving care and service delivery, through advanced nursing roles and practice. I strongly believe that is coming to fruition as I pursue post-doctoral activities and continue to embed my unique contribution to the knowledge-base of advanced nursing, through dissemination and ongoing practice-based activities.

Reviewing my thesis, I believe this is articulated through the narrative of my lifeworld story of pursuing all elements of this DProf. It is hoped that readers can also engage with both my personal achievements, as well as positive outcomes realised and that continue to be realised as I drive on through the spiral of developing advanced nursing and its practice; continuously sharing the what, how and why of advanced nursing and taking others along pathways with me. This involves influencing, shaping and developing people, processes and frameworks."

### **9.3 Meeting the DProf aims and objectives - the 'finsh line'**

On reaching this point, it is pertinent to review aims and objectives, returning full circle, to the start of this process. This DProf journey started with pursuit of the practice development within the hospital (PD Project 1) and university (PD Project 2). The over all aim for undertaking these projects was to contribute to new, improved ways of working related to advanced nursing and its practice. PD1: Specialised Nurse Review (SNR) was undertaken (process) with a project team at the hospital (people), and was based on PD methodology and action research (framework) . It successfully achieved its aim of developing a career and career development framework for the hospital, job descriptions and service and role development. The project was disseminated to other hospitals locally and more widely through regional and national networks. This led to the second cycle of PD, with a similar project undertaken in another hospital where I moved employment, in order to lead the project. This resulted in successful development of an advanced practice framework for the second hospital (Appendix 13).

The aims and objectives of the literature review included conducting a literature review of advanced nursing and its practice to inform the DProf, PD and research elements. This was achieved and proved a means for ensuring the PD and research were informed by current literature and with addition of a narrative literature review to the knowledge-base of advanced nursing, through the written review within this thesis. There was also opportunity to share themes extracted from it, with advanced nursing students and practice colleagues, in relation to PD initiatives. The literature review was instrumental in further developing understanding and knowledge of research methodologies, appraisal of research, and keeping me up-to-date with the current knowledge-base of advanced nursing. The qualitative research study, informed by the PD and literature review, all at the forefront of advanced nursing, resulted in a unique

contribution, with new knowledge generation, aimed at improving professional practice, underpinned by humanisation dimensions and 6Cs nursing values.

"With regards to meeting the personal narrative aims, I have conceptualised and reflectively articulated personal narrative, charting my post-graduate researcher journey, demonstrating contemplative scholarship, in relation to professional practice of advanced nursing, and related education and research. I have developed greater depth of understanding and knowledge of reflective practice, applying reflective and reflexive skills throughout each element of the DProf and activities embedded within them, applying these to personal narrative writing at doctoral level. I have built and achieved mastery of my reflective and reflexive skills, based on three levels of reflexivity - personal, relational, organisation/system. Personal narrative is now embedded within the context of my professional practice, enabling development of contemplative scholarship at doctoral level. I have reflected on significant stages of my progress towards successful completion of this study, as a researching professional, using personal narrative to demonstrate development and mastery of new, enhanced academic and professional practice skills, through my holistic lifeworld and emergent knowledge. This is captured in my personal model of advanced nurse (Figure 8, Section 9.2).

Drawing on Bolton's (2014) reflective concepts, I have moved along my journey from unquestioning questioning towards questioning questioning, as knowledge and understanding of my subject and methodologies for professional enquiry have developed. From being unsure of what I was exploring and what questions to ask, to knowing how to answer questions. Certain uncertainty depicted the chaos as I set off on my quest, but this has progressed towards certain certainty, with confidence and competence in my capabilities as an advanced nurse, educator, practice developer and researcher. The illustration of my conceptual model from fusion of PD, literature review and research findings shows my innovative, creative approach, in keeping with serious playfulness. Johns (2005) cognitive to mindful reflective model aligns to Bolton's concepts, as I reflect how I have moved along the continuum, from cognitive to mindful and embodied newly developed capabilities within the four pillars of advanced practice, as my transformed embodiment of being an advanced nurse

Celebration of personal achievements, through undertaking different elements of this work, alongside personal, professional development within my professional practice is

captured through various dissemination activities and career progression steps I have made since commencing my DProf. Appendix 14 offers a snapshot of key activities and achievements and significant career progression aspects, along with acknowledgements of some key contributions that have resulted as I have been undertaking the DProf..

My journey has been outlined, alongside my personal embodiment of academic and professional practice development, on reaching my final destination. This is cognisant of an emergent professional profile encompassing enhanced and developed competencies and capabilities, with resultant synergy of higher level practice as an advanced nurse, practice developer, educator and researcher. I now embark on a new journey with advanced nursing at its heart, driven by my expanded level of expertise and experience, pursuing further collaborative PD and planning other research studies focused on advanced nursing, embedding my knowledge and skills firmly within professional practice.

As I reach 'the finish line', I have created a body of work of academic and professional practice that demonstrates coherence across the four DProf elements, culminating in presentation and defence of this thesis. I now start a new stage of my professional and academic career, with a plethora of new knowledge and skills and foundation of expertise and experience, related to advanced nursing and the people, processes and frameworks associated with it. I am committed and motivated to continue to explore and develop advanced nursing, with the aim of enhancing and improving patient care and healthcare delivery as a result and look forward with enthusiasm to meeting the challenge."

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## Appendix 1 MySporting Analogy: Olympic champion and my DProf

"As a keen, amateur runner, I was excited to be caught up in the Olympic experience in 2012. Parallels between pursuing my DProf and an athlete working towards and competing in an Olympic Games event struck me as a way of making sense what I was undertaking and what the elements of the DProf were about, from a wider team perspective. Using a safe environment, in terms of sports, as a familiar and comforting analogy for me personally, would help unravel and make better sense of my pursuits. I used the analogy of Jessica Ennis' journey towards competing in the 2012 Olympic Games and her success in winning an Olympic Gold medal at the Heptathlon event (Ennis and Broadbent 2012). Jessica's personal and professional development as a World class athlete and journey towards winning an Olympic Gold Medal in the Olympic Games, as a member of the Great Britain team, provides an ideal text to parallel my own path towards achieving my own goal of completion of the DProf.

Putting myself in her shoes, it is possible to see similarities, albeit within a completely different context. I am female, part of a bigger, wider team or teams, a team leader for my own DProf. I have been both a team player within collaborative teams for the PD projects. Jessica held an influential, leadership role in the GB team as the face of the games and was a good, proactive, influential team player. (2013) All elements of my DProf are separate entities but make up a coherent whole. Jessica had to compete in each discipline, as an individual athlete, but all the disciplines put together make up the whole event of the Heptathlon. Jessica was required to break down each individual discipline, analyse each element and work on them all, in order to achieve the required standard of performance, when put back together as the whole (Heptathlon event). Each one needed individual planning, organisation, implementation, reflection on action and evaluation over and over again, to refine and meet what was needed, but also within the context of the overall event, in its entirety. Each discipline followed a similar process with outcomes.

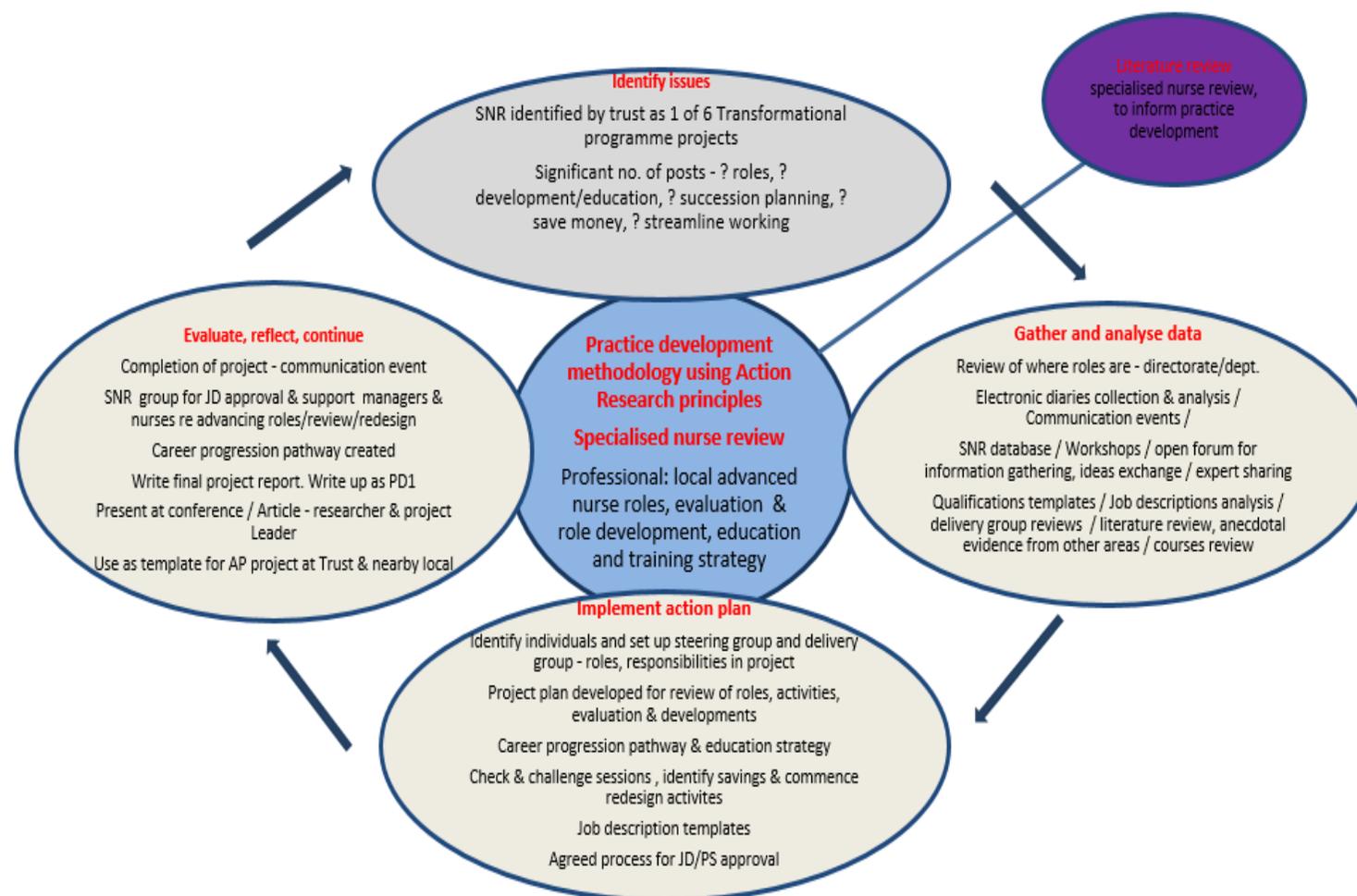
Similarly, each aspect of my DProf has numerous actions, each with an outcome to be achieved within their own right and as part of the whole. My DProf is a journey, much as Jessica saw her progress towards Olympic success – *"I believe we all have a journey. It may be in Sport or something completely different."* Jessica's ultimate goal of winning the gold medal can be likened to my ultimate aim of completing and defending my D.Prof. – *"Journey's end – I am the Olympic Champion"*. (Ennis and Broadbent 2012). It felt like I was at the start of training for an endurance running event. Jessica Ennis embarking on her

epic Olympic journey paralleled to my own doctoral journey; I was keen to consider my journey using the analogy - my personal Olympic Gold!." (2013)

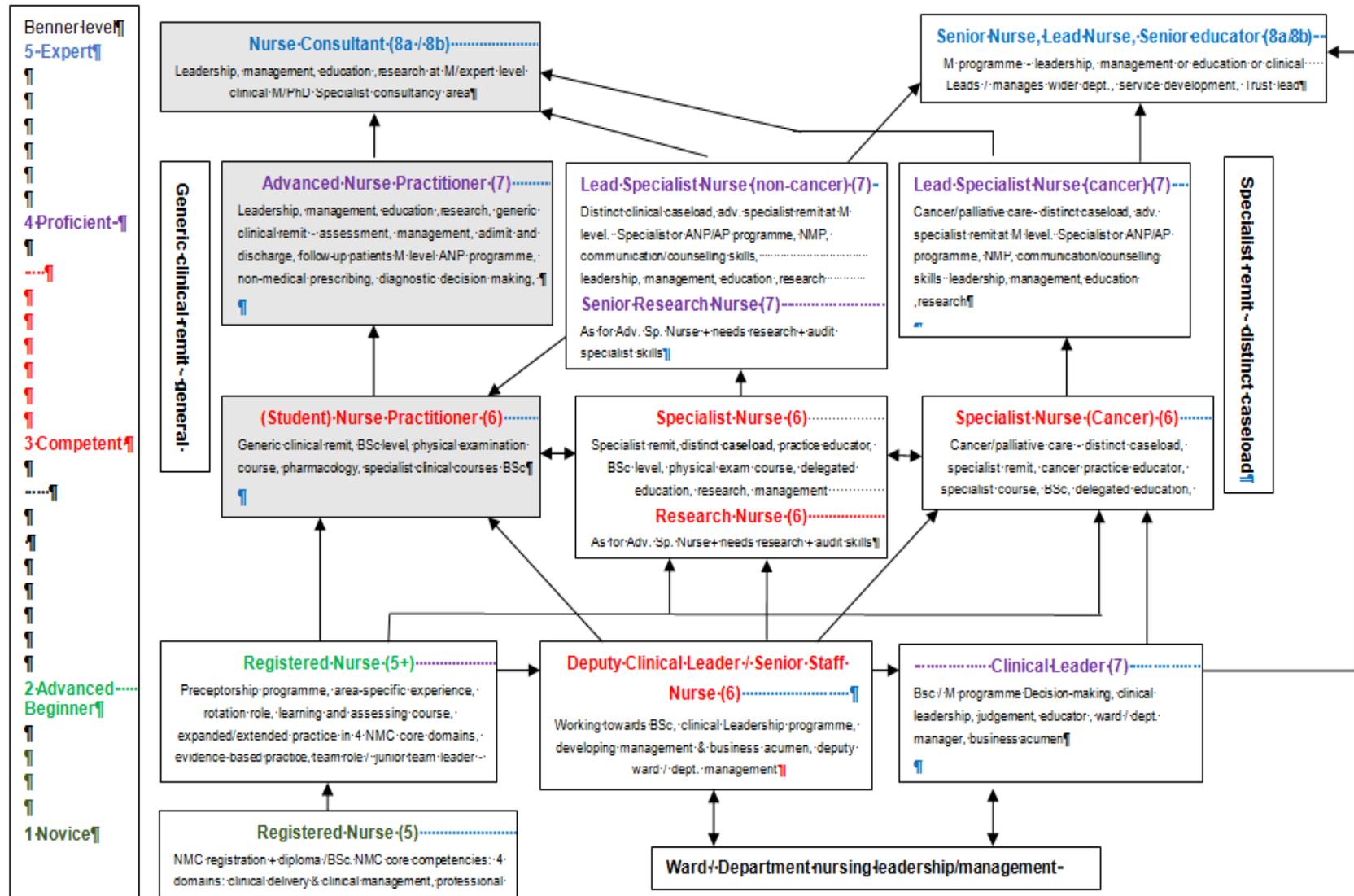
"During the first couple of years of my DProf, my sporting analogy took a leading role. However, as I approach progression, I am finding this is less important as I have a clearer sense of how I am travelling on my journey and can articulate this to others, as well. My original plan was to maintain the sporting analogy throughout the whole DProf, drawing on it to make sense of all elements. However, I have decided this is no longer necessary. This is a huge step forward for me and clear indication of my on-going development and comfortable place I feel I am in with my DProf" (2016).

## Appendix 2 Practice development projects 1 and 2

### Appendix 2.1 Practice Development Project 1 (PD 1): Specialised Nurse Review (SNR)



## Appendix 2.2 Advanced and specialist nursing framework from PD Project 1: SNR



## Appendix 2.3 PD Project 2: Advanced practice education curriculum development

### Extract from report on the advanced nursing education curriculum development undertaken as PD Project 2 - 2/10/2015

University's faculty of health and social sciences has been running academic programmes to prepare experienced registered nurses for professional clinical practice roles at an advanced level for twenty years. This started with Advanced Nurse Practitioner programmes, firstly at BSc (Hons) level and since 2002, at Masters level, which were accredited by the Royal College of Nursing.

The current Post-graduate diploma Advanced Nurse Practitioner was validated in 2013, when BSc (Hons) ANP programme was closed, in line with the consensus agreement that Advanced level practice should be at Masters level. The publication of a number of guidance documents for Advanced Practice, by the Department of Health (England) DH (2010), Wales (NILAH 2010) and Scotland (NES 2010), prompted BU to review its Advanced Nurse Practitioner programme and revalidation of the programme in 2013. This brought the whole programme in line with this national guidance and other International and National elements. The RCN accreditation was not continued as the national guidance documents provided a robust framework against which to benchmark the competencies, skills and knowledge to enable students to exit as safe and competent Advanced Nurse Practitioners professionally and with Masters level academic awards. In order to ensure the programme meets the benchmark criteria of the DH Advanced Level Nursing: a position statement (DH 2010), all units within the programme are core units. The only flexibility is in year 2, when students either opt to do independent and supplementary prescribing or the two identified alternative units. Despite this variability, the two elements mirror one another in terms of the majority of the contents and assessment. Since this revalidation in 2013, two cohorts of students have completed the post-graduate diploma Advanced Nurse Practitioner programme, which has been well-evaluated by the students themselves, academic staff and employers, from both an academic and a professional role perspective. Additionally, all of the units within the programme are currently offered as stand-alone units within the post-graduate CPD framework, with students either undertaking these single units or building units into other Masters programmes. Students who access these units come from across non-medical health care professions, including nurses, midwives, physiotherapy, occupational therapy, speech and language therapy, podiatry, paramedics and operating department practitioners.

Since inception back in the 1990's the programmes delivered have been extremely popular, attracting students from a wide geographical area, with employers seeing preparation of their staff as fit for purpose and practice as Advanced Nurse Practitioners. Currently students undertaking PGDiP Advanced Nurse Practitioner programme can exit at this point or can pursue their studies by enrolling on the top-up programme of MA Advanced Practice. This programme involves preparation for and implementation of a Service improvement project. This replaced the original more traditional dissertation, as it was felt that for practising ANPs, service improvement was a more suitable option, enabling them to demonstrate and practically apply advanced knowledge and skills within their own practice settings, relating to service delivery and improvement. A unique feature of the programme since its inception, is its generic nature, being relevant and attracting nurses working in all clinical areas, regardless of speciality or type of service provision. Students come from primary, secondary and intermediate care settings, emergency and planned hospital admission areas, continuing care for patients across the life span - from paediatric to elderly care, mental health and prison services.

## Appendix 2.4 Presentation to stakeholders on new education programme



**Development of  
Advanced Practice  
frameworks for the UK:  
Practice and Education**

Hilary Walsgrove (Programme leader PGDIP ANP BU)

www.bournemouth.ac.uk



### Challenges for Advanced Practice development in the UK

- Roles developed in an ad hoc manner
  - Quick fixes to skill shortages
  - No agreed definition or clear role descriptors
  - Numerous different titles
  - No agreed competencies or standardised education
  - Lack of a structured clinical career framework
  - Lack of workforce planning
- www.bournemouth.ac.uk



### What has helped overcome challenges?

- Government support for advanced practice in variety of documents
  - Professional support through Nursing and Midwifery Council and Royal College of Nursing, other professional bodies
  - Guidance from the Departments of Health for England, Wales, Scotland 2010
- www.bournemouth.ac.uk



### UK Advanced Practice standards

- RCN Advanced Nurse Practitioner competencies (2010)
  - NMC Advanced Nurse Practitioner definition (2005)
  - DH Advanced Level Nursing (2010)
  - Scottish Government Advanced Nursing Practice Roles: Guidance for NHS Boards (2010)
  - NLIA Framework for Advanced Nursing, Midwifery and Allied Health Professional Practice in Wales (2010)
- www.bournemouth.ac.uk



### Advanced Practice – framework and tools

- 4 pillars of Advanced Practice - Clinical, Research, Education and Management / Leadership.
  - Numerous appropriate definitions of Advanced Practice
  - Toolkits and frameworks used to promote use of appropriate competences to meet needs and nuances of roles, and to articulate principles in the form of the pillars of practice
- www.bournemouth.ac.uk



### Overview of proposed Advanced Nurse Practitioner programme development

Post-graduate diploma Advanced Nurse Practitioner  
All core units, DH (2010) Advanced Practice (Nursing) criteria used to benchmark

Year 1:  
Professional issues for Advanced Practice unit  
Advanced History taking and physical assessment unit  
Advanced Health Assessment and decision-making unit

Year 2:  
Independent and supplementary prescribing OR principles of disease processes and management of therapeutic interventions unit  
Advanced Practice portfolio unit

Top-up programme leading to MA Advanced Practice – Preparation for Service Improvement Project and Service Improvement Project units

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### Appendix 3 CASP and Crombie critical appraisal checklist

CASP checklist qualitative papers, case study - question responses										
Question	1	2	3	4	5	6	7	8	9	10
2.3	Y	Y	Y/?	N	N	Y	Y	Y	Y	Y
2.5	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2.6	Y	Y	Y	Y	Y	?	Y	Y	Y	Y
2.9	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2.10	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2.11	N	Y	Y	?	Y	Y	?	?	Y	Y
2.12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2.17	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2.18	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2.20	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2.21	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2.22	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
23/1	?	Y	Y	Y	Y	?	Y	Y	Y	Y
24/2	Y	Y	Y	Y	Y	Y	Y	?	Y	Y
25/4	Y	Y	Y	Y	Y	Y	Y	?	Y	Y/?
28/6 +LR	Y	Y	Y	Y	Y	Y	Y	Y	Y	?
35/13	Y	Y	Y	?	Y	Y	Y	?	Y	Y/?
37/15	Y	Y	Y	N	Y	?	Y	Y	Y	Y
Participatory action research & service evaluation (used qualitative checklist)										
Question	1	2	3	4	5	6	7	8	9	10
2.7	Y	PAR	Y	Y	Y	Y	Y	Y	Y	YY
2.16	Y	PAR	Y	Y	Y	Y	Y	Y	Y	YY
2.19	Y	SE	Y	Y	Y	Y	Y	Y	Y	Y
33/11	Y	SE	Y	Y	Y	Y	Y	Y	Y	YY
Systematic review, literature review, document review using CASP										
Question	1	2	3	4	5	6	7	8	9	10
2.4	Y	Y	Y/?	Y	Y	Y	Y?	Y	Y/?	Y/?
2.13	Y/?	Y/?	N	?	Y	Y?	?	Y	N	Y
2.14	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
25/3	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
27/5	Y	Y/?	N	Y	Y	Y?	Y	N	N	Y
28/6+qual	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
29/7	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
30/8	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
31/9	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
32/10	Y	Y	N	Y	Y	?	Y	Y	Y	Y
34/12	Y	Y	Y	Y	Y	Y	Y?	?	N	Y
38/16	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Survey, questionnaire when not part of qualitative study (adapted version of Crombie's critical appraisal tool - not all questions used)										
Question	1	2	3	4	5	6	7	9	11	12
2.8	Y	Y	Y	?	Y	Y	Y	Y	Y	Y
2.15	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RCT using CASP										
Question	1	2	3	4	5	6	7	8	9	10
2.1	Y	?	Y	Y/?	Y	Y	N/A	N/A	Y	?
2.2	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	Y
35/14	Y	Y	Y	Y	Y	Y	10/30	10/10	Y	N

## Appendix 4 Literature review tables

Author/s , title and journal	Methodology / methods, Limitations	Participants, location, setting	Themes
Stage 1 literature review- Historical and current context, definitions			
1.1 Brown, S.J., 1998, A framework for advanced nursing practice. Journal of professional nursing	literature review - no methodology presented - more of discussion paper not empirical data – but signpost to empirical papers reviewed.	USA Review research papers / lit. reviews aim to develop conceptual frameworks of Advanced nursing. Hospital community settings	Conceptual framework of Advanced nursing- wide scope of practice, incorporates patient management usually undertaken by Drs but with strong Nursing orientation, core values of nursing, respect for patients values Resolution of conditions, improved functional status, clinical outcomes equivalent physicians, higher patient satisfaction, compliance
1.2 Rolfe, G., and Phillips, L-M., 1997. The Development and evaluation of the role of an advanced nurse practitioner in dementia – an action research project. IJN	AR Project – 18 months develop new ANP role, evaluation. Small-scale, single setting, internal validity, not generalisability. Good- actual ANP experienced AR researcher. Appropriate methodology project - clear description	1 ANP and researcher developing role. Patients, carers, other healthcare professionals in unit. South England	Role developed based on specific needs of particular service, patients, carers. pioneering ANP as ' <i>forerunner</i> '. High patient satisfaction, service contribution, quick assessment, early intervention, easier accessibility, improved quality of care and quality of life, increased staff development, stronger MDT, enhancing role of nurse
1.3 Manley K. ,1997. A conceptual framework for advanced practice: an Action Research project operationalising an Advanced Practitioner / Consultant Nurse role JCN	3 year study Action Research - cycles - practice development, longevity AP / consultant nurse role development. Links role to its context and outcomes internal validity, not generalisable	Single Nursing Development Unit. Researcher worked in unit. Involved all team UK	Strong clinical leader, change agent, patient advocate, client-based practice 4 pillars - Expert practitioner, education, research, consultant - Conceptual framework - client-based practice, expert criteria in practice, based on Hamric model (1989) from USA client-based practice

1.4 Hicks, C., and Hennessy, D.,. 1998. A triangulation approach to the identification of acute sector nurses' training needs for formal nurse practitioner status JAN	Triangulation approach Questionnaire survey of nurses and their managers and Drs, with regards to practice and training NP roles	50 Advanced clinical nurses, 50 managers, 50 Doctors 1 Hospital Trust UK Purposive sample	Enhanced clinical role, referrals, advanced clinical and psychosocial assessment, decision-making about clinical problems, high level communication, manage risk Direct patient care primary focus	
Government / professional body documents set scene, context, support identification characteristics, framework/model of advanced nursing Evolutionary phase: RCN 1996 nurse practitioner competencies, updated 2002, 2008 –ANP RCN 2010. RCN guide ANP role, competencies and programme accreditation; National Organisation of Nurse Practitioner Faculties 1990; 2008; International Council of Nursing definition AN 2002, update 2011; NMC 2005, Development phase: NES 2010 Advanced nursing practice framework Scotland, NLIAH 2010 Welsh Advanced practice framework, DH 2010 Advanced level nursing: a position statement; UK - Definition nurse practitioner / advanced nurse practitioner; Patient assessment, decision-making, complexity. Welsh document –M level education. English – DH 2010 – level practice expected nurses working advanced level, direct patient care. 4 themes / pillars, criteria. grounded direct care. RCN domains – assessment, management patient health/illness, nurse patient relationship, professional role, education function, managing, negotiating healthcare delivery, monitoring, evaluating practice, respecting culture, diversity. Revised each stage to acknowledge developments ( <i>4 pillars</i> ) Masters-prepared nurse expert knowledge-base, complex decision-making skills and clinical competencies for expanded practice” 4 pillars –clinical practice, leadership, education, research.				
2nd stage literature review- papers 2011-2016				
Author/s and title and journal	Methodology / methods Limitations	Participant population	Experience, characteristics, framework, descriptions, interpretations. Contribution patient care, service delivery, impact, review, evaluation	Themes: C = Characteristics, M = model. Contribution = Con
2.1. Venning et al 2000 RCT comparing cost-effectiveness of GPs and Nurse Practitioners in primary Care British medical journal	RCT comparing cost-effectiveness GP and NP in primary care Quantitative data but need to understand why patient satisfaction higher	20 general practices England and Wales 1716 patients	Characteristics - Consultation	C consultation M - Doctor substitution primary care Con - Similar - cost-effectiveness. Consultation process, patient satisfaction, health status, return visits.
2.2. Kinnersely et al 2000 RCT of NP versus	Multicentre RCT to ascertain any differences between	10 General practices in South Wales and SW England, 1368 patients.	Characteristics - Resolution of symptoms, care, investigations, referrals,	C Resolution of symptoms, care, investigations, referrals, information-giving, same day consultation

<p>GP care for patients requesting “same day” consultations in primary care</p> <p>British medical journal</p>	<p>NPs and GPs consultations needs more qualitative approach to explore communication skills/information giving</p>		<p>information-giving, same day consultation</p>	<p>M - Doctor substitution primary care  Con - patient satisfaction, resolution symptoms and concerns, care, investigations, referrals, information.  Supports wider acceptance NPs same day consultations</p>
<p>2.3. Mick, D.J., and Ackerman, M.H., 2000. Advanced practice role delineation in acute and critical care: application of the Strong Model of Advanced Practice</p> <p>Heart and Lung</p>	<p>Differentiate roles CNS/ACNPs  Pilot study - test Strong Model previous developed by authors.  Descriptive, exploratory, questionnaire  Good use tested model.- confirmation through own research - conceptual framework, bias?</p>	<p>USA  N=18, USA  Expert panel of APNs and CNSs across 3 centres, numerous specialist areas  Purposive sample</p>	<p>characteristics - CNS and NP roles share similar attributes - differences noted in focus.  ANP - history taking, physical examination, diagnosing, diagnostic procedure performance  CNS - education, research, leadership  Models - Fits with Strong Model of AP - devised 1994  Ackerman et al -</p>	<p>C - history taking, physical examination, diagnosing, diagnostic procedure performance  M - Fits with Strong Model of AP in hospital setting</p>
<p>2.4.Horrocks et al 2002 Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors</p> <p>British medical Journal</p>	<p>Systematic review of RCTs and prospective observational studies  Superficial data – confirms requirement for greater depth of data of qualitative nature</p>	<p>Cochrane controlled trials register &amp; other databases, other forms search data  11 trials,23 observational studies.  based on 34 studies largely quantitative nature</p>	<p>Characteristics - consultations, investigations, prescribing, referrals.</p>	<p>C - Consultations, investigations, prescribing, referrals - equivalent care to doctors  M - Doctor substitution primary care  Con - Patients more satisfied with care nurse practitioners, no difference in health status, ANPs longer consultations, made more investigations. No differences in prescribing, return consultations, referrals. Quality of care in some ways better for NP consultations. Effectiveness ANPs – Consistently demonstrates high quality care and patient satisfaction.</p>

<p>2.5. Marsden et al 2003. Nurse Practitioner practice and deployment: electronic mail Delphi study Journal of Advanced Nursing</p>	<p>Delphi method email correspondence - part of larger DoH project NP education &amp; practice Draws on large-scale project, appropriate sample Valuable expert consensus data - Wide-ranging</p>	<p>24 expert Advanced practitioners UK. Purposive sample</p>	<p>characteristics - Autonomy, prescribing, NP deployment and practice and education.</p>	<p>C - Autonomy, prescribing, education M - clinical and education</p>
<p>2.6. Carnwell, R., Daly, W., 2003b. Advanced nurse practitioners in primary care settings: an exploration of the developing roles Journal of Clinical Nursing</p>	<p>Qualitative exploratory design incorporating a longitudinal element Interviews then follow-up interviews. good quality, volume of deep data, Good – 2 interviews, longitudinal approach, across settings</p>	<p>21 ANPs interviewed 15 follow-up interviews 15 months later W. Midlands, UK</p>	<p>Characteristics - Advanced assessments, diagnostic skills, strategic role, developments patient care level. Model - Career pathway along continuum to consultant nurse</p>	<p>C Advanced assessments, diagnostic skills, strategic role, developments patient care level M - Career pathway along continuum to consultant nurse. Primary care</p>
<p>2.7. Bryant-Lukosius, D., and DiCenso, A., 2004. A framework for the introduction and evaluation of advanced practice nursing roles. Journal of Advanced Nursing</p>	<p>Participatory action research - evidence-based, patient focus process APN role development Multiple participants different professions, patients. Single setting. Implement PEPPA framework AP - based on large body of APN research</p>	<p>Environmental stakeholders as participants - enabled shared goals of APN practice, APNs, Drs, patients Canada</p>	<p>Characteristics - addressing health needs through delivery of coordinated, collaborative relationships. Patient-centred approach, adapted to suit patient population involved Model - Framework for introduction and evaluation of APN roles - PEPPA - based on research</p>	<p>C collaborative relationships, addressing health needs M Patient-centred, PEPPA - based on research Con - addressing health needs through delivery of coordinated, collaborative relationships. Patient-centred approach, adapted to suit patient population involved</p>

<p>2.8. Ball, J., 2005. The results of a survey of Nurse Practitioners conducted on behalf of the RCN Nurse Practitioner Association Royal College of Nursing</p>	<p>Survey on behalf of RCN NP Association. Postal survey of NP roles. Large sample, superficial data, only RCN</p>	<p>N=1021 NP role respondents who belong to NP association UK</p>	<p>Characteristics - direct self-referrals, patients without diagnosis, make diagnosis, differential diagnoses, comprehensive history taking, physical exam, autonomous decision-making, assessment of health needs, referrals Model - Primary and secondary care NP model - clinically-focused roles. Post-holders degree or Masters (82% of sample)</p>	<p>C - direct self-referrals, patients without diagnosis, make diagnosis, differential diagnoses, comprehensive history taking, physical exam, autonomous decision-making, assessment health needs, referrals M -Primary and secondary care NP model - clinically-focused, degree Masters</p>
<p>2.9. Donnelly, G., 2006. The essence of advanced nursing practice. Journal of Advanced Nursing Practice</p>	<p>Hermeneutic phenomenology Open-ended interviews Depth of data - good quality, appropriate sample, details included - trustworthiness</p>	<p>Purposive sample of 8 APNs and CNSs with Masters degree in APN Canada</p>	<p>Clinical judgement, reasoning, holism - how APNs maintain nursing values, advocacy, nursing experience, Integration of theory and practice. Model - leader developing nursing practice, influence clinical, policy decisions, clinical developments - 3 themes characterise</p>	<p>Themes C Clinical reasoning, holism, advocacy M leaders in developing nursing practice, influence clinical and policy decisions, clinical developments - 3 themes characterise APN. Model - nursing values, perspectives ground APN (<i>4 pillars</i>).</p>
<p>2.10. Norris, T., and Melby, V., 2006. The acute care nurse practitioner: challenging existing boundaries of emergency nurses in the UK. Journal of clinical Nursing</p>	<p>Descriptive, exploratory design, Questionnaires, semi-structured interviews – opinions of Doctors and nurses</p>	<p>Questionnaires (n=98), interviews (n=6). Sample of nurses and doctors, 7 emerg depts. and MIU units in UK</p>	<p>Characteristics - Blurring of boundaries. Traditional advanced skills e.g. suturing. Autonomy of roles. Contribution - Need for advanced nurse practitioners</p>	<p>Themes C Traditional advanced skills e.g. suturing. Autonomy, Blurring boundaries M Blurring boundaries with doctors</p>
<p>2.11. Yeager et al. 2006. An acute care nurse practitioner model of care for</p>	<p>Descriptive paper of development of roles in 2 different institutions in 2</p>	<p>Ohio, USA</p>	<p>Characteristics - Mix of medical and nursing responsibilities. Care management of specific</p>	<p>Themes C Mix of medical and nursing responsibilities. Care management of specific populations e.g. neurosurgical clinical, . Discharge planning education, leadership</p>

neuro-surgical patients Critical Care Nurse  Critical Care Nurse	different states Not empirical 2 case studies of role profiles role development. Significant vol data - depth		populations e.g. neurosurgical clinical, . Discharge planning education, leadership and research roles Model - primary element = clinical bridge gap between nursing and medical.	and research roles M primary element = clinical bridge gap between nursing and medical ( <i>4 pillars</i> ) Con - Physical presence in unit. Collaboration nurses, MDT, doctors
2.12.. Gardner, G., Chang, A., Duffield, C., 2007. Making nursing work: breaking through the role confusion of advanced practice nursing Journal of Advanced Nursing	Interpretative qualitative study - In-depth interviews deductively analysed and tested against published AP nursing model, research-informed model developed	9 ANPs 3 acute hospitals Random, purposive sample Australia	Characteristics - High level autonomy, decision-making and clinical skills. Similar parameters to 4 pillars AP. Model - Operational model of service parameters and analysis framework of AP nursing role.	Themes C High level autonomy, decision-making and clinical skills. Similar parameters to 4 pillars AP. M Blending extended practice activities with standard nursing functions. conformed to Strong model of AP (Ackerman et al 1996) clinical care, education, research, leadership and support of systems ( <i>4 pillars</i> )
2.13. Sheer, B., B., and Wong, F.K., 2008. The development of advanced nursing practice globally. Journal of nursing scholarship	Data from documentary resources available in INP/APNN of International council of nurses by 2 experts in advanced nursing practice – conference publications, bulletins, network communications	Areas examined guided by key informant survey on ANP self-administered questionnaire 14 countries, 5 continents. Confirms development of advanced nursing practice as global trend to improve global health	Characteristics - Scope of practice = advanced health assessment, diagnosis, disease management, health education and promotion, referral ability, prescribing diagnostic procedures, medication and treatment plans, admission and discharge rights, patient caseload management, collaborative practice, evaluation of healthcare services	Themes C advanced health assessment, diagnosis, disease management, health education + promotion, referral, prescribing diagnostic procedures, medication and treatment plans, admission and discharge rights, patient caseload management, collaborative practice, evaluation of healthcare services  M Expanded scope of practice, higher level of practice than 'normal' level nurse
2.14. Duffield et al, 2009. Advanced nursing practice: a global perspective	Small-scale literature review	Review titles, roles scope of practice ICN ANP members	Characteristics - Commonalities - right to diagnose, prescribe, autonomous level in no. of	Themes C diagnosis, prescribing, autonomous M differences globally based on regulation

Collegian			practice settings. Differences globally - regulation, registration	status
2.15. Sandhu et al 2009. emergency nurse practitioners and doctors consulting with patients in and emergency department: a comparison of communication skills and satisfaction Emergency medicine journal	Comparison content of consultations & patient satisfaction - patient questionnaire & videotaped consultations, analysed using Roter interaction analysis system. Identified need further research re impact	296 consultations analysed and compared between ED ANPs and SHOs (n=10), Registrars (n=7), GP trainees (n=12) UK	Contribution - Outcome measures: length of consultation, relationship building, partnering, data gathering, patient education/counselling. No significant difference in consultation length. ENPs and GPs focused more on patient education/counselling	Themes C consultations, partnership with patient, patient education/counselling  M Merging of Doctor and nurse function
2.16. McNamara, S., et al. 2009. Development and implementation of the specialized NP role: Use of PEPPA framework Nursing and Health sciences	Service evaluation - test of PEPPA framework of AP (Bryant-Lukosius & DiCenso 2004)	Canada	Characteristics - multifaceted role - mostly direct patient care, clinical support, Partnership working, holistic approach, critical thinking, evidence-based practice, Education and research. Model - PEPPA framework of AP, Merging of nursing knowledge and Advanced practice ( <i>4 pillars</i> )	Themes C mostly direct patient care, clinical support, Partnership working, holistic approach, critical thinking, evidence-based practice, Education and research.  M PEPPA framework of AP, Merging of nursing knowledge and Advanced practice ( <i>4 pillars</i> )
2.17. Kucera et al. 2010. Advanced nursing practice: a futures model derived from narrative analysis of nurses' stories. Aus. Journal Adv Nursing	Narrative analysis of nurses' stories - exploring aspects of AP	59 APNs - mental health, child and family health, acute and aged care across Australia	Characteristics - Complex care situations, Assume responsibility for optimising care. Model - AP - multidimensional nature of AP, inherent complexity dynamism, Rescue, recognition, responsibility	Themes C Complex care situations, responsibility for optimising care M multidimensional nature of AP, inherent complexity and dynamism, Rescue, recognition, responsibility

<p>2.18. Gardner et al, 2010. The work of nurse practitioners</p> <p>Journal of Advanced Nursing</p>	<p>Work sampling methods - descriptive study</p> <p>Randomly-spaced observations of work activity with reference to an established set of work categories</p> <p>Data analysis using SPSS</p> <p>No comparative groups</p>	<p>Random sample 144 nurse practitioners, expressed interest.</p> <p>Purposive - heterogeneity</p> <p>N=30, observations unit of analysis = 12,189</p> <p>Australia</p>	<p>Characteristics - 30 work activities - in top 10 - physical assessment, history taking, patient interaction, documentation, performs procedures, Focus on direct patient care, teaching.</p> <p>Suggests high level of administration / indirect patient care activities - not seen in other countries' research</p> <p>Model - Blend of nursing and extended practice functions</p>	<p>Themes C physical assessment, history taking, patient interaction, documentation, performs procedures, Focus direct patient care, teaching. administration / indirect patient care activities</p> <p>M Blend of nursing and extended practice functions</p>
<p>2.19. Barton and Mashlan. 2011. An advanced nurse practitioner-led services: consequences of service redesign for managers and organizational infrastructure</p> <p>Journal of Nursing Management</p>	<p>Service review and evaluation of secondary care ANP-led service. Evaluated ANP team role in clinical setting</p> <p>Interviews, opinion data and latent content analysis.</p> <p>Theoretical sampling</p> <p>Single setting, internal validity</p>	<p>1 acute hospital based elderly care rehab service. ANP team UK. 38 professionals and non-professionals within rehab. Purposely selected</p>	<p>Characteristics - advanced assessment skills and knowledge.</p> <p>Model - Functional substitution service model.</p>	<p>Themes C advanced assessment skills and knowledge. autonomy, holistic, clinical expertise, patient management</p> <p>M Functional substitution service model</p> <p>C - Positive impact care delivery. Alternative clinical approach viewed positively. Consistency, continuity, reliability within autonomous clinical role, best qualities of nursing practice more efficient, more holistic, continuity clinical expertise, high standard of patient management</p>
<p>2.20. Fleming and Carberry. 2011. Steering a course towards advanced nurse practitioner: a critical care perspective</p> <p>British association of</p>	<p>Grounded theory and potentially develop explanatory theory associated with transition to ANP within ITU. Individually-focused interviews</p>	<p>25 participants, Scotland. 9 ANPs educational programme from 3 ITUs. 5 doctors, 5 critical care nurses, 3 nurse managers, 4 junior doctors, 3 nurse directors</p>	<p>Characteristics - share wide knowledge-base with nurses. Role model. Embraces medical / nursing expertise, working between teams.</p> <p>Model - synthesis of expert nursing practice with traditional medical values. Integrating previous expert</p>	<p>Themes C educate nurses, role model, medical/nursing expertise, MDT</p> <p>M synthesis expert nursing practice with traditional medically-orientated knowledge and skills - conceptual model</p> <p>Con - Things done more quickly, continuity. Benefits for patient care, service delivery, timely interventions, influencing patient outcomes positively, support nurses at</p>

critical care nurses			nursing knowledge with specific medically-orientated knowledge and skills, data-generated conceptual	bedside – unique contribution to care/service
2.21. Nieminen, A-L et al. 2011. Advanced Practice nurses' scope of practice: a qualitative study of advanced clinical competencies  Scandinavian journal of caring science	Description exploration ANP clinical competencies. Competency domains not clearly defined in Nordic countries. Qualitative approach. Analysis using inductive content analysis	Focus group interviews CNSs expert functions paed, internal medicine surgical units.(n=26), APN students (n=8). Finland	Characteristics - Autonomy. 5 main themes – assessment of patient care needs and nursing care activities, caring relationship. Multi-professional team working, leadership in a learning and caring culture, development of competence and nursing care	Themes C Autonomy - assessment patient care needs, nursing care activities, caring relationship. Multi-professional team working, leadership in learning and caring culture, development of competence and nursing care M 4 pillars
2.22. Fagerstrom L., and Glasberg, A-L., 2011. The first evaluation of the advanced practice nurse role in Finland - the perspectives of nurse leaders Jou. of nursing management	Exploratory study reviewing new ANP roles. Descriptive nurse leaders' experiences of ANP role. Qualitative, content analysis of data Multi-centre, appropriate sample for perspectives	Interviews 7 nurse leaders - managers of new post-holders across 7 organisations. 17 newly examined ANPs 1 year after graduation	Characteristics - Care of patients chronic and acute diseases - important resource, development of evidence-based nursing and improving availability of healthcare services for patients. Autonomous and independent roles.	Themes C Care of patients chronic and acute diseases - resource, development evidence-based nursing, improving availability healthcare services for patients. Autonomous independent roles. M (4 pillars) Con - Developed from patient needs and needs of organisation. Important for development of evidence-based nursing
2nd stage of literature review -papers 2012-2016				
23/1. Neville and Swift 2012 Measuring impact of the advanced	Case study design – suite of case studies - Sparse information re impact of AP roles	North West England.	Model - 400 roles introduced to improve quality of care and to reduce costs, increase capacity and extend range of	Themes C M Blend nursing and medical function Con - improve quality of care, reduce costs, increase capacity, extend range services

practitioner role: a practical approach Journal of nursing management			services available to patients and to reduce medical workload	available to patients, reduce medical workload
24/2.. Williamson et al 2012 an ethnographic study exploring the role of ward-based Advanced nurse practitioners in an acute medical setting Journal of Advanced nursing	Ethnographic study to explore ANP roles. Formal informal interviews semi-structured. Descriptive data. Non-participant observation Single-setting, range participants, detailed description	2 stage recruitment 5 ANPs medical ward, 14 ward nurses, 5 patients interviewed. 1 large acute hospital setting NW England	Characteristics - lynchpin, using expertise, networks and insider knowledge of healthcare to facilitate patient care, ward-based ANP, pioneering role, role model, quality holistic care Model - role more than just doctor substitution.	Themes C lynchpin, using expertise, networks, insider knowledge of healthcare to facilitate patient care, pioneering role, role model, quality holistic care M ward-based ANP facilitating nursing/medical practice - more than just doctor substitution Con ---. Pivotal role facilitating nursing / medical practice, facilitating patient journey, continuity care
25/3. Jokiniemi, K., Pietila, A-M, Kylma, J., Haatainen, K., 2012. Advanced Nursing Roles: a systematic review	To explore and describe APN roles in 3 countries – UK, USA, Australia. Systematic search, analysis inductive content analysis	Studies in systematic review – (n=42). – empirical research studies – qualitative and quantitative	Characteristics - Role domains and dimensions – dependent on context. Personal characteristics – strength, creativity, dynamics, adaptability, empathy. Similar roles – synthesised into APN role generally	Themes C Personal characteristics – strength, creativity, dynamics, adaptability, empathy M Synthesis of APN role generally - generic
26/4. Dalton 2013 perceptions of the advanced nurse practitioner role in a hospital setting  British journal of nursing	Qualitative cross-section design embedded in interpretative philosophy, phenomenological and grounded theory. Focus groups, interviews Single-setting, range of participants.	6 doctors, 6 nurses, 6 ANPs non-probability sample in 1 hospital. Not much qualitative data support experiences of ANPs, contribution to patient care.	Characteristics - Highly complex role, diverse, autonomous practice, role vagueness and ambiguity. Clinical and managerial leadership in out-of-hours. Decision-making for evidence-based therapeutic interventions, administer interventions, initiate treatments	Themes C, autonomous practice,. Clinical and managerial leadership in out-of-hours. Decision-making for evidence-based therapeutic interventions, administer interventions, initiate treatments M Highly complex role, diverse, role vagueness and ambiguity

<p>27/5. Donald et al 2013. A systematic review of the effectiveness of advanced practice nurses in long-term care</p> <p>Journal of Advanced nursing</p>	<p>Systematic review of quantitative studies – of effectiveness in meeting health needs of older adults through advanced practice nurse roles - Further exploration of range of issues</p>	<p>12 electronic databases and other data sources. 4 prospective studies in 15 papers.</p>	<p>Long-term care settings with APNs lower rates of depression, urinary incontinence, pressure ulcers, aggressive behaviours, increased satisfaction of family members</p>	<p>Themes C clinical long-term care M Con - Long-term care settings with APNs – lower rates of depression, urinary incontinence, pressure ulcers, aggressive behaviours, increased satisfaction of family members</p>
<p>28/6. Begley et al 2013. Differences between clinical specialist and advanced practitioner clinical practice, leadership and research roles, responsibilities and perceived outcomes (the SCAPE study)</p> <p>Journal of Advanced nursing</p>	<p>Mixed method approach – comparing roles. Literature review, focus group interviews with key stakeholders, Delphi and evaluative studies SCAPE study of Clinical nurse, midwife specialist, advanced nurse, midwife practitioner</p>	<p>Ireland Advanced and specialist nurses and midwives – 23 case studies of ANPs/CSs from 13 sites across each region of Ireland from 2008-2010</p>	<p>Advanced practitioners give a higher level of care, particularly at strategic level. Improved clinical practice and service delivery, greater clinical and professional leadership, increased research</p>	<p>Themes C direct patient care, emotional support, leadership, research M (4 pillars) Con Satisfaction with physical care, emotional support for service users greater for APs</p>
<p>29/7. Dowling, M., Beauchesne, M., Farrelly, F., Murphy, K., 2013. Advanced Practice nursing: A concept analysis International journal of Nursing Practice</p>	<p>Concept analysis from data on electronic databases using Rodger's evolutionary method. To describe concept of advanced practice nursing roles internationally</p>	<p>Used range of literature including dissertation abstracts and nursing texts and professional organization websites</p>	<p>Characteristics - Attributes of advanced practice nurses. Leadership and autonomy considered central to effective performance of advanced practice role.</p>	<p>Themes C leadership, autonomy, clinical M (4 pillars)</p>

<p>30/8. Ramis et al 2013 experiences of being advanced practice nurses within Australian acute care settings: a systematic review of qualitative evidence International Journal evidence-based healthcare</p>	<p>Systematic review different countries. deeper understanding role in its defined context 1990-2011 Lived experience described population voices of nurses to be heard, positive, negative</p>	<p>3 published studies, 1 unpublished dissertation. 216 findings into 18 categories of nurses reported working at advanced level</p>	<p>Expert level of knowledge</p>	<p>Themes C Expert level of knowledge, clinical M (4 pillars)</p>
<p>31/9. Jennings et al 2014. The impact of nurse practitioner services on cost, quality of care, satisfaction and waiting times in the emergency department: a systematic review. International journal of nursing studies</p>	<p>Systematic review and narrative analysis and synthesis of studies. Delivery of quality of care in ED</p>	<p>4 electronic databases 2006-2013, 2 reviewers, 14 papers for appraisal. 2 quasi-RCTs, 10 observe, descriptive design studies, retrospective audits case control, case series</p>	<p>ENPs - positive impact quality of care, patient satisfaction, waiting times McClellan et al 2013 – cost-effectiveness, Dinh et al 2012 – quality of care, Effectiveness – Colligan et al 2011</p>	<p>Themes C Con positive impact quality of care, patient satisfaction, waiting times McClellan et al 2013 – cost-effectiveness, Dinh et al 2012 – quality of care, Effectiveness – Colligan et al 2011</p>
<p>32/10. O’Connell, J., Gardner, G., and Coyer, F., 2014. Beyond competencies: using a capability framework in developing practice standards for advanced practice nursing. Journal of Advanced nursing</p>	<p>Discussion paper – systematic search of data from electronic databases Wide range of papers, not empirical research but enabled signposting to original research to review</p>	<p>Australia and new Zealand, data applicable generally across advanced nursing practice</p>	<p>Characteristics - - complexity – necessitates move procedural competency approach to educational framework reflective functional knowledge, such as capability. Capability builds on existing competencies as a continuum. Core generic competencies informed by capability framework. Advanced level nursing – can</p>	<p>Themes C complexity, apply competence in unfamiliar and familiar situations. Reflexive interpretation of knowledge and skills M– Capability as a framework for advanced nursing practice standards.</p>

			apply competence in unfamiliar and familiar situations. Reflexive interpretation of knowledge and skills. Model - Capability as framework advanced nursing practice standards. practice nursing	
33/11. Jackson, A and Carberry, M., 2014. The advanced nurse practitioner in critical care: a workload analysis	Service evaluation data collection form to capture clinically- and patient-related activities of post-holders. To explore specific tasks and scope of workload of ANPs. Analysis using descriptive statistics	9 ANPs in 1 critical care centre in Glasgow – newly created posts, UK – 1 week's data from post-holders. Limitations – 1 centre, only new post, interpretation activities post-holders self-report	Characteristics - 46% weekly workload – patient ward round and activities associated with this. 12% weekly workload – independent patient assessment traditionally performed by trainee anaesthetists. Mainly assessment and prescribing. Broad nature required prescribing Model - Specific roles traditionally associated with medical staff.	Themes C patient ward round and associated workload, independent patient assessment, prescribing M Specific roles traditionally associated with medical staff.
34/12. Hutchinson, M., East, L., Stasa, H., 2014. Delivering consensus on the characteristics of advanced practice nursing: meta-summary of more than 2 decades of research  Nurse researcher	To investigate essential features, differences various categories advanced practice nurses, to derive integrative description of defining characteristics, meta-summary of existing literature, systematic review. Limitations – small	50 manuscripts met inclusion criteria. Data – surveys, small samples, behaviour and task description questionnaires focused on role perceptions and time spent on tasks. Less common are qualitative interviews, self-reflective inquiry, focus group studies, case reviews	Characteristics - 7 domains of advanced nursing practice. Autonomous or nurse-led extended clinical practice, improving systems of care, developing practice of others, developing/delivering education and activities, nursing research/scholarship, leadership external to organisation, administering programmes, budgets, personnel.	Themes C Autonomous, extended clinical practice, education, research/scholarship, improving practice, management function M (4 pillars) consistency of model

	sample size, low quality studies that lacked validity and reliability. small amount of data reported		Model - Domains similar across categories of APNs – suggests more consistency across categories than previously thought. Attention on capturing frameworks. (4 pillars)	
35/13. 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 Journal of advanced Nursing	To report secondary analysis of data collected from case study phase of SCAPE national study (see above), doesn't draw out experiential aspects of ANPs and contribution to care	Non-participant observation APs (n=92 hours), interviews clinicians (n=21), patients (n=20), directornursing/midwifery (n=13) and documents	Characteristics - Makes visible leadership contribution of APs Leadership, capacity and capability building of MDT	Themes C leadership, education, clinical practice based on evidence M (4 pillars) Con - measures of esteem, new initiatives for clinical practice and care delivery,.Provides evidence of leadership outcomes. Makes visible leadership contribution.
36/14. Jennings et al 2015. Evaluating emergency nurse practitioner service effectiveness on achieving timely analgesia: A pragmatic RCT  Academic emergency medicine	RCT comparing NP and standard medical practice impact of ENP on care delivery needs to be evaluated through further research	Major hospital in Australia 260 patients randomised ED patients	patients presenting with pain – outcome measure – time to analgesia, time to analgesia from presentation documentation changes pain scores. Narrative findings from review - ENP services impact patient satisfaction and waiting times positively. Nurse practitioner and service effectiveness through superior performance in timely analgesia	Themes C M Con - ENP services impact patient satisfaction and waiting times positively. Nurse practitioner service effectiveness through superior performance in achieving timely analgesia for ED patients
37/15. McDonnell et al 2015 An evaluation of the implementation of	Collective case study evaluate impact implementing ANP on patients, staff	District general hospital in North England. 2011-2012. Strategic stakeholders n=13,	Ward-based ANPs, education of staff, team leadership, service development	Themes C Ward-based ANP, education, leadership, service development M - (4 pillars) Con - positive impact on patient experiences,

<p>Advanced nurse practitioner roles in an acute hospital setting</p> <p>Journal of advanced nursing</p>	<p>organizational outcomes. interviews, non-participant observation of practice</p> <p>Little known about impact of ANPs on patients, staff and organizations. Further research needed</p>	<p>followed by 3 individual case studies – medicine, orthopaedics, surgery, interviews n=32</p>		<p>outcomes and safety. Improved staff knowledge &amp; skills, competencies, enhanced quality working life, distribution workload and team-working. ANPs contribute organizational priorities targets policy development</p>
<p>38/16. Martin-Misener et al 2015. Cost-effectiveness of nurse practitioners in primary and specialised ambulatory care: a systematic review</p>	<p>Systematic review of RCTs to determine cost-effectiveness of nurse practitioners delivering primary and specialised ambulatory care</p> <p>3 trials – narrow scope</p>	<p>RCTs evaluated nurse practitioners in alternative and complementary care roles and reported health system outcomes</p> <p>11 trials</p>	<p>NPs equivalent to better outcomes than comparators and potentially cost-saving.</p>	<p>Themes C M Con - NPs have equivalent to better outcomes than comparators and are potentially cost-saving</p>

## Appendix 4.1 Themes - characteristics, models, contribution

2nd stage of literature review 2000-2011 and 2012-2016 and added 1st stage of literature review

Themes - related to characteristics, models, contribution	Categorised themes personal characteristics, 4 pillars of advanced practice
<p>Characteristics</p> <p>1.1 clinical, clinical reasoning, not in rigid protocols, holistic, autonomy, accountability. Leadership - systems management, broad remit</p> <p>1.2 independent, professional autonomy clinical decisions, plan manage care, advancing clinical practice. Strategic level role, work with other agencies; researcher, education role, Service lead/manager for defined caseload</p> <p>1.3 strong clinical leader, change agent, patient advocate, client-based practice</p> <p>1.4 Enhanced clinical role, referrals, advanced clinical and psychosocial assessment, decision-making about clinical problems, high level communication</p> <p>2.1 consultation - medical model</p> <p>2.2 Resolution of symptoms, care, investigations, referrals, information-giving, same day consultation</p> <p>2.3 history taking, physical examination, diagnosing, diagnostic procedure performance</p> <p>2.4 Consultations, investigations, prescribing, referrals - equivalent care to doctors</p> <p>2.5 Autonomy, prescribing, education</p> <p>2.6 Advanced assessments, diagnostic skills, strategic role, developments patient care</p> <p>2.7 collaborative relationships, addressing health needs</p> <p>2.8 direct self-referrals, patients no diagnosis, diagnose, differential diagnoses, comprehensive history taking, physical exam, autonomous decision-making, assessment health needs, referrals</p> <p>2.9 Clinical reasoning, holism, advocacy</p> <p>2.10 Traditional advanced skills e.g. suturing. Autonomy,</p>	<p>Personal characteristics – strength, creativity, dynamics, adaptability, empathy</p> <p>Similar parameters to 4 pillars AP. administration / indirect patient care activities. role model, lynchpin, pioneering role, role model, high level communication, collaborative relationships, collaborative practice, partnership with patient, Partnership working, patient interaction, MDT, caring relationship, Multi-professional team working, Advocacy, patient advocate, emotional support</p> <p>autonomy, professional autonomy, Autonomy, autonomous decision-making, Autonomy, High level autonomy, Autonomy, Autonomous, autonomous practice, equivalent care to doctors, medical/nursing expertise, Complex care situations, using expertise, Mix of medical and nursing responsibilities, Blurring boundaries, Expert level of knowledge, Reflexive interpretation of knowledge, skills, accountability, Clinical pillar</p> <p>responsibility optimising care, independent, independent roles, holistic, holistic, holism, holistic approach, quality holistic care, independent patient assessment</p> <p>advancing clinical practice, apply competence in unfamiliar and familiar situations, Resolution of symptoms, care, investigations, referrals, extended clinical practice, clinical expertise, Traditional advanced skills e.g. suturing, advanced health assessment, diagnostic procedure performance, Clinical reasoning, clinical reasoning, not in rigid protocols, decision-making, critical thinking, Decision-making for evidence-based therapeutic interventions, diagnosing, based on evidence</p> <p>Leadership pillar</p> <p>leadership . leadership, leadership Leadership - systems management, broad remit. leadership in learning and caring culture. leadership, service development Strategic level role, work with other agencies. evaluationhealthcare services; improving practice, management function</p> <p>Service lead/manager defined caseload . Service lead/manager for defined caseload strong clinical leader, change agent. strategic role, developments patient care level improving availability healthcare services for patients. , insider knowledge of healthcare to facilitate patient care; , networks. managerial leadership in out-of-hours</p> <p>Research pillar</p>

<p>Blurring boundaries</p> <p>2.11 Mix of medical and nursing responsibilities. Care management specific populations e.g. neurosurgical clinical, . Discharge planning education, leadership and research</p> <p>2.12 High level autonomy, decision-making clinical skills. Similar parameters 4 pillars</p> <p>2.13 advanced health assessment, diagnosis, disease management, health education + promotion, referral, prescribing diagnostic procedures, medication and treatment plans, admission and discharge rights, patient caseload management, collaborative practice, evaluation of healthcare services</p> <p>2.14 diagnosis, prescribing, autonomous</p> <p>2.15 consultations, partnership with patient, patient education/counselling</p> <p>2.16 mostly direct patient care, clinical support, Partnership working, holistic approach, critical thinking, evidence-based practice, Education and research</p> <p>2.17 Complex care situations, responsibility for optimising care</p> <p>2.18 physical assessment, history taking, patient interaction, documentation, performs procedures, Focus direct patient care, teaching, administration / indirect patient care</p> <p>2.19 advanced assessment skills and knowledge. autonomy, holistic, clinical expertise, patient management</p> <p>2.20 educate nurses, role model, medical/nursing expertise, MDT</p> <p>2.21 Autonomy - assessment patient care needs, nursing care activities, caring relationship. Multi-professional team working, leadership in learning and caring culture, development of competence and nursing care</p> <p>2.22 Care of patients chronic and acute diseases - resource, development evidence-based nursing, improving availability healthcare services for patients. Autonomous independent roles.</p> <p>23/1 nil; 31/9 nil; 38/16 nil</p>	<p>research , research, researcher, research roles, research/scholarship, evidence-based practice, development evidence-based nursing</p> <p>Education pillar</p> <p>Education , education, education, , education, education, education, education role, educate nurses, development of competence and nursing care, teaching, information-giving, patient education/counselling, health education + promotion, resource</p>
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<p>24/2 lynchpin, using expertise, networks, insider knowledge of healthcare to facilitate patient care, pioneering role, role model, quality holistic care</p> <p>25/3 Personal characteristics – strength, creativity, dynamics, adaptability, empathy</p> <p>26/4 autonomous practice,. Clinical and managerial leadership in out-of-hours. Decision-making for evidence-based therapeutic interventions, administer interventions, initiate treatments</p> <p>27/5 clinical long-term care</p> <p>28/6 direct patient care, emotional support, leadership, research</p> <p>29/7 leadership, autonomy, clinical</p> <p>30/8 Expert level of knowledge, clinical</p> <p>32/10 complexity, apply competence in unfamiliar and familiar situations. Reflexive interpretation of knowledge and skills</p> <p>33/11 patient ward round and associated workload, independent patient assessment, prescribing</p> <p>34/12 Autonomous, extended clinical practice, education, research/scholarship, improving practice, management function</p> <p>35/13 leadership, education, clinical practice based on evidence</p> <p>36/14 pain management role</p> <p>37/15 Ward-based ANP, education, leadership, service development</p>	
<p>Model</p> <p>1.1 Conceptual framework of Advanced nursing- wide scope of practice, incorporates patient management usually undertaken by Drs but with strong Nursing orientation, core values of nursing, respect for patients values</p> <p>1.2 (4 Pillars) Role developed based on specific needs of particular service, patients, carers. pioneering ANP as 'forerunner'</p> <p>1.3 ( 4 pillars) Expert practitioner, education, research,</p>	<p>Medical and nursing model</p> <p>incorporates patient management usually undertaken by Drs but strong Nursing orientation, primary element = clinical bridge gap between nursing and medical ward-based ANP facilitating nursing/medical practice - more than doctor substitution</p> <p>Patient-centred, PEPPA - based on research, PEPPA framework of AP, Merging of nursing knowledge and Advanced practice</p> <p>Blending extended practice with standard nursing functions. conformed Strong model of AP (Ackerman et al 1996), Fits with Strong Model of AP in hospital setting</p>

<p>consultant - Conceptual framework - client-based practice, expert criteria in practice</p> <p>ward-based ANP facilitating nursing/medical practice - more than just doctor substitution</p> <p>1.4 Direct patient care primary focus</p> <p>RCN, DH Docs - (4 pillars) 4 pillars – clinical practice, leadership, education, research. range underpinning principles – autonomous practice, critical thinking, high levels of decision-making, problem-solving, values-based care, improving practice. ICN - Masters-prepared nurse with an expert knowledge-base, complex decision-making skills and clinical competencies for expanded practice</p> <p>2.1 Doctor substitution primary care; 2.2 Doctor substitution primary care</p> <p>2.3 Fits with Strong Model of AP in hospital setting; 2.4 Doctor substitution primary care</p> <p>2.5 clinical and education; 2.6 Career pathway along continuum to consultant nurse. Primary care; 2.7 Patient-centred, PEPPA - based on research</p> <p>2.8 Primary and secondary care NP model - clinically-focused roles, degree or Masters</p> <p>2.9 leaders in developing nursing practice, influence clinical and policy decisions, clinical developments - 3 themes characterise APN. Model - nursing values, perspectives ground APN (4 pillars). ; 2.10 Blurring boundaries with doctors</p> <p>2.11 primary element = clinical bridge gap between nursing and medical (4 pillars)</p> <p>2.12 Blending extended practice with standard nursing functions. conformed Strong model of AP (Ackerman et al 1996) clinical care, education, research, leadership and support of systems (4 pillars); 2.13 Expanded scope of practice, higher level of practice than 'normal' level nurse; 2.14 differences globally based on regulation status</p> <p>2.15 Merging of Doctor and nurse function; 2.16 PEPPA framework of AP, Merging of nursing knowledge and Advanced practice (4 pillars); 2.17 multidimensional nature of</p>	<p>Merging of Doctor and nurse function, Blurring boundaries with doctors, Blend of nursing and extended practice functions, synthesis expert nursing practice with traditional medically-orientated knowledge and skills - conceptual model, Blend nursing and medical function</p> <p>ward-based ANP facilitating nursing/medical practice - more than doctor substitution</p> <p>ED ANP working same standard as doctor - suggests same practice elements</p> <p>ANPs primary care alternative, complementary roles, comparison doctor practice</p> <p>Doctor substitution model</p> <p>Functional substitution service model</p> <p>Doctor substitution primary care, Doctor substitution primary care, Doctor substitution primary care, Specific roles traditionally associated with medical staff</p> <p>Model - 4 pillars of advanced practice and overarching conceptual model</p> <p>Conceptual framework of Advanced nursing- wide scope of practice, Expanded scope of practice, higher level of practice than 'normal' level nurse</p> <p>acute care ANP with expert level of knowledge, Synthesis APN role generally - generic</p> <p>Direct patient care primary focus</p> <p>RCN, DH Docs range underpinning principles – autonomous practice, critical thinking, high levels of decision-making, problem-solving, values-based care, improving practice. ICN - Masters-prepared nurse with an expert knowledge-base, complex decision-making skills and clinical competencies inherent complexity and dynamism, Rescue, recognition, responsibility, complex role, diverse, role vagueness, ambiguity</p> <p>Long-term care settings with APNs</p> <p>Capability as a framework for advanced nursing practice standards</p> <p>Career pathway along continuum to consultant nurse. Primary care differences globally based on regulation status</p> <p>clinical and education, 4 pillars – clinical practice, leadership, education, research. (4 pillars). (4 pillars) consistency of model</p> <p>Nursing values-based model</p> <p>leaders in developing nursing practice, influence clinical and policy decisions, clinical developments - 3 themes characterise APN. Model - nursing values, perspectives ground APN</p>
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AP, inherent complexity and dynamism, Rescue, recognition, responsibility

2.18 Blend of nursing and extended practice functions; 2.19 Functional substitution service model; 2.20 synthesis expert nursing practice with traditional medically-orientated knowledge and skills - conceptual model

2.21 4 pillars; 2.22 (4 pillars); 23/1 Blend nursing and medical function

24/2 ward-based ANP facilitating nursing/medical practice - more than just doctor substitution; 25/3 Synthesis of APN role generally - generic

28/6 (4 pillars); 29/7 (4 pillars); 30/8 (4 pillars)

31/9 acute care ANP with expert level of knowledge

32/10 Capability as a framework for advanced nursing practice standards

33/11 Specific roles traditionally associated with medical staff

34/12 (4 pillars) consistency of model; 35/13 (4 pillars) ;

37/15 (4 pillars)

36/14 ED ANP working to same standard as doctor - suggests same practice elements

38/16 ANPs primary care alternative complementary roles - comparison doctor practice

**Themes related to Contribution**

1.1 resolution of conditions, improved functional status, clinical outcomes equivalent to physicians, higher patient satisfaction and compliance

1.2 High patient satisfaction, service contribution, quick assessment, early intervention, easier accessibility, improved quality of care and quality of life, increased staff development, stronger MDT, enhancing role of nurse

1.3 client-based practice; 1.4 manage risk

2.1 Similar - cost-effectiveness. Consultation process, patient satisfaction, health status, return visits - compared with GPs

2.2 patient satisfaction, resolution symptoms and concerns, care, investigations, referrals, information. Supports wider acceptance NPs same day consultations

2.3 *nil*; 2.4 Patients more satisfied with care nurse

2.5 *nil*; 2.6 *nil*; 2.7 addressing health needs through delivery of coordinated, collaborative relationships. Patient-centred approach, adapted to suit patient population involved

2.8 *nil*; 2.9 *nil*; 2.10 *nil*

2.11 Physical presence in unit. Collaboration nurses, MDT, doctors

2.12 *nil*; 2.13 *nil*; 2.14 *nil*; 2.15 *nil*; 2.16 *nil*; 2.17 *nil*; 2.18 *nil*

2.19 Positive impact care delivery. Alternative clinical approach viewed positively. Consistency, continuity, reliability in autonomous clinical role, best qualities of nursing practice more efficient, more holistic, continuity of clinical expertise, high standard of patient management

2.20 Things done more quickly, continuity. Tangible benefits for patient care, service delivery, timely interventions, influencing patient outcomes positively, support nurses at bedside – unique contribution to care/service

2.21 *nil* 2.22 Developed from patient needs and needs of organisation. Important for development of evidence-based nursing

23/1 improve quality care, reduce costs, increase capacity, extend range of services to patients, reduce medical workload

resolution of conditions, improved functional status, clinical outcomes equivalent to physicians, quick assessment, early intervention, resolution symptoms and concerns, care, investigations, referrals, high standard of patient management. Long-term care settings with APNs – lower rates of depression, urinary incontinence, pressure ulcers, aggressive behaviours, increased satisfaction of family members. Satisfaction with physical care

Similar - cost-effectiveness. Consultation, health status, return visits - compared with GPs, Supports wider acceptance NPs same day consultations, NPs have equivalent to better outcomes than comparators and are potentially cost-saving, reduce costs, increase capacity, extend range of services available to patients, reduce medical workload, manage risk, ENP services impact and waiting times positively. Nurse practitioner effectiveness service effectiveness demonstrated through superior performance in achieving timely analgesia for ED patients, positive impact on patient experiences, outcomes and safety.

High patient satisfaction, patient satisfaction, patient satisfaction, Patients more satisfied with care nurse, Alternative clinical approach viewed positively. Information, client-based practice, addressing health needs through delivery of coordinated, collaborative relationships. Patient-centred approach, improved quality of care and quality of life, Positive impact care delivery. Developed from patient needs and needs of organisation, improve quality of care, emotional support for service users greater for APs

service contribution, accessibility, adapted to suit patient population. Physical presence in unit. Collaboration nurses, MDT, doctors, Consistency, continuity, reliability in autonomous clinical role, best qualities of nursing practice more efficient, more holistic, continuity of clinical expertise, Things done more quickly, continuity. Tangible benefits for patient care, service delivery, timely interventions, influencing patient outcomes positively, support nurses at bedside – unique contribution to care/service. Pivotal role facilitating nursing / medical practice, facilitating patient journey, continuity care, ANPs contribute organizational priorities targets policy development, positive impact quality of care, patient satisfaction, waiting times - McClellan et al 2013 – cost-effectiveness, Dinh et al 2012 – quality of care, Effectiveness – Colligan et al 2011

increased staff development, stronger MDT, enhancing role of nurse. Important for development of evidence-based nursing, measures of esteem, new initiatives for clinical practice and care delivery,. Provides evidence of leadership outcomes. Makes visible leadership contribution. Improved staff knowledge & skills, competencies, enhanced quality

<p>24/2 Pivotal role facilitating nursing / medical practice, facilitating patient journey, continuity care  25/3 <i>nil</i>; 26/4 <i>nil</i>; 29/7 <i>nil</i>; 30/8 <i>nil</i>  27/5 Long-term care settings with APNs – lower rates depression, urinary incontinence, pressure ulcers, aggressive behaviours, increased satisfaction Family members  28/6 Satisfaction with physical care, emotional support for service users greater for APs  31/9 positive impact quality of care, patient satisfaction, waiting times McClellan et al 2013 cost-effectiveness, Dinh et al 2012 quality of care, Effectiveness – Colligan et al  32/10 <i>nil</i>; 33/11 <i>nil</i>; 34/12 <i>nil</i>  35/13 measures of esteem, new initiatives for clinical practice and care delivery,. Provides evidence of leadership outcomes. Makes visible leadership contribution  36/14 ENP services impact patient satisfaction and waiting times positively. Nurse practitioner effectiveness service effectiveness demonstrated through superior performance in achieving timely analgesia for ED patients  37/15 positive impact on patient experiences, outcomes and safety. Improved staff knowledge &amp; skills, competencies, enhanced quality working life, distribution workload and team-working. ANPs contribute organizational priorities targets policy development  38/16 NPs have equivalent to better outcomes that comparators potentially cost-saving</p>	<p>working life, distribution workload and team-working.</p>
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## **Appendix 5 Researcher diary extracts**

2012: **Grounded Theory 2 day workshop.** Good to network with other PhD students and share ideas and thoughts. I had gone along assuming I would be the 'thick one' but was pleasantly surprised to feel that I wasn't! This helped me start considering what research methods I could use.

**2012 PD1; SNR – not missing opportunity to explore subject matter in more depth:** I felt I wanted to enhance service development aspects of PD 1: SNR, give it a deeper and more qualitative feel. As a PD project, the review and evaluation and action plans realised as a result, were successful and achieved what was required for the hospital. But, personally and professionally, I felt this was too great an opportunity to miss, in looking in depth at the advanced nurses within the local context. I felt my responsibilities were twofold, 1) disseminating project by writing detailed account of project that could be shared widely. This would comprise a report written as article for publication. 2) to take evaluative and development work to deeper level by utilising a different methodological approach. This would provide opportunity to explore in depth more qualitative aspects related to participants, through a distinct research study. I felt I had responsibility as a lead nurse, ANP and educator, to undertake research that would add to the body of knowledge of nursing and more specifically, advanced nursing. I needed to share this expertise and my experience by adding a research strand to my professional practice role. PD1 was a large-scale, locally-based project, which generated vast amounts of data and there was potential to take elements and work in greater depth with these. This was an exciting prospect as I could decide what to concentrate on that would be valuable for advanced nursing; useful for nurses, service and education providers locally; but relevant to other advancing and advanced nurses, employers, educators elsewhere.

**2013 Reflecting on PD1 and my advanced nursing immersion:** I spent time reflecting on the project, considering what evaluative work had been done and developments realised. I read research reports and literature related to the subject, to get an up-to-date perspective. I needed a more recent feel for things. What emerged was a desire to find out more about the real substance of these advanced nurses, (not just a list of roles and responsibilities) and what contribution they make to patient care and service delivery. My experience, expertise and immersion in the practice and educational settings gave me broad, anecdotal evidence of positive impact of these

roles. I was also open to be challenged by anecdotal evidence as I worked through my research. Keeping an open-mind as I undertake interviews may uncover some negative impact aspects of the roles. I don't approach this with rose-tinted glasses that advanced nursing is the only option. My immersion in this world keeps me grounded in reality of challenging aspects of practice and when advanced nursing may not be the answer. I can think of incidences when such roles have been replaced by another model of care or patients have expressed dissatisfaction in care and treatment received by advanced nurses.

**2013 Research methodology selection:** Positive impact, anecdotally and within the local context and my experience of other advanced nursing exemplars that I come into contact with elsewhere, was lending itself to qualitative research,. However, lack of research knowledge and skills, at this stage, was stopping me have a clear idea of an appropriate methodology. I attended a number of useful research workshops and read around approaches and methodologies.

**2013/14 Research proposal:** Having thought I would undertake 10-12 interviews , I realise this is ambitious, and I am targeting quite a homogenous group, so may not benefit from so many. I now realise there were flaws in my research proposal and my lack of knowledge in relation to phenomenology was apparent. Although ethics approval submission was successful and I was able to progress..

**2014 Progressing IPA research study:** In some ways it was a good exercise to scrutinise my research proposal again as I realise now (a year down the line) how far I have progressed in my knowledge around this approach and how I have now been able to refine my understanding and moved further forward, in deciding Interpretative Phenomenological Analysis (IPA), as a methodology, will fit what I really want to explore. Also, I realise I need to focus and reduce the subject matter, as this needs to be a small-scale project, and won't be possible to undertake to any great depth, if I don't focus it down and keep it small-scale and really tightly under control. All of this has been enormously helped by attendance at group sessions and advice and guidance from programme leader, student colleagues, and supervisors who have experience and knowledge of phenomenology and advanced nurses. An extremely useful 2 day IPA workshop - I am even more determined that this is exactly the right approach and I am really keen now to move forward. I reflected-in-action throughout the 2 days and it confirmed for me that this was exactly right for this project. The

workshop was superb and although a novice researcher and even more novice in IPA, I learnt a huge amount and am now putting this knowledge into practice.

**2014 Justification for me as the researcher :** Another consideration was justification relating to *me* as a member of PD1's team, *me* as a recognised senior nurse within the Trust and *me* as programme leader for the ANP programme at the university, where most of the potential cohort for the research will have enrolled for advanced practice education. This could potentially compromise credibility of the research in terms of relationships with participants. I needed to be mindful of this as I recruited my participants and throughout interviews. I took this into consideration, and selected participants, from the PD cohort, if they had expressed interest, rather than asking them directly. A number of nurses, during PD1, said they would like to share their stories with me. As PD1 had finished and I had moved posts clinically, to a different hospital, this eased things, as I was no longer part of a senior nursing establishment where they were employed.

**2014/15 Considering my research participants:** I believe my knowledge and experience and subjectivity won't compromise the research process or negatively affect outcomes. It is not general information or objective perspectives I am exploring, but individual nurses' own thoughts, feelings and experiences of their own roles. As long as I let them tell their stories and interpret what they are saying from interview transcripts themselves, without putting my opinions forward, I will succeed in a good exploration, highlighting how *they* themselves contribute to patient care and service delivery (not how I see their roles and contributions). This will be aided by the structured and systematic approach that my choice of methodology (IPA) can provide. My personal opinion is that my background and knowledge-base in the subject and knowledge the participants have of me, will enhance rather than hinder the research.

**2014 Testing waters – trial interview:** I undertook a 'test' interview, using prompt questions from my interview schedule that had been through ethics approval. I now felt I had experience from the test interview together with a sound background of interviewing patients, carers etc. in a clinical setting, using a high level of communication skills, to gather information within a trusting relationship, to undertake successful interviews for the study . Although I had an interview schedule I was going to leave participants to tell their stories with minimal prompts. This would be within the

context of the methodology and methods appropriate to IPA, as well as a way of gathering the data.

**2015 1<sup>st</sup> real interview:** I approached my 1<sup>st</sup> 'real' interview, with trepidation, as this was 'the real thing'. I should have had more confidence in myself as, looking back, the interview went well and yielded some really good quality data (I think!).

(Short extracts from whole diary only included)

## Appendix 6 Email confirmation of ethical approval for research study

From: [onlineservices@bournemouth.ac.uk](mailto:onlineservices@bournemouth.ac.uk) [onlineservices@bournemouth.ac.uk]

Sent: 30 October 2013 10:59

To: [hwalsgrove@bournemouth.ac.uk](mailto:hwalsgrove@bournemouth.ac.uk)

Subject: Your ethics checklist "What contribution can advanced nurses make to patient care within an acute hospital setting? A Phenomenological study that explores the lived experience of advanced nurses and investigates their contribution to patient care in an acute hospital setting" has been approved.

[[http://www.bournemouth.ac.uk/assets/enquiry\\_images/bu\\_logo.jpg](http://www.bournemouth.ac.uk/assets/enquiry_images/bu_logo.jpg)]

Dear Hilary Walsgrove,

Your checklist has been approved by [REDACTED]

You can now print a hard copy of the checklist at <https://ethics.bournemouth.ac.uk>.

If you have any questions regarding this please contact your ethics supervisor.

Thanks,

Research & Knowledge Exchange Office

For more information please contact

us<[REDACTED]@bournemouth.ac.uk?subject=Online%20Ethics%20Checklist%20Query>.

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## **Appendix 7 Documents for participation**

### **Appendix 7.1 Interview questions prompt sheet**

Interview schedule: focus on the lived experience of advanced nurses working at the hospital and the contribution to patient care and service delivery

Experiences of being an advanced nurse

Can you tell me what it means to you to be an Advanced Nurse in this hospital?

What sense do you make of this experience?

What do you consider to be the attributes / qualities that perhaps set you aside as an advanced nurse?

How have you arrived where you are now as an advanced nurse? What took you to the decision to do develop as an advanced nurse?

How long has it taken for you to feel you are functioning as an advanced nurse and how do you interpret this?

Contribution to patient care and service delivery

Can you identify any aspects you think are your unique contribution to patient care

Do you think you have a positive impact on delivery of the service you work within?

Are there any potential negative impact aspects?

Is there something that sticks in your mind that was a really positive or negative experience, something a patient has said or people have said to you, anything particular?

Any particular challenges you've had along the way?

Is there anything else you would like to say, particularly in relation to your experience of being an advanced nurse and in relation to the contribution you make to patient care and service delivery?

Please feel free to add anything else you think might be useful

## **Appendix 7.2 Participant Information Sheet**

You are being asked to take part in a small-scale research study that forms part of the researcher's (Doctor of Professional practice student's) thesis, which focuses on advanced nursing in an acute hospital setting. Before you decide, it is important for you to understand why the research is being done and what it involves. Please take time to read the following information carefully and discuss it with others if you wish. Take time to decide if you wish to take part. Thank you very much for taking the time to read this information.

What is the purpose of the study?

This small-scale study forms part of the larger whole of the doctorate final thesis, relating to advanced nursing and its practice. The wider study also includes two practice development projects, alongside this research study, which interlink and will make up the main body of a professional doctorate thesis. The two main projects were as follows: 1) a review and evaluation of advanced and specialist nursing roles leading to creation of an advanced nursing framework for a local hospital Trust (██████); 2) Development of an advanced practice educational programme at ██████████ university, based on the data gathered from the over all study, including this qualitative research study that will explore a small number of advanced nurses' experiences, from the hospital who were part of the participant cohort from the hospital project Specialised Nurse Review (SNR) project. It is anticipated that these enquiries will identify impact and / or value added, of these roles on patient care and service delivery, from the perspectives of the advanced nurse participants themselves.. The aim, identified as the research study above, is to explore the experiences of what it means to be an advanced nurse at the hospital and the participants perspectives of their contribution to patient care and service delivery, from the advanced nurses' own perspectives.

Why have I been chosen?

You have been chosen to participate in this study, as you have been identified as working in an advanced nursing role in an identified acute hospital setting within the United Kingdom. This will enable the researcher to gain insight into the lived experience of being an advanced nurse in the hospital and to gain your perspective on what impact /contribution the role has on the care of the patients who fit into the remit of the identified role.

Do I have to take part?

The researcher would be really appreciative if you did agree to take part as your input would be really valuable for gaining an excellent insight into the advanced nurses

within the context of the hospital setting and this will be crucial for enhancing the quality of the study, by finding out about the actual experiences of advanced nurses.. However, you are not under any obligation to agree to take part in the study, for any reason, if you don't want to.

What do I have to do?

You will be invited to take part in a one-to-one interview with the researcher, at a mutually agreed time and place, within a quiet and confidential setting of an office (wherever suits you best and that you would feel most comfortable in). The whole of the interview will be audio-taped. During the course of the interview that will last approximately 45 to 60 minutes, the researcher will ask you to talk about what it means to you, to be an advanced nurse, from your own perspective. She will ask you a few key questions, just as a guide to keep the interviews on the right topic area and ask you to also talk about what you think the impact your role is on patient care and service delivery, from your personal perspective (details of which can be found on the questions prompt sheet). You will have time to think about what you want to say and can write notes to bring in to the interview, if you so desire, in advance of the agreed interview day as the interview prompt sheet will help you with the focus of the interview and what the researcher wants to find out about from you about your own experiences, thoughts, and feelings. If you do not wish to answer a particular question you are asked, then your wishes will be respected by the researcher. There are no right or wrong answers to questions as this is all about your own personal experiences and your perspective.

What are the possible disadvantages?

The researcher appreciates that you are busy in your practice area and it is difficult to take time out for an interview such as this. A disadvantage might be the impact taking you out of your role has on your busy schedule. The researcher will endeavour to keep to the agreed timings and the mutually agreed time and date for the interview that fits with your own schedule. It is possible that some questions asked may potentially cause distress or be of a confidential nature. The researcher will ensure your privacy, confidentiality and anonymity are maintained. Should you feel at all distressed, then the interviewer will stop the interview, offer you any support or help you identify a source of support, if she is unable to do so.

What are the possible benefits of taking part?

The researcher will be able to use the interview data to add to the body of knowledge of advanced nursing and its practice, based on the perspectives of individuals directly involved. The data will strengthen the education and career framework of advanced

practitioners both from a local as well as a wider perspective. The interviews will provide an opportunity for advanced nurses to present their experiences, what might be considered as their life-world, and to identify their contribution to patient care and service delivery. This information can then be disseminated widely through publication of the researcher's final thesis and other publications/conference presentations.

Will my taking part in this study be kept confidential?

Yes. The audio-tapes will only be available to the researcher who will transcribe them herself. Any identifiable data will not be included in the transcripts and a pseudonym will be used to conceal your identity and the place where you work. Once the interviewer has written up her findings, this information will be available to you to ensure you are happy that the information remains confidential and that you have not been misinterpreted. The researcher's supervisors at the university will be supporting the post-graduate researcher and will, therefore, also have access to the audio-taped interview and written transcript so they can advise the researcher, on their analysis of the data. A colleague of the researcher who works as a healthcare professional in another area will also read the interview transcripts and analysis of the data to provide an objective view on the researcher's interpretations of your interview, again, to help support the researcher's analysis. The tapes will be kept in a secure, locked cupboard, only accessible to the researcher, for a period of 5 years, or until the completion of the researcher's final thesis.

What will happen to the findings from the research study?

The findings will be included as a section of the researcher's final doctoral thesis. Articles for publication and conference presentation will be produced to disseminate results to interested parties locally, nationally and Internationally, again ensuring your anonymity as much as possible.

Who has reviewed the study?

The study has been reviewed by the researcher's research supervision team and approved through Bournemouth University's research ethics committee.

**Contact for further information?** Hilary Walsgrove email;

[hwalsgrove@bournemouth.ac.uk](mailto:hwalsgrove@bournemouth.ac.uk) tel. no. 01202 961764 or 07961276225

Thank you for taking part in this study. Your input is invaluable and greatly appreciated by the researcher.

**Appendix 7.3 Consent form for Qualitative research study**

**Organisation:** Bournemouth University / [REDACTED] Hospital

**Title of Study:** An Interpretative Phenomenological analysis study that explores the lived experience of advanced nurses and their perspective of their contribution to patient care and service delivery in the acute hospital setting

**Aim of study:** To capture the lived experience of advanced nurses within a local acute hospital setting and to explore the contribution they make to patient care and service delivery

**Researcher's position:** Lecturer Practitioner & Doctor of professional practice student (BU) / Pre-assessment Lead Nurse ([REDACTED]) (previously) and currently project lead nurse for advanced practice framework development [REDACTED]

**Researcher's name:** Hilary Walsgrove. **Contact details:** 01202 961764 / 07961276225 Email: hwalsgrove@bournemouth.ac.uk

Consent:

I, .....give consent to have an audio recording of myself while being interviewed by the researcher.

I understand that excerpts of the taped interview may be used in future conference and journal paper publications. The taped interview may not be shared by anybody other than the researcher, her supervisory team at Bournemouth university and a healthcare professional colleague from out of the area, who will review the interview transcripts for accuracy.

All excerpts of the taped interview given in the final thesis paper will remain anonymous and I will not be identified.

I am not required to answer any specific questions if I choose not to and have the option to withdraw at any time from the interview or study and the tape destroyed

The researcher will retain the taped interview until completion of the study or up to five years and then it will be destroyed. The tape will be destroyed in accordance with Data Protection and the Bournemouth Research Ethics Code of Practice (2009).

The procedure and intended use of the taped interview have been explained to me by.....

I understand that I will not be identified in the study and any information given will be anonymous.

I ..... agree to take part in the study.

Signature of participant:..... Date.....

Signature of Researcher:.....Date.....

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## **Appendix 8 Layers of analysis**

### **Appendix 8.1 1st layer analysis - Initial thoughts & reflection on Ann's interview**

**(Before)** This was the background to starting Ann's interview - trepidation, wanting to get it right, knowing that I can't keep interviewing people and discarding data. That isn't fair on interviewees giving their time to me and I don't have the time to interview, transcribe and then discard interviews. I want to get it right first time as that will help ensure I get to the heart of thoughts and feelings of the participants. I am conscious of that all the participants have known me in the PD team and may think that is the type of information I need. However, this was some time ago now and thankfully, I have been delayed in pursuing this study. I actually now think this is a good thing as I have had the chance to immerse myself in methodology, to really understand what it is all about and confirm for myself that this is the type of approach to help answer my research questions. I have been able to divorce myself from the very different methodology of PD and to stand back and allow the flexible, open nature of IPA to guide my interviews. I find this exciting as I am really keen to delve deeply into interviewees' experiences and feel that I now can. Having had a trial run and having reviewed numerous other interviews and reports of studies that used questioning and prompting techniques, which demonstrate the way the interviewers extracted the data. Nonetheless, I am still a bit anxious. I have written myself notes and prompts for my interview with Ann, as I know she is a bit of a talker and I will need to interrupt her on occasions, to bring her back to topics. I will keep this with me during the interview and if I feel her going off-tangent, will refer to it.. Here goes!

**(After)** I was able to keep Ann reasonably on-track and used some simple prompts to keep focused and ensure that I didn't just leave her to describe her experiences. She certainly was reflecting critically on these experiences as we went along and I gave her prompts to help her make sense of what she was saying, here and there. I did feel I was using an interpretative stance, to a certain extent, as we progressed, and will continue to do that as I analyse the transcript. Ann has given me lots of data, some of it quite surprising. I thought she would be more practical but she has been quite deep and insightful about experiences of being an advanced nurse. I understand from the interview what she does, how she does it, what keeps her doing the role and what she thinks she contributes to patient care. Whether this is just an over all impression at this stage and when I come to analyse it, the data won't be so right I don't know. But at this early stage I feel excited, and confident that I am going about this study in the right

way, adding to knowledge through little insightful snippets of interviewees experiences and perspectives. I felt privileged to have had the opportunity to record Ann's experiences. I did think that hers would come across as a doctor substitute role, but, that is not what I have come out of the interview feeling. This feels very different from my interview with Belinda, both very relaxed and positive, it seemed to flow well and follow a logical route through Ann's experiences. I felt my prompting was in line with IPA approach and that the data will be analysed well using an IPA process. I didn't feel at any point uncomfortable and I know Ann was comfortable to share her experiences and be encouraged to reflect. She thanked me at the end of the interview as she had found it really cathartic, sharing experiences and giving her a positive boost. She said it had invigorated her and reminded her of why she was doing the job - She never gets a chance to talk about herself, to reflect on the good things she does as she is always so busy. Have now transcribed this interview and feel that my approach was good enough and with a bit of tweaking, I can follow a similar pattern for my 3rd interview, with Charles.

**Initial notes from interview data:**

Ann finds it difficult to describe what she does but tries to explain it to people in simple terms as more than a 'normal' nurse but with add-ons to nurse rather than taking on a doctor role. She sees advanced nurse role as one that is different from an ordinary nurse and from that of a doctor, it encompasses lots of different elements of the patient's pathway. Autonomy within the role, in planning and organising the workload and managing patients is at the heart of what she does, making high level decisions about managing patients is key. Ann sees her role as central, very much the centre of a team, offering support and guidance to nurses and junior doctors, being a challenge to the more senior doctors as well. She feels this has come from years of experience, as well as a sound knowledge-base and targeted education and training.

## Appendix 8.2 Extracts from transcript analysis

Extract 1: Fiona's original transcript with initial thoughts; **Red = Interviewer H**, *Black italics = interviewee F*, **Green bold = non-word semantics**

Fiona: 6th interview so felt comfortable about able to support interviewee exploring their experiences through broad, opening questions, keeping flow of information supported by prompts with IPA focus with hermeneutic cycle aspects during interview - description and sense-making by interviewee and preliminary element of interpretation during interview through my interviewing technique. Interview with advanced nurse who has been in this post for 15 years and developed as part of a team of ANPs in an acute setting. Thus interview about own life-world story but very focused on this story tied in with journey of development and establishment of practice and role of distinct group of ANPs. Over all impression of strong nursing focus with adoption of medical elements added to role for the good of patients. Compassion and caring approach very much based in nursing roots strongly reflected and team perspective predominates. This is more generic model due to nature of where they have developed in role, rather than a specific, specialist element as core to function. Similar to other participants is interviewee's sound background in area developed in, basis of developing role. Incorporates leadership and education, as well as service improvement into their experience. Focuses on life-long learning as key to advanced nurse. Contribution to patient care from personal perspective given through patient stories recalled and back to contribution to patient care, added value of advanced nurse in this area from the team perspective.

1. H - OK what I want to find out is a little bit about your experience of being an advanced nurse, particularly in relation to you working at the hospital so just around what it means to you to be an advanced nurse. *1. F I think I have kind of specialised in 1 field and so it's been. There were 2 sort of pathways for development into a senior role in the area I've specialised in (Yeah). 1 of them was a more managerial role, the other was a much more hands-on, patient care, patient-focused (umm) and that was the route that I really wanted to do so becoming an ANP (umm) was the natural pathway for me to have been able to develop.* 2. H - So you made a decision around what pathway you wanted to take.

2..**F interrupts...**yeah well it kind of happened, it was sort of, I'd reached a certain level and the next level on from that at an advanced nurse level (**Umm**) was either sort of managerial. But it was almost, kind of, made for me, in a way. The actual department was quite forward-thinking and wanted to introduce ANPs and I was (**umm**) one of the 4 that was involved in setting up the service, so it was very much, from ground-level, very new, never had ANPs working in the area (**umm**) before (**umm**) so it was very much a trial and error.

3. F We sort of looked at other areas and what they were doing, we'd been to other hospitals and done an introduction to nurse practitioner and seen how it had worked there (**Umm**) and brought that back to where we were working before we even started it and so it was very much a learning about what the service needed (**Umm**) as well as development of yourself (**Right yeah**) so maintaining that you actually developed your skill, building on the foundation, you know (H um right) that you already had. Then utilising that to take it forwards (**right**).

4. F Actually making sure that service provision was safe, that patients were safe, you are a safe practitioner, (**umm**), and taking it from there.  
(TEXT MISSING AS SAMPLE ONLY)

Extract 2 - Start of 2nd layer analysis Gina's original transcript with non-word semantics

Red = Interviewer H , *Black italics* = interviewee G, Green bold = non-word semantics

<p>Interviewer H</p> <p>1.I just want to know a little bit about your experiences of being an advanced nurse and what it means to you, to find out how it is for you, what it means for you, what sense you can make of advanced nursing and you as an advanced nurse in the hospital where you work.</p> <p>4. So you started off, you said you'd gone on for so long <b>both laugh</b> so at some point you started on this journey?</p>	<p>Interviewee Gina</p> <p>1.Oh crumbs, umm! I find it very difficult because I feel like I've been doing it for so long (um) that I 've not really thought about it, I suppose I looked back at where I came from and think about what I'm doing now and I just think there are so many aspects to it umm about managing care, making decisions, about being responsible for a team and I'll work as a team and being part of a bigger team as well (um) so like the ward and the medical staff (right) and the input you have with all the teams and they expect you to have and that you end up having with them as well <b>quite animated here</b></p> <p>2.So it's quite a, it's such a big role and it sort of like it feels like it's a bit of everybody else's role and the bits that they don't want as well <b>Both laugh, right</b> so you end up taking on all the bits because <b>laughs</b> you don't seem, you seem to fit with a foot in every single camp (yeah) so because you fit with a foot in every camp you do a bit of everybody's, bit of your own and at the same time you see everybody else's role and you see, you look at it from the outside almost sometimes what everybody else is doing because you don't fit into any 1 group really (no)</p> <p>3. And sometimes in the beginning when there were only 1 or 2 of you it could be quite difficult because you weren't involved in any group whereas now we are a big group (ah right).</p> <p>3.We're like a group of NPs in our own right now whereas before it used to be quite difficult (um) when you were the only 1 and you didn't really fit into any group as such (um)</p> <p>4.Yeah so when I started which was 20 years ago now they wanted, it wasn't even a NP role, it was called a Nurse Practitioner but I don't know, it wasn't an advanced nurse practitioner.</p> <p>5.I don't know what it really was because it was a project that they had, that they needed some help on the ward for the medical staff really, so <b>like a replacement doctor?</b>.it was more continuity, there was no continuity on the medical side because your HO would go every 3 months</p> <p>6. They didn't know anybody who knew the care of the patients on the ward, there was no-one who was pre-assessing the patient (right) because they were being done by the doctors on the ward when they came in (right) for their surgery so there was no preparation.</p> <p>(text missing as only sample)</p>
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Extract 3 - 2nd layer analysis, highlighted text of Emily exploring personal, team, general perspective

<p>7. Can I just interrupt you there? You talked about ..umm...learning something about yourself as a person <i>umm</i>, yes so does that suggest there's a link between umm...the person doing the role and you as a person</p> <p>8. So what sort of things do you think you would, because that is quite .. <i>interrupts here</i></p>	<p>7. <i>yeah, yeah</i></p> <p>8. I think you don't know what you don't know!</p> <p>9. You never fully know your capabilities and some people are very happy to be in a little sphere of familiarity—<i>obviously doesn't feel this suits her</i> in a specialist area (Umm)</p> <p>10. And some people go – 'you know what there are probably other things out there for me to learn something that they can learn from (Umm) but possibly they can contribute to because it works both ways (Umm).</p> <p>11. Looking at dynamics of a team, it's not just the individual person, it's the collective that everybody brings and contributes that can make something really successful <i>animated, showing passion for what she is saying.</i>(Umm).</p> <p>12. OR...if it's not successful then hopefully people would learn from that, to say that "How can we make it successful?"</p> <p>13. So I think that it's <i>not just the clinician you can be, it is the person that you are</i> that helps the dynamics of that (Umm, umm). <i>Long pause.</i></p> <p>14. It's a bit the <i>ingredients in a cake... laughs...</i> Every one is a different ingredient and it's the combination of those ingredients (Yeah) <i>real passion in her tone now, that creates something really fantastic</i> <i>emphatically said.</i></p> <p>15. But also you <i>can have the wrong ingredients</i>, that creates something really not so fantastic (Umm).</p> <p>16. So it's about <i>looking at your resources, looking at the capabilities</i>, not just their existing needs but their future potential ones (Yes) because <i>I think we have always got to be one step ahead - "This is where we're at but where are we going to?"</i></p> <p>17. Yes, yes I thought it was a really exciting opportunity to see what I could do as a person (Um I see).<b>(text missing as only sample)</b></p>
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### Appendix 8.3 Extract 4 – Ann’s transcript with preliminary notes

*Participant making sense of experience, Researcher/interviewer - interpreting during interview; researcher questioning and interpreting from transcript = researcher prompts **Bold green - semantics**. Text missing after point 8 as this is only extract from full transcript*

Original transcript	Exploratory comments
<p>1. So I just wanted to talk to you about what your experiences are of being an advanced nurse, what it means to you, you know, <i>your life experience of actually being in this post</i>.</p> <p>1. Ann - Well It's like I've always said to people (umm), it's very hard to actually <b>pauses</b> put a description on what I do because people don't understand <b>emphasis</b> what the role is particularly well but I suppose when you talk to a patient or people outside of the actual health service my explanation would be that I have a general nurse background with extended training that's given me the expertise and knowledge-base to do what, to a certain extent <b>thoughtful pause</b> what junior doctors used to do, still do, umm, and it just, that's what I think my actual role is, sort of what I am (umm).</p> <p>2. I guess what I am so and I think they can understand that (umm) because it just means you're I suppose a bit like a 'super-nurse' <b>ironic, jovial tone</b> if you want to give it (H <b>giggles</b>) a common term that you want someone to understand.</p> <p>3. It's got extended skills but it does involve a lot more than that <b>getting louder and animated</b> actually in practice. (ok, um).</p> <p>4. Um, you are looked at differently, expectations of you are far greater, (um),</p> <p>5. You are supposed to be more autonomous, you're not like the traditional handmaiden to the doctors,</p> <p>6. You know, that, I think that over the years has changed and you are accepted as being somebody that can actually make a proper clinical decision (um). <b>getting animated here</b> and that you can not just take orders from somebody (umm)</p>	<p>1. Trying to elicit and get participant to reflect on experience, on why and how rather than what they do - life experience, what means to you</p> <p>1. Implication is she has been asked to define her role on regular basis over the years because people don't understand what she does. Interesting start to interview as my initial question was to tell me about her experience. Maybe this gave her time to think about what her experience is. Her way of describing what she does is by being able to describe it to someone outside health service.</p> <p>2-8. This puts her lifeworld experience in context of nursing – nursing always where she starts and what her experience centres around. General nursing background, extended training,</p> <p>2. What I am - understanding of, through 'common term' - again concerned with getting people to understand</p> <p>3. Extended skills - a lot more than this, looked at differently, greater expectations of you (doesn't say, who by? Or is this a personal expectation that is greater perhaps?)</p> <p>5. <b>More autonomous</b> (than who?) (text missing as only sample)</p>

**Appendix 8.4 Extract 5 - Diana - interpretation, key words/phrases for themes**

Red = interviewer, *Black italics* = interviewee describing, *Blue italics* = interviewee making sense, Green = researcher staying close to participant phenomenological and start of analysis, **Green bold** = lifeworld constituents, **BLACK CAPITALS** = researcher interpreting. Text missing before point 14 and after point 18 as this is only extract taken from transcript

<p>(Left Hermeneutic)</p> <p>14. Um, so you also talked about level of experience then, perhaps with the junior doctors you could see that you had the answers to some of those things?</p> <p>She believes she had the level of experience required to be an ANP <b>spatiality, inter-subjectivity, embodiment</b></p> <p>15. Is that something else, is it at a point where you get to in your experience, knowledge or is that part of it as well, <i>your level of expertise</i>?</p> <p>15-17. Need the level of expertise and experience to deal with and manage situations in *speciality which she has got as an advanced nurse with many years of experience of knowing how. Then implies that newer nurses aren't so able to manage situations as she does in an advanced position – again – keeping herself in line with her nursing roots, whilst she can manage situations <b>spatiality, inter-subjectivity, temporal</b></p> <p><b>NEED EXPERIENCE TO BE AN ADVANCED NURSE IMPLIES NEWER NURSES NOT IN POSITION TO, PUT HERSELF IN DIFFERENT FROM THEM inter-subjectivity CAREER</b></p> <p>18. Yes, so managing those types of situations, very experiential I suppose (<i>D-umm</i>) you'd call it.</p>	<p>13. Yes, yes, junior doctors, so a lot of their roles, I would think, why can't we do this, why can't nurses do this, it would make a lot more sense? (<b>H umm</b>) and it was just that inquisitiveness that led me to kind of say OK well what else is there that I can do that is advanced, can take me forward <b>career progression rather than for patient benefit here??</b></p> <p>14. Yes, yes</p> <p>15. Yes, I think that if you are going to be an ANP you've got to have a definite level of experience, level of 'worldly' experience – you've seen it, you've done it (<b>umm</b>), you've been exposed to it (<b>umm</b>).</p> <p>16. And especially in (*speciality) we get a lot of junior nurses who don't know how to manage it because it can be quite rare, <i>so you have to have that experience (Yes)</i>, and <i>I think being advanced and I have got the years behind me, of experience, to know how to deal with such situations and manage these things and to think on your feet (umm)</i>. <i>How to manage these situations.</i></p> <p>17. With a lot of new nurses it can be quite scary, it can be quite new, they're not quite sure how to manage the situations (<b>umm</b>). learn about medicine (<b>umm</b>). (text missing as only sample)</p>	<p>(Right Hermeneutic)</p> <p>SHARED (S) AND INDIVIDUAL (I) THEMES</p> <p>Moved words and phrases to boxes below</p>
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**General summary of interview:** Passion for what she does really comes through and her pride in terms of being a nurse, very patient-centred, very team-based approach, sees it as taking on aspects of medical role but adding to it with the nursing elements, always coming from a nursing perspective, which is based on her philosophical underpinning of what her identity as a nurse is, very much around the rapport with patients, education and so on, but able to do the more technical, clinical aspects that is medical job. Recognises increased level of responsibility and knowing her limitations and being aware that when she doesn't know something she will go and find out. Education is part of what she does and so is service/practice development if changes are going to improve patient care. Sees these elements as not just for her but core to all ANPs. Sees experience as important and reiterates this throughout. Does a fair bit of comparing doctors and ANPs as wants to put across that ANPs offer more, can do the doctor's role but also adds to this with the holistic aspects traditionally seen in nursing, and this is interpreted in terms of patient perceptions and other staff. Challenging and changing Practice is part of being an ANP. Both her phenomenological dialogue of being an ANP and the interpretive element that goes along with it comes from firstly a personal perspective then moves very much to the team perspective and what the team do as ANPs and then moves back when she wants to get her strong opinions over about quality patient care, to a personal perspective again. communication being key to this and interactions with patients, patient education, also the change agent in her and colleagues, wanting to do better for patients because they know what is needed. Sees self as in a senior role and that as such these type of things are important for her to do.

**KEY WORDS AND PHRASES** - selection from 1st few sub-ordinate themes interpreted by researcher and lower level themes emerging as key words/phrases of participant's own words

**Theme: Responsibility, pushing boundaries:** Lot of responsibility, Pushing boundaries but works within scope of practice, aware of limitations. Understand consequences of their actions because of level they work at as ANPs, Difficult being ANP but wouldn't do it if was easy, suggests they are a body of people who need and want to be challenged, Stepping out of that environment, Know the consequences of our actions, You know your limitations

**Theme: level of nurse** - Nurse but at a higher level, Next of level for a nurse, higher level, Not like a ward nurse

**Theme: Experience, knowledge** - Years of nursing experience - 9 years prior to journey of advanced nursing, Level of 'worldly experience' 15. quote. Advanced = years of experience and knowledge, Needs to adopt black and white attitude, directive when in life and death situations - experience comes from, couldn't do as junior nurse without full experience, If you want to be an ANP - year of experience and knowledge, we can change things, we can challenge practice, Have to have that experience to deal with situation

### **Appendix 8.5 Commentary following review by supervisory team**

**Belinda:** "This interview was my pilot interview but as some good data came from it and with permission of Belinda, I used some of this interview in my final write-up. Only key points were pulled out as there was incorrect focus in this initial interview done prior to my full understanding of IPA process. I was advised by my supervisors that this didn't meet IPA approach. Belinda agreed to be interviewed again now I had done several interviews and my supervisors were happy the new approach was now more on track. Belinda was happy for me to pull any key points that did come out in the first interview to add to her 2<sup>nd</sup> more IPA-focused interview. I struggled on occasions to get my questions out clearly and reviewing the questions I did ask, I think my nerves did affect the clarity of the questions I asked. When the interviewee did find an area she wanted to talk about, she did so with a passion and chatted away very easily."

Most of the interview is very focused on her own personal experience and there is a depth of reflection on her journey from being a specialist nurse passionate about her specialist area through to her consultant level post. She is very nursing orientated throughout. She puts herself in a category with other consultant nurses here and there, but she appears to be in quite an isolated nursing role, within the MDT and is very aware of this and how ground-breaking her role is. There is great emphasis on her not having support that she would have liked especially from senior nursing colleagues.

**Sharing transcript with supervisor** to ensure my thoughts around the over all interview and the detail in the interview was largely similar and as objective as possible, worked on my initial impressions which were jotted down throughout interview transcript and merged these with the slightly different interpretation of the supervisor to come up with more balanced view of the interview in its own right with as much bracketing as possible of my own personal interpretation during and immediately following the interview.

**Charles:** Starts with collective description of what it means to develop advanced nursing, stresses experience and practice alongside education. Moves quickly to same experience he personally had as he developed ANP practice, focusing on experience and what sense he makes of it. He explores his own journey from when he started out through development phase to where he is now, having felt he has been an advanced nurse for 4 years, despite being in a role for 12 years. There are some aspects based on collective perspective but not as member of a team, more generally. He talks about advanced nurse concept from general perspective, and a more collective experience,

with little of himself in here, applying concept to what he does. He moves to making sense of his journey and interpreting what it is about and what he would like to do to enhance it. He focuses on service development and comparing their service with other areas, reflecting on what they provide and seeing their own service is good, mainly him here with a little related to 'we' in his own setting. He comes back to making general, quite powerful comments about advanced nursing and what it means, with use of personal points to illustrate these.

**Sharing transcript with supervisor** to ensure my thoughts around the over all interview and the detail in the interview was largely similar and as objective as possible, worked on my initial impressions which were jotted down throughout interview transcript and merged these with the slightly different interpretation of the supervisor to come up with more balanced view of the interview in its own right ensuring appropriate bracketing in relation to my own personal interpretation.

### **Appendix 8.6 3rd layer of analysis - Sample member-check by participant**

Email confirmation from Emily and Charles after review of transcript, analysis, themes, key quotes

**Emily** ...It was really good to read your interview transcript; it brought back a few memories of the ANP course! I have reviewed the full transcript and the themes / quotes and I do think you have captured the key aspects of my experience of being an advanced nurse and my contribution to patient care. I only have 2 queries re your interpretation of my answers -see document attached.

I am more than happy for your friend to review the transcript, analysis & themes.

I hope this helps....

**Charles...** Thanks transcript ok , it just looks odd written down!

## **Appendix 8.7 Sample analyst colleague's comments**

After review transcript, analysis, interpretation, themes, quotes - email confirmation

I have read through the other transcripts and can find very little to suggest. They are all so interesting and found Fiona's examples quite moving. Just a tiny comment about Gina's. In 2.1 you say she sees her role as predominantly clinical but in 2.2 that the role is more nursing focussed. Seems a bit contradictory. Other than that I thought the analysis of the transcripts was accurate. Happy to look at the others if you would like me to and have time. Good luck with it all. I shall be really interested to read your eventual findings.

I have read Charles and Belinda's interviews. All seem to reflect accurately what was said I think. Small points about Belinda's

2.1.1 Training nurses - she seems frustrated by this - doesn't think the structure is conducive to nurses having a sense of autonomy

2.3 You mention a potential lack of confidence in her but I felt she was frustrated by the lack of concrete guidance. She is the only one who has mentioned the concern re legal clarity which I thought was an interesting theme not explored elsewhere.

Finally I have got round to Diana! Sorry again for the delay. As with the others I think your analysis of the transcript rings true and could find no discrepancies. I have to say reading all of them has informed my own practice and has made me a little more receptive to the nurses' contributions in my own area of Lithotripsy. Funnily enough we are just starting a nurse/radiographer lead clinic so I can now see how the 2 roles have something unique to offer so thank you for asking me to do this. I shall be so interested to read your findings.

## **Appendix 8.8 Extract 6: Gina's narrative account, themes, key quotations**

**1.2 Knowledge, skills, competence:** Gina discussed how they needed to develop elements of medical knowledge and skills, gaining confidence to use both medical and nursing skills together, which gave them a broader practice. Thus she added to what she was doing and training from an in-house perspective, showing development of skills and knowledge through experience of being in the role but with the addition of educational courses in areas such as physical examination and prescribing. This suggests she sees these elements as being akin to advanced nursing practice. Things are easier now for other trainee ANPs coming through as there is a training programme. She reflects on learning through experience and courses and thinks she could have just carried on as she was but she had itchy feet and a desire to keep learning and progressing.

1. Sub-ordinate themes: 1.1 Developing as an advanced nurse, experience; 1.2 Knowledge, skills, evidence-based practice

**1 Quotations:** "Every time I keep learning something new each time, you know, different roles"

"I could still do the job that I loved, I could still have the children and I could still manage to do the courses I needed to do ..."

"It's just you've got to keep trying new things and learning new things .....There's something in me that I have to."

"...then go and do the prescribing course, now actually, it's starting to click, falling into place ... all of the courses and all of the courses and everything I've done is all just falling into place..""

Key words and phrases

**Doing it for so long** 20 years ago wasn't even a NP role, staff nurse E grade on ward for years, **Education and training** - Physical examination course, Prescribing course, **Personal experience - life-world of being an advanced nurse** - Starting to click - Her experience of being an ANP, A changed role really, Evolving all the time, Continually changing, Don't know when it came more advanced, all the courses and everything I've done all falling into place, When it became more nursing, Do what I wanted within reason

## Appendix 8.9 Sample of shared and unique themes

No highlights = some shared and individual phrases/words not fit into categories of subordinate themes, colour-coded indicating shared experiences in subordinate theme categories, red font and yellow highlighted = individual experiences in themes

### 2.1.1 Subordinate themes categories a. EDUCATOR, SUPPORT ROLE

**Diana** Educate our colleagues; Education and support to everybody; let's do some research

**Emily** want to be involved in future development of ANPs/APs; Always been involved in education; Nurturing skills and learning within nursing and medical team - Improved service provision; be prepared to look at all different facets, see what can bring out of people; Teaching, want to check they're OK; Nice to share that with other ANPs; With experience and support you'll find a niche where you fit in; You hope you leave your mark for some reason and inspire people; If you sew a seed, let's give this a go; Is there something else going on here?; I would have liked a role model; One of most gutting things would be if someone couldn't come and talk to me; Invariably make sure everybody else is all right; They don't question it, but if they do, you are always happy to give an explanation;

**Belinda** Supporting other staff giving good quality care; enable doors to open for other people; Advise them, give them extra push they need, then go off and do their own thing; chatting to people because they want my advice; Make sure workforce have knowledge and skills to deliver what's being expected of \*\*\*\*

### 2.2 Subordinate themes: Philosophical underpinning nurse, Identity and title, relationships

**Diana** Values being nurse - basis of identity, important to reiterate to patients what you are; My nursing background; Nursing side of things; Still have nurse in title; Wants to be valued as advanced nurse, not doctor; I could have been a doctor, I want to be a nurse and I want to be the best; I'm a nurse, I'm an ANP; Advanced nurse; Become / be an ANP; Advanced practice; being advanced; Professional identity of ANP DH (England) (2010) emerging; We're all qualified but all have different backgrounds, qualities; difference in our experience as ANPs and level of expertise. Difficult being ANP but wouldn't do it if easy; ANPs need and want to be challenged; Stepping out of that environment as a nurse; It's the nurse, ANP has those unique abilities

**Gina** We are nurses but we've got a slightly different role; DH (England) (2010); still a nurse; I'm not a doctor, I'm a nurse - really important to me to actually remain; I am a very hands-on nurse, Maybe as nurses; We're not unique, we're not elite; being comfortable within your own role as nurse, as your own person; Need to kind of prove

yourself more as ANP; The core of what I want to do is want to be good nurse working with extended skills; Very satisfying, very rewarding, trying and testing; A lot of job satisfaction;

**Emily** Developing more of an identity; Didn't really know who I was; Didn't have a professional identity; From nursing perspective, creates an identity within myself; Myself as an ANP; Have to be a proactive individual; more lateral perspective, think outside the box; Not just clinician you can be, but the person that you are - Me as a person - I actually enjoy my job; I'm not religious, I'm quite spiritual, I think it's an integrity; A professional integrity underpins what's important for you as individual;

**Belinda** Nurses dip in and out and luxury they have real crossover of skills with tendrils into all different elements; become an anomaly - senior nurses don't know how to deal with, how to support; Within organisation, consultant nurse group/AHP consultant group; having the title of consultant; Making sure some sort of pathway for advanced practice so someone given title you know they are credible; When you get title people expect more;

**Fiona** Still do the job I loved; Definitely, definitely a nursing role; I like my ward-based role - haven't lost ward nurse skills but has added to them;

## Appendix 9 Sample of preliminary, comprehensive list of themes

Shared themes indicated by initial of participants and 4 pillars

Super-ordinate theme 1: Becoming an advanced nurse

Sub-ordinate themes: 1. starting on the journey 2. Questioning - my inquisitive nature - clinically nose 3. Doing it for so long 4.. when passionate about something, it's easier 5. Taken time and experience . Comes from experience Level of 'worldly experience 6. Experience - huge amount of experiential learning - life-skills, experience knowledge, Phronesis - quite wise at what you need to do

evolving all the time; an advancing role because it's never-ending FG You've got to keep learning all the time E I'm learning every day and that is really exciting, something that is continually progressing FG Advanced nurse training - Constant learning GF didn't have advanced skills ; very medically-led, led by consultants CG medical replacement to clerk patients at first CGF didn't do any prescribing, no physical examination, just clerking patients in FG didn't have advanced skills GF constantly improving yourself to improve the service and for patients C

.4. Taken time and experience something in me, need to be that kind of person to do this job CBG drive for learning - how I am E sorted out what I needed and asked for it BAC it's advancing that's given me that passion FBC I'm passionate about improving services CAB don't know what we don't know E not just the clinician you can be but the person that you are E It's not what you do but the way you do it - the way you do it can make a huge difference or whether it works or not for the patient and the team E ABCDEFG

not until you get to advanced level that you can shine from an intellectual level BAC learning how to holistically manage a patient from beginning to end and all that goes in between CFABDG Experiential development through patients .ABCDEFG I am a nurse with advanced skills developed over years ABCDEFG high level of skill makes you into a nurse. not just something you can suddenly go into if you've been a nurse for a yearF (all) within a year I'd got my own beds on the \*\*\*unit as a consultant B

5. Experience - huge amount of experiential learning - life-skills, experience knowledge GFDCBA Experience of managing things through patients CABFD learn to achieve best patient care CADFB need to be aware of what can happen - sometimes difficult to teach that - it could end up being something different CBFDA use your own autonomy to learn CBE suddenly realise how far you've come from when you didn't even pick up a tendon hammer EFG intuition, experience does play a part EGACD having had training in advanced practice, comes from experience DABCF

6. Questioning - my inquisitive nature - clinically nose y E Got to be inquisitive, got to want to ask questions EACD Wanting to know more, wanted to be better DACEF challenging - ABCDEFG work things out. nose y devil! F 7. Phronesis - quite wise at what you need to do CDE maybe that comes with time done on the job, experience and a bit of wisdom ABCDEFG intuition, experience plays a part, ECFG times when I had to question my own competence - I'd like you to check because times I felt I was working beyond my sphere of competence BCE don't know what you don't know EG clinical skills and knowledge important but actual foundation - talking to patients, building a relationship, gaining their trust, making them feel comfortable FACG that he needs to do this through course whereas didn't say this from clinical perspective as more aligned to experiential learning C my role has developed with more critically ill patients, completely changed scope of practice that I'm seeing now, really challenged me because I am working, seeing patients like a doctor F because we have to refer to medics so you have to know because they are going to ask questions, so you don't want to look like an idiot! F

9. Critical thinking - at level with my advanced practice that is challenging me with critical thinking knowing why you do something - the bit ANPs have, need to be aware of what can happen need to know why, when using protocols C

Super-ordinate theme 1: Becoming an advanced nurse

Sub-ordinate themes:

1. Starting out on the journey - when passionate about something, it's easier 2.

Questioning - my inquisitive nature - clinically nose y

3. Education, knowledge, skills - need to underpin it with knowledge, Phronesis - quite wise at what you need to do, Critical thinking 4. Taken time and experience . Doing it for so long 5. Experience - Level of 'worldly experience, huge amount of experiential learning - life-skills

Super-ordinate theme 2. Being an advanced nurse

2. Sub-ordinate themes 1. (medicine & nursing) use medical knowledge and nursing skills together (C) 2. Nursing professional identity, philosophical underpinning, definitely, definitely a nursing role ,nurse but at a higher level] (All 4 pillars) 3. it's a very multi-faceted role for me, unpredictable, knowing why you do something, it's the bit ANPs have (All 4 pillars) 4. When you're looking after a patient, dealing with a patient, diagnosing them, which is what we do (Clinical) 5. Remain focused on patient care, seeing patient through whole patient pathway, Holistic patient care, continuity (Clinical) 6. Educator role, support role (Education) 7. Leadership, teamwork, service development:-. passion to change things (Leadership/management) 8.. Humanising

aspects, relationships, Communication skills (all 4 pillars) 9. Level of responsibility, safe practice, pushing boundaries, autonomy (Clinical) 10. Comparing advanced nurse with doctors and non-advanced nurses 11. Different models of advanced nurse angles/disciplines part of every camp, knowledge borrowed from all angles/all disciplines G it's about looking at the patient, at what they need G would just see a little bit of us, a little bit of an episode from an ANPG You're an ANP but to make a difference F doing something very simple one minute and resuscitating someone the next F maybe my flexibility with that - it's important to me and my humour! F BECAG on the ward teaching or service developing CAG nurturing skills and learning in the medical and nursing team - improved service provision E B A we've got the rest of the ANPs involved in the education as an element of their role, of teaching, as an extended role F (TIES IN WITH TEAM LEADER ASPECT OF HER ROLE) no senior nurse support - lines of responsibility from a nursing point of view, doesn't happen B isolated working at a higher level - need formal support mechanism, become an anomaly - senior nurses don't know how to deal with you, how to support you B having a consultant nurse group in same speciality, similar role, better support B

Leadership, teamwork, service development: lead by example EBFAGCD responsibility as a leader because of your knowledge and skills, brings everything together CBA the team dynamics; making decisions together as a team G E D B A dynamics of the team, really important part of it, even though you are working in a slightly different role FABD very aware of being part of a team stepping in and out of roles FA didn't know where you fitted GE let's make it better DCABFG humanising aspects, relationships Patient-centred - unique abilities - takes patient through full patient pathway DABCFG always been about the patient and their experience; making sure patient gets best treatment, best care DABCF Nursing professional identity; title philosophical underpinning - I am still classed as a nurse ABDFG value being nurse as basis of identity DAFB have nurse in title DCB nursing focus GA F E D C B I want to be a nurse DAF advanced bit by your name CBD important not to lose your nursing skills A, (F adds "has to be the foundation of it actually, at the core of the role" ) felt I was just a nurse, it's what's taken me as far as I have, why I'm good at what I do because I'm a nurse AD if I'd wanted to be a doctor I'd have done medicine DB kept our nurse basis but utilising extended (text missing as sample only)

## Appendix 10 Individual lifeworld constituents: words and phrases

Temporality	Spatiality
<p><b>Diana:</b> I've changed; comes with experience; there every day; always patient</p> <p><b>Emily:</b> Times when I had to question; 1<sup>st</sup> year focused on skillset; comes with time in job; use time well so good patient outcome; spending 5-6 minutes with someone</p> <p><b>Fiona:</b> Not something if you've been a nurse for year; always enquiring nature; doing something simple 1 minute, then resuscitating someone;</p> <p><b>Gina:</b> Doing it so long; 20 years ago wasn't even NP, didn't have advanced skills, didn't do any prescribing; evolving all time; don't know when more advanced, when more nursing; if give them time (patients) Mood/emotional attunement</p> <p><b>Ann:</b> I like ward-based role; extra confidence in you; love F1 development part, they're brilliant; understanding it, feeling it, having compassion; nice to be there for them; having time with the patient who is upset; ; I love my job</p> <p><b>Belinda:</b> re-assuring, genuinely interested in his family;</p> <p><b>Charles:</b> then happy to call myself ANP; passionate about improving services; explaining reasons why without scaring them; confident;</p> <p><b>Emily:</b> vision was pivotal; soften clinical efficiency of medicine; understood emotional impact for patients; drive for learning; inquisitive; clinically nosey; they're going through grotty time – a person who can make things seem better; different ingredients in a cake creates something fantastic – satisfying diffusing difficult situation; compassion, passionate approach; busy but human exciting;</p> <p><b>Gina:</b> still do job I love; made huge difference</p>	<p><b>Charles:</b> best practice; advanced bit by name; own autonomy; improving self to improve service; leadership role deficit; holistic care; close patient contact; evolved for needs of service; on ward teaching, serviced developing; challenging; excellent standard of care; prescribing, clinic, diagnosing, assessing, treating, follow-up</p> <p><b>Diana:</b> challenging norms; aware of limitations; advanced practice</p> <p><b>Emily:</b> ANP course pivotal; proactive, fulfilling role; intuition; capabilities</p> <p><b>Fiona:</b> Multi-faceted; technical skill – medical; changed scope of practice; deeper foundation knowledge; know where change needed; safety for patient; extended skills and knowledge; advanced knowledge; looking after, diagnosing, prescribing; cared for somebody; can spot something earlier in patient; changed scope of practice; level of assertiveness for own protection; safety for self and patient; know where change needed on shop-floor; patient get treatment, additional information</p>

## Appendix 10 (continued)

### Inter-subjectivity

**Ann:** not just orders from somebody; more knowledge than ward nurse; seeing patient whole pathway; support, education junior doctors; part of team; what junior doctors do – actual role; broader spectrum than doctor; general nurse not clear boundaries; clinic – not nursing role– other ANPs; people don't understand role

**Belinda:** as consultant; patient have to see doctor no senior nurse support; essential nursing care, very dependent patients; supporting other staff giving good quality care; enable doors to open for them; advise them, give them extra push; MDT working makes a difference in \*\*\* care; when get title people expect more; make decisions about patient management without consulting colleagues; being true to nursing, not mini-doctor; nursing focus not medical; aligned how senior medics work; CN group better support; wasn't just looking at the patient, more widely; knowing patient; so few of us, people don't realise level decision-making and responsibility

**Charles:** best patient care; need to know why, defines advanced role; reflecting on other people; if haven't got close patient contact, not say you are ANP; management patients –whole picture, funding etc.; CNS,ANP, training role built needs of service; consultants as back-up; people come straight to you for answer; recognition skills by consultants; nurses follow protocols, doctors don't; can reassure patients - my common-sense; on same wavelength as patient; have understanding can share with patients

**Fiona:** kept nurse basis; resistance from nursing colleagues; junior doctors there because have to be whereas we want to be; medics more black and white, nurses add in few colours; nursing on patient cues, read body language more, verbal communication more than doctor; all got different styles (other ANPs); nursing skills blended, merged with technical skills, care-giving, putting patient at ease; have to refer to medics so have to know; role developed, more seriously critically-ill patients; seeing patients like doctors; learning something new, can take forward with another patient; building relationships; got rest of ANPs involved in education; aware of being part of team, stepping in, out of roles; working as team even though slightly different role

**Gina:** medically-led role; medical replacement to clerk patients at first; come ask you first; bit of everybody else's role, bits they don't want; foot every camp, respected every camp; knowledge borrowed all angles/disciplines; know care of patients; no continuity medical side; signpost them; wasn't expecting to see nurse, glad I saw you; difficult thing for them to talk about; if doctor does it, has to come back and see me, 1 visit not 3; make decisions together as team; manage team – responsible for development, training, appraisals; measurable as part of everybody else's care; she didn't have experience, for decision (Specialist nurse; different – other surgical ANPs)

## Appendix (continued)

### Embodiment

**Ann:** as normal nurse, just did stuff, now know what's important; haven't lost ward nurse skills, added to them; comes from experience gives you more (than ward nurse); knowing why do something – bit ANPs have; made me better at doing nursing things; caring, compassionate nature – still there in advanced role; part of team although practice autonomously; have to be able to stand up – no, literally: still classed as nurse – important not to lose nursing skills; why I'm good at what doing because I'm nurse; know my own boundaries, aware, your own decision, not dictated to you; decision-making, responsibility for decision-making key part; what I am; slide between medicine and nursing; do something basic then do what even registrar can't do; if haven't got knowledge-base, information, no advanced nurse role works; not want run clinics - moving away from traditional nurse; looked at differently, expectations greater; accepted as person makes proper decision; always bedside nursing, helping someone

**Belinda:** driven – sorted out what needed and asked for it; not until advanced practice that you can really shine, intellect point of view; combination essential nursing care, very dependent patient, mixture essential nursing tasks alongside complex; high level thinking, decision-making; nurses dip in and out, have luxury, have real crossover skills with tendril into all different elements; become anomaly; having confidence in own ability while still safe; making decisions where buck stops with me; aligned with how senior medics work; true to nursing, not just mini-doctor

**Charles:** experience managing things through patients; open-minded - clinical situations; know why using protocols –defines advanced role; being there for her, empathy, honesty; experience, common sense; picked that up as ANP, prevented heart attack; questioning, challenging why people doing things; autonomous practice – prescribing, making decisions myself; need to be aware what can happen, could end up something different; something in me, need to be that kind of person to do job; learning how to holistically manage patient, beginning to end-point, all in between; responsibility as leader because of knowledge, skills, bringing everything together; encompasses all that, managing in timely way, reassuring patient, giving them confidence – then tell ANP from non-advanced; if don't have close patient contact, not say ANP

**Diana:** always about patient, their experience; I've changed as person, still determined but wiser; making sure patient gets best treatment and care, taking patient through whole pathway; level of worldly experience; having time for patients, consistency, availability, there every day; nurse basis of my identity – have nurse in title; I'm a nurse, I'm an ANP; I want to be nurse and want to be best; pushes boundaries but work within scope of practice; skills associated with medicine; nurse but higher level

**Emily:** developing my vision pivotal in working out my identity; times when questioned my competence and asked people to check things; drive for learning, how I am, don't know what don't know; part of it questioning, part of it being on ANP course; an integrity that underpins what you do as individual; different specialities, didn't fit model; didn't know where I fitted into team, now I do –collective everybody brings and contributes; satisfying to diffuse difficult situation – good outcome for patient, giving quality care you know in heart should be happening; efficiency, effectiveness, but human factors, having time to listen; opportunity to turn manic situation into something busy but human; more I understand,

## Appendix 11 6Cs nursing values words and phrases

**Care** - use time well so good patient outcome; extra confidence in you; seen quicker; nice be there for them; like ward-based role; if see you confident; soften clinical efficiency medicine; going through grotty time –person can make things seem better; busy but human; ward-nurse skills; decisions based on evidence, experience; whole patient pathway ; best practice; holistic care; close patient contact; excellent standard of care; prescribing, clinic, diagnosing, assessing, treating, follow-up; Multi-faceted; cared, can spot something earlier in patient; broader picture – all aspects; unexpected, complex norm; continuity; trouble-shooting; do everything then discharge - 1 visit; multi-functional, specialist; know patient, build trusting relationships, add in gaps, something additional; patient-centred; support other staff giving quality patient care; Remain focused on patient-care, on excellent standard of care always my focus, where it all comes from; combination essential nursing care, very dependent patient; want to be nurse, want be best; best patient care

**Compassion** - there every day; always about patient, spending 5-6 minutes with someone; give time (patients); love F1 development, they're brilliant; love my job; understanding it, feeling it; compassion; genuinely interested in family; having time with patient who is upset; understood emotional impact for patients; advancing given me passion; having compassion, passionate approach; still do job I love; fulfilling role; compassionate nature; when passionate about something its easier; patient good journey,, middle patient's pathway; continuity core element

**Courage** - practice autonomously; isolated working at higher level; limits of practice and knowledge; own autonomy; challenging; challenging norms; aware of limitations; safety for patient; changed scope of practice; level of assertiveness for own protection; safety for self and patient; know my own boundaries, aware of that; your own decision, not dictated to you; decision-making, responsibility for decision-making; having confidence in own ability while still safe; making decisions where buck stops with me; pushes boundaries but work within scope of practice

**Competence** - had training; taken me as far, 5 years to get to level of confidence; not until advanced practice; still learning, comes with experience, evolving all time; doing something simple 1 minute, then resuscitating someone; Not something if you've been a nurse for year; drive for learning; training in advanced practice; extended skills but lot more; higher level skills; on ward teaching; capabilities; intuition; deeper foundation knowledge; technical skill –

**Communication** - re-assuring, different ingredients in cake creates something fantastic – team; satisfying diffusing difficult situation; people scared, aren't expecting be there – communication skills huge; empowering, facilitating others ; conversation with patient; empowered her; on patient cues; on same wavelength; have understanding can share with patient; time to listen; difference to patients; opportunity to own condition, empowered take care of their health; patient at ease; signpost them; wasn't expecting to see nurse, glad I saw you

**Commitment** - passionate about improving services; passion to change things; vision pivotal; made huge difference, dearth nursing research; important have essential nursing care spot-on; leadership style, political voice; improving self to improve service; evolved for needs of service;

## Appendix 12 Sample individual accounts

### Charles, Emily, Fiona - Becoming & being an advanced nurse, as an ANP

**Charles** - Safe practice as core. "I think it is recognising something else that can come in as part of that protocol [ ] an awareness and being alert that something could change, deviate from that, [ ] And it's something difficult for nurses, because we are quite protocol-driven." Lacked confidence, fits 'imposter syndrome', later credibility as ANP, recognition by consultants, seeing other ANPs elsewhere, validated advanced nurse status. Critically reflected how empowering, as synthesised new 'persona' as ANP. Evidence-based practice, own model. "Assessing a patient, diagnosing the patient, investigating and treating the patient and then following the patient up [ ] yes, yes, I would say it encompasses all of that, and managing it in a timely way and reassuring the patient and giving them confidence, they would then be able to tell an ANP apart from somebody who perhaps wasn't advanced. [...] I would say it's about clinical practice, it's having that step that I wouldn't have had before. [...] encompasses lots of nursing skills." Satisfaction training, education, role modelling, humanising aspect - sharing knowledge; agency, togetherness, sense making, embodiment in educator role for staff and patients.

"Sharing my knowledge with other people is really important and means so much, a huge part." patients as problem to manage, biomedical influences akin to medical role, giving rather than sharing knowledge to enable decisions, paternalistic approach, characterised by powerful, authoritative actions. "[ ] to give them an experience, my experience of how this process will be.." "But the other ANPs are in training so they would get the consultant, but really doctors aren't involved." Clinically things can change suddenly - alert, adaptable to keep patients safe, open-minded, able to judge, comes with experience, backed with education. "Experience I think and common sense [ ] manage it better [ ] so things like checking bloods, and then acting upon them and then somebody suddenly becomes unwell, somebody crashes or bleeds on the ward, there are all sorts of things you need to do there." sense of leading on his values - hot data of life-world experience, aligned dimensions of humanisation and 6Cs. Reflexively compared himself other ANPs; unless functions with core elements advanced practice, didn't feel able to call himself ANP, but now does. Life-world experience. Nursing philosophy - caring, empathy, being there for patients, nurturing them through.

**Emily** -After ANP programme competently questioning diagnoses, medical conditions, making appropriate referrals, based on competence. *"I was able to question the diagnosis."* Reflected on learning clinical skills and increasing sphere of competence, aware may be working outside scope but wanting to check wasn't, building confidence. Important relationship with consultants - learning new skills clinical assessment. Now in position to share experience, supporting new ANPs. Experience more than set of skills - empowering patients to take care of own health. *"To be prepared, to look at all the different facets and see what you can bring out of people to make something happen [ ]. I think the empowerment elements are really good."* Advanced nurse - hidden things, human elements, *"still do those tasks and make it human..[ ]. For me that personal human element is important..[ ], you have to be a person so they can relate to you and they can talk to you."* embodiment advanced nurse identity, within framework humanising care dimensions / 6Cs. Educator *"nurturing skills and learning within the nursing and medical team"* improved service, fits advanced nurse. Encourages people to observe, referring to her approach as *"like a mother hen."* Often most experienced member of team with junior doctors. Humanising approach really important, part of gaining identity. Personal integrity through needing to know doing right by patients, person-centred, humanising approach, *"an integrity that underpins what's important for you as an individual."* Now identifying as embodiment of advanced nurse. Personal underpinning philosophy medical colleagues not see same, could only see junior doctor replacement

**Fiona** *"hands-on, patient-focused..and that was the route that I really wanted to do so becoming an ANP was the natural pathway."* Developed according to new ways of working as service developed, revolutionary, at time. *"evolved over time"* always with patients at centre. Understands needs of people, couldn't pinpoint where comes from, sixth sense, based on experience, suggestive of intuition. Develop enough to know make difference, humanising 6Cs underpinning. *"going back to basics, being able to talk to a patient"* - core nursing skills important, key to advanced nurse, as technical clinical skills - task-orientated, but advanced nurse, not necessarily higher level technical skills, not heart. Breaking bad news, difficult conversations, before was support role to doctor. Educator - big part, advanced level knowledge, experience, keeping up-to-date helps.

## **Ann, Diana, Gina's unique contribution to patient care and service delivery as ANPs**

**Ann** Huge gap between being a ward nurse and having to wait for doctor to do something, not apparent - gap has filled with ANP. *"That sort of huge gap between being a ward nurse and having to wait desperately for a doctor to do something has gone. You don't if you've got ANPs there.."* Examples from practice - able to give key information to patients, not keeping them waiting knowing nothing, having to wait for doctor to return. Acknowledged ward nurses don't have time she has - added value to patient care she can offer. All from patient-centred approach, focused on patients' uniqueness, sense of agency and place, togetherness significant. Helps allay anxiety for patients, only possible because she has advanced knowledge as advanced nurse. She made unique contribution by being there for patient, as constant presence throughout pathway, ensuring they have good experience, and this is from team perspective. This took her back to personal values-base firmly embedded in 6Cs. *"..it's the patient [ ] when they leave the ward, even when they've died, I know that, yeah, they actually had a really good journey...and their experience is good."*

**Diana's** contribution - combination doctor's / nurse's role, interactions with patients, education, change agent in her and colleagues. She reflected back positively on what ANP team achieved. Some linked to knowing patients, having knowledge about their treatments, care, medicines and having knowledge and skills to provide an educator role to patients. Specialist pathway, realised because ANPs driving service and continue to work on nurse-led services. Compassion when she talked about specialist service, one of unique contributions from personal perspective, with nursing identity as the "immediate nurse". Example of patient treated well, in timely manner, humanising framework, concentrating patient uniqueness, sense of agency, sense-making, togetherness. Poignant occasion - patient thanked her for saving his life, sensitivity, compassion for patients. " He takes my hand and says, 'thank you ever so much, that was fantastic, thank you, you saved my life'...and its knowing that patient's had the best quality of care, that he recognises that actually you took the time to talk to him, trying to explain to him why he's having it done, what's the significance, and you come away thinking that's what should happen every single day...this is the quality I want to give.."

**Gina:** "One person that they can get hold of, who knows them, who has that contact with them, it's quite valuable for them really, quite nice for them.[ ] I think for the patient, yeah, really knowing them and I think the other thing is we tend to be the first

line of troubleshooting for most people so if there's a problem most people come to us first and we will either be able to sort it or we tend to know where to get it sorted"

Example of patient with lots of complex problems, questioned why they were having procedure, ? improve her quality of life, involved really challenging consultants' decisions. Sense of patient's uniqueness, personal journey, agency humanising care and 6Cs approach. Example of dealing with men in (speciality) clinic - personal problems - see her firstly as woman and nurse but always satisfied with their care, even though expecting to see doctor and male one. "I think, it's quite difficult thing for them to talk about and if you can give them that time and just gently question them you know I think it makes a difference ... and I think communication skills, I think they make a huge difference really"

# Appendix 13 Poster presentation 2<sup>nd</sup> cycle PD project 1 at different hospital



## Enhanced and Advanced Practice Framework Development

Project team: Yvonne Jeffrey (Assistant DoN), Hilary Walsgrove (Consultant Nurse), Maria Smith (Recruitment Nurse), Martin Hatley (Superintendent)

### 1. Introduction

#### Background:

Health and social care has changed significantly in recent years, leading to new roles emerging in response to complex and wide-ranging needs of people, families and communities. Within the UK, a proliferation of new and Advanced Practice (AP) roles is seen, with one of the main drivers being to meet the challenges related to clinical and workforce need (DH 2010). There is a growing body of evidence to demonstrate the positive impact of these roles and healthcare systems have been increasingly interested in supporting their introduction and development, as a means of sustaining the ever-growing demand for efficient and effective services with a strong patient focus. There has, however, been an associated lack of clarity around definitions, titles, roles and governance.

Key to the progression of AP roles in England is development of a nationally agreed Advanced Practice framework (Willis 2012; HEE 2015), currently under construction, that is building on previous work from across the UK, including DH (2010); NES (2010); NLIAH (2010). Also, focus on development of health and social care support roles, such as assistant practitioner and associate nurse has set an agenda to consider the full repertoire of clinical practice roles, across all levels, as a means of meeting requirements for current and

future health and social care (HEE 2015).  
Local context: HEE (Wessex) funding enabled a clinical project team at Poole Hospital NHS Foundation Trust to identify and develop

HEE's objective is to develop a more flexible workforce that is able to respond to the changing patterns of services."

### 2. Review and evaluate Phase

Questionnaires and interviews—review of role questionnaire based on Scottish AP Toolkit (NIAH 2010) modified for local setting. Interviews with individual staff and focus groups. Interviews with individual staff and focus groups. Enhanced data capture.

**Results:** Total 164 questionnaire completed—Midwifery, 22% AHP and HCS, approximately 100 group interviews with participant cohort.

#### Condensed Themes related to services and

- Frees up Consultant time & reduces their workload
- Improved training and development, clinical supervision, professional support for staff
- Service Development
- Enhanced team working – improved working relationships across service and region
- Reduced waiting times, continuity of care, improved patient experience, achieve targets, reduction in breaches
- Improved Communication / liaison across services, improved patient experience, client group (Primary and secondary care liaison)
- Resource for staff across settings professional development
- Admission avoidance, early treatment, improved patient experience/ pathway
- Improved patient experience/ pathway
- Stable workforce—improved care, more staff

#### A snapshot of good practice case studies

Including: Older Persons Advanced Nurse Practitioner

## Appendix 14 Dissemination activities, career progression and contributions

### **Practice Development project 1: Specialised Nurse review (SNR)**

Project shared with local trust - led to similar career progression pathway (2014)

Worked with local hospital development and implementation of their AP framework (2014)

Joined project group AP framework regional HEE - shared project 1st meeting (2014)

**Contributions:** framework for hospital, job descriptions, education and training strategy, increased awareness and understanding of advanced nursing, improved governance, more whole systems-based practice and service developments. Template for other trusts to use for their own framework developments.

### **PD Project 2: Advanced practice education curriculum development**

Project disseminated nationally educators meeting (2014). Maintained networks

International symposium Rotterdam (2015) Netherlands, Sweden, Germany, Ireland, USA

ANP programme taught session - good practice example (2013 ongoing)

Advice support to local trusts education & training (2013, 2014, 2015)

Working Swedish university - supporting development new education framework (2014)

**Contributions:** new programme validation in line with DH criteria, up-to-date literature for reading list, improved delivery of programme, up-to-date development of programme fit for practice and purpose, led to further developments - sharing of curriculum with other HEIs and educators nationally and Internationally.

### **All developments**

Co-author chapter Advanced Practice book (published 2015) - **contribution to literature**

Represented PD1 trust and trust where moved jobs to, HEE Wessex Advanced Practice development events, development group - practice/education (2014, on-going)

External examiner 2 universities UK - sharing AP education expertise (2012 and on-going); External assessor validation programme another HEI (2015)

**Contribution** of my experience and expertise drawn from undertaking PD and research shared widely and used to develop practice and education of advanced practice regionally and nationally

### **2<sup>nd</sup> cycle of PD Project 1 at different hospital**

Approached by local trust lead AP framework project - project lead post April 2016; Poster presentation national conference (2016);

Poster presentation - PHFT Framework - AAPE UK 2018

**Contributions:** advanced practice framework for hospital (similar to PD1), job descriptions, service and practice developments linked to project work, education strategy, expanded practice development group set up to manage and support developments, county-wide group set up joint development forum

### **2<sup>nd</sup> cycle of PD project 2 – further curriculum development**

Represent HEE Wessex AP events, presented curriculum development regional (2016)

New advanced practice education programme - presentation 2016

All development from 2<sup>nd</sup> cycles of PD

Approached to undertake joint project HEE Wessex/UoS/BU developing ACP programme

Income generating project for university, abstract International Conference ICN/APPN

**Contributions:** new knowledge creation and PD initiatives to enhance and build on the knowledge-base of advanced nursing and its practice. Sharing expertise and new knowledge widely and locally, has led to developments, such as new modules of learning and apprenticeship advanced clinical practice programme that I am leading on.

**Career progression alongside DProf, emphasis on education and research pillars**

Career progression 2012 clinically operational, with service development leadership practice role at hospital, department, operational level, educator role university to 2017 current role - strategic, with consultancy elements for organisation, regionally, nationally, Internationally, for practice/educator role at hospital/university, direct result of PD and DProf; 2006-2011 Lead nurse pre-operative assessment SNR project Hospital, programme leader ANP working operationally advanced nurse, clinical leader, service development lead for department (operational, service & department level), joint appointment university (programme leader post); 2011-2012 launch SNR project, start DProf., more strategic role expert advisor advanced practice and education, project delivery team (strategic element of post, team level)

2012: consultancy appointment to develop new pre-op assessment unit at another trust. Completed consultancy (service lead department level), clinical leader, ANP department (operational post). Maintained joint appointment, strategic, expert advisor (strategic level contribution)

2016: Approached for CN AP- lead/manage AP framework development project at local trust, links national, regional work (Strategic, departmental, operational). completed, contract extended to implement framework, undertake AP projects, represent trust local, regional. Wider curriculum development, national, International AP programmes (Strategic, operational contributions). 2017: HEE project with another HEI alternative programme AP education, development

