Lived experiences of nurses as they engage in practice at an advanced level within emergency departments in New Zealand

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Abstract

At this present time New Zealand has seventeen Nurse Practitioners™ none of whom work in the emergency setting; nonetheless emergency nurses throughout New Zealand are practising at an advanced level in departments nationwide. The aim of this research project was to examine the lived experiences of five nurses as they prepare for, and engage in practice at an advanced level within emergency departments in New Zealand.

The theoretical framework for this project was one of phenomenological enquiry based on a synthesis of Husserlian and Heideggerian philosophy. Following a form of purposive sampling to select participants, unstructured in-depth interviews were used as the method of choice for data collection. The concept of data horizontalisation integrated within Colaizzi's (1979) procedural steps for data examination guided the analysis and findings of this work.

Descriptions of the participants lived experiences, underpinned by Husserlian principals, identified eight subjects that were explored in-depth from their perspective. This was followed by further analysis, interpretation and discussion of the phenomenon under review from the researcher's perspective; guided by the fundamental elements of the Heideggerian approach to enquiry.

The results show that there are numerous similarities to be had in common with our colleagues overseas in relation to the many issues that impact on nurses working in or toward advanced practice within emergency departments here in New Zealand. However there also exist issues that are unique to the New Zealand context and as such have the potential to impact either positively of negatively on the development of the advanced nursing role in this country, such as the Health Practitioners Competency Assurance (HPCA) Act 2003 and other legislation that relate either directly or indirectly to the scope of practice for advanced practitioners, whatever their area of expertise.

The research process identified several concepts that require further debate and discussion; from which knowledge can be gained that will either add to or augment the body of knowledge that is required for the advancement of nursing practice within emergency departments here in New Zealand.

ACKNOWLEDGEMENTS

The foundation for this work goes back much further than the two academic years taken to complete this thesis; therefore initial acknowledgement must go to Dr Annette D Huntington for her sound advice and continuing support, from our fist meeting shortly after my family and I emigrated to New Zealand, onwards. How right you were when advising me to undertake the Research and Methodology paper to gain an understanding of the research culture here in New Zealand.

Secondly I wish to express my gratitude to my mentor Kim van Wissen who with a sublime process of subliminal management facilitated free lateral thinking while all the time keeping the work on track. Thank you Kim, I honestly would not have completed this work without you.

To my family, especially my wife Deborah, for support and encouragement.

Finally I gratefully acknowledge the participants without whom this work would never have been realised. Thank you for your honesty, compassion, motivation, professionalism and empathy; all attributes one expects yet are rarely accredited to individual members of the nursing profession. You all share these characteristics in equal and full measure; this work is a testimony to you.

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Chapter One

Introduction: Objectives and aim of this research project

Objectives and aim of this research project

Throughout the world various spheres within the nursing profession both in form and context are experiencing major change. Colleagues from countries such as America and the United Kingdom are forging ahead in the process of transforming nursing itself into a more autonomous profession. Other countries such as Australia and Canada are also contributing to this phenomenon. New Zealand itself has not stood in the shadows while this change has been occurring.

The advent of the Nurse Practitioner™ concept in New Zealand may well be in its infancy, however its development and implementation has not gone unnoticed. As demonstrated by internationally renowned nursing luminary Brian Dolan, during his keynote speech at the New Zealand Emergency Nurses Conference held in Auckland 2002; this will be highlighted and discussed in context during chapters three, six and eight of the work respectively

At this present time, November 2005, New Zealand has seventeen Nurse Practitioners™ none of whom work in the emergency-nursing setting. Nonetheless work in this specific area is occurring; therefore the author proposed to undertake research in to the perceptions and experiences of nurses as they prepare for, and engage in practice at an advanced level within emergency departments throughout New Zealand.

Research from America and the United Kingdom, where nurses have been practicing at an advanced level in some form or other for the past forty years, indicates that the path taken toward professional autonomy has not been an easy one to tread. As will be discussed, there has been much misinformation, negativity and opposition to the development of these roles in these two countries.

Both America and the United Kingdom have a well-established research culture within the nursing paradigm; however as will be shown in chapter three, such research tends to be based on the positivist, objective bio-medical model of care rather than the holistic whole-person approach. Notwithstanding this, research from both these countries has and continues to contribute to the overall advancement of the profession.

In contrast to the American and United Kingdom perspective, whereby research of this nature has predominantly been carried out using quantitative methods; the author [student researcher] proposes to use a qualitative approach to explore the real life experiences of these individuals, as they strive to expand the profession within their given field. As will be analysed and discussed the qualitative approach to research has much in common with the underlying principals of nursing, with its holistic, individualised approach. Taking into account socio-cultural, politico-economic, religious and spiritual needs alongside the physical variables that exist within each individual.

The theoretical framework chosen for this project was one of phenomenological enquiry based on a synthesis of Husserlian Transcendentalism and Heideggerian Hermeneutics, utilising unstructured in-depth interviews as the method of choice for data collection. The fact that this phenomenon is in the early stages of development in New Zealand limits the numbers of research participants available, therefore a form of purposive sampling, primary selection, was used to select participants. The concept of data horizontalisation integrated within Colaizzi's (1979) procedural steps for data examination guided the analysis and findings of this work.

The main objectives of this project were one, to explore the perceptions and experiences of nurses as they prepare for and engage in practice at an advanced level within the emergency department setting here in New Zealand. Two, that information produced from the research would enhance the body of knowledge related to the phenomenon under investigation; which will subsequently assist in the development of the Nurse Practitioner™ Emergency and Trauma role here in New Zealand.

However having made the above statement, in this present age of increased patient attendances and elevated emergency department waiting times; exacerbated by a shortage of experienced medical and nursing staff. Ultimately the long term aim of this project would be that information gleaned from the work will assist in improving patient care for those individuals attending the emergency department by offering a more diverse set of appropriate options related to their health needs; which would eventually include assessment and treatment by autonomous nurse practitioners within the emergency department setting here in New Zealand.

Ethical Considerations

Ethical approval for this study was sought from both Massey Universities Human Ethics Committee and Wellington Regional Ethical Committee; written informed consent was obtained from all participants (Appendix A). An information sheet that outlines the aims and objectives of the research proposal was designed for potential participants prior to the start of the project (Appendix B). Included within this information sheet is a full description of the methodology. Further to this emphasis is placed on the fact that the participants are seen as equal partners in this research project and that they along with the author have a shared ownership of the venture. Moreover the participants were empowered to withdraw any or all of their material without question at any time during the project.

Note:

Depending on the context in which it is written the author will refer to themselves as either "the author" or "student researcher" throughout this work.

Chapter Two

Background to the study: Incorporating lived experiences of the author

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The author has been a member of the nursing profession for the past twenty-two years. The first nine years were spent in the acute psychiatric discipline of nursing. Following a return to university as a mature student the author moved into the emergency and trauma field of nursing. In December 1998 the author was awarded Specialist Practitioner Status: Health Promotion Accident and Emergency Nursing, and admitted to the then United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC); now Nursing Midwifery Council (NMC), specialist practitioner section of the Nursing Register with a recorded entry to this effect.

Over the past seven years the author has held a variety of senior positions within differing emergency departments, Senior Staff Nurse, Clinical Nurse Educator and Charge Nurse roles, both in the United Kingdom and here in New Zealand. At this present time the author holds the position of Clinical Nurse Manager at the Emergency Department Hutt Hospital, Hutt Valley District Health Board (HVDHB). Having worked at a senior level with inconsistent aspects of autonomous practice dependent on the employing health authority the author has developed a passion for the advancement of the nursing profession in terms of autonomy and professional practice within the emergency field.

Since January 2003 the author has been facilitating a nurse led initiative at Hutt Valley District Health Board's Emergency Department (ED) entitled "Nurse Track". This project initially involved five ED nurses including the author all of whom have had extra training to take on the responsibility of the role. All have been accredited by HVDHB and the Accident Compensation Corporation (ACC) to assess, treat, refer if appropriate, discharge and arrange follow up for those individuals attending the department with minor presentations. The aims of this initiative were to provide a more efficient client service, promote ED nursing autonomy and have a positive effect on the waiting times experienced by attendees at the emergency department.

The project piloted in July 2003; following this successful trial period, which included an audit of the service, targeting appropriate clients who were offered the opportunity to be seen by a nurse rather than by one of our medical colleagues, the initiative was fully sanctioned by the DHB. As of August 2004 the service was available, staff

numbers permitting, from Fridays through to Mondays; moreover the project has entered the second phase of development whereby the nurses involved have been receiving supplementary training in aspects such as requesting radiography screening and interpretation of x-rays. Further to this more nurses have been invited to join the programme bringing the total numbers involved to eleven. It is hoped that eventually the service will be available twenty-four hours a day seven days a week.

Enhancing this background information and further qualifying the need for research such as that undertaken in this current project the author offers the following that formed the basis of work published in the nursing press in 2003 (Davies, 2003).

Changing Emergency Department Practice

Introduction

It is acknowledged that the increasing number of attendees and increased waiting times experienced at Emergency Departments (ED) throughout New Zealand are now a fact of life. Furthermore the shortage of medical and nursing staff are compounding the stressors that both patients and staff have to deal with (Frank, 2001). There is no quick fix solution available and unfortunately even in the unlikely event that further funding is made available; simply throwing money at the problem is not the answer. We who are involved in this field of nursing need to take on board new ideas and strategies; develop innovative processes and practices, to challenge the existing system. With the ultimate goal of constantly changing work practices to provide a modern professional service that effectively meets the needs of our client group.

A brief overview of the current situation here in New Zealand will be examined; contrast will be made with similar health care systems internationally. Subsequently examples of current innovation within the field of emergency nursing in New Zealand will be reviewed followed by an analysis of the Nurse Practitioner role and finally a discussion relating to other possible ideas, strategies and practice that could be integrated within a system change will be undertaken.

Current Position

Waiting times in the ED throughout New Zealand are increasing; individual departments are constantly exceeding their recommended triage treatment times.

Many people are experiencing extraordinarily long waits for treatment; paradoxically it is those individuals who present with relatively minor complaints who generally have to wait the longest.

There are several theories as to why this position exists; however one cannot discount the fact that the chronic shortage of nurses and medical staff is one of the primary causative factors. New Zealand is not alone in this respect; Australia, UK and the USA for example, are all experiencing this phenomenon (op. cite.). Compounding the situation is the fact that more individuals are attending the ED. Many of these attendees are presenting with primary health care problems and minor complaints that could be dealt with by other health care professionals such as After Hours Surgeries, General Practice, and Pharmacies. Yet for whatever reason many individuals choose to attend the ED rather than access health care elsewhere.

Emergency care has been and always should be free at the point of delivery, however, historically hospitals have been built in and around areas of lower socio-economic status, and as such one cannot ignore the fact that financial considerations have some bearing on these presentations.

Innovative practice

An excellent example of innovative practice here in New Zealand can be found in Auckland's Middlemore Hospital. Since March 2001 they have provided a nurse led minor injuries service that has selected as its target group those individuals attending the emergency department with minor injuries, mostly triage groups four and five. This enables the medical staff to concentrate on the more acute presentations. They have a staff of four Clinical Nurse Specialists, who provide cover seven days a week between the hours of midday to midnight.

Michael Geraghty one of the four involved in the project presented a paper at the Emergency Nurse Conference in May 2002. The preliminary results of a survey carried out at the department show clients have been satisfied with the service they had received; moreover many believe they were seen within an acceptable time frame and by an appropriate health care professional. Michael also discussed the fact that

the initial resistance from medical staff dissipated as the project started to yield positive results.

A similar nurse led initiative is currently under development at Hutt Hospital; although based on the same principals as that in Auckland there are subtle differences that reflect regional and local circumstances. It is envisaged that this project will be implemented in the not too distant future. The author would like to take this opportunity to thank Michael and his colleagues for invaluable guidance and advice in the development of this project.

Nurse Practitioner

With the advent of the Nurse Practitioner here in New Zealand, one can see how the role could be integrated with that of the clinical nurse specialists' initiatives. The Nurse Practitioner however would have a broader remit to triage, treat, refer if appropriate, discharge and, arrange follow up for attendees from all categories of triage. Moreover the Nurse Practitioner would have the authority to triage out if appropriate, to GP's for example. Studies such as those by Tye & Ross (2000) demonstrates that the standard of clinical competence by Emergency Nurse Practitioners compare favourably with that of House Surgeons within the emergency setting. Moreover recently research demonstrates that in some instances quality of overall care provided by Nurse Practitioners from a variety of settings to be superior to that of medical colleagues, as discussed by Horrocks (2002); paradoxically this research was presented in an eminent medical journal.

As mentioned in the introduction many individuals attend the emergency department with primary health care presentations. Amongst the sub-culture of hospitals these are often referred to as "inappropriate" attendees, and are consequently treated as if they themselves are the problem. Not the product of a system offering a fee for service in one sector compared to another service that is free at the point of delivery. Thirty or forty dollars per General Practitioner (GP) visit may not seem much to those in the high-income bracket, however others from less privileged backgrounds have an entirely different perspective.

In the UK there is talk of employing GP's in the ED to cover those identified times where it has been shown that a high proportion of attendees are those with primary health care complaints. Again looking at the Nurse Practitioner role here in New Zealand, there is no reason why individuals with a qualification in primary health could not be integrated within the system to provide a similar service (Department of Health UK 2001).

Other initiatives such as employing specialist paediatric and mental health nurses within the ED are areas that could also be considered (Harrison 2001). Again the author has been fortunate enough to work in units where these services have been available. Such nurse specialists can deliver care to their client group at an advanced level. Moreover working with colleagues who have this expertise can be extremely satisfying both in practical, professional and educational terms. Again this is a concept that could possibly interface with the Nurse Practitioner role in the future.

Systems Change

At the aforementioned Emergency Nurse Conference keynote speaker, Brian Dolan the first UK Emergency Nurse Consultant, editor of the UK journal Emergency Nurse, original nurse adviser for the hit TV shows Casualty and Holby City spoke of past and current initiatives that have been and are presently being implemented in Ireland and the UK. He urged nurses here not to make the same mistakes that have been in made in these countries, rather to learn from them. He was of the opinion that many practices could be adapted to the New Zealand situation. He spoke for example of the development of Medical Assessment Units (MAU) and Surgical Assessment Units (SAU). These are units within the hospital setting that are totally independent of the ED, whereby GP referrals are assessed, initially treated and then found appropriate beds in the hospital.

Figures from an unpublished study currently in progress at one of our major hospitals demonstrate that for a given 12-month period (01/05/01-30/04/02), 16.5% of the total admissions through the ED were GP medical referrals alone: Average time in department of 2 hours 58 minutes (data available on request). Somewhere along the line ED nurses have taken on the responsibility of working up these patients prior to arrival of the medical/surgical staff. Furthermore they then find that they are expected

to deliver care and assist in procedures that should ideally be carried out in the definitive care setting; this care is often delivered adjacent to the nurse's allocated ED workload.

The author has personally worked in two hospitals where MAU's were implemented and the workload stress was immediately relieved. Both patients and staff benefited from a decrease in waiting times, more individual patient contact time and quality of care delivered. However the implementation of such units should not be a case of robbing Peter to pay Paul. Suitably qualified nursing staff along with adequate funding and resources is needed if such initiatives are to prove a success.

Conclusion

This article has discussed possible ways of addressing the increasing attendances and waiting times experienced in many an ED throughout New Zealand, no doubt the former has a profound effect on the latter. Some would state that there are too many "inappropriate" attendees at the emergency department. The author would argue that there is no such phenomenon as "inappropriate attendee" only inappropriate service delivery.

As has been shown we are not alone in experiencing this phenomenon, however we are in the envious position of being able to observe how others have addressed their situation. We can then adopt and adapt practices along with developing our own initiatives to assist in addressing the unique situation that exists here in New Zealand. If we as health professionals wish to eliminate ever increasing waiting times, enhance client satisfaction and improve our service to meet the needs of those for whom we allude to advocate, not to mention to whom we are ultimately accountable. Then we in collaboration with other health care providers need to be pro-active not re-active in our response to new challenges. The world of health care is changing; New Zealand has been and is at the forefront of such care, however to stay there we need to adopt new working practices and to embrace change. In short we need to "think outside the box".

Update October 2005:

At the second combined Emergency, Paediatric and Neo-Natal Nursing Conference 2005, held in Christchurch, attended by both national and international nursing/medical delegates and presenters, many presentations, workshops and discussions were concerned with the issues and concepts discussed and analysed in the above work. It is apparent that within the emergency field of nursing and medicine such topics are considered contemporary, relevant and appropriate for further discussion on the national and international stage. As will be evidenced in this work, as it progresses and unfolds the links to the phenomena under question will become clear.

Chapter Three

Literature Review

Literature Review

Introduction

Advanced practice nurses (APN), emergency nurse practitioner (ENP), clinical nurse specialists (CNS) and nurse practitioners (NP) have been working in some form or other in emergency departments throughout North America for the past 40 years, and the UK since the early 1990's (Cole et al. 2002; Walsh, 1999a). However it is only in more recent times that the role has developed and has emerged as a speciality in its own right (Venning, Durie, Roland, Roberts & Leese, 2000). This development has been in response to several variables, the two most notable of which have been individual nurses motivation for self improvement/professional development, and the need to deliver a more effective service in these days of limited budget, nurse, doctor shortages and increasing number of attendees at the emergency department. (Sanning-Shear & Selfridge-Thomas, 1997).

At this present time New Zealand has seventeen Nurse Practitioners™ none of whom work in the emergency department setting (Nursing Council of New Zealand, 2003). However there are several hospitals throughout New Zealand who have, or are in the process of developing the role of clinical nurse specialist as a precursor for applications for the status of Nurse Practitioner™ Emergency and Trauma (Geraghty, 2002). As has been the case internationally there has been much misinformation, negativity and resistance to the development of these roles from the medical profession (op.cit.). Furthermore other allied health professionals; specifically radiologists and radiographers have also voiced concerns over the development of the role (Lindley-Jones & Finlayson, 2000a).

Methods

The search strategy consisted of a systematic review of two main bibliographic databases; namely CINAHL and Medline. This was augmented by a search of both Hutt Valley Health and Capital & Coast Health's library and Intranet sites and the kind offer of the New Zealand Resuscitation Council to use Otago Universities Medical School facilities. The search concentrated on the period 1990 to the present. Search terms consisted of the following key words and phrases; education, evaluation, demographics, nurse practitioner, emergency nurse practitioner, clinical nurse specialist, advanced nurse practitioner, emergency department, x-ray interpretation.

The student researcher was unable to access any appropriate research material related to the experiences and perception of nurses within emergency departments as they prepare for and undertake advanced practice within these settings. There appears to be little or no information available on this specific subject; moreover and perhaps more significantly there also appears to be scarce information of a phenomenological nature available on the development of nurse practitioner roles from other disciplines within the profession.

This lack of information however can be viewed in a positive light; in keeping with the tenets of phenomenological research it is important that the literature review not generate preconceptions of the phenomena under study. Many but not all phenomenological researchers refute the idea of literature searches within their methodology as they can be seen to influence and/or induce preconceptions within the researcher (Omery, 1983): this issue will be discussed further in chapter four.

As a consequence of this apparent lack of available information related to the research phenomenon, the following literature review concentrated on the associated subject of the development and effectiveness of nurses working at an advanced level within emergency departments and its applicability to the New Zealand context. For this work the term nurse practitioner will be used to supplement, emergency nurse practitioner, advanced practice nurse and clinical nurse specialist. All these terms denote individuals practicing at advanced levels, either fully or semi-autonomously, whilst at the same time recognising that there are subtle and sometimes major differences between the terms and interpretations within the roles (Walsh, 1999b).

Inclusion criteria:

Articles used in the review were to be published research articles, using acceptable terminology that denoted individuals or groups of nurses working at an advanced level within emergency departments such as: advanced practice nurse, emergency nurse practitioner, clinical nurse specialist and nurse practitioner. Education and evaluation of educational processes in relation to those groups mentioned. Finally the subject of requesting and/or interpretation of x-rays by nursing staff warrant inclusion. Excluded were non-research articles, reviews and publications that expressed personal opinion on the subject matter.

Results

Results of search:

Out of a total number of 858 articles 84 where chosen for initial review, this number was then reduced to 28, which in turn was further reduced to 15. This attrition rate can be attributed to the large number of reviews and non-research articles related to the subject; exacerbated by the fact that there exists a large body of research describing nurse practitioners from across the nursing spectrum. The author recognises that such a small crop of literature has extremely limited scope for generalisation.

Of the 15 articles chosen nine were written by senior medical staff based in the emergency department. The other six were written by a combination of nursing academics with an emergency background and senior nursing staff from within the speciality. Eight of the articles were published in an eminent medical journal. The other seven were published in a combination of nursing research journals and mainstream nursing publications noted for their support of nursing research (Appendix C).

Findings

The literature under review provided some fascinating insights into how the nurse practitioner role has developed since its inception in the late 1960's. The studies all came from either the United States of America (USA) or the United Kingdom (UK). Articles, reviews and other work from Canada and Australia were included in the initial evaluation, however none fitted the criteria for inclusion; the author acknowledges that given different time parameters and using expanded search methods other suitable material may have been found.

It would appear that it is in these two countries (USA & UK) that the concept of the nurse practitioner has flourished. However it is not to say that there has been a flawless development of the role. Although the studies were quite diverse in their content and context there emerged four prominent features throughout: Firstly the need for the nurse practitioner role, secondly the effectiveness and evaluation of the role, thirdly the issue of education and finally the resistance to the development and implementation of the role. These will be described below in the context of the literature review.

Need for the role:

Increasing number of attendees to the emergency department, coupled with a medical and nursing shortfall alongside ongoing financial considerations have led to ever increasing waiting times in emergency departments throughout the USA and UK. The development of the nurse practitioner role has gone some way in addressing these issues (Lindley-Jones & Finlayson, 2000b). Another factor that has had a major impact on the development of the role has been the reduction in junior doctors working hours (Dolan, Dale & Morley, 1997). The use of nurse practitioners in the emergency department is expected to rise significantly in response to these factors (Meek, Ruffles, Anderson & Ohiorenoya, 1995; Tye & Ross 1998). Tachakra and Deboo (2001) predict that as the use of nurse practitioners rises so will the demands made on them to mange more diverse patient presentations.

Effectiveness and evaluation:

Questions have arisen in regards to the effectiveness of nurse practitioners, studies such as those carried out by Freij, Duffy, Hackett & Cunningham (1996) and Meek et al. (1998) show that nurse practitioners are just as competent and effective as senior house officers in the emergency setting. Indeed some authors suggest that their studies show that nurse practitioners are more competent than senior house officers in the emergency department (Mann, Grant, Gully & Hughes 1998; Salt & Clancy, 1997). Furthermore Cole and Ramirez (2000a) find that nurse practitioners provide a better cost effective service than junior doctors. In regards to evaluation of the role it is acknowledged that ongoing audit of role effectiveness is required (Tye & Ross, 2000), alongside issues such as cost effectiveness evaluation (Dolan, Dale & Morley, 1997).

Education:

Cole and Ramirez (1999) studied the efficacy of nurse practitioners educational programmes. Although their results validated the programmes studied, they advocate for the ongoing development of such programmes if the nurse practitioner role is to remain effective. A more recent study by Marsdem (2003) calls for a more coherent development of the role, with the emphasis on continuing education. However for the role to develop in this current climate of purchaser provider market ethos within the health environment, with ever-present financial constraints, appropriately targeted resources will be required for ongoing nurse practitioner education (Walsh, 1999b).

Resistance to the role:

Professional resistance to the development of the nurse practitioner role has been quite overt and none too subtle. Studies show the main protagonists would appear to be radiographers and radiologists (Meek et al. 1995). However Lindley-Jones and Finlayson (2000b) find they are not alone, medical staff have also voiced their opposition to the role, interestingly their numbers include some emergency department consultants. It would appear that the issue of ordering and interpreting x-rays is the main stumbling bloc despite many studies that show nurse practitioners to be equal to and in some cases more competent in this respect than senior house officers and other junior doctors (Freij et al. 1996; Lindley-Jones & Finlayson, 2000a; Mann et al. 1998; Meek, Kendall & Porter, 1998; Salt & Clancy, 1997).

Discussion

The American perspective:

America has a well-established nursing research culture, and as discussed their nurse practitioner role development dates back four decades. One could rightly assume that this would result in a significant body of knowledge in this field of nursing. While reviewing articles for inclusion in this work it became evident that the prevailing methodology from the American perspective appears to be of a quantitative nature. Furthermore studies that would at first appear to fall under the qualitative paradigm, following analysis show a major quantitative component (Cole, & Ramirez, 1999; Cole & Ramirez, 2000a). One explanation for this could lie in the culture of financially driven research that is evident in the USA health sector, whereby funding and resources need to be justified within a fiscal economy (Heard & Harris, 1999). The major pharmaceutical companies are major players here and their research has historically been one of a quantitative nature (Vogel, 2002) Moreover the American concept of the nurse practitioner within the emergency setting is aligned with the bio-medical model of health care delivery (Curry, 1994). Nurse practitioners in America carry out far more advanced techniques than their counterparts in the UK; for example chest drain insertion and saphenous vein cut-downs (op. cit.). Some would argue that this is an example of how nursing has progressed, others would counter this with the suggestion that nurses are becoming "maxi-nurses" or "mini-doctors" and are moving further and further away from the fundamentals of nursing (Walsh, 1999a). However in terms of research one can see that quantitative methodology lends itself more

readily to this model of health care compared to qualitative methods that are more concerned with subjective meanings and interpretations of experience; which subsequently are less likely to have a direct effect on allocation of funding (Minichiello, Sullivan, Greenwood & Axford, 1999).

The United Kingdom perspective:

The development of the nurse practitioner role in the UK has grown steadily over the last decade. Recent figures show that they are used in approximately 69% of major emergency departments throughout the UK (Tye & Ross, 1998). This is up 6% on a prediction of 63% following studies by Meek, Ruffles, Anderson and Ohiorenoya (1995). In contrast with American there appears to be a void regarding empirical research specific to the nurse practitioner role in the emergency setting; related areas of interest show an abundance of quantitative data (Ibid). Research that is available to the nurse practitioner role explicitly has a tendency to show that qualitative methodologies are the tools of choice for this particular subject matter compared to the quantitative approach prevalent in the USA. However this in itself is fraught with problems as discussed by Read and George (1994), who found that the relatively small numbers used in qualitative research design causes issues with validity for those researchers more accustomed to quantitative methods. Moreover there also tends to be an over reliance on patient satisfaction audits to measure the effectiveness of the nurse practitioner role. Avis and Bond (1995) advise caution against over reliance on such a transparent indicator of quality; they advocate the use of a wide range of evaluative approaches alongside a variety of explicitly applied research approaches. One could interpret this to mean a balanced approach using both qualitative and quantitative methodologies. Unfortunately as with America the market place philosophy is now the norm and as such the nurse practitioner role is inevitably going to be assessed and evaluated in relation to its cost effectiveness in terms of the current era of purchaser/provider health care delivery.

The New Zealand perspective:

The concept of the nurse practitioner role in whatever setting is quite new to New Zealand, yet even at this early stage there exists controversy and resistance (Mackey, 2003); its relevance to the emergency setting remains an area that needs considerable research. Issues such as role parameters, academic qualifications and education all need to be further addressed and evaluated. Brian Dolan international key note speaker and editor of *Emergency Nurse,* speaking at the national conference of the College of Emergency Nurses in Auckland, May 2002, advised New Zealand nurses to learn from the situation that exists in the UK, whereby there is no nationally recognised standard for nurse practitioners. Nurses who have attended courses from as little as two weeks duration to full three-year degree courses can call themselves nurse practitioners if they so wish (Marsden, 2003). Dolan also advised New Zealand nurses not to go the American route and model themselves on the bio-medical approach, where he feels the essence of nursing has been lost. Rather he advises New Zealand nurses to analyse and evaluate both systems taking from them what is deemed best and appropriate for the New Zealand situation.

That is not to say that certain nurses are not working in an advanced capacity in the emergency arena. Since February 2001 four emergency nurses at Auckland's Middlemore Hospital have been working as clinical nurse specialists at their emergency department. This initiative is being supported at government level and endorsed by the New Zealand Nursing Council (Geraghty, 2002). Geraghty has been the main driving force behind the venture and has been involved with the project from inception. As with issues already discussed he and his colleagues found that there existed a degree of resistance from both medical and radiology staff, however since the project has found to be a success the resistance from medical staff has subsided: Michael Geraghty (personal communication, November 17, 2002).

As discussed in chapter three the author is currently facilitating a similar project to that of Geraghty within the Wellington region and is encountering similar resistance from medical and radiology staff (Davies, 2003).

Conclusion

It is acknowledged that the ever increasing number of attendees and increased waiting times experienced at emergency departments throughout new Zealand are now a fact of life. Individual areas are constantly exceeding their recommended triage treatment times, furthermore a paradoxical situation is occurring whereby those presenting with relatively minor complaints have to wait the longest (Cassie, 2002).

As discussed the role of the nurse practitioner in the USA and UK has been developed in response to an identified need. The studies reviewed show that in terms of effectiveness, nurse practitioners compare favourably with SHO's in the emergency setting. However one urges caution, as there appears to be no published studies to the contrary. Furthermore SHO's tend to be transient in the emergency setting compared to nurse practitioners who are permanently employed in the area. It would be interesting to view the results of studies comparing the efficacy of nurse practitioners with higher-grade permanent emergency medical staff.

Education is another area where we find a wealth of available information regarding the role of the nurse practitioner. In relation to the New Zealand situation where the concept of the emergency nurse practitioner is in its infancy, comparing and contrasting the differing systems of the USA and UK. One tends to favour the UK model whereby nurse practitioners are educated to a level that enables them to deal with patient presentations that are on the less severe level of acuity, rather than the American system of teaching advanced skills based on a bio-medical model of care.

Finally an issue that has been prevalent throughout the work, that of resistance to the role by colleagues from medicine and radiology, there appeared to be a distinct lack of in depth knowledge or information on this particular matter in the literature. However even at this early stage of development of the Nurse Practitioner™ role in differing spheres of nursing here in New Zealand there are rumblings of discontent. It remains to be seen how this resistance, if any, will manifest itself in relation to the development of the role within the emergency department setting.

Chapter Four

Theoretical Framework

Theoretical Framework

Kvigne, Gjengedal and Kirkevold (2002) find that nursing today with its individual holistic approach to care shares many of its underlying beliefs and values with the philosophical school of thought of phenomenology. Research methods derived from phenomenology are looking for the true meaning of phenomenon as experienced by the individual, and described by those individuals themselves. Edmund Husserl is generally acknowledged as the founding father of phenomenology, with philosophers such as Heidegger, Gadamer, Sartre and Merleau-Ponty further developing the method over time (Cohen, 1987; Crotty, 1998); however it is prudent to note that Immanuel Kant was the first person to be credited with describing phenomenology in 1764 (Ibid).

Phenomenology falls within the qualitative research paradigm which was initially part of a countermovement to positivism, whose advocates theorise that human experience cannot be researched in a quantitative manner; it is not possible for our emotional thinking self to be reduced to numbers. Furthermore it is also theorised that the way an individual perceives a particular occurrence cannot be generalised to the entire population. How one individual reacts to a given phenomenon will be entirely different to how another individual reacts to the same phenomenon, moreover the individual's reaction to said phenomenon may vary from one day to the next (Munhall, 1994).

Schools of thought:

Phenomenology as a modern day research method derives many of its characteristics from its philosophical base; it is an approach that is used to help understand an individual's experience of a particular occurrence in their life; attempting to analyse, gauge and understand that persons feelings, thoughts and beliefs that surround the experience (Wilson, 1993). The underlying assumptions of phenomenology are reality, subjectivity and truth. Within certain phenomenological methodological approaches it is also assumed that the researcher will put aside their perception of an experience and maintain objectivity so that the presentation of the individuals experience is true and unbiased (Taylor, 2000); this is termed *bracketing* and is a concept that formed an integral element of this research project. Bracketing will be

reviewed in the next chapter and discussed in-depth in relation to its use in this project in chapter seven.

In respect to undertaking research the phenomenological paradigm itself is sub-divided into two main groups, those who refer to Husserlian Transcendentalism, and those who identify with Heideggerian Hermeneutics. Both these methods are firmly entrenched within the phenomenological tradition, however it is recognised that there are marked philosophical differences between them (Annells, 1996). Acknowledging that each perspective has a complex, intricate make up; further to fully appreciate, understand and describe the minutiae of the separate approaches, bearing in mind the word limit and the emphasis of this work, would be beyond the scope of this project. However the author offers the following; firstly a comparison of the concepts of epistemology and ontology, followed by a concise analysis of the fundamental principals of each perspective as they relate to the phenomena under investigation.

Epistemology:

Epistemology: the theory of knowledge, esp. the critical study of its validity methods and scope (Collins Concise Dictionary, 2001)

To generate knowledge there must exist a theory of knowledge, epistemology is a way of explaining and understanding how we know what we know (Crotty, 1998)). In other words epistemology is the knowledge that informs theory and the theory that informs knowledge. There is a range of epistemologies, and each is embedded in the theoretical standpoint of the differing methodologies.

Philosophical hermeneutics from a Heideggerian perspective are principally subjectivist in nature; therefore it is removed epistemologically from the Husserlian objectivist position. Reeder (1989) finds that many of those that allude to philosophical hermeneutics do not consider understanding as a way of knowing rather a "mode of being". The epistemological stance within the philosophy is not a dominant feature as a result of this ontological viewpoint; however there are hermeneutic thinkers such as those from the Husserlian school of thought who give emphasis to the epistemological over and above the ontological. From this standpoint the associated epistemological perspective is objectivist in nature and holds that

meaningful reality exists. To paraphrase Crotty (1998), a tree is a tree apart from the fact people may be aware of its existence or not; when individuals become aware of its existence they discover a meaning that has been there all along.

Ontology:

Ontology in the post-modern research context needs to be clarified in respect to its connotation in both the philosophical and phenomenological research milieu. A succinct philosophical definition of ontology can be given as the "science or study of being" (Blaikie cited in Crotty, 1998, p.10). However there is a need for nurse researchers to recognise that in comparison to the former definition ontology in the present day research context relates to one of a theoretical perspective; it sits alongside and is sometimes quite indistinguishable from epistemology; indeed numerous researchers find that the two concepts are inextricably linked in terms of phenomenological research (Ibid). It is important to recognise this difference in definition, contextual use and its application to modern nurse research as many eminent writers such as Koch, (1995) and Paley (1998) find that there is very little or no connection between Heideggerian Hermeneutics and the procedures described by certain nurse researchers claiming to use this methodology. Moreover Paley suggests that many nurse researchers have fastened on to the idea of interpretation and translated it to mean that only the respondent's accounts of their experiences and their interpretations of these experiences are of any value. To Paley such writers are merely attempting to justify their own research methodology and as such this invalidates their research. From a philosophical perspective, meaning derived from ontology lies in the individual's transaction with a situation such that the situation constitutes the individual and the individual constitutes the situation, the aims are to identify and provide an understanding of the variety of constructions that exist about a phenomena; understanding is not a way of knowing, rather it is a mode of being (op. cit.).

In comparison to epistemology in terms of definition ontology is not aimed at theory construction rather it seeks understanding. However the fundamental philosophical perspective of ontology not withstanding; from gaining understanding one inevitably develops new knowledge, therefore it stands to reason that from new knowledge acquisition, theory construction can feasibly be attained. Further to this from a nursing perspective this knowledge can then be utilised to develop new practice and or

enhance existing practice. An analogy can be drawn here with the differences evident between clinical audit and research in its broader sense; clinical audit seeks to establish the effectiveness or otherwise of a known intervention in order to improve or discontinue said intervention, whereas research is concerned with generating new knowledge to advance and develop future interventions. So as is evident, whether one takes an objective epistemological viewpoint or a subjective ontological-existential perspective, the end product results in knowledge generation, which from the nursing professions perspective in terms of research can only result in a positive outcome.

Husserlian Transcendental Phenomenology:

Phenomenology became the methodology elaborated by Husserl that came to mean the study of phenomena as they appear through the consciousness (Husserl, 1931). Fundamental to Husserl's approach was the recognition of experience as the ultimate ground and meaning of knowledge, emphasising epistemological questions of knowing and concentrating on the experience as experienced by the individual (Koch, 1995). In comparison to the Heideggerian approach this method, notwithstanding its defining title, also utilises hermeneutics as an intrinsic element of its methodology.

Husserl introduced the concept of "lived experience" or the "life world" as it was originally known. Husserl claimed that this life world paradoxically is not readily accessible because it is generally taken for granted and/or perceived as common sense. The aim then is to re-visit these taken-for-granted experiences and re-examine them bringing to light the ultimate structures of the consciousness and to critically evaluate the role they play in "making sense of it all". Therefore the researcher utilising Husserlian phenomenology asks about the meaning of human experience; reality as the life world. The benchmark of genuine phenomenological enquiry according to Husserl is that of describing the individuals' experience (ibid).

There are three dominant notions that are fundamental to Husserlian phenomenology: bracketing (phenomenological reduction), essences and intentionality:

Bracketing

Merleau-Ponty (1962) finds that all assumptions about the causes, effect and wider implications of the phenomenon under inspection need to be eliminated or put to one

side if the concept of bracketing is to be attained. The research question can be answered by a process of phenomenological reduction, to achieve this the researcher needs to eliminate all preconceived notions of the subject under examination Further the researcher then needs to disconnect from the whole concept of the phenomenon, this is not to doubt its existence rather than to refrain from judgement (op. cit.) Husserl perceived this as a suspension of belief in the "outer world" so as not to impact on the research question; the reality of this outer world is neither confirmed nor denied it is "bracketed". The researcher is then said to be examining the phenomenon from a totally objective standpoint, thus negating any bias that the researcher may bring to the phenomena under scrutiny. Husserl also had an ultimate level related to his theory on transcendental phenomenology whereby researchers should be able to bracket out not only the outer world but also that of individual consciousness (Schultz, 1972).

Essences

A fundamental aspect of Husserlian phenomenology is that it should be a descriptive psychological process that brings to light the essences that make up the consciousness and perception of the human world. It was envisaged that one could come face to face with the definitive structures (*essences*) of the human consciousness. Husserlian phenomenology assumes a mind-body divide, whereby the mental content and its constituent symbolic representations and constant interpretative processes, can be presented in a systematic mode if they are examined in such a manner that they are brought to consciousness by cognitive processes. It is this detached examination of the *essences* that makes this approach objective rather than subjective. Cognitivists perceive an individual's knowledge, understanding and intentions as originating in the mind, from this perspective the mind is the only source of meaning and interpretation therefore it is possible to isolate and study *essences* (Thompson, Locander & Pollio, 1989).

Intentionality

Intentionality defines the fact that Husserl's concept was that the mind is directed toward objects, and it is this directedness that he termed intentionality. The idea is based on the assumption that the one thing every individual could be certain of was his or her own conscious awareness. The foundations of an individual's knowledge of

reality would therefore start with this awareness. Husserl theorised that there must inevitably be a content in the mind that accounted for this directedness, therefore the intentional content would manifest as a description of reality, whatever that reality may be for each individual (Dreyfus & Dreyfus, 1987).

Heideggerian Hermeneutics:

Hermeneutic phenomenology can be seen as the investigation arm of philosophical hermeneutics. The latter is a post-modern philosophy that has emerged to occupy a prominent place in the deliberation of existential issues (Thompson, 1990). The work of Heidegger, who is considered the prime instigator of modern hermeneutics, arose from the work of Husserl, under whom Heidegger studied in his early years (Annells, 1996) Heidegger's approach is based on two fundamental concepts; historicality of understanding and the hermeneutic circle. These two concepts are inextricably linked and to gain an understanding one must be aware of Heidegger's related ideas: background, pre-understanding, co-constitution and interpretation.

Background

The concept of background in this context is a fundamental element of the hermeneutic circle. An individual's genealogy or background is what gives that person a culture they have from the moment of their birth. This is handed down through the generations and gives that individual the tools to understand their world; it is this understanding that determines what counts as real for the individual concerned. Heidegger's stance supposes that meanings, skills and practices cannot be made completely explicit, as each individual's background, even those from the same culture, is different (Benner & Wrubel, 1989).

Pre-understanding

This term was utilised by Heidegger to describe the organization and meanings of a culture, which include that culture's language, practices, science and art, which already exist before an individual gains understanding. Humans always come to a given situation with some form of pre-understanding, it is a structure of our very being and not something that can be eliminated, it already exists within us. Therefore from this standpoint it can rightly be surmised that our interpretations on any given subject will to some degree or other be influenced by such pre-understandings.

Co-constitution

Co-constitution refers to the supposition that individuals and their world co-constitute each other. Individuals shape and construct the world in which they live based on their experience and background; conversely the world constructs and shapes individuals. From this perspective there is no division between the person and the world. An elementary assumption of Heideggerian phenomenology is the inseparable unity between the person and the world. The world already exists before the individual gains understanding and the ability to analyse their version of the world be it in a cultural, historical or social perspective.

Interpretation

From a Heideggerian perspective individuals cannot come to any given situation without reference to their background, each encounter requires an interpretation. This interpretation will be based on that individuals "historicality", their cultural background, experiences, socialisation, moral and value systems. This historicality provides a framework from which individuals can grasp concepts and ideas in advance. Heidegger (1962) finds we cannot have a world and/or a life at a cultural level except through acts of interpretation. Our capacity to understand is rooted in our definitions; these definitions are based on our self-interpreting ability.

That is not to say that for a given situation, if faced with the same situation in another context or at a later date that an individual may have a different interpretation if that individual were to be in possession of knowledge and experience that they did not have possession of in the first instance.

The hermeneutic circle

The phenomenological perception of the person from a Heideggerian standpoint arises from the ontological as opposed to epistemological of Husserl, "what does it mean to be a person". What it is to be a person relates to *dasein;* being already in this world. We are socialised into our roles in this world, this understanding of being represents the existential notion of *dasein.*

Dasein is a German word with no direct translation, it means "being in the world", having a concept of the meaning of being a human; it can refer to an individual or as a

general way of being within our world (Heidegger, 1962). Therefore the researcher brings to the situation within the context of interpretation his/her pre-understanding; this is inextricably linked to the participants' interpretations. Thus in the final analysis the findings of a given research question will be a combination of interpretations from both the participants and the researcher, giving rise to the third element, the hermeneutic circle.

Comparisons between approaches:

As previously mentioned there are important philosophical differences between both these approaches in undertaking research: Husserl emphasises the epistemological questions of knowing, in comparison Heidegger focuses on ontological-existential questions of how individuals come to an understanding. Husserl's approach and main goal is to describe the phenomena as experienced by the participants whereas the Heideggerian position is that the researchers themselves assist in generating research data precisely because of the concept of the "hermeneutic circle" as reviewed in the previous section (Koch, 1995).

Having noted these fundamental differences there does exist however a paradoxical element that inextricably links the two perspectives; both groups base their research activity on the individual's lived experience, which will be discussed in-depth later in this chapter, and as such in practical terms there is little to choose from between their differing methods except in their interpretation and usage of hermeneutics (Paley, 1998). The former concentrate solely on the participants interpretations of their lived experiences as told by the participants themselves, while the latter in comparison relies on the subjective interpretation of the researcher's lived experiences as an integral part of the research process (Koch, 1995).

As this mode of enquiry has developed over the past decade it is noticeable that a synthesis of methods is occurring as the methodology evolves; especially so among certain nurse researchers, with whom the author identifies in respect to this work, who are utilising a fusion of methodological enquiry from the differing phenomenological approaches to acquire their own method (Beach, 2001). Traditionalists argue against such a fusion; others counter that this is a natural progression as such a relatively

"new paradigm" in research terms, attempts to gain its identity (Koch, 1995; Bannister, Burman, Parker, Taylor & Tindall 1998.)

Hermeneutics:

Hermeneutics is the bringing to understanding concepts that involve language and text (Leonard, 1989). Martin Heidegger (1889-1976) is considered to be the prime instigator of modern hermeneutics with subsequent philosophers and researchers such as Gadamer (1987) and Crotty (1998) adapting and refining his work in the deliberation and development of phenomenological enquiry; moreover as mentioned previously Husserls work also utilises hermeneutics as an integral element of its approach (Annells, 1996).

In the context of this research project hermeneutics will involve the analysis of the spoken word that has been recorded in text form. The work of hermeneutics is not to develop a procedure of comprehension but to clarify the conditions in which understanding takes place (ibid). From this fundamental basis such work can then be advanced, as is the case with this undertaking; which will involve a secondary analysis of the information generated, leading to an in-depth investigation of issues affecting nurses in New Zealand related to the phenomena in question.

Heidegger (1962) finds that humans are interpretive beings; we are constantly interpreting phenomena to make sense of our world. These interpretations are based on the individual's background, culture and previous experiences. We are what we interpret ourselves to be, in other words we are self-interpreting beings. Taylor (1994) finds that our capacity to understand is rooted in our own definitions; these definitions are ultimately our interpretations and our interpretations of our interpretations. These interpretations are expressed in a variety of ways, emotionally and behaviourally, artistically and scientifically: however in our day-to-day lives it is through speech that many of our interpretations manifest themselves.

In terms of this research project, information and data was collected via the medium of in-depth phenomenological interview, which is but one method of data collection within this research methodology (Beck, 1992). The data collected was subsequently transposed into text form from which rich meaningful information relating to the

individuals experiences and their interpretations of these experiences was gleaned (Mulhall, 2002).

Transferring hermeneutics from its philosophical roots to its use in modern day research as a method of enquiry into the lived experiences of individuals is often a complicated and paradoxical process. One can find a multitude of interpretations and modifications of phenomenological philosophy and research methodology. However researchers such as Taylor (1994) find that hermeneutic phenomenology is by far the most suitable method for researching nursing phenomena as it is seen to focus on the experience of the individual nurse who exists within a health paradigm and who is constantly creating personal meanings and interpretations related to and within this paradigm. Further, it is in the telling and the descriptions of the various lived experiences of these individuals that meanings, interpretations and understandings can be brought to the fore and explored (Munhall, 1994).

Lived Experience:

Rooted in the philosophical tradition, phenomenology, developed by Husserl and Heidegger (Koch, 1995), is an approach that concerns itself with what the life experiences of individuals mean to those individuals and how these life experiences shape and impact on their day-to-day lives. The phenomenological researcher asks the question: What is the *essence* of this phenomenon as experienced by this individual and/or group of individuals? Researchers who allude to phenomenological methodology for their research assume there is an *essence* that can be understood (Thompson, Locander & Pollio, 1989). The phenomenological researcher explores subjective phenomena as experienced by the individual in the belief that essential truths about reality are grounded in the individuals lived experience. Phenomenological researchers further assume that human existence is meaningful and interesting because of the individuals' consciousness of that existence.

The focus of phenomenological enquiry is what the individual experiences in relation to a given phenomenon, how they interpret those experiences and how these interpretations affect the individuals lives, be it socially or professionally. Taylor (1994, p33) finds that our capacity to understand is rooted in our own individual interpretations and definitions; we are what we define ourselves to be:

> We are self-interpreting, self defining, living always inside a web of significance we ourselves have spun. There is no outside detached standpoint from which we gather and present brute data. When we try to understand the cultural world, we are dealing with interpretations and interpretations of interpretations.

Phenomenological researchers deem that lived experience, as experienced by each individual gives meaning to each individuals perception of a given phenomenon. The aim of phenomenological investigation is to describe fully the lived experience and the perceptions to which it gives rise within the individual. However it is at this point in the phenomenological research process whereby the two main schools of thought have historically held differing views. Those who identify with the Husserlian method emphasise epistemological questions of knowing and concentrate on the experience itself as lived through by the individual. In comparison those who equate with the Heideggerian approach focus on existential-ontological questions of how people come to understand, concentrating on the experience of understanding. As is obvious these differing approaches can have quite marked effects on the findings of a given research project. The former claim to describe the experiences, definitions and interpretations of the individuals as they appear and this is considered the primary data of the research. In contrast, the latter approach from their perspective, find that the researcher's interpretations of the individuals' interpretations form the primary data of their research; this concept has been termed the "fusion of horizons" by Gadamer (1989).

One cannot deny that Heidegger is seen as the prime mover and founder of modern hermeneutic phenomenology (Benner & Wrubel, 1989). However Heidegger himself was a student of Husserl; and importantly Husserlian transcendental phenomenology remains pertinent to the modern age (Dreyfus & Dreyfus, 1987). As previously mentioned, many modern nurse researchers acknowledge the contribution that both these influential greats have made, and have taken an approach that utilises a synthesis of both methodologies (Diekelmann, 2001).

This combined approach has been influenced to varying degrees by Merleau-Ponty (1962) who's work, derived from the ideas of both Husserl and Heidegger, has been

identified within the nursing profession as a perspective that shares nursings concern for people as embodied, holistic beings. It is this combined approach that forms the fundamental basis for this research project. Firstly the lived experiences of the participants will be described, followed by an analysis of these lived experiences, which will incorporate the researchers interpretations of the participants' experiences. Thus presenting an overall phenomenological picture of the topic under investigation.

Validity and reliability:

A fundamental question that now arises is how valid, within investigative study terms, are the findings generated from research that examines the concept of lived experiences?

Validity and reliability are important factors within the research paradigm, however their milieu within qualitative as opposed to quantitative research is entirely different (Warren, 1994). These concepts are not addressed in the same manner as when conducting quantitative research as the issue in phenomenology is not whether another investigator or methodology would come up with similar findings, rather it is whether the findings are worth paying attention to (Ryan, 1996).

As previously discussed one area that ensures validity in the phenomenological context is that the researcher themselves posses specific interview skills so as not to corrupt the data in any way (Beck, 1992). Further, this is enhanced by the argument that the true test of validity within phenomenological research is whether the findings are verified as an accurate representation of their experiences by those who had undergone the experience (Oiler 1982). The techniques of participant ownership and review of data throughout the various stages of the research process provide validity in this respect, due to the perceived and interpreted "truths" of the experiences as confirmed by the research participants themselves (Beach, 2001). Incorporated into the research design used for this work was a concept know as member checking, at a number of stages throughout the research process transcripts were returned to the participants to validate the data and its analysis to show that they are a faithful and true representation of the participants experiences, perceptions and interpretations (Ibid). Some phenomenological researchers find that member checking may jeopardise reliability if the participant is not happy with the transcribed account and wishes to change or withdraw data (Leonard, 1989). However other researchers from

within the paradigm believe that this concept of member checking is a vital component of the research process and adds to the concept of validity in the phenomenological context. Furthermore participants in this project were, as with many phenomenological research studies, empowered to withdraw their participation and/or their data at any time during the project. The former is seen by some as an intrinsic factor, and the latter a possible consequence of performing phenomenological research (op. cit.). As it transpired with this project none of the participants disagreed with the information produced; furthermore, and perhaps more importantly neither did any of the participants wish to withdraw any of their data or participation from the study.

Generalisability and Limitations of the research project:

In terms of data analysis generalisability like validity and reliability as evaluation criteria do not fit within the qualitative paradigm. It is theorised that the way an individual perceives a particular occurrence cannot be generalised to the entire population. As previously discussed how one individual reacts to given phenomenon will be entirely different to how another individual reacts to the same phenomenon, and that reaction itself may vary over time (Munhall, 1994). One cannot possibly generalise the findings from a qualitative research project with limited participants such as this one. Nonetheless, and in this respect more importantly, what the findings from qualitative research do is enable researchers to increase understanding where previously there was little information or awareness bringing to the fore issues that require debate and discussion. This in turn has the potential to inform future practice (Wilson, 1993); which as stated at the outset of this work, along with examination of the lived experiences of emergency nurses as they prepare for and practice at an advanced level, was another of the primary objectives of the project.

Trustworthiness:

The issue of trustworthiness within phenomenological research not unlike validity, reliability and generalisability relate to the fact of whether the findings of the enquiry are credible, believable, accurate and right (Sanders, 2003) Unlike quantitative research whereby objectivity, validity, reliability and generalisability are used as criteria for evaluation, the process within qualitative research is not prescribed (Minichiello, 1999). Some authors within the phenomenological paradigm have used

the concepts of credibility, transferability, dependability and conformability as analogous with the quantitative methods as criteria for evaluation (Lincon & Guba 1974) Another similar method popular in phenomenological inquiry is the use of Sandelowski's four factors: truth-value, applicability, consistency and neutrality. However once again here within the phenomenological paradigm we find differing interpretations and conflicts (Singer, Scott, Wilson, Easton & Weeks, 2001). To ensure trustworthiness in the context of this research the author has utilised interdependent concepts discussed in the previous chapters under validity and reliability, generalisability and limitations, inextricably linked with the concept of member checking whereby the participants were empowered to withdraw any of their data either partially or wholly at any time throughout the process. These are seen as fundamental principals that would provide credence to the analysis and findings of this research project; and as such the author is satisfied that this has been achieved.

Chapter Five

Methodology/Research Design

Methodology

The methodology chosen for this study was that of a mixed hermeneutic phenomenological approach, integrating Husserlian and Heideggerian underpinnings and principals. Utilising Colaizzi's (1978) procedural steps, unstructured in-depth interviews were the method of choice for data collection. Due to the fact that this phenomenon is in the very early stages of development in New Zealand and as such numbers of research participants are limited, a form of purposive sampling, primary selection, was used to select participants (Munhall, 1994). Data analysis and findings involved a two-phase process integrating the concept of data horizontalisation to provide research results (Taylor, 2000). Part one of the analysis concentrated solely on the participants' experiences, from which full descriptions of these experiences would be documented. The second phase involved a detailed examination and discussion of selected issues raised during the study, based on a combination of the participants, and the researchers interpretations, experiences and perspectives relating to the development of the nurse practitioner role within emergency departments in New Zealand.

The author's approach notwithstanding, acknowledges that many phenomenological researchers disprove of taking a structured or sequential approach to their research methodology. Many within the paradigm feel that to be truly of a phenomenological nature one must not and cannot develop a set of steps, but rather must proceed as the direction of the experience indicates without the restrictions such a structure would impose; for these researchers the method is the approach (Patton, 1980).

This definition of phenomenology as an approach may well suit some traditionalists inside the phenomenological paradigm, however this is not always the case within the nursing profession. Omery (1983) finds that nurses tend to be sensitive to accusations that their discipline is neither scientific nor a science; and as such a more definitive methodology (in relation to phenomenology) was a prerequisite to its effective implementation.

Heidegger (1962) and subsequent influential philosophers such as Gadamer (1987 & 1989) both allude to the theory of not having a system or set of rules in relation to research methodology. However concepts and notions central to the work of

Heidegger and Gadamer can, and have been used as a guide for the development of procedural steps for undertaking phenomenological research; such as those conceptualised by Vann Kamm, Giorgi, and Colaizzi (Omery, 1983). These procedural steps have been adopted and adapted by numerous nurse researchers using a synthesis of methodological enquiry from the differing phenomenological approaches to acquire their own method; Beach (2001) demonstrates this quite effectively with their research methodology. To some, but not all, from within the phenomenological research paradigm this is an accepted form of practice; which fits well with Omerys' description of those nurses who require a recognised and accepted phenomenological methodology for their research (Paley, 1998).

Research Design

The following is an overview of this projects research design; firstly a synopsis to give a broad perspective then an in depth analysis of each section:

Participant selection: purposive sampling/ primary selection

Five participants: all of who are working in an advanced capacity within an emergency department setting.

Data collection: informal, in-depth unstructured interviews

One on one interviews to collect rich illustrative data exploring the participants lived experiences related to the phenomenon under enquiry.

Bracketing

Researcher attempts to suspend or neutralise preconceptions, beliefs and biases about the research phenomenon and participants by utilising past experience and engaging in a process of self-awareness.

Data analysis

Adaptation of Colaizzi's (1978) procedural steps: process taken post data collection, prior to and including data analysis.

Participant selection:

The verity that this phenomenon is in the early stages of development limits the number of potential research participants. A major goal of phenomenology as with other qualitative studies is to extract the greatest possible amount of information from the available candidates (Polit & Hungler, 1999). Furthermore it is suggested that the ideal numbers of participants for phenomenological studies number approximately four to eight (Morse, 1994).

Incorporated into the research design was a form of purposeful sampling known as primary selection (Ibid). This is a process whereby the researcher uses prior knowledge to recruit participants. The author had identified five participants who are currently working within the emergency department setting, practising at an advanced level. Of the five, four are female; all participants are of European descent, age range 35-49 with an average time of ten years spent working within the emergency department setting. All are studying at Masters level and have expressed an interest in the Nurse Practitioner™ Emergency and Trauma role. This method of primary selection does have its critics(op. cit.), however research has shown that when applied correctly it has been found to be an efficient method of data collection within the qualitative paradigm (Morse, 1989)

Data collection:

Data was collected during one to one unstructured in-depth interviews between the researcher and respondent, of duration between 45-90 minutes. This style of interviewing is a recursive model; the purpose of which is for the interviewer to gain relevant data that is rich and informative through a conversational interaction process with the respondent (Mulhall, 2002). Although unstructured in nature the interview was based on an "interview guide" containing areas and issues central to the theme of the research (Appendix D). However it was the respondent who mainly directed the interview, with only negligible intervention on the part of the interviewer. Questions were open ended in nature to allow flexibility in probing areas of particular interest and relevance to the respondent, related to the theme of the research (Minichiell er al. 1999)

The interviews were carried out in a mutually agreed setting between the respondents and researcher. Although it was not envisaged that the subject matter would elucidate strong personal emotional issues; in the unlikely event that the content of the interaction did cause undue concern for either party, both respondent and researcher were empowered to request a time out period; with possible premature termination of the interview if appropriate. The participants were further empowered to withdraw all or part of their contribution to the research project at any time.

As a consequence of the research phenomena's relative infancy, one off interviews were chosen as the desired method for this project; evidence suggests that serial interviews carried out in such circumstances have the potential to lose spontaneity, as the participant has time to reflect between sessions and may impart or hold on to information in subsequent interviews that could contaminate the data (United Business Media, 2003).

Dobbie (1991) suggests that the research design used within a phenomenological perspective ideally facilitates the collection of descriptions, while preserving the spontaneity of the participants lived experiences. This was achieved during interview with the use of an audiotape, leaving the researcher free to concentrate on the interaction itself. Using a combination of refined counselling skills including an awareness of non-verbal interactions and communication to gather related data (Mulhall, 2002). Contextual non-verbal behaviour exhibited during interview was written up in note form following the session so as not to distract from or corrupt the experiences of the participants as recounted by them during the interview process (Coward, 1990). The author has a background in psychiatry/psychology with experience of the interview technique in both a professional context, and as a component of undergraduate study.

Bracketing:

There are intrinsic difficulties, conflicts and biases surrounding the issue of performing research where the researcher knows the participants. However a fundamental assumption inherent within certain forms of phenomenological inquiry in relation to data collection is that the researcher takes an objective stance and utilises the concept of "bracketing" or *epoche* as described by Husserl (1931). This involves

placing one's preunderstanding, prejudices, ideologies or theories to one side and maintaining total neutrality (Kvigne et al, 2002). Looking at the experience with wide-open eyes, with knowledge, facts, theories held at bay; concentrating on the experience is absolutely necessary. Becoming absorbed in the phenomena without being possessed by it is equally important (Oiler, 1982).

Omery (1983, p54) states:

> The phenomenological method is approaching the phenomenon with no preconceived expectations or categories, performing some form of bracketing to define the limits of the experience, and then exploring the meaning of that experience as it unfolds for the participants.

Utilising this notion of bracketing during the data collection phase was a pivotal component of the research design. The ability to undertake phenomenological interviews requires a certain degree of skill; furthermore to be able to attain the concept of bracketing is paramount if phenomenological inquiry is to achieve validity (Beck, 1992; Paley, 1998). The author acknowledges that there is some thought from within the phenomenological movement itself, that this concept is unattainable as some areas of preunderstanding are so ingrained they may be difficult to consciously identify. Philosophers such as Gadamer (1989) of who Heidegger was mentor, not only feel that this concept is unattainable, moreover they find that researcher prejudice, preconceptions and constant interpretations are an integral part of hermeneutic phenomenology from their philosophical standpoint. However bracketing is a technique that many nurse researchers utilising phenomenological hermeneutics have incorporated with varying degrees of success into their research methodology over recent years (Kvigne, Gjengedal & Kirkevold, 2002).

Data analysis:

The purpose of data analysis in phenomenology is to preserve the uniqueness of each lived experience of the phenomenon while permitting an understanding of the phenomenon itself (Banonis, 1989).

Incorporated within this research design at the data analysis stage the author has utilised an adaptation of Colaizzi's (1978) procedural steps. Although generally accepted that Husserlian principals underpin Colaizzi's approach (Koch, 1995), it in itself is derived from existential (Heideggerian) phenomenology. Furthermore, it is a method that has been adopted by hermeneutic researchers from the nursing profession (Sanders, 2003), and has reached a position of prominence within the field during the latter part of 20th century (Ibid).

Overview of the author's adaptation of Colaizzi's (1978) procedural steps:

1. *All interviews transcribed verbatim and read several times in order to gain a feel for them.*
2. *Verbatim transcripts returned to participants for confirmation of validity and permission to continue.*
3. *Each interview analysed for common topics and experiences. Searching for significant statements and phrases that pertain to the phenomena under investigation.*
4. *Data distilled down to clusters of themes.*
5. *Write up full account of participants' experiences in relation to identified themes.*
6. *Written accounts returned to participants for conformation of validity.*
7. *Researchers analysis and interpretation of data written up*
8. *Final thesis presentation.*

All interviews were transcribed verbatim then read and re-read to gain a feel for them, to become immersed in them without becoming overwhelmed by them (Jasper, 1993). Following this phase of the research process the transcripts were returned to the participants (point 2 above) for confirmation of validity and permission to continue. This initial act of returning the transcripts to the respondents is a slight deviation from Colaizzi's prescribed procedure. However such a move is deemed necessary, by some researchers including the author of this work, as a component of the validation process and constituted the first of two phases of integrated "member checking" to

ensure that these transcripts were a true version of the participant's accounts (Beach, 2001).

Omery (1983) provides an excellent overview of the various methods of analysing qualitative data; advocating the use of data analysis tools that are formulated from the basic ideas of other tools, adapted for use by the specific researcher for their studies. All of the techniques Omery discusses involve to some degree or other the transcribing of material, the coding of data into clusters, themes, categories and/or classifications. Attributes of the phenomena are identified from which descriptions, conclusions or a combination of both are fashioned. This process of objective data/phenomenological reduction, which is rejected by the subjective interpretive Heideggerian approach, yet is embraced by the Husserl school of thought within phenomenological enquiry has been termed "the horizontalisation of data" by more recent researchers. Further it is an aspect of phenomenological methodology used extensively by phenomenological nurse researchers (Taylor, 2000; Munhall, 1994).

Each interview was scrutinised for common topics and experiences, from which meanings were formulated. This data in turn was distilled down to clusters of themes to provide a full description of the participant's experiences. This stage of the research process was driven by Husserlian underpinnings, the researcher was not utilising and/or analysing their (the author's) interpretation of the participants experiences; rather the researcher was examining the participant's experiences, meanings and interpretations of their individual lived experiences as discussed and described by themselves. Utilising the concept of bracketing it is envisaged that these interpretations are a true reflection of the participants' experiences and not interpretations imposed by the researcher (Jasper, 1993). These descriptions were then written up to provide full similes of the participant's experiences. Upon completion of this phase the author once again returned the work to the participant's, the second phase of the member checking process, for further confirmation of validity and permission to continue (op, cit.). The final phase involved a return to Heideggerian principals whereby the researcher further analysed the data generated by the participants to provide interpretations based on the researchers experience and their interpretation of the participants interpretations.

This method of analysis is a synthesis of descriptive and hermeneutic phenomenology, which are two of the six methods identified by Spiegelberg (Annells, 1996), historian of the phenomenological movement that are common to all interpretations or modifications of phenomenological philosophy/research. As discussed and described in chapter four, an essential component of this study was the merging of fundamental principals and underpinnings of the two major schools of thought within phenomenology to generate an approach that was both appropriate and unique to this research project.

Chapter Six

Analysis and Findings

Analysis and Findings

This phase, analysis and findings, presents results of the data based on Husserlian principals, as discussed in chapter four and five of this work, describing the participants' experiences, interpretations and meanings that are pertinent to them as individuals in relation to the identified topics that have emerged as the research has progressed.

Data analysis and findings within phenomenological research are an integrated concept, unlike quantitative research whereby the analytic phase and the findings are two separate entities (Jasper, 1994; Polit & Hungler, 1999). The purpose of data analysis in phenomenology is to:

> Preserve the uniqueness of each lived experience of the phenomenon while permitting an understanding of the meaning of the phenomenon itself.
>
> (Banonis, 1989, p38)

As outlined in chapter four and five, this first phase of the work will concentrate exclusively on the participants experiences and the interpretations of such experiences as told by the participants themselves; bringing to the fore their descriptions and meanings and documenting them as such.

Integrated within and forming a fundamental tenet of the data analysis stage was the concept of data horizontalisation; from which issues and subjects for discussion were developed. Data horizontalisation involved scrutinising each interview for common topics and experiences, from which meanings could be identified and formulated. This data in turn was distilled down to clusters of themes to provide full descriptions of the participant's experiences (Kvigne et al. 2002). The findings generated from the analysis of the data were extremely varied in nature and covered an abundance of topics related either directly or tenuously to the phenomena under investigation. Initially two hundred and forty three individual subjects were identified (Appendix E), these reduced down to fifty-eight topics or shared experiences. Following further analysis these fifty-eight were again reduced in number to twenty-four themes and/or clusters of subject matter that the author found to be applicable to the research topic.

The final number of topics selected for inclusion was determined somewhat by the word limit imposed on this project and not by the data generated. In the final analysis the author has identified eight subjects that are deemed relevant for inclusion in this work.

Of the eight subjects raised, several compare with those that have been identified in similar studies performed in America and the United Kingdom; notwithstanding this they warrant inclusion, as they are pertinent to the situation here in New Zealand; moreover the majority of those issues that came to the fore are unique to the New Zealand context.

Many of the issues within the subjects discussed were re-visited several times within different contexts throughout the interviews; this was guided entirely by the participants. On several occasions it would appear that the participants were contradicting themselves; moreover the vast majority of the identified themes are intrinsically linked and cannot therefore be totally disassociated from each other. However for ease of presentation the author has presented the analysis/findings in a systematic order.

The following are the eight subjects chosen for inclusion in this work:

1 Need for the advanced nursing role within emergency departments in New Zealand
2 Nurses currently practicing at an advanced level within emergency departments in New Zealand
3 Development of the advanced nursing role within the emergency department in New Zealand
4 Education in relation to advanced practice within emergency departments in New Zealand
5 Resistance to the development of the advanced nursing role within emergency departments in New Zealand
6 Mistakes/Errors
7 International perspective of the advanced nursing role within emergency departments

8 The medical profession and lay public perception of advanced nursing practice in New Zealand

1: Need for the advanced nursing role within emergency departments in New Zealand

The need for the advanced nursing role was discussed under three identified sub headings: Professional development in terms of the nursing profession, personal development and escalating number of attendees with lack of experienced emergency care doctors.

Professional development:

All the participants were aware of the current changes taking place within the nursing profession here in New Zealand with regards to the nurse practitioner role and although there are not at present any nurse practitioners identified as working within emergency departments in New Zealand the importance of this role within nursing as a whole was evident. Josie, Kevin and Ann saw the development of the profession as "emancipation" and an "empowerment" of nurses and nursing to move forward out of the shadow of the medical profession. Josie found that nursing practice had changed over time within emergency departments and that the development of the nurses' role specifically in the emergency setting has risen exponentially over recent years and as such the "power differential" and dynamics between medical and nursing staff were changing as nursing developed into a more autonomous profession.

Carla was more forthright and stated "it was time for others; doctors, nurses, management and the general public to accept the development of the advanced nurses role" we are no longer the doctors "handmaidens". Sue stated she was frustrated as being seen as "just a nurse" in light of the high standard of continuing education that many nurses undertake to improve their theoretical and practical ability and thought it was a "sad indictment that nurses continually had to prove themselves" to their peers, doctors and other allied health staff.

Personal development:

The participants saw personal development as a fundamental aspect of developing the advanced nursing role itself. Kevin found that he was on a constant learning curve in relation to personal development, especially so since attaining senior status within his department. He found that not only were his responsibilities greater, other people's expectations of him within the role had increased. He stated that it was important to "recognise my limitations and do something about it". Ann has found the transition to

working in a more autonomous fashion "very challenging and scary" and along the same lines as Kevin finds that nurses have to "recognise our own weaknesses and address them". All participants were in agreement that they could not sit back on their laurels, change is happening and it is a constant phenomenon that nurses have to keep up with in order to maintain their personal development. However there were some discrepancies evident in what was perceived to be an acceptable level of personal development in terms of academic achievement. Sue notwithstanding her statement regarding nurses having to constantly prove themselves, and Josie were advocates of masters level study in contrast to Carla and Ann who although supportive of continuing education questioned the need to attain a masters degree. Paradoxically they like all other participants were undertaking masters level study at the time of the research project. Josie thought it important to achieve such a level of academia in order for nurses to demonstrate to medical and other allied health professionals that nurses themselves are capable of such achievements. Whereas Carla and Ann who even though they are aware of Nursing Councils standards for nurse practitioner status thought that nurses who wished to practice at an advanced level did not necessarily need a masters degree to practice at that level.

Escalating numbers of attendees with lack of experienced emergency care doctors:
The ever increasing numbers of patients attending the emergency department and the subsequent rise in waiting times, particularly for those with lower acuity presentations, is a topic that has had much discussion both within the profession and the media over the past twelve months.

Carla found that one of her main stressors was the actual workload that each emergency nurse had per shift, and the fact that this workload had increased over recent years. The participants were aware that some of the benefits of the advanced nursing role within the emergency department would be the ability to treat lower acuity presentations thus lowering the waiting times and providing a service that was patient centred. Josie who has a background in management and audit stated "doctors numbers overall within New Zealand are down" and this they found was reflected in the numbers of experienced emergency doctors within their respective units. Some units are working with inadequate numbers of medical staff, where other units are utilising locums from other specialities and yet others utilising junior doctors many of

whom have had no previous emergency experience as night and weekend cover. This was perceived by the participants as exacerbating waiting times, providing poor service delivery and a main factor in adding further stress to an already stressful environment. The participants find that nurses working in an advanced capacity within emergency departments practice on par with if not better than junior medical staff, indeed Kevin quoted a study from the United Kingdom that showed emergency nurse practitioners out performing senior house officers within emergency departments in terms of diagnosis and treatment of minor injuries. Sue further backed this by stating "nurse led emergency clinics in the Emergency Department within the UK have had a significant effect on decreasing waiting times".

2: Nurses currently practising at an advanced level within emergency departments in New Zealand

Nurses currently practicing at an advanced level within emergency departments were discussed under three sub headings; Recognition for nurses already working at an advanced level, those involved in advanced emergency nursing practice projects and pay and remuneration.

Recognition for nurses already working at an advanced level:

Josie, Sue and Kevin were at pains to point out that many nurses are already practicing at an advanced level within emergency departments in New Zealand, yet they do not receive the recognition or remuneration that they felt such individuals should be entitled to. Carla found that the development of the nursing role within emergency nursing was merely formalising a form of patient care that has been going on for years, recognised but not officially accepted by either medical colleagues, management or the nursing hierarchy.

Josie voiced concerns about the legalities of the customs and practices that nurses had incorporated into their individual practice over the years. She gave the theoretical example of a patient presenting with a minor laceration, being attended to by a nurse and sent on their way without being officially booked into the department or being seen by a doctor. Her concern was, what if something had gone wrong, the patient developed an infection or the nurse had missed an occult neurovascular insult for example. She stated that the nurse concerned "would not have a leg to stand on" if taken to court. Therefore she was extremely pleased that the role was being developed and that the informal form of patient cares that Carla talked about was becoming formalised with official recognition.

Kevin further supported this viewpoint from another perspective by expressing the fact that unofficially nurses orientate and support junior doctors during their three to six month placements in the emergency departments in a variety of ways including providing advice on how to treat specific presentations. On the other hand he also finds that many junior doctors when they first arrive in the emergency department are quite friendly and are happy to receive advice from senior nursing staff, yet he was disappointed to note that a high number of these individuals appeared to change their attitude toward nursing staff the longer they remained in the department and the more confident on the surface they appeared to become. In Kevin's opinion over time one

reverted to being "just another nurse" and not the trusted colleague of a short while before.

Those involved in advanced emergency nursing practice projects:

Three of the participants are involved in projects being run at two of the countries emergency departments whereby senior emergency nurses have received additional training that enable them to triage, treat, refer if appropriate and/or discharge home certain attendees at their departments who present with minor acuity problems that fall within an identified scope of practice that has been sanctioned by each organisation.

Josie finds that although nurses involved in the project at her organisation are dealing "only with minor injuries" it is a move in the right direction, indeed she states that it is nurses themselves " who are responsible for innovative practice" such as these projects within emergency departments in New Zealand. Kevin has found his involvement with his organisations project a rewarding and satisfying experience although at times he admits to feeling a little out of depth. Paradoxically in his case he feels more comfortable being a nurse leader in resuscitation attempts and caring for individuals who require non-invasive ventilatory therapy (CPAP/BiPAP) and/or invasive ventilatory therapy. However he admits that society is probably not ready to accept nurses diagnosing, prescribing and treating such presentations independently of any medical input at this moment in time; notwithstanding the fact that such incidences do occur, especially when working alongside junior or inexperienced doctors after hours or on weekends.

Ann discussed the issue of the increased numbers of attendees at the emergency department with subsequent increased waiting times over recent years as being a major factor as to her involvement and support of the project within her organisation. She found it extremely frustrating that those individuals who presented with relatively minor problems had to wait for very long periods of time to be seen by a doctor, when a suitably qualified and experienced nurse could have dealt with them independently. She also found that in her experience she had often been asked by patients and/or relatives why a nurse could not have seen and dealt with them for their complaint.

Pay and remuneration:

Kevin was very passionate in relation to this subject, he states " the government and management treat us like s—t and pay us s—t". In his opinion nurses will never get a decent wage because "the government know they have us over a barrel, and even when we do get a pay rise it is usually spread over a protracted time frame and we lose benefits such as special duty rates". He believes that nurses working in advanced roles should get paid a wage that reflects their added responsibility and accountability, however he feels that such a concept will not be soon in coming.

Carla again like Kevin has very strong views on pay, she feels that her particular organisation does not respect the senior nurses on the floor. "for my role I get an extra fifty cents an hour more than a top grade staff nurse", in her opinion this in no way compensates for the added work load, stress and responsibility that goes with her position. She also talked about her organisations Clinical Career Pathway (CCP) and stated that she was "disgusted' that the organisation she worked for thought it acceptable to reward senior nurses with a "paltry sum every two years, and even then its taxed".

Sue and Ann both thought that the system in place in the United Kingdom would be a good model to adapt to the New Zealand situation; there exists a grading system in the UK that goes from A to I. Grades D E being the equivalent of a staff nurse working on the floor, grades F and G denoting senior nurses with pay going up in relative terms throughout the grades. Sue feels that this would be a fair and equitable way of recognising nurses working at an advanced level. Further to this Ann feels that such a system would encourage senior nurses to remain in clinical practice without moving into management or education for better pay and conditions.

Josie while recognising that nurses felt underpaid, and as such at this moment in time there does not appear to be a system in place that recognises financially nurses who work in advanced capacities, talked about the prospect of nurse practitioners being rewarded with a salary that reflects their position within a given speciality. She cited one of the key note speakers at the 2003 Emergency Nurses Conference Mia Carrol, who suggested that nurse practitioners in New Zealand could and should earn a salary of between $80-90,000 and feels that this would be a huge incentive for individuals to work toward gaining nurse practitioner status.

3: Development of the advanced nursing role within the emergency department in New Zealand

Development of the advanced nursing role within the emergency department setting was discussed under four identified sub-headings: Perceptions of the role of the emergency nurse, training and accreditation, scope of practice and national and international recognition.

Perceptions of the role of the emergency nurse:

Kevin states that historically nurses within the emergency setting and elsewhere have been perceived to be the "doers without any evidence based practice, now with research based practice nurses are seen as a threat by other health care practitioners". He feels that this supposed threat to other professional health care providers may well, if not already, become a component of a whole set of issues that will form barriers to the development of the advanced nursing role within the emergency department setting.

Josie discussed a similar issue in terms of practice development relating specifically to nursing practice and how it has changed over time in the emergency department. She stated that the perception is still prevalent among allied health care providers the lay public and to some degree other nurses that "doctors make the decisions nurses do the practice" she added, "this will not be the case with nurse practitioners". Josie feels it is nurses themselves who are pushing the frontier empowering themselves to move forward in their practice.

All participants at some stage or another mentioned the perception that other professionals and the lay public have of nurses, even in this modern age, still being the doctors "handmaidens". Carla was particularly concerned that nurses themselves were not that aware of what their colleagues in differing specialities were doing, stating that "even other nurses do not know what we do in the emergency department". Josie and Kevin find that it is a matter of education and communication; nurses have to get the message across to other health professionals and the public at large that nursing has changed. Nurses have to induce "cognitive dissonance' in these people to demonstrate that nursing is developing into an autonomous profession in its own right.

Training and accreditation:

All participants were aware of the fact that at present there does not exist a certified national training programme for nurses wishing to extend their practice within the emergency setting.

Kevin and Josie who have extensive experience working in different hospitals both here in New Zealand and abroad find there are discrepancies between emergency units in regards to what nurses are empowered to integrate into their practice; this empowerment appears to be driven by local policies rather than national guidelines. For example Kevin related his experience of working in two regional units within New Zealand not separated that far geographically. In one unit the registered nurses are trained to cannulate, venepuncture, suture and cast within their first six months of arrival in the department, in comparison to the other emergency unit whereby only senior nurses perform venepuncture/cannulation under medical supervision and did not cast or suture at all.

Sue finds it quite frustrating that even when nurses undertook a course such as the Advanced Cardiac Life Support course (ACLS) that the nurses concerned depending on where they worked were not empowered to incorporate their newfound skills into their practice, "what is the point of being taught how to defibrillate if you are not allowed to use the skill". Further to this Sue was also perplexed and frustrated that even as a senior nurse when one moves from one unit to another one's skill level and experience are not always recognised within the new department even though one was employed on the strength of these two variables. Ann supports this by sharing the fact that even though individuals' bring skills, in some cases quite advanced skills, with them to the unit she works in they still have to go through the hospitals internal accreditation process to get recognition for these skills. She cites venepuncture for example, regardless of how long a nurse has been performing this procedure they still have to go through the hospital based training programme before becoming accredited to perform the skill in his/her new work setting; moreover she asks, "why do nurses have to do this when the doctors don't have to".

Scope of practice:

The two hospitals that are involved in these advanced practice projects have developed a scope of practice that relates to their specific organisation alone. Kevin, Josie and Ann reiterate that the projects they are involved with deal only with minor

presentations with some modifications relating to the individual nurses background, experience and qualifications; for example Ann is a wound care specialist and as such feels comfortable dealing with presentations that other nurses on the same project at her hospital would refer on to medical colleagues.

Josie meanwhile views the whole process as an ongoing evolving concept; within her organisation she is working on the issue of nurse-initiated x-rays as it is planned to extend the future training within her organisation to include below knee and below elbow examination. She finds it quite frustrating that although many nurses working within the emergency department are capable of carrying out an ankle assessment utilising the Ottawa ankle rules, an internationally recognised set of examination criteria, they still have to request a medical colleague to sign off a radiography request form before they can send the patient to x-ray as the radiology department of her organisation will not accept a nurses signature. Josie also had some concerns in relation to extrapolating the project out toward Nurse Practitioner™ Emergency and Trauma as envisaged by the Nursing Council of New Zealand, how would one define one/s individual scope of practice in terms of how, what, where and when. Despite such frustrations all participants appeared quite contented at the way in which their units were approaching the issue of advanced practice within their specific emergency department; comments such as "it's a start" (Kevin) and "we have to work to get people on board" (Josie) bear testament to this.

National and international recognition:

Carla, who at the time of the research interviews was preparing to become a part of her organisations advanced nursing project, voiced some concerns regarding the fact that nurses on such projects would not necessarily gain from them in terms of moving to another emergency department as the projects are only recognised locally; moreover the issue of pay became apparent again as she found herself in a dichotomy of wanting to advance her practice yet would receive no further remuneration for the added responsibility and accountability of her expanded practice.

Josie was very much of the mind that nurse practitioners working in the emergency department setting were inevitable; however the processes to achieve this were not yet in place. She discussed the concept of emergency clinical nurse specialists, whom she perceived to be a step above an emergency nurse working in an advanced capacity, yet practicing at a level below that of a nurse practitioner. She then posed the

question; is Nursing Council attempting to trademark the term clinical nurse specialist? Kevin was more specific in terms of national and international recognition in relation to the Nurse Practitioner™ Emergency and Trauma role in particular; he would like to see the concept developed so that nurse practitioner training and accreditation was of a uniform nature nationwide; as this would give the qualification and status standing with our colleagues nationally and internationally. Further to this he felt that Nursing Council of New Zealand were heading in the right direction in terms of setting standards for the status of nurse practitioners, however he feels that although nursing council have published a generic overview of the process there does not appear to be any specific guidelines for individuals wishing to peruse the qualification within emergency and trauma nursing. Kevin thought that individuals having to set out and define their own scope of practice within such a broad discipline, as emergency nursing was a somewhat abstract concept.

4: Education in relation to advanced practice within emergency departments in New Zealand

Education was discussed in terms of nurses currently practising at an advanced level within emergency departments with a view to attaining Nurse Practitioner™ status. Three broad categories were identified; masters level study, area specific courses and theory: its relation to practice.

Masters level study:

Both Sue and Josie feel that for nurses practising at this echelon, masters level study leading toward a masters degree is a vital fundamental component of the whole concept of advanced nursing practice. They felt that it is important to demonstrate to other health care professionals especially our medical colleagues that nursing be recognised and respected as a profession in its own right; and that the acquisition of an academic qualification at this level is an important factor in gaining that recognition. However they held differing views on what constituted appropriate academic study for nurses practising in an advanced capacity within emergency nursing. Sue feels that such study should be of a broad nature, covering all aspects of advanced nursing practice and its related concepts, whereas Josie in comparison feels that the academic qualification should be area specific with a named masters degree relating to emergency and trauma; focussing mainly on emergency care related issues only.

In complete contrast Carla and Ann both questioned the need for a masters degree; Carla paradoxically, considering her imminent involvement in an advanced nursing initiative within her organisation, felt quite strongly that nurses were being cajoled somewhat into perusing continuing education and becoming involved in research at masters level. She feels that nurses are not being given the recognition for anything they may have done prior to undertaking masters level study in terms of accreditation for prior learning, be that theory or practice based. She was quite frank about her own position, in that the only reason she herself was involved in masters level education was the fact that in her opinion it was the only way she could see of improving her career choices, yet she was not fully committed to or did not embrace the concept of nurses having to gain a masters degree in order to practice at an advanced level.

Ann asked the question several times "masters level, do we need it?" like Carla she also felt that it was an issue that was being forced onto nurses wishing to work in an

advanced capacity. Further she felt that masters level study was being forced upon practitioners by those within the nursing hierarchy who no longer practice at unit or ward level; whose agenda was to prove to those outside the profession that nursing is academically on a par with other recognised health professions, namely medicine. However unlike Carla, Ann has found the undertaking of academic study challenging and rewarding, furthermore she concedes that she has "learnt a hell of a lot" both personally and professionally. However Ann reiterates that on a personal level, although recognising the need for continuing education, she feels that the requirement of a masters degree for nurse practitioner status is debatable.

Kevin was of the opinion that nursing itself was an environment whereby one was constantly learning and developing professionally. He voiced the opinion that when individual nurses "come to think they know it all, maybe it was time for them to leave". He also felt that it was a natural progression if an individual was so inclined to move upwards academically, from diploma to degree through to masters and beyond, and although he personally thought that an individual could function in an advanced role such as nurse practitioner quite adequately without a masters degree he recognises the fact that standards and criteria have to be set and that it is up to individuals themselves to decided what to do if they wish to advance their practice.

Area specific courses:

Quite apart from the academic issues discussed it was apparent that the participants found value in courses that put certain prominence on psychomotor skill development; moreover the emphasis was on courses that are area specific to the emergency department. The participants were all of the belief that it was essential for their current level of practice and for future development that they are seen to be proficient practitioners in emergency nursing care.

Carla, Kevin, Josie and Ann had all participated and passed the Trauma Nursing Core Course (TNCC), all participants had achieved New Zealand Resuscitation Council (NZRC) level 6 provider status; with Sue attaining the NZRC instructor certificate. Josie and Kevin had passed the Paediatric Advanced Life Support Course (PALS); further to this Kevin had attended the medical practitioners Advanced Paediatric Life Support Course (APLS). All participants were experienced in the use of plaster of paris for casting, with Josie having experience with synthetic materials used for long term limb immobilisation. All except Sue were proficient at suturing to varying

degrees, with Josie being the most experienced feeling quite comfortable suturing the face including around the lips and eye lids.

All participants were trained in the Australasian Triage System (ATS), with again Josie having a national instructor certificate for this particular course. Sue, Kevin and Ann had all recently completed training in the use of Continuous Positive Airway Pressure (CPAP) and Bi-phasic Positive Airway Pressure (BiPAP). All participants had received ongoing training in the use of the Oxylog 2000, which appears to be the portable ventilator of choice used in the participants' resuscitation rooms within their differing organisations, with Kevin being the only participant who felt comfortable caring for a ventilated patient independently. Again all participants utilised venepuncture and cannulation in their practice, arterial blood gas sampling being confined to Josie and Kevin. Ann was adamant that such courses where invaluable to her practice she states that over time "more has been expected of senior nurses" therefore the individuals "skill level needs to be up" coupled with a "broad knowledge base"; this she finds is essential in the current climate of nursing shortages especially with regard to experienced staff. Carla mentioned the fact that these days due to the shortage of experienced emergency nurses, certain individuals in her opinion are being promoted to senior roles within emergency departments without the necessary experience and/or qualifications; so for her it was imperative that she be able to demonstrate advanced practice skills in her senior position.

Kevin found it important that senior nurses be able to take a leadership role in certain instances. He cited the resuscitation room as an example; he is of the belief that senior experienced emergency nurses are on a par with if not better equipped than junior or mid-grade doctors in dealing with trauma, cardiac, peri-arrest or arrest situations, especially paediatrics. From Kevin's viewpoint he feels he has witnessed too many of these situations "go to custard" due to inept medical practitioners unable to acknowledge their limitations in such circumstances. He feels passionately that suitably experienced emergency nurses should step up to the mark and take over the leadership role in a resuscitation situation if the attending doctor is obviously out of their depth. Moreover he states " it is almost always a nurse that initiates a resuscitation attempt so why aren't we empowered to run the whole thing". He reiterated the ethos of the NZRC level 6 courses, in which the Resuscitation Council themselves advocate that it is not always the most qualified individual, in terms of a

medical degree, that should lead resuscitation attempts, rather it should be the most suitably experienced and/or proficient individual for a given instance.

Theory and its relation to practice:

There were many ambiguities present in relation to theory and its practical application in the emergency department. Carla was of the mind that the subjects she had previously studied and was presently covering in her masters degree course had no value in the day-to-day practical aspect of her work. She stated that she "had no time for all that fuzzy stuff" and that she was only undertaking the course to gain the letters after her name in order to advance her career.

Josie in comparison was a true advocate of the theoretical component, of what she saw as a fundamental requirement, for advanced practice. To her it is imperative that individuals wishing to practice at an advanced level within the emergency department setting have the necessary theory/skill balance. She feels that over the years experienced emergency nurses have acquired skills that far outweigh those of many doctors who come to work in the emergency department and further to this many medical staff recognise this fact themselves; however nurses until recent years have not had the academic background that she feels is necessary to consolidate their position in the eyes of other health care professionals. She voiced the opinion that many doctors spend years studying and working toward a specific discipline in which to become a specialist and/or consultant. Compare this to experienced emergency nurses who have spent many years in their speciality, they already have the vast majority of skills needed to practice at an advanced level, and much of that practice is research, evidenced based, all that is required for many of them is to update their theoretical knowledge to an accepted standard, and this she feels lies at the masters level of study.

Sue again thought that much of what she was studying at masters level was more than applicable to the practicalities of hands on nursing. She had recently completed resuscitation and emergency care papers through Otago University and found that these particular papers gave her a better insight and understanding of concepts relating to the psychomotor skills she had acquired on the NZRC level 6 provider and subsequent instructor courses. She plans to diversify her study over the coming years, moving away from area specific papers to cover related elements of health care as she

feels it is important to gain a broad overall appreciation of health care issues that impact either directly or indirectly on emergency care.

Ann finds herself in somewhat of a dichotomy; while questioning the need for masters level qualification for advanced practice, she states she has "really enjoyed the experience", and although she is not really into "all that tree hugging " Ann admits to being able to relate some of the content of her theoretical study to her practical work in ways that had not been apparent to her before embarking on her studies. Nonetheless she still finds that some of the subject matter that she has covered is far to abstract and has no place in practical application within the emergency department setting.

Kevin finds that there is a correlation between education, theory, practice and experience; they are not inseparable in relation to advanced nursing practice. Following on from the fundamental nursing education one must build on their theory to suit their practice and this needs to be backed up with experience. However he feels that there must exist a balance between them, there is no point, in Kevin's opinion, in having all the appropriate academic qualifications and not having the ability to practice at a level suggested by them. Conversely bearing in mind the standards published by nursing council for nurse practitioner status he recognises the need for nurses who practice at an advanced level to have the required academic background. Further to this Kevin feels that the theoretical study that individual nurses pursue should at all times be applicable to their specific work place.

5: Resistance to the development of the advanced nursing role within emergency departments in New Zealand

Resistance to the development of the role was discussed under five sub headings; medical resistance, radiologist/radiographer resistance, emergency nurses resistance, other health professionals resistance and breaking down barriers.

Medical resistance to the development of the advanced nursing role within emergency departments:

Josie finds that in her experience many doctors are paying only "lip service" to the concept of the advanced nursing role within emergency departments here in New Zealand. She feels that many in the medical profession are aware of what has been evolving internationally in relation to the development of the role and in conversation with medical colleagues on the surface they may appear supportive; however her personal opinion is that the role is perceived as a threat by many doctors within the emergency field. Further to this she adds that paradoxically many of those who have voiced opposition are experienced senior emergency doctors as opposed to junior or middle grade medical staff.

Ann and Carla talked about how nursing practices within the emergency department have evolved over the years. They both mentioned "the extended role" in terms of venepuncture, cannulation, casting and suturing for example. Indeed on this subject Josie stated "extended role skills of the past are now routine skills for the emergency nurse". In years gone by such duties were the preserve of the emergency doctors, particularly the junior grades, Ann and Carla talked about the opposition that was apparent in those days to nurses taking on such responsibilities; now they find that we are at a stage whereby the doctors are quite happy to have given up these 'minor tasks' and are quite happy for nurses to perform such mundane interventions on their behalf, thus lightening their work load. However when it comes to nurses wishing to adopt more autonomous practice within the emergency department in terms of patient assessment, treatment and referral, nurses are once again not seen as competent to carry this out.

Sue and Kevin talked about "restricted practice' and "archaic hospital systems" as being primary barriers to the development of the role. They find that Hospitals have traditionally taken the bio-medical approach to care coupled with the present purchaser/provider managerial driven environment, augmented by the fact that many

of the senior hospital administration and managerial positions are taken up by medical staff. At unit level Kevin has found that in his experience he has developed a trusting relationship with many of his medical colleagues yet there is always the "them and us" attitude when it comes to certain issues, especially so in terms of nurses taking on more responsibility and autonomy in their practice. He along with Sue feel that there should be no need for conflict between doctors and nurses, both recognising that the other has certain strengths and weaknesses in differing aspects of patient care.

Radiologist/radiographer (radiology) resistance to the development of the advanced nursing role within emergency departments:

All participants felt strongly about radiology and its apparent resistance as a profession to the development of the nurses' role within the emergency department..They all concentrated on the issue of nurse initiated x-ray requests. The participants found it extremely frustrating that in their respective organisations that this was the one issue that caused so much consternation. All were in agreement that if nurses were empowered to request x-rays for certain presentations; such as ankle injuries for example then this would help alleviate waiting times and expedite the patients journey through the department. Carla found that they (radiology) just would not accept a nurse referral; they want a doctor to refer not a nurse.

Josie talked about the use of the Ottawa ankle rules whereby the practitioner utilises a well researched internationally recognised assessment tool to examine a patients ankle, which in her organisation is carried out at triage by experienced emergency nurses, the department in her organisation flatly refuses to accept a nurse referral, absurdly the nurse can fill the x-ray request form in yet a doctor must sign it off before the patient can attend the radiology department. Further to this Kevin talked about his organisation and how when approached about accepting nurse referrals the department head stated that 'it was against the law for a nurse to request an x-ray". Kevin says he finds that quite a ridiculous statement as he knows form personal experience that at one of the South Islands major emergency departments the triage nurse utilises an assessment form that is based on the Ottawa ankle rules, if the patient meets the criteria stated on the form he/she is then sent to the x-ray department with a request for ankle views signed off by the triage nurse. To his dismay when he attempted to discuss this with colleagues from the radiology department with a view to developing a similar system they would not engage in dialogue on the subject. Sue

feels that the barriers put in place by radiology in some organisation to prevent nurses from referring patients for x-ray screening is basically a "power struggle" that involves all three professions nursing, radiology and medicine; with radiology and medicine unable to accept the fact that they may well have to relinquish some of their power. She feels that whereas nurses want such changes in order to deliver an improved service for patients that will assist in decreasing waiting times, increase patient satisfaction and alleviate stress for both staff and patients, our colleagues from radiology and medicine have a differing agenda.

Emergency nurses resistance to the advanced nursing role within emergency departments:

Josie has found that in her experience many of the "old school nurses" do not approve or support the development of advanced nursing roles within the emergency department setting. Some nurses of long standing within emergency departments do not want to disturb the status quo; they have done things a certain way for many years and that's the way they want it to stay; further to this Josie finds that many nurses resent any questioning of their practice and are resentful of any attempt to up-skill or take on board the concept of continuing education. She feels that some individuals are going to have to take a long hard look at their practice with the advent of competency practising certificates.

Carla thinks it will take a long time for many nurses who work in the emergency field to come to terms with such changes in practice. Carla freely admits to being one of those nurses for whom continuing education and advanced practice were not concepts that she readily accepted; she was quite content to come to work and function as a staff nurse with the minimum effort. Her main concern was that many nurses who work within emergency departments are deemed senior after having spent the minimum time in the speciality. In her view some individuals are climbing the career ladder based solely on their academic qualifications and not enough hands on experience in the emergency field. Following a period of personal reflection Carla decided that she did not want to "be left behind" hence she embarked on her own process of continuing education to augment her experience in the emergency department.

Both Ann and Kevin found it quite disconcerting that nurses from within the emergency setting questioned the need for advancing the role, especially toward nurse

practitioner status. For Ann this first became apparent when she was invited to become one of the primary members of her departments initiative for senior accredited nurses to independently assess, treat, refer and/or discharge lower acuity presentations. Ann states 'I could not believe what I was hearing, people seemed so against the idea". She feels that some of the opposition may have come from those who felt they were being left out of the scheme. However she reiterated that there were clear guidelines laid down by her organisation as to who would be eligible to partake in the initiative and "anyway we had to start somewhere".

Sue was the most affected by this particular subject, having advanced relatively quickly through the seniority ranking within her organisation. She feels that certain individuals are being unfairly judged by their colleagues for wanting to advance their career. Sue shared the fact that she had "contemplated leaving the department" for that very reason. It is a paradox that nurses are forever talking about getting a better deal of things, and when some actually attempt to do so their peers within nursing ridicule them.

Kevin thought that much of the opposition from emergency department nurses stems from the fact that many see the idea of nurse practitioners as an elitist concept; nurses who take on added responsibility and accountability by practising in an advanced capacity within emergency departments are seen by others as taking that first step toward gaining nurse practitioner status. Kevin feels that advanced practice nursing or nurse practitioner status is not for everyone; people should be comfortable with the level that they function at as long as that function is based on evidence-based practice. You do not have to be an advanced practitioner to engage with the principle of evidence-based practice. He believes that advanced practice status is within the reach of every emergency nurse; they just have to want to attain it.

Other health professionals' resistance to the development of the advanced nursing role: Three main allied health professional bodies came under discussion here; nurses working in other areas, occupational therapists and physiotherapists. Sue finds it is the latter two professions that she has had negative experiences with, again as with radiographers/radiologists she has found that they are reluctant to, or flatly refuse to take referrals from a nurse as opposed to a doctor referring a patient for treatment. Moreover she finds that on the odd occasion that a referral is accepted she has encountered a condescending manner from colleagues in these areas. Carla feels that

when occupational therapists or physiotherapist come to the department they view us as "just the nurse" and prefer to liaise with medical staff in relation to individual patients care. She relates an incident whereby she referred a patient to the physiotherapy department and was told quite brusquely by a junior member of staff that it was not appropriate for a nurse to refer a patient and that "it is professional courtesy for a referral to come from a doctor". Ann states that 'nursing degrees count for nothing, we are not respected by other health professionals such as physiotherapists and occupational therapists", she again related that she has experienced negativity and even a degree of hostility when interacting with some colleagues from these disciplines.

Ann feels that nurses are still perceived by other allied health professional groups as "doctors handmaidens' who "do not understand the role or concept of advanced nursing within the emergency environment". Kevin finds it is other nurses from differing specialities that have caused him to reflect: "nursing colleagues from other areas do not realise the extent of the registered nurses role in emergency let alone nurse practitioners'. He goes on to further state that in his opinion the "nurses development in emergency is seen as a threat by other health professionals". Although he did contend that nurses working in the emergency area might be just as ignorant as to the developments occurring elsewhere within nursing; his partner works on a medical unit and he states he has "no interest whatsoever in medical nursing on the wards".

Josie who has been involved, at managerial level, in attempts to change practice in relation to the interaction with other disciplines and the emergency department finds like Ann that other allied health professions still perceive nurses as the doctors handmaidens, and like Kevin that they have no idea of how much emergency nursing has changed in relation to what nurses actually incorporate into their practice. She finds it quite frustrating that nurse led initiatives within the emergency department are automatically assumed by allied health professionals to be either promoted by or assumed to be under the direction of medical staff. As an example in Josie's department the use of Continuous Positive Airway Pressure (CPAP) therapy was developed and implemented by nursing staff, yet is was the medical staff that received all the kudos from colleagues in other areas of the hospital for introducing such a therapy into the emergency department. Further to this when the medical unit made inferences that they would like to develop a similar programme and requested

assistance from the emergency department they were somewhat surprised that they would be dealing with the nursing not medical staff.

Breaking down barriers:

Kevin states that as emergency nurses "we need to break down barriers" if emergency nurses are to be accepted as fellow professionals by other allied health professionals, especially in relation to advanced practice. To do this he feels that emergency nurses themselves must improve relationships with other health professional groups. Emergency nurses need to be open and honest with colleagues, he feels that education and information are the keys to getting the message across; that emergency nurses are not a threat to our colleagues in other disciplines, they are merely looking to advance the profession in their own field.

Sue also thinks that education and information are important tools in breaking down barriers, however she is an advocate of cross discipline/unit training as an aid to engender reciprocal respect. Sue feels that courses such as the New Zealand Resuscitation Council level 6/7 core course, where nurses, doctors and other health professionals actually train and work together go a long way in improving relationships; demonstrating to each other that we all have the capacity to learn skills and techniques from each others respective disciplines to improve patient care, and that certain aspects of patient care are not the preserve of one professional group.

Ann has found that her studies at university have brought her in to contact with other health professionals from differing fields; from talking to colleagues and learning about their area of expertise in an out of hospital context she feels that she has gained an insight into aspects and issues related to health care that she was previously unaware of. Ann found that her university study days have become a forum for the sharing of information and networking, gaining an insight and appreciation of how others work which in turn she hopes will benefit emergency nurses in their quest to advance their practice. Josie finds it is a matter of inducing "cognitive dissonance" into our colleagues from other areas, she feels that emergency nurses have to demonstrate that they can practice in an advanced capacity, both competently and professionally. It serves no purpose to keep telling colleagues what emergency nurses are capable of; emergency nurses must validate their practice in the eyes of others to gain acceptance in relation to advanced practice within the emergency department. It may take time yet Josie feels that the more colleagues from other disciplines are

exposed to the concept and practice of the advanced nursing roles the easier acceptance will become.

6: Mistakes/Errors

Mistakes and how they are perceived to be addressed in New Zealand were discussed under two categories, comparing and contrasting the medical and nursing council approach, and the media and Accident Compensation Corporation (ACC).

Comparing and contrasting the Medical and Nursing Council approach to errors:

Kevin, Ann and Josie were all scathing in their views on how the medical profession is perceived in relation to the way they deal with complaints against its members and their apparent disciplinary process; examples of high profile cases both in New Zealand and abroad were discussed. Kevin was of the opinion that there exists an "old boy network" amongst the medical profession whereby doctors cover up mistakes for each other, he feels that doctors are socialised into this mind set from their very early days in medical school. He also stated that no matter how well he got along with his medical colleagues that he 'would never trust any of them" in situations where a mistake or an error had been made. He related examples that he had personally experienced whereby medical colleagues had made blatant mistakes in relation to patient care and had subsequently attempted to blame nursing staff.

Ann finds that even when doctors are brought to account with the Medical Council that they are treated very leniently, moreover Ann also felt that the Medical Councils processes are not transparent and a lot of what goes on is out of the public eye behind closed doors. And like Kevin, Ann was of the opinion that nurses have to be very wary of their medical colleagues when a mistake has occurred because no matter how well you think you know each other the doctors will invariably stick together to the exclusion of their nursing colleagues.

Josie talked about the contrasting ways in which she felt the medical profession and the nursing profession dealt with such issues. She feels that even though both controlling bodies have historically policed themselves nursing council has in her opinion consistently come down harder on nurses who have made mistakes in comparison to how the medical council has dealt with similar issues, moreover Josie feels that the nursing council has again historically been more open and transparent in relation to its disciplinary processes. Further to this Josie and Kevin both mentioned the health Practitioners Competence Assurance Act 2003 (HPCA) which came into force on 18th September 2004 and the fact that with this new regulatory body for health care practitioners which incorporates both Medical and Nursing Council,

would hopefully allow for a fairer more transparent process across all health care disciplines in dealing with health care complaints. Carla, although not as passionate on this subject as the other research participants, did find that she felt mistakes brought the worst out in people and that there did appear to her to be dynamics evident whereby medical colleagues would be extremely supportive of each other in such situations, however nurses on the other hand tended to distance themselves from each other and to some extent attempt to foster the blame off onto others. Further to this Carla dislikes the apparent "backbiting and backstabbing" that goes on in the coffee and smoke areas, she feels that nursing as a profession lets itself down in such instances.

The Media and Accident Compensation Corporation (ACC):

All participants mentioned their dislike of the media and they way in that it sensationally approaches and deals with health care issues. Uppermost in everyone's mind were the events last year surrounding the case of the young lady with meningitis who died at home after seeking health care at two centres. One of the participants (name withheld) states that they know the nurse involved in the case and that they felt the media "crucified her" and did not report on the incident in an objective and fair manner, rather its reporting was emotive, blame seeking and sensationalised.

Josie felt that the media was responsible in some way for reinforcing the stereotypes within nursing such as the old dragon, the angel, the whore and the effeminate homosexual. Ann was concerned that with advanced practice and breaking new ground in the emergency care field came the very real possibility that errors and mistakes have the potential to occur. Her concern was in the event a mistake did eventuate how would it be dealt with, would there be organisational processes in place to protect the individual, or would the individual concerned have to rely on their union or private insurance; she also mentioned ACC and how reports in the media always seem to link mistakes and ACC together. Ann also raised the very same concern, she revealed that one of the reasons she was reluctant to become involved in advanced practice initially was centred on the possibility of making a mistake and how it would subsequently be dealt with. Ann again mentioned ACC, however she was unsure of how ACC, the Health and Disability Council (HDC) and the HPCA worked in relation to what regulatory body dealt with what complaint. Sue and Carla also voiced concerns about this confusion over how ACC fits into the larger picture.

They were unsure if ACC was a government organisation or a quasi-government organisation and whether it was a disciplinary body responsible for health care practitioners and their practice.

7: International perspective of the advanced nursing role within emergency departments

Kevin, Sue and Josie who had all attended the emergency nurses conference in Auckland 2002, and the emergency and flight nurses' conference Christchurch in 2003 admit to being influenced in their thinking by the keynote speaker, Brian Dolan. Brian is an internationally renowned Emergency Nurse, who was one of the United Kingdoms first Emergency Nurse Practitioners he is also editor of Emergency Nurse: the journal of the RCN A&E Nursing Association and was the initial nurse adviser for the hit television show Casualty. Kevin who has worked in the United Kingdom has been following the development of the role in that country and feels that it is a model that nurses here in New Zealand could adapt and work with. He also finds that British nurses have undergone much the same experiences as New Zealand nurses are currently going through as the role has developed in the United Kingdom over the past decade. Sue quite liked the concept of integrating services within the emergency departments, such as minor injury nurse led clinics, general practitioner and nurse practitioner primary health care clinics.

Sue is certain that there is scope for these kinds of initiatives within emergency departments here in New Zealand. Sue especially liked the idea of utilising the concept of "streaming" whereby attendees at the emergency department are initially allocated into streams, these streams define whether the individual is attending with a primary care, secondary care or acute emergency care presentations. They are then seen by the appropriate practitioner be that a doctor, nurse practitioner, other health provider or referred on to another department/unit; thus decreasing waiting times and improving patient service. Josie and Kevin were both of a mind that New Zealand should not copy the British model outright finding that dealing only with minor presentations, as is the case with British emergency nurse specialists, would not fit into the way they perceived the role developing here in New Zealand.

Kevin in particular would like the advanced role to develop so that it incorporates "care across the board" in relation to emergency attendee presentations. He was concerned that if he personally took on a role that was similar in form to the British model that he would lose his trauma and cardiac management skills. Josie talked about integrating the concept of other nurse practitioners or advanced nurse specialists from differing areas working within the emergency department. She gave the example of paediatric nurse practitioners working within certain departments in the United

Kingdom, and how effective they have been reported as being. Carla finds that her organisations senior emergency nurse accreditation programme is quite like that in existence in the United Kingdom, however on a much smaller scale, she states "we just don't get the numbers through the department as in emergency departments in the UK". Ann who like Kevin has worked in the United Kingdom likes the way the advanced nurses role in emergency has developed over there, she has also worked in America and feels that the American model would not be right for New Zealand. Ann finds that the American model of nurse practitioner had developed more along bio-medical lines rather than nursing, and that such nurses were working more as technicians as opposed to emergency nurses. Josie commented that the American system has developed with litigation in mind in contrast to other countries that have nurse practitioners; she fears that this may well be the case here in New Zealand in the coming years.

8: The medical profession and lay public perception of advanced nursing practice in New Zealand

The medical professions perception of advanced nursing roles in New Zealand was considered in its broader context in comparison to the previous discussion around barriers against the development of the role. This topic was found to be intrinsically linked to the associated subject of the lay publics perception of advanced nursing practice.

The medical professions perception of advanced nursing practice:

Ann feels that in the present situation of nursing shortages, especially in relation to experienced emergency department nurses, is that medical colleagues who work with nurses in the emergency department setting expect more in terms of specific psychomotor skills such as cannulation, venepuncture and catheterisation for example. She feels that some of the worse culprits are medical/surgical registrars and senior house officers who assess their patients in the emergency department prior to the patient being admitted to the ward. 'They know we are capable of performing these procedures in ED so they get us to do them rather than them having to perform definitive care procedures on the ward, yet we get no recognition". She feels that medical staff are quite happy for nurses to perform such procedures without acknowledging the high level of skill required to undertake such activities. Further she feels that there exists a double standard; at times our medical colleagues appear to recognise and appreciate the work of senior nurses and at others "we are not allowed to do anything, we are just nurses".

Kevin's thoughts on this subject align themselves with Ann's statement, he also feels that to many of his medical colleagues he is perceived as being a highly skilled practitioner in certain aspects of his practice, yet in others he feels that he is perceived as "just a nurse". This he finds very frustrating especially considering that in his view the nursing staff initially manage many of the acute presentations to the emergency department. Some doctors he finds are quite scathing and dismiss the initial assessment carried out by nurses despite being inexperienced emergency department physicians themselves. He further feels that the more experienced doctors are more perceptive to the concept of autonomous nursing practice than their junior colleagues, many of whom he finds put on a front to cover up for their own inadequacies. Josie observes that many of our medical colleagues recognise that some nurses have

extremely high skill levels, in many cases more so than themselves, and as such this is perceived as a threat to some within the medical profession; additionally Josie finds it quite amusing that when challenged on a specific aspect of care, even in the face of contrary evidence, many medical colleagues state, "I'm the doctor" and "if you wanted to be a doctor why don't you go to medical school". To Josie these are examples of behaviour and attitude that are ingrained within the psyche of many medical practitioners; further to this Josie relates a distressing statement made by a senior medical colleague whom she has worked with for a long time and who she has always considered a friend and colleague " nurse practitioners, so what".

In contrast Carla feels that it is nurses themselves who reinforce such damaging attitudes amongst medical colleagues. She finds that many nurses, including experienced practitioners, have a negative perception of where they stand in comparison to doctors. Carla states that in the final analysis many nurses perceive that " a medical decision will always override a nursing decision" and as such nurses with such a perception of themselves, their ability and their profession will almost always adopt a subservient position.

Lay publics perception of advanced nursing practice:

It is Carla's opinion that the publics' attitude toward nursing in general compared to the medical profession is that the old stereotype of the doctors' handmaiden still exists. Carla states that there is "absolutely no public awareness of the nurse practitioner role"; she feels that the concept just does not exist in the publics' psyche. To the lay public, nurses are there to do the doctors bidding, they decide what is to be done for the patient and the nurse carries out the physical act of attending to cares. Kevin adds to this, he feels that the public have no idea how nursing has advanced generally let alone having an understanding of individual nurses practicing at an advanced level, or of pursuing nurse practitioner status. Further to this, in his opinion, nursing is not perceived as a profession amongst the lay public; the public know nothing about nursing research or autonomous practice within the nursing profession. Ann like Carla, again, mentioned the notion of doctors' handmaidens in the publics' mind set. "They (the public) do not understand the role or concept of nurse practitioners". To Ann the aforementioned stereotype remains prevalent in the wider community she feels that a public education process should be instigated to raise the profile of nursing generally; it is only when the public have grasped the concept of

nurses as autonomous practitioners in their own right that Ann feels the nursing profession can promote advanced practice in specialist areas.

Josie finds it quite ironic that in her experience the general public have become more aware of their own rights in regards to heath care over recent years yet there does not seem to exist the same degree of knowledge out there in relation to the development of nursing as a profession. Like the others the "doctors handmaiden" concept again came to the fore. However in Josie's case she feels that the media has had a significant input into strengthening this age-old stereotype, with popularist programmes such as Shortland Street and ER for example reinforcing the mythical doctor nurse relationship. Sue in contrast states, " the public do not know or necessarily care about advanced nursing practice or nurse practitioners". She feels that the public are very appreciative of what nurses do for them, yet it is still the doctors that the public look to for definitive guidance in relation to their health care. In her opinion even in areas where nursing initiatives have been implemented, such as the Ottawa ankle rule assessment tool at triage for example, the general public still assume that all nursing assessments and procedures are overseen by a doctor either directly or indirectly. Sue again calls for a process of public education and awareness of nurses' roles in general as opposed to promoting specialist areas alone.

Conclusion to analysis and findings

Nurses' verbal accounts of their experiences:

This chapter has presented the subject matter from an objective Husserlian viewpoint, concentrating on the participants' subjective experiences, observations and interpretations rather than from the Heideggerian, [student] researcher perspective. The information presented came entirely from each individual's verbal account of his or her experiences. In essence these nurses have related their "stories". Phenomenology as a method supports nurses in relating their stories and assists the researcher to explore how these lived experiences have impacted on their practice and perception of health related issues.

Much has been written over recent years of the need for nursing to become more scientific in its approach especially in relation to nursing research (Peat, 2001); however, like older more established cultures, Maori for example, nursing until recent times has historically been a predominately oral culture (Street, 1992). If this oral culture is not valued nursing itself may be in danger of ignoring and possibly losing a fundamental aspect of its intrinsic make up. Street observed that nurses are learning to value themselves and their oral culture through processes that facilitate them verbalising their experiences. These stories are driven by their personal experiences in both professional practice and social interactive contexts:

"The oral culture of nursing values the capacity for subtle nuances and expressive meanings" (Street 1992, p19).

In relating their experiences these nurses have reflected on their world-view and experiences as interpreted by themselves. They have described their perceptions through their own interpretive processes; whether these interpretations are based on subconscious symbolic representations or definitive conscious structures based on personal conscious awareness is irrelevant. What is important is that their descriptions, experiences and interpretations are real to them as individuals (Dreyfus & Dreyfus, 1987).

This phase of the work was searching for the *essences* and *intentionality*, as described by Husserl and reviewed in chapter four, inherent within this group of nurses. These

concepts manifest themselves as the "lived experiences" of the nurses as described by themselves; emphasising questions of knowing (epistemology) concentrating on their experiences and interpretations of their life world (Koch, 1995). As discussed, with nursing having a distinctive oral component within its overall cultural makeup, the method utilised for this research project, requiring nurses to verbalise their experiences, became more appropriate as the process developed. Moreover the then examination and analysis of the spoken word recorded in written form, utilising the concept of hermeneutics, enabled the [student] researcher to analyse and present data in a form which further qualified the methodology and research design utilised for this work.

Chapter Seven

Post interview discussion: Bracketing

Bracketing

As previously discussed the concept of bracketing is an essential constituent of this study. However the author has found that utilising the concept within this research design did bring to the fore issues that were not obvious prior to undertaking the interviews. These will now be discussed in relation to bracketing itself as a unique fundamental component of the first phase, analysis and findings, and its relativity to the project as a whole.

Bracketing as described by Husserl, expects that the researcher be able to eliminate all preconceived ideas from their consciousness (Koch, 1995). The author found this concept quite difficult if not impossible to achieve. One could argue that this form or interpretation of bracketing can be seen as originating from and belonging to phenomenology's philosophical theoretical underpinnings; and cannot be directly achievable in a real world context (Kvigne et al, 2002). Nevertheless there exist other definitions of bracketing that would fit with its use in modern day phenomenological research. Beck (1992) finds that researchers need to *temporarily* suspend or *put to one side* their own beliefs related to the phenomenon under question in order to maintain an objective standpoint. One could again argue that this interpretation only serves to justify its use by researchers utilising the concept, and further how do they then prove that bracketing is a valid research technique?

In relation to its use within this project during the interview and first phase of analysis and findings the author attempted to maintain objectivity at all times; this was a hard fought battle and the author had to constantly remind themselve's of the importance of impartiality, self-examination and self-awareness. The main focus of the interviews was after all to facilitate the participants in expressing their experiences, and to document the findings as described by the participants, not for the researcher to contaminate the data with their own interpretations of the phenomena under discussion. In achieving this goal the author was greatly assisted by the usage of the interview guide (Appendix D) as an aid to maintaining a detached approach and ensuring the interview remain focused on the subject matter.

Nonetheless if one expects ones work to be taken seriously one must acknowledge identified deficits either personally or within the research design itself, and although

the author is confident that they outwardly maintained a detached approach the same cannot be said for the subjective psycho-emotive aspect that was experienced during the interviews and the first phase analysis. The author found that they were constantly identifying with the subjects and issues that the participants deliberated and brought to the fore. This experience certainly links in with Heidegger's concept of pre-understanding and one can see why those who allude to a pure Heidegger's approach refute the notion of bracketing.

Husserl himself found that at a specific level the use of bracketing is not so much a matter of doubting the existence of the subject matter, rather it is way of disconnecting from them, a certain refraining from judgement (Koch, 1995). However Husserl also described an ultimate level of transcendental phenomenology whereby the researcher bracket out not only all preconceived ideas and perceptions but also the individual consciousness (Schultz, 1972).

The author can certainly identify with the former and relate to this definition of the concept; stating with assurance that this was the approach taken in terms of the research project. Further the constant self-examination and awareness that was required in terms of utilising the concept of bracketing fits well with Jasper's (1994) findings that the use of bracketing involves the "deliberate examination" by the researchers of their own beliefs about the phenomena and related issues, requiring "temporary suspension" in an attempt to identify and correct them; thus demonstrating that the researcher is applying vigorous means to avoid influencing both the collection and interpretation of the data.

In terms of the latter definition, having the ability to bracket out ones individual consciousness, how does one accomplish this and further how does one prove that the concept has been attained? Quite legitimate questions in terms of trustworthiness and authenticity for qualitative work. The author feels that on a personal level this concept is unachievable; due mostly in part to the fact that modern day nurse researchers are performing research within their specific area of expertise in an attempt to expand the profession, as is the case with this research project. The author can once again see the value of arguments that refute the technique of bracketing as described in its purest from (Kvigne et al. 2002).

To demonstrate the soundness of the technique and in order to justify its use in this study, a component of the research procedure was to return to the participants their individual transcripts followed by the written up accounts of their experiences for confirmation of validity and permission to continue. The participants were empowered to withdraw any or all of their material at any time during the study. All participants were in agreement that the accounts were a true representation of their experiences and not that of the researcher; further that none wished to withdraw any material. The author is confident that the use of bracketing in the form described by Jasper (1993) and Koch (1995) was utilised to good effect.

Chapter Eight

Discussion:

Issues affecting the development of the Nurse Practitioner™ role within emergency departments throughout New Zealand.

Discussion

Phase one of the findings and analysis examined the experiences of the research participants as lived by them; preparing for and engaging in practice at an advanced level within emergency departments here in New Zealand. This second phase will involve a discussion based primarily on the authors experience and interpretations, acknowledging that they are inexorably linked to that of the participants; which will examine issues that have the potential to affect the development of the nurse practitioner role within the emergency setting here in New Zealand. This discussion will build and expand on several of the identified themes that have been raised and explored in chapter six.

Augmenting the data and information generated by the research participants the author will be utilising personal knowledge, information and experience alongside knowledge, information and experience gained from other health care professionals from both within and outside of the emergency setting whose viewpoints and perspectives have been deemed relevant to the topics under discussion. Some could argue that inclusion of such material detracts from the significance of the research findings and affects their authenticity. However to counter this the author has made explicit throughout the work that the first phase of the analysis and findings will be presented solely from the participants viewpoints based on the principals of qualitative research from a Husserlian philosophical standpoint. In contrast to this the second phase, the discussion, would be presented from the authors perspective based on Heideggerian principals.

To achieve this the author as a student of qualitative research has included information based on anecdotal communication from other appropriate sources. The individuals quoted are not related personally, professionally or socially to the original research participants. The author has used personal discretion in utilising a pseudonym for that individual whose contribution relates to aspects of legislative issues within the discussion, this individuals name will be marked with an asterisk*.

To avoid confusion, when referring to research participants in this phase of the work their names will be suffixed by the upper case letters RP.

The discussion itself will be undertaken in two stages. Stage one will commence with 1: An examination of the current situation with regards to the advanced nursing role in New Zealand; this will be followed by 2: A breakdown of the requirements for the Nurse Practitioner™ role as defined by Nursing Council of New Zealand. 3: Will address the question Nurse Practitioner™ Emergency and Trauma reality or concept? 4: Emergency nurse practice development in New Zealand will then be deliberated. To conclude this stage, 5: The concept of developing a national emergency nurse practitioner programme will be discussed.

The second stage of this discussion and the final aspect of this work will examine two legislative issues that will show themselves to be pivotal areas of concern in relation to the development of advanced emergency nurse practice and will no doubt ultimately have a bearing on those seeking the status of Nurse Practitioner™ Emergency and Trauma in New Zealand. Firstly an overview of the Health Practitioners Competency Assurance Act 2003 will be undertaken, this will be superseded by an analysis of the significant aspects of the Injury Prevention, Rehabilitation and Compensation Act 2001 with emphasis on areas that relate to nursing practice, the development of nursing practice, possible barriers to the development of advanced autonomous practice and the need for all nurses to be aware of how legislation affects their practice whatever their area and/or level of expertise.

Discussion: Stage One

1: Current Situation

This sub-chapter relates to the lived experiences of the research participants as interpreted and described by them in sections 1, 2 and 3 of chapter six.

At the time of writing this thesis there were no Nurse Practitioners™ working within the emergency department setting in New Zealand who held Nurse Practitioner™ Emergency & Trauma status. There are however individuals working within emergency departments here in New Zealand who are working toward that goal (Geraghty, 2002; Davies, 2003).

Having worked in several different emergency departments and having experienced varying degrees of autonomy in relation to practice, governed mostly by the particular employing authorities local policy and procedure processes, the author has developed a concise definition of a nurse practitioner, and can be given as:

> A registered independent practitioner who works alongside fellow health care professionals on an equal standing in terms of autonomy, status and practice.

The key word here being "independent", with all the associated meanings and interpretations that is attached to it in a health service context.

Several District Health Boards (DHBs) within New Zealand have clinical nurse specialists working within their emergency departments. This is to be applauded and can be seen as a move in the right direction toward autonomous professional practice. Moreover the introduction of the role of clinical nurse specialist within emergency departments in New Zealand has in some cases gone hand in glove with other initiatives launched in an attempt to address waiting times and improve the service offered by individual DHBs (Geraghty, 2002).

The primary difference between a clinical nurse specialist and a nurse practitioner lies in the aforementioned definition and the term independent. Whereas a nurse practitioner plies their trade as an independent practitioner the clinical nurse specialist, recognising that they are senior nurses within their speciality and that they

as individuals, possess advanced skills within their particular setting, work under the supervision of their medical colleagues (op. cit.). For those nurses who wish to promote nursing as a professional autonomous profession some may question how can one be viewed as a colleague with equal status if one works continuously under the supervision of another!

The major dilemma in the New Zealand context with the term clinical nurse specialist lies in the fact that the title is local in nature, meaning that it is only recognised by that particular institution. There is no national qualification, certification, recognition and/or registration for the role unlike our contemporaries in the United Kingdom and America (MOH, 2002). The training for the clinical nurse specialist role in emergency departments within New Zealand has mostly been in-house with some recognition of prior learning and in some cases recognition of overseas qualifications (Geraghty, 2002). Yet again however the title and psuedo-qualification are non transferable and as such are invalid when an individual wishes to apply for a similar position with a different organisation.

Compare this to the United Kingdom where the status of clinical nurse specialist, whatever the speciality, is recognised by a separate entry on the professional register (Nursing Midwifery Council, 2004,) under the auspice of the title "specialist practitioner", the status of specialist practitioner on the NMC register is acknowledged throughout the European Union and as a consequence is transferable from one institution to another. To gain this status individual nurses' must have completed a recognised post registration course at degree level within a particular speciality (Walsh, 1999).

Although there are some issues evident with the development of the nurse practitioner role, the clinical nurse specialist role within the United Kingdom has a well-defined entry requirement, educational and course structure. Further to this these clinical nurse specialists enjoy a salary that is commensurate with their skill set and position related directly to the national grading system for nurses that is in place in the United Kingdom.

Brian Dolan (personal communication, May, 23 2002).

A paradoxical situation that exists here in New Zealand is the fact that when one reaches the top of their particular pay scale within their DHB, usually step five, one is deemed a senior nurse within this speciality regardless of whether one has undertaken further study that is specific to ones area of practice or not. Many nurses are perceived by their junior colleagues to be senior merely due to the amount of time spent in one particular area, regardless of individual ability; moreover this situation is perpetuated by many long serving members of staff. Numerous "senior" nurses find it very hard to accept that their younger and/or less experienced colleagues may well posses the commitment and motivation to move their personal career forward at a pace that threatens their position within the institutional hierarchy; this perceived threat often extends to experienced staff who have moved institutions yet remained in the same field.

Michael Johnson (ED, personal communication, December 1, 2004).

Granted that with the advent of Competency Practising Certificates individual nurses have to demonstrate a commitment to post registration development; however that commitment is open to interpretation; further to this, one has merely to meet the requirements at the basic level to qualify for their practicing certificate. One might rightly question, do seventy-five hours independent study either indirectly or directly associated with the practitioners area of expertise within the past five years equate with an area specific masters level research project undertaken within the same time frame? Compounding this situation is that practitioners are requested to sign a self-declaration stating they have met nursing councils requirements for their practising certificate; some might view this process as fundamentally flawed due to the fact that in the event one were audited and had not met nursing councils requirements it would be easy enough to fabricate the information required, especially so in relation to the documentation of self learning time that counts toward the minimum requisite hours of study required by nursing council (Carla & Kevin, RP).

2: Nursing Council of New Zealand; requirements for the role of Nurse Practitioner™

This sub-chapter relates to elements of the lived experiences of the research participants as interpreted and described by them in sections 2, 3 and 4 of chapter six. Nurse Practitioners™ in New Zealand are certified to practice as such by the Nursing Council of New Zealand. Nurse Practitioners™ have a defined scope of practice that reflects significant clinical and theoretical expertise within their identified area of practice. Nurse practitioners are defined as autonomous practitioners (NCNZ, (2001), who like their colleagues from other health care disciplines do not require supervision for their practice. Nurse Practitioners™ work within a scope of practice that identifies their individual field of excellence. This scope of practice includes reference to a particular client group within which the nurse practitioner is certified to practice on an autonomous basis. Nurse Practitioners™ are qualified and empowered to make independent and/or multidisciplinary decisions in partnership with colleagues from other health care disciplines together with specific individuals, whanau/families and communities in relation to the care required by them. The individual nurse practitioner will have as core values an emphasis on health promotion/education, maintenance of health and disease prevention. Furthermore these values will be intrinsically linked to the practice of nurse practitioners that work in the acute care environment (MOH, 2002).

Requirements for the role of Nurse Practitioner™ Emergency and Trauma:

Nursing Council of New Zealand (NCNZ) has described a robust generic process for gaining endorsement of Nurse Practitioner™ status (NCNZ, 2002). To examine this process in minutiae would be beyond the scope of this work, however aspects of the process that relate to acquisition of the status Nurse Practitioner™ Emergency and Trauma will be reviewed and discussed in this section.

To be applicable to apply for the status of nurse practitioner an individual must meet the following criteria:

- Registration as a nurse in New Zealand appropriate to the intended scope of practice.
- A minimum of four years post registration experience within the Emergency and Trauma setting.

- Possession of a clinical masters degree or its equivalent.
- Meets the advanced nursing practicing competencies as described by NCNZ relating to the Emergency and Trauma setting.
- Describes a scope of practice within the Emergency and Trauma setting.
- Possession of a current annual practicing certificate.
- Good professional and personal standing
- Possession of a personal practice portfolio

Nursing Council has stated that it will take until 2010 to see full implementation of the Nurse Practitioner™ model. However during this transitional period there is recognition that there are already nurses within the New Zealand workforce who have considerable clinical experience augmented with appropriate postgraduate education who could meet the requirements for acquisition of Nurse Practitioner™ status; subsequently nursing council will consider appropriate individuals under its equivalence policy (NCNZ, 2001). Those individuals who meet the stated criteria will be assessed by a panel of fellow health care professional that include: a professional nurse leader with national and international understanding of advanced nurse practice, a nurse practicing at an advanced level with the ability to critique practice, a peer, not necessarily a nurse, from the same field as the applicant, a nurse with expertise in education experienced in the assessment of advanced competencies and one other panel member who may be a lay person (NCNZ, 2002).

Arguable the most contentious and potentially ambiguous variable of this process relates to the individual nurse defining and describing their scope of practice within the emergency and trauma paradigm. Nursing Council asks that the individual describe the parameters of their nursing practice within this milieu. Emergency and trauma nursing has such a broad assortment of presentations ranging from minor injuries through to major trauma, not to mention the high volume of primary and secondary health care attendees; moreover within these groups alone emergency nurses are dealing with a population that ranges from paediatrics through to geriatrics. Some would suggest that the whole is greater than the sum of its parts and to have expertise that transcends all presentations would be beyond that of a given individual (Ann, Carla, Josie, Kevin & Sue, RP). Nursing Council does however state that individual Nurse Practitioner™ applicants can define a "speciality or sub-speciality"

(NCNZ, 2002, p11). This sub-speciality concept may well be more applicable to the situation as it exists here in New Zealand at the present time, with nurses either considering the "Emergency" or "Trauma" aspect of the Nurse Practitioner role as an area to specialise in as opposed to a combination of both.

3: Nurse Practitioner ™Emergency and Trauma: reality or concept?

This sub-chapter relates to elements of the lived experiences of the research participants as interpreted and described by them in sections 2, 3, 4, and 7 of chapter six.

The questions arise:

Does New Zealand have individual nurses who have the ability to function autonomously across the spectrum of the emergency and trauma arena?

Is there a call for Nurse Practitioners™ Emergency and Trauma at this present time in New Zealand?

Comparing and contrasting emergency nurse practice development with that of the United Kingdom and America, one finds that in the UK context the emphasis with Emergency Nurse Practitioners (ENPs) is one of dealing with minor injury presentation (Marsden, 2003); whereas in America Nurse Practitioners who work in trauma centres are employed for their expertise in dealing with major trauma while other nurse practitioners are employed to specialise in the treatment of minor presentations in appropriate clinics/departments (Cole & Ramirez, 2000b). Granted that there exists a huge difference in population, culture and life style between these two countries, and the emphasis on nurse practitioner development has evolved to suit those countries particular needs. Not surprisingly therefore that within the American system it would appear from the research available that there are very few if any nurse practitioners that are employed to work in the emergency and trauma field per se (Ibid).

In the New Zealand context due to the varied of geographical locations and population numbers, verses major trauma incidents, the necessity for stand-alone trauma centres cannot be justified. This in itself would question the requirement for specialist trauma nurse practitioners. However there does exist, as discussed in earlier sections of this work, a recognised need for nurse practitioners in the emergency field, who specialise in the treatment of minor injuries. The author has specific interest, expertise and experience in trauma, arrest and peri-arrest management; however they recognise that in financial terms it would not be economically viable for a DHB to employ a trauma nurse specialist, whose work may well be limited, compared to

employing a minor injuries nurse specialist who could carry out a full time role. The answer may lie in examining the role of nurse practitioners in trauma and emergency from both the aforementioned countries, America and the United Kingdom; then juxtapose them alongside a theoretical model here in New Zealand. The New Zealand model could possibly be a synthesis of appropriate concepts from both the UK and USA models, integrating ideas and practices that are unique to New Zealand.

As previously demonstrated research indicates that the numbers of attendees at emergency departments throughout New Zealand are insidiously rising each year (Cassie, 2002); this is compounded by a lack of experienced medical and nursing staff. In an attempt to combat these and other variables nurses are working in advanced roles within individual departments throughout New Zealand. However, as reviewed in chapters two, three, six and this current chapter such roles, as the Clinical Nurse Specialist,, at this present time in New Zealand are recognised on a local basis only. Further, the nurses' in these roles deal predominately with minor injury presentations working under either direct of indirect supervision of their senior medical colleagues.

With all the international evidence available no one could legitimately argue that the time is not right for the development of the autonomous nurse specialist/practitioner role within the emergency department setting here in New Zealand; though the role may not quite manifest itself as the title Nurse Practitioner Emergency and Trauma™ may suggest! A concept that may well be worth considering here in New Zealand is to develop the role of a Nurse Practitioner™™ that specialises in minor injury presentations, such as the United Kingdom model, with or without the sub-specialty of trauma management, such as the American model. This latter section of this concept may well be of interest to those institutions such as Auckland, Wellington and Christchurch who have the facilities to treat major trauma, in comparison to the former who may well appeal to those smaller DHBs who see very little or limited trauma presentations.

4: Emergency Nurse practice development in New Zealand

This sub-chapter relates to the lived experiences of the research participants as interpreted and described by them in sections 1, 2, 3, 4, 5, 7 and 8 of chapter six.

Some would argue that the emphasis on individuals applying for and gaining the status of Nurse Practitioner™ Emergency and Trauma would be better placed on addressing the fundamental issue of developing a national programme of education for all nurses entering the field of emergency nursing (Lawless, 2004b). At this time in New Zealand such a programme does not exist; each individual hospital throughout New Zealand offer their own orientation package for nurses who work in the emergency department, typically a four to six week process. These orientation packages are then augmented to some degree or other by extended mentoring, clinical supervision, in-house courses and in some instances support for further education via higher centres of learning. However there is no consistency in this approach nationally as discussed by Lawless, (2004a); recognising that there exist a number of high quality education programmes for emergency nurses throughout the country that encompass both theory and practical skill acquisition, for example the Certificate in Emergency and Trauma Nursing offered by Victoria University, the Post Graduate Certificate in Resuscitation offered by Otago University and courses such as the Trauma Nursing Core Course (TNCC) and the New Zealand Resuscitation Council level 4-7 courses. However the evidence suggests that access and support for such courses are limited. Furthermore it could be argued that individuals who manage to access these courses do so at inappropriate times in relation to their career progression in the emergency field, or indeed others are hampered in their endeavours to access appropriate education:

> "I found the certificate in emergency and trauma nursing too academic for me considering I was inexperienced in emergency nursing, I question its benefit for those new to the speciality"
>
> Todd Muschet (ED nurse, personal communication, November 7, 2004)

> "They have taken me off the ENPC course because I have only been employed in this department for six months"
> Trevor Meyle [experienced adult trauma nurse] (personal communication, February 10, 2005)

As it stands presently the career development for individual nurses who work in emergency departments throughout New Zealand is an extremely disjointed process, with individual nurses accessing courses erratically and in some cases inappropriately. Then there are funding issues, some nurses willing to fund their own continuing education while other expect their organisation to be wholly or partly responsible for funding. Many career orientated nurses who perceive themselves as motivated in respect to continuing education find it hard to reconcile themselves to the fact that there exist other nurses within emergency departments occupying senior positions with very little or limited recognised post-graduate qualifications, who in their opinion are in these positions through tenure not merit (Josie, RP). Another annoying issue for some individuals is that of moving institutions and not retaining or gaining any recognition for previous experience, qualification or seniority within emergency nursing:

> "I have been a registered Emergency Nurse Practitioner (ENP) in the UK working autonomously for the past five years. Coming to a new country where this is not recognised is extremely frustrating"
> Karen Shaw (personal communication, May 19, 2005)

One could argue that what is required is a national and internationally recognised programme that supports nurses from when they first enter the speciality in relation to professional development that takes the individual on a journey of proficiency from novice to expert practitioner within the emergency-nursing field. In 2004 the College of Emergency Nurses embarked on such a programme. The college has called for interest for a working party to be involved in the development of a national education framework for emergency nurses. Their aim is to provide consistency in the development of emergency nurse practice, improve the theory practice gap, prepare emergency nurses to enter appropriate post graduate courses, improve the delineation of nurse roles in emergency nurses nationally and to ultimately define a pathway for

the emergency nurse practitioner role within New Zealand. The goal is to achieve a national framework that will assist emergency nurses in acquiring skills and knowledge that will enable them to practice safely and competently within the emergency setting.

This initiative is to be applauded and given the recognition it deserves, however one may question the fact that whilst on face value it would appear to be the answer to a defined problem, is it not too ambitious a plan considering the leap in concept from developing a national framework of education and career development for those new to emergency nursing through to defining a pathway for the emergency nurse practitioner role. The reader will notice that the author does not use the trademarked term here, as one of the contentious issues with the college of emergency nurses plan is to gain more influence over the learning provided in postgraduate courses than the tertiary course providers themselves as discussed by Lawless, (2004b). Further, at the time of this work going to print the College of Emergency Nurses states it has an unsecured! $10,000 grant to scope up the venture (Lawless, 2004a). So as one can see this project is in its very early embryonic stages of development. One can only hope that this project receives the support that will be required for it to be successful. However to achieve their goal the College of Emergency Nurses may well need to review their underlying ethos and be prepared to work with other organisations such as the tertiary institutions in a spirit of mutual respect and cooperation to achieve their long term goals.

5: Emergency Nurse practitioner programme development

This sub-chapter relates to elements of the lived experiences of the research participants as interpreted and described by them in sections 3, 4, 5, 7 and 8 of chapter six.

Notwithstanding Nursing Council of New Zealand guidelines in relation to application for the status of Nurse Practitioner™ Emergency and Trauma, of which at the time of writing the author is aware of five individuals from differing District Health Boards across New Zealand who are preparing portfolios and working toward the application requirements. Consideration must be made for the future development of an emergency nurse practitioner programme that will ultimately lead to the qualification of Nurse Practitioner™ Emergency and Trauma for those individuals who wish to pursue this career path.

No doubt the first individuals in New Zealand who achieve the status of Nurse Practitioner™ Emergency and Trauma will be worthy recipients. Moreover each individual will have defined their own area of practice within the speciality in line with nursing council guidelines, and each award will be unique to that individual. However one must legitimately ask two important questions, the first of which would be: upon receipt of the qualification, regardless of the fact stated by Nursing Council, would the individual nurses' qualification and status be recognised nationally or only by the employing DHB where the successful candidate works at the time of application? The rationale for this question being that the organisation within which the applicant works will have knowledge of that individuals strengths and weaknesses and will no doubt have had some input into the application process to some degree or other and as such will have assisted the individual applicant in defining his/her practice that would eventually be undertaken in the supporting institutions emergency department setting where provisions may well have been made for the successful applicant. Contrast this to another institution that knows nothing of the individual seeking to work as a nurse practitioner within their emergency department; given that this is such a new phenomenon here in New Zealand, with all the associated potential pitfalls and localised political conflicts, some of which have been explored in phase one of the findings of this work; one might question the chances of a successful outcome for an outside applicant for such a position. The authors' personal knowledge

of those individuals currently working toward application for the status of Nurse Practitioner™ Emergency and Trauma would certainly suggest the former is a reality; one can only pontificate in relation to the latter until such a situation arises. Further to this, and perhaps more importantly, will the qualification and status of Nurse Practitioner™ Emergency and Trauma be recognised internationally? This second point of international recognition for the status of nurse practitioner whatever the speciality an individual nurse practises in is extremely important; for the fact remains that Nursing Council of New Zealand does not automatically accept or recognise nurse practitioner qualifications from other countries, paradoxically that includes countries such as the United Kingdom and America with which historically, reciprocal nursing registration recognition has been in place. Granted that Nursing Council does have in existence an equivalency policy under which overseas nurses can apply for nurse practitioner status (NCNZ, 2001). However this is more of less the same process that an internal candidate from New Zealand currently has to go through to apply for nurse practitioner status. There does not exist an automatic equivalency process such as that for initial nurse registration; how then can Nursing Council of New Zealand expect other countries with which they have strong links to accept their version of the nurse practitioner qualification if that reciprocal respect is not extended to these countries. Nursing council's argument is that it wishes to have in place a robust system of assessment where the ultimate aim is to ensure public safety (Ibid). Nonetheless one cannot deny that such robust systems exist in the countries mentioned, who incidentally have a longer history of the nurse practitioner phenomenon than New Zealand.

Using the United Kingdom as an example, from which the vast majority of overseas nurses within New Zealand are drawn (NCNZ admin dept personal communication 2005). The evidence exists to demonstrate that, while recognising the processes in place for emergency nurse practitioner training and qualification are fragmented within the United Kingdom (Picton, 2005); in other areas of nursing there, there are well defined educational courses and professional development pathways delivered at graduate and post graduate level (Ibid); such as that expected by Nursing Council of New Zealand for nurse practitioner status here, which lead to individuals achieving either specialist practitioner or nurse practitioner status. Furthermore such qualification and/or status lead to a recorded entry on the United Kingdom

professional nursing register (Nursing Midwifery Council UK, 2003). Once attained this recorded entry of specialist practitioner/nurse practitioner status is a transferable qualification recognised both nationally and internationally with countries that have reciprocal agreements in place within the northern hemisphere.

> **Note:** At the time of writing this section of the work, August 2005, in the United Kingdom, nationally agreed standards of training for emergency nurse practitioners (ENPs) are being demanded by members of parliament on a powerful parliamentary watchdog. In a report published May 2005 the Commons Public Account Committee stated that the skills and competencies required by ENPs should be specified and the minimum content for their education curriculum defined (Picton, 2005).

With this in mind, what is required in the New Zealand context is the development of a programme of education for emergency nurses, as discussed in the previous chapter, that should go hand in glove with the development of a programme for potential emergency nurse practitioners, encompassing both advanced theory and practice, that has a defined framework leading the individual down a pathway toward the goal of Nurse Practitioner™ Emergency and Trauma status. Moreover the end product should be a qualification that is recognised not only nationally, but also on the international stage

At this present time such a programme for potential emergency nurse practitioners does not exist; how then could this process be addressed?

In keeping with nursing council requirements that nurse practitioners have an academic background at masters degree level, this would seem to be the obvious place to start; however paradoxically it could also be seen as the mid-point for such a process! At this present stage, potential applicants for the status of nurse practitioner here in New Zealand are required to possess a clinical masters degree or its equivalent as an integral component of the application process, the stipulation being that the masters degree be applicable to the applicants proposed area of practice. It would seem logical therefore that to gain the status of Nurse Practitioner™ Emergency and Trauma within New Zealand that a post graduate programme be developed which is unique to this qualification in this country. To develop such a programme it would require that

all interested parties such as Nursing Council, tertiary institution, the College of Emergency Nurses, medical council and any other appropriate organisations and/or individuals work in a collaborative manner to achieve this aim. It would also appear logical that the first individuals who are successful at gaining the status of Nurse Practitioner™ Emergency and Trauma here in New Zealand be involved in the process.

Consideration would need to be given on the constituent parts of the programme, one would assume that such a programme because of its ultimate clinical application would not be purely theoretical/academic in nature, on the other hand it could not conceivably be totally practical in makeup either; what would the theory-practice split be? Deliberation would also be required on what if any prior learning, either theoretical and psychomotor skill based in nature, could be considered as counting toward the qualification, or will it be a programme where all successful applicants start from scratch on an equal footing regardless of previous achievements? Further to this thought has to go into entry requirements for access to such a programme; would there be a defined time frame, as is currently the case, whereby individuals will have to have spent several years within the speciality, with or without evidence of a commitment to personal professional development within the emergency setting? Ultimately will there be a requirement within the programme for an original research project or can the qualification be feasibly attained by undertaking papers alone?

What then of the situation when one has successfully completed their specific masters degree, is one automatically conferred with the title Nurse Practitioner Emergency and Trauma™ and empowered to practice as an autonomous practitioner?
The reader will have noticed that in a previous chapter the author referred to the acquisition of a specific masters degree as being a potential "mid point" in the process of gaining the status of Nurse Practitioner™ Emergency and Trauma. As with any qualification within nursing, many perceive the attainment of a particular qualification as a point in time whereby the individual has gained the academic credential, they now have to reinforce this by acquiring the practical element. The author suggests that consideration be made in relation to a process of internship, not unlike our medical colleagues in their trainee internship (TI) year, whereby the individual has to successfully progress through a stated period of time in the practical arena under the

guidance of a nominated clinician. This nominated clinician may well be one of the pioneering nurse practitioners or a senior medical colleague who has shown interest and been involved in the programme development process. Upon successful completion of this internship the individual is then granted the status of Nurse Practitioner™ Emergency and Trauma. Alternatively this process of internship could well be integrated into the process at a different stage in the programme, the second or third year for example.

What such a programme would effectively be doing is to turn the current process on its head and present a formalised logical pathway for attaining the status of Nurse Practitioner™ Emergency and Trauma. Presently one has to meet the experience, knowledge, skill and academic requirements as laid down by nursing council in a manner reflects the situation as it stands now. It is very much an individualised format and reliant on a multitude of factors as to whether the individual is successful with their application or not. This will of course change over time as more individuals seek to achieve the qualification. The nursing profession owes it to itself to ensure that an objective standardised programme that is recognised both nationally and internationally be developed that will empower individuals to achieve their goal.

Comment

Heideggerian hermeneutical phenomenology focuses on the question of ontology as opposed to that of epistemology; Heidegger (1962, p94) states:

"We shall seek the worldhood of the environment by going through an ontological interpretation of those entities within the environment which we encounter".

In this modern era within New Zealand such phenomena are occurring and nurses, including the author, are seeking to understand their ever-changing environment; to do this we are constantly interpreting our experiences in light of our own personal world view. We are in effect experiencing *dasein* (being in the world), as reviewed in chapter four, whether we are aware of this phenomena or not (Ibid). Moving on to stage two of the discussion these concepts become even more relevant when one reflects on certain external variables that are so important to the phenomena under question that one would be foolish to ignore them. The author would go so far as to state that the

following issues are that significant to the development of advanced nursing roles in New Zealand that they deserve consideration for in-depth research at Masters or Doctoral level in their own right.

Discussion: Stage Two

Legislative issues related to autonomous nursing practice in New Zealand:

The following sub-chapters of this work relate directly to the lived experiences of the research participants as interpreted and described by them in section 6 of chapter six.

It is vitally important in terms of everyday nursing practice that individual nurses' are aware of current legislation in relation to their practice. Legislation constantly changes and as such health professionals need to be aware of these changes so that they may practice accordingly. Indeed as will be discussed, during the timeframe of this work changes have occurred in law to specific Acts that affect all Registered Health Practitioners. With this in mind, in line with stated objective two of this research project, that of enhancing the body of knowledge, this final phase of the work will review two key areas of health related law that directly affect the practice of Health Care Practitioners: the Health Practitioners Competence Assurance (HPCA) Act 2003 and the Injury Prevention, Rehabilitation and Compensation (IPRC) Act 2001.

Possibly one of the most important issues to arise out of this research project has been the discussion related to the potential consequences of nurses making mistakes when practicing in an autonomous capacity. What if any safeguards are there for the individuals who find themselves in such a predicament? Can they rely on vicarious liability on the part of the employer? Is indemnity insurance the answer? Or does the answer lie with the individual practitioners themselves?

As with any other cutting edge area of health care, especially with regards to new practices and procedures, the potential threshold for mistakes for those practicing in a totally new paradigm of autonomous nursing practice will be lower than that of normal established nursing practice (Tye & Ross, 1998). With autonomous practice comes added responsibility and accountability: for those nurses wishing to pursue such a career path here in New Zealand it is vitally important that they have an in-depth understanding of how the law affects their practice, their fitness to practice, their future practice and perhaps more importantly how the law can relieve them of their fitness to practice.

One assumes that in this current era the modern day nurse has more awareness of the overall picture of health care, especially in relation to how external factors influence and govern nursing practice; however as is often the case with assumptions one cannot make such an supposition with confidence. Take for example the full implementation of the Health Practitioners Competence Assurance Act 2003 (HPCA). This is possibly the greatest legislative change to affect nursing as a profession within New Zealand in recent times. Most nurses here in New Zealand, one would hope, were aware that this Act came into force on the 18th September 2004 replacing the Nurses Act 1977 (NCNZ, 2005). However, having an awareness of the existence of this act does not necessarily imply a full understanding of said act, moreover it does not imply an understanding of how this act interfaces with other legislative acts which have an important bearing and influence over those nurses wishing to advance their practice, be it working in a more autonomous fashion within their speciality, or formally taking the path toward nurse practitioner status. Further to this there exists a specific act on the New Zealand statute books that interfaces with the HPCA Act that has the potential to affect the careers of those individuals wishing to practice autonomously; this act is the Injury Prevention, Rehabilitation and Compensation Act 2001 (IPRC, 2001).

The penultimate section of the work will give a brief overview of the Health Practitioners Competence Assurance Act 2003 and its relation to the nursing profession in terms of this research project. This will be followed by a discussion on the Injury Prevention, Rehabilitation and Compensation Act 2001 Act, its implications and how it may have some influence over the decision to pursue the autonomous career path for those wishing to gain nurse practitioner status here in New Zealand.

Health Practitioners Competence Assurance (HPCA) Act 2003: its relation to the nursing profession with respect to the subject matter of this research project

The primary purpose of the Health Practitioners Competence Assurance Act 2003 is to protect the health and safety of the public by ensuring that health practitioners, in this case registered nurses, are fit and competent to practise. This act builds on the core functions of the Nursing Council in relation to the activities of education, registration, health and disability monitoring and the investigation of nurses whose practise have come into question. The Nursing Council as with all other bodies appointed by the HPCA Act is hereafter referred to as the "Authority" and in this context is responsible for the Practice of Nursing as defined by the HPCA Act (op. cit.). The Authority will continue to set standards for education and audit in respect of educational institutions responsible for the education of nurses in New Zealand. It remains the registration body for nurses, maintaining the register and issuing annual practicing certificates. The authority will continue to receive notifications of health issues that may prevent an individual nurse from being able to practice. An important addition under the Act is that the Authority will also receive notifications about nurses who pose a risk to the public by practicing below the standard required for competence to practice here in New Zealand.

Under section 11 and 12 of the HPCA Act the Authority describes the nursing profession in terms of scopes of practice. It is under these sections of the act that nurse practitioners will be governed. However until such time that a sanctioned educational course for the qualification of Nurse Practitioner™ Emergency and Trauma is developed, the process for gaining said qualification would remain convoluted. Firstly the individual nurse will have to describe their individual scope of practice to the Authority. The Authority will then, in the event of a successful application, have to describe that individual scope of practice under section 11 (1) and have it published in the *Gazette* (Ibid) prior to the individual being sanctioned to work as a Nurse Practitioner™ Emergency and Trauma in New Zealand.

Registered nurses are responsible and accountable for their actions and/or omissions which have an effect on individual patient care, such accountability is contextual in nature and in cases where the individual is practicing under the supervision of another, definitive responsibility or accountability for a given situation is debatable. However

this will not be the case for nurses working as autonomous practitioners, as they will ultimately be accountable for their practise. Under New Zealand law everyone has the right to complain about the conduct of a practitioner. Under section 64 of the act complaints about an individual practitioner will initially be made to the Health and Disability Commissioner, the Commissioner will then decide if they need to refer the complaint to the Authority for further action. The Authority may or may not suspend an individual during an investigation if there are sufficient grounds to do so. A Professional Conduct Committee appointed by the Authority actually investigates the complaint. The Professional Conduct Committee has a wide range of options open to it for any given situation, however in the event it wishes to pursue an allegation of alleged professional misconduct the case is referred on to the Health Practitioners Disciplinary Tribunal, this is an independent arm of the HPCA Act and replaces the previous process whereby such a case would be heard and dealt with by the Nursing Council of New Zealand. The Health Practitioners Disciplinary Tribunal will consist of a chairperson, who is a lawyer, four panel members of whom three are to be professional peers of the individual brought before the tribunal and a layperson. The members of this tribunal have the responsibility of making the definitive decision required of a given case; which may ultimately include removal of an individual's fitness to practice status and/or removal from the register.

This brief analysis of selected themes of the Health Practitioners Competency Assurance Act 2003 demonstrates how greatly the act impacts on the nursing profession as a whole, let alone those who wish to pursue a more autonomous career within nursing. The final section of this work will demonstrate how further legislation on the statute books here in New Zealand interfaces with the HPCA Act 2003 to define established nursing practice and will no doubt have some degree of influence on the development of autonomous nursing practice within New Zealand.

Injury Prevention, Rehabilitation and Compensation (IPRC) Act 2001: its relation to the nursing profession in respect to the subject matter of this research project

Both citizens and non-citizens within New Zealand have a right to place a claim for medical misadventure with the Accident Compensation Corporation (ACC) if they feel they have suffered a personal injury as a result of treatment given either directly or indirectly by a registered health professional; furthermore when the claim is received by the company they must by law action the complaint within a specified time frame of 14 working days (IPRC Act, 2001). The Accident Compensation Corporation bases all its work in relation to medical misadventure on the Injury Prevention, Rehabilitation and Compensation Act 2001. Specifically sections 32, 33, 34, 38, 62 and 284. The following is an analysis and discussion on how these sections of the Act relate to current nursing practise and have the potential to influence the development of autonomous nursing practice here in New Zealand.

To the student researcher's knowledge no official data is available within the public domain, however at any given time ACC processes approximately 1000 claims for medical misadventure, of these approximately 20% (200) are claims relating to medical error or medical mishap on behalf of registered nurses.
Marc Welsh* [ACC] (personal communication, December 10, 2004).

For ease of presentation and to avoid unnecessary repetition the remainder of this section apart from that marked with an astrix* is referenced from the IPRC Act (2001). The following are abridged definitions relating to specific sections of the act.

Section 32, definition of medical misadventure: Personal injury caused by medical error or medical mishap. The term medical in this context does not apply solely to the medical profession it relates to all registered health practitioners regardless of speciality. The requirements for medical misadventure claims are:

- Personal injury - The claimant has to have suffered a physical injury or a mental injury, which is the outcome of a physical injury.
- Causal link – There has to be a direct link between the medical treatment and the injury suffered by the claimant.

- Medical Error or mishap – Medical error or mishap has to have occurred at the time of medical treatment.

Section 33, Medical Error: A medical error occurs when someone is injured because the person treating them did not provide treatment of a reasonable standard; it includes situations when a health professional is negligent about a patients diagnoses, treatment or consent. It is not a medical error just because the patient did not get the desired result, or it transpires that another decision about the patients' treatment may have been more appropriate. ACC is not a disciplinary body and does not take any disciplinary actions against any health professionals found in error, nor does it report them to any other medical body. This latter part of section 33 is misleading as section 284 subsection 1 reads:

> "The Corporation may at any time bring to the attention of or refer to any appropriate person or authority any matters concerning medical error or medical mishap'

Further to this section 284 subsection 2 reads:

> "The Corporation must report an incident it accepts as medical error to the relevant professional body and the Health and Disability Commissioner"

Section 34, Medical Mishap: A medical mishap occurs when the correct treatment was properly given but a patient experienced a complication that was both rare and severe. This complication must clearly be because of the treatment, not an existing medical condition. Rare means that less than 1% of people would have experienced that complication from the treatment (for example only one person out of a hundred taking a drug would have a certain reaction). Severe means that because of the complication experienced by the individual, said individual was:

- In hospital for 14 days or
- Was significantly disabled for at least 28 days or
- If the person being treated died.

As an example: the most prevalent claim made against nurses processed by ACC is related to the procedures of venepuncture and cannulation; thrombophlebitis and infection successively. These claims are rarely accepted as they are a known and accepted complication related to these procedures; the incidence for associated thrombophlebitis and infection runs at approximately 15-20%, so the complications are not rare as defined by this section of the act. (Marc Welsh* [ACC] personal communication, December 10, 2004).

Medical error is deemed the more serious of the two, and under section 284 (2) of the act will be referred on to the appropriate authority and the Health and Disability Commissioner; this will then be dealt with under section 64 of the HPCA Act 2003 as described in the previous section. Medical mishap is deemed just that, a mishap, however under section 284 (1) a medical mishap can be referred on to the aforementioned bodies. Further to this and more concerning is that under section 284 (5) (a) a health practitioner may be reported to these bodies even in the event that they are not found in error. Compounding this is the fact that all claims, including those that are dismissed in the early stages of investigation whereby the health practitioner is not aware that a claim has been made against them, are kept on record at ACC headquarters in Wellington indefinitely. Registered health professionals who have a claim being processed against them are referred to as the "Involved Health Professional", and do not become aware of the claim if it has been declined within the first 14 days. It is only after this time frame when the process enters its second stage that they are notified of the claim being processed against them. (Marc Welsh* [ACC] personal communication, December 10, 2004).

Section 38, Date on which person is to be regarded as suffering personal injury caused by medical misadventure: The date on which a person suffers personal injury caused by medical misadventure is the date on which the person first seeks or receives treatment for that personal injury as that personal injury. This is an extremely important section to understand. A claim can be made in retrospect with no time limit. So as an example: what is the situation whereby an individual makes a claim against a current nurse practitioner who was not an autonomous practitioner at the actual time of the alleged medical misadventure? According to the law as it stands the claim would be processed against an individual as an autonomous practitioner in their present

position not in the actual context of when the alleged misadventure occurred. For many nurses who work under the direct supervision of another registered health practitioner, a doctor in the vast majority of cases, their practice is covered to some extent by section 34: 10 (a) which states "given by or at the direction of a registered health professional". This of course will not be the case with autonomous practice.

Section 62, Decisions on claim for personal injury caused by medical misadventure: When actioning a claim for personal injury caused by medical misadventure the Corporation must either; in the case of medical error obtain and have regard to independent advise from a suitably qualified person or body, or in the case of medical mishap have regard to independent advice from a suitably qualified parson or body, or information obtained in a similar case or class of case. This again causes problems for the potential nurse practitioner within the emergency field; there are presently no suitably qualified peers to obtain independent advice from, moreover one cannot give independent advice on a claim if the independent advisor personally knows the health practitioner that the claim is being processed against, which may well be the case when the first successful candidates for Nurse Practitioner™ Emergency and Trauma are sanctioned to practice. The chances are that such independent advice would be sort from a medical colleague; the question that then arises is can this really be classed as independent advice in such a case?

As is obvious the legalities associated with this subject matter are immense and unfortunately until such time an individual practicing in an autonomous fashion is faced with such circumstance here in New Zealand one can only ponder on the potential procedure and outcome of such a situation. Individual organisations may well offer vicarious liability for the actions of their employee, the individual may well have indemnity insurance, Nursing council in its former guise may feel that their guidelines to practice are watertight and will cover such situations; however all of this will not be enough to protect the individual autonomous-practitioner/nurse-practitioner having their fitness to practice endorsement withdrawn if a given situation were to warrant such action. At this moment in time, relative to the development of autonomous nursing roles here in New Zealand, the only protection available to individual practitioners, is to have an in-depth understanding of the law, how it affects their practice and the potential consequences for them in the event of an adverse situation.

Note: As of July 1st 2005 an amendment to the Injury Prevention, Rehabilitation and Compensation act 2001, *Treatment Injury Provision*, came into being. The amendment introduces a new category called "Treatment Injury" which replaces medical misadventure caused during treatment by a registered health professional. Individuals who suffer injury as a result of seeking medical treatment will non-longer have to prove that the health professional who provided said treatment was at fault, or that the injury was "rare and severe" to receive assistance from the Accident Compensation Corporation (ACC). This change has occurred in part related to the fact that under the old legislation co-operation between ACC and involved health professionals was adverse and protracted at times because an anomaly existed whereby health professionals in many cases had to give evidence against themselves. Apart from the change in terminology and the specific change to the confirmation of fault and the rare and severe clause the remainder of the act remains in force. This law change affects all registered health professionals and does not change an individuals right to complain to the Health and Disability Commissioner if they are not satisfied with the standard of care they have received from a registered health professional. All claims lodged before July 1st 2005 will be dealt with under the old legislation. It is estimated that it will take approximately 9-12 months to decide on these claims
Eileen Reilly [ACC] (presentation HVDHB, July 23, 2005).

Conclusion: Discussion

A true ontological approach requires that the researcher [student] themselves participate in the process of gaining understanding, as it is the researchers interpretation of the participants experiences and their combined interpretations of these experiences that lead to understanding (Annells, 1996). As stated previously, this phase of the work would involve an examination and discussion of issues relating to the development of the nurse practitioner role within emergency departments in New Zealand. It is in essence based on the Heideggerian concepts of background, pre-understanding, co-constitution and interpretation. In keeping with the underlying principals of qualitative research from within the Heideggerian paradigm, the discussion was generated the authors world-view and lived experiences.

One cannot deny that the author's world-view, experience and interpretive processes are inextricably liked to that of the research participants. Therefore we have a situation whereby the ontological concept of understanding is juxtaposed and inexorably linked with the epistemological question of knowing; and as such the author acknowledges that stage two of chapter eight; discussion, in contrast to stage one could be perceived by some to be more of a descriptive process rather than a discussion in the literal sense; this could then be interpreted as to be leaning more toward the Husserlian approach to enquiry. The author counters this by rationalising that the use of a hermeneutic phenomenological method informed by Heidegger required that the author gather information which identified essential features of actual and/or perceived reality, thus addressing the ontological question of an individuals experience of "being in the world" and transposing that to the every day reality of being a nurse practising as a health professional in twenty first century New Zealand.

The subjects reviewed in discussion stage two are a legislative reality and are yet to be tested in terms of autonomous nursing practice. What the author has done by broaching these issues is to describe, discuss and begin to interpret the possible implications that such legislation will have on the development of advanced nursing roles here in New Zealand.

Validity of this research project:

The question now arises, how valid and reliable are the research analysis, findings and discussion of this work in the New Zealand context?

Bearing in mind that as discussed in chapter five many nurses tend to be sensitive to accusations that their disciplines are neither scientific nor a science (Omery, 1983). A paradox exists between those who advocate that nursing today which shares many of its underlying beliefs and values with the philosophical school of thought of phenomenology; therefore the concepts of validity, reliability, generalisability and trustworthiness, do not apply (Kvigne, 2002), with the fact that there exist many nurses and nurse researchers who although alluding to qualitative research methodologies wish for a more structured scientific approach to qualify their work (Paley, 1998). Further to this as reviewed in chapter four the concepts of validity, reliability and generalisability are viewed differently from the qualitative perspective as opposed to the quantitative standpoint.

The issue here is whether the findings are authoritative and trustworthy and therefore worth paying attention to in the New Zealand context. As is apparent the issues that have been chosen for discussion in this work are relevant to the phenomenon under investigation; further to this the author is confident that information gleaned and discussions generated by this work are authoritative and trustworthy in relation to the phenomena in question. However and possibly more importantly there are many other issues and subjects that came to the fore, again related to the phenomena under review, that as a result of the limitations of this work were not given the consideration they deserve. The student researcher is convinced that many of these issues and subjects would generate further information and understanding that would contribute to the body of knowledge required for the development of the Nurse Practitioner™ Emergency and Trauma here in New Zealand. This fact in itself qualifies the need for more research to be undertaken into this area to explore the phenomena more thoroughly.

Chapter Nine

Summary

Summary

This project has examined the lived experiences of five emergency department nurses as they engage in practice at an advanced level within emergency departments throughout New Zealand; utilising a phenomenological approach based on a synthesis of Husserlian Transcendentalism and Heideggerian Hermeneutics.

The information generated together with the many differing viewpoints, perceptions, biases and evident passion for the subject material has far exceeded any pre-conceived notions that the author, coming from an emergency nursing background themselves, could ever have predicted. For example the quantity of individual issues raised through the interviews numbered in the hundreds, not withstanding the process of data horizontalisation used to identify clusters and themes of subject matter, one was left with an incredible amount of information and data that unfortunately due to the constraints of this work one either mentioned only briefly or not at all. Further to this of the eight issues identified for in depth analysis and discussion in the findings chapter all are worthy of research as individual subjects in their own right.

As described at the outset this phenomenon, of advanced nursing practice within emergency departments, is in its infancy in New Zealand; a consequence of which limited research participant numbers. Moreover the nursing profession as it stands presently here in New Zealand there would be very little chance of, if not knowing someone personally, not being aware of certain individuals from within the emergency nursing arena who are seen by their peers as nurses who are taking the field of emergency nursing forward and are in some cases preparing themselves to apply for the status of Nurse Practitioner™ Emergency and Trauma (Davies, 2003; Geraghty, 2002). With these facts in mind the author chose as a methodology the qualitative method of phenomenology. Which again, as discussed in chapter four aligns itself perfectly with the underlying ethos, principals and fundamentals of modern day nursing.

The research participants themselves required very little prompting or encouragement throughout the interviews; the enthusiasm and obvious commitment generated such an enormous amount of energy and intensity related to the subjects under discussion. Very often it was not what was said, rather it was how it was said that revealed the underlying passion that all the participants were endowed with. Colleagues from other

areas of nursing could be forgiven for thinking that coming from similar working environments the participants may posses shared values and perceptions; this was definitely not the case. On many occasions throughout the interviews the participants contradicted themselves and in relative terms each other; however there did exist many common insights, observations and sensitivities; which were identified within the themes chosen for discussion.

Other related issues and conflicts arose throughout the duration of the project, which again surprised, exasperated and excited the author as they experienced the highs and lows associated with such a project; the most surprising of which was the utilisation of the concept of bracketing. This one unique concept that was fundamental to the research design caused such turmoil, doubt and internal conflict for the author, and as a point of fact came close to ending the project in the early stages; that it deserved a chapter in of itself. As discussed in that chapter the author finds that bracketing in its purest form as described by Husserl (Koch, 1995) was unattainable, however an adapted version of bracketing as described by Beck (1992) whereby the researcher temporarily suspends their own beliefs related to the phenomena under question, while at the same time acknowledging they exist, was in fact attainable and as such appropriate for use in this project.

The transcription (undertaken by the student researcher) and data analysis process utilising the concept of data horizontalisation was a long arduous affair, with each interview being scrutinised for common topics and experiences; however as Jasper (1993) finds, this gave the author the opportunity to fully immerse themselves in the subject matter. Following the research design as outlined in chapter five and adhering to an adaptation of Colaizzi's (1978) procedural steps, again summarised in that chapter, the transcripts were returned to the participants for confirmation of validity and permission to continue. This process was repeated again at a latter stage following further analysis of the data; the participants were empowered to withdraw any or all of their material at any time during the project without question; however no objections or issues of any nature were voiced regarding the material and/or subject matter that the data generated. The intention remains for all participants to receive a copy of this work when finalised in keeping with the ethos and the underlying fundamental principal of shared ownership of the project.

As outlined in both chapters four and five, the first stage of the research process was driven by Husserlian underpinnings, the student researcher intent on examining the participant's experiences, meanings and interpretations of their individual lived experiences not their (the student researcher's) interpretation of the participants' interpretations. An essential concept here was the use of "bracketing" with the student researcher attempting to put aside their own pre-conceptions, ideas and related issues regarding the research subject and concentrating solely on the participants perspective; again bracketing and its use in this project was reviewed in-depth in chapter seven.

As discussed in chapter six, analysis and findings, several of the issues, concepts and barriers evident in relation to the development of the advanced nursing role here in New Zealand have been experienced in other countries, such as the United Kingdom for example. Nevertheless there also exist many issues contributing to the development of the role here in New Zealand, both positive and negative, that are unique to the New Zealand context. While the main objective of the project was to explore the perceptions and experiences of nurses as they prepare for, and engage in practice at an advanced level within the emergency department setting here in New Zealand, an underlying thread throughout the work has been the development of the role of Nurse Practitioner™ Emergency and Trauma. Further to this it is anticipated that information produced from the work will aid in adding to the body of knowledge that is required for development of the role here in New Zealand, this was addressed in chapter seven the discussion on issues affecting the development of the nurse practitioner role within the emergency departments in New Zealand.

Chapter eight, discussion, was based entirely on Heideggerian principles, as outlined in that chapter, incorporating the authors experiences, interpretations and interpretations of the participants interpretations; engaging with and expanding on data generated by the participants; as outlined in chapter six. Due to the limitations of this work the author was in a position whereby they had to choose subject matter in order of priority, as it would have been impossible to explore all the issues generated by the research data in-depth. The student researcher has previously acknowledged in this work that many of the identified issues are deserving of research in their own right.

However working within the parameters of the project has lead the student researcher to identify eight specific concepts that need to be addressed, analysed and discussed further in relation to the development of the role Nurse Practitioner™ Emergency and Trauma within New Zealand. They are as follows:

1. Development of a nationally recognised programme, around a structured curriculum, within New Zealand that results in a specific qualification, with content that covers both theory and psychomotor skill development, for emergency department nurses, agreed upon and developed jointly in collaboration between the Universities' and the College of Emergency Nurses.

2. Development by the DHBs, Universities' and the College of Emergency Nurses of a nationally agreed generic orientation programme for emergency nurses in New Zealand. Again incorporating both theoretical and skill development deemed appropriate for individuals at this stage of their career within emergency departments.

3. Promotion of a national framework of expected professional development processes, agreed upon by the above named agencies, to be achieved within the emergency department setting over a specified time frame. Ie 2-4 years.

4. Development of the Clinical Nurse Specialist (CNS) role within the emergency field as an independently recognised national qualification by Nursing Council and the above named agencies, with a separate entry onto the nursing register.

5. Possible development of an internship programme as part of the transition process for those individuals wishing to move from CNS status to Nurse Practitioner status within the emergency department setting in New Zealand.

6. Promotion of the Nurse Practitioner: minor injuries role, annotated with "trauma specialist" for appropriate individuals or visa-versa.

7. Programme of public and professional education in relation to the roles of CNS and NP (Generic to the nursing profession).

8. Specific content of all relevant graduate and post graduate courses to include mandatory education relating to legal issues in order that all registered practitioners whatever their speciality gain an in-depth understanding of New Zealand law and how it relates to their individual scope of practice.

End Note:

At the time of writing the final draft of this thesis (November, 2005) there are two submissions being processed by Nursing Council that may or may not lead to the first Nurse Practitioner™ Emergency and Trauma here in New Zealand; the results of which should be known late this year or early 2006. (Michael Geraghty personal communication, September 24, 2005).

The author wishes these colleagues well in their endeavours. They are, with anticipation, the first of many, leaders in their field, nurses who have passion and vision. Nurses, not unlike the research participants' individuals, who can see, think through and rationalise concepts from the broader perspective; whose ultimate aim is not one of self-promotion, rather to provide a service that benefits their patients whilst at the same time moving their own field of expertise forward. From these applications whether successful or unsuccessful will come knowledge. Knowledge that will assist in the wider context of the concept of advanced nurse practitioners in emergency departments throughout New Zealand. Hopefully some of the issues and dilemmas that have come up for debate and exploration within this work will augment this knowledge in some way.

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APPENDICIES

Appendix A

Consent Form

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Research Title:

Lived experiences of nurses as they engage in practice at an advanced level within Emergency Departments in New Zealand

PARTICIPANT CONSENT FORM

THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF TEN YEARS

- ❑ I have Read the information sheet and have had the details of the study explained to me
- ❑ I have had an opportunity to ask questions and have had them answered to my satisfaction, and I understand that I may ask further questions at any time
- ❑ I understand that anonymity and confidentiality will be respected an maintained by the student researcher and their supervisor
- ❑ I understand that taking part in this study is voluntary (my choice0 and that I can withdraw my participation and/or any information I have provided with no questions asked
- ❑ I understand that the data I will provide will not be used for any other purposes or released to others unless written consent has been obtained from me (the participant)
- ❑ I understand that the finished results will not use my name and that no opinions will be attributed to me in any way that may identify me
- ❑ I agree/do not agree to the interview being audio taped
- ❑ I understand that the interview may take between 45-90 minutes to complete and will be held in a location convenient to myself
- ❑ I understand that the audio-tapes, transcripts of the tapes and any notes will be assigned a number. Further all material will be kept in a secure location known only to the student researcher and their supervisor
- ❑ I understand that I will be given the option of either having my tape destroyed or kept for archiving
- ❑ I understand that following a period of 5 years all data that I provide will be destroyed/archived *(Delete as appropriate)*
- ❑ I understand that I will receive a copy of my transcript for review at least twice throughout the study for validation and to give permission to continue
- ❑ I understand that I will receive a copy of the research findings at the conclusion of the study

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- ❑ I understand that ethical approval has been obtained from Massey University Human Ethics Committee and Wellington Regional Ethics Committee.
- ❑ I agree to participate in this study under the conditions set out in the information sheet

Participant Signature: **Date:**

Full Name (Printed)

Witness Signature: **Date:**

Full name (printed)

Committee Approval Statement:

This project has been reviewed and approved by the Massey University Human Ethics Committee, WGTN Protocol 04/7. If you have any concerns about the conduct of this research, please contact Mr Jeremy Hubbard, Acting Chair, Massey University Campus Human Ethics Committee: Wellington, telephone 04 801 2794 ex 6358, email J.J.Hubbard@massey.ac.nz

Appendix B

Information Sheet

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Lived experiences of nurses as they engage in practice at an advanced level within Emergency Departments in New Zealand

INFORMATION SHEET

Student Researcher: Mark Davies BSc(Hons)
[redacted]
[redacted]

Supervisor: Kim van Wissen RC_pN MA
Tel: (04) 801 2794 ex 6755
Email K.A.Vanwissen@massey.ac.nz

Dear colleague,

I am currently in the process of undertaking a Masters Degree in Philosophy at Massy University Wellington; my present employment is as the Clinical Nurse Educator for the emergency department Hutt Valley District Health Board. I write to you to ask if you would consider participating in a research study as part of my degree requirements.

The purpose of my research study is to describe the experiences of emergency nurses in New Zealand as they engage in advanced practice within the emergency department setting.

The criteria for inclusion in this study are that the individual concerned is:

1 Practising at an advanced level within the emergency department setting

2 Has expressed an interest in the Nurse Practitioner™ role and is in the process of working toward a Masters Degree.

I have identified that you meet the requirements for inclusion in this study.

The philosophy behind the study indicates that if you agree to participate you have an equal right to all information in whatever form that is generated by the study. Your anonymity and confidentiality will be respected by assigning your interview a number that only my supervisor and I have access to.

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Your participation will involve a one off audio taped interview with me, of duration between 45-90 minutes. The interview format will be that of a discussion, starting with some relevant questions as opposed to the question and answer style of interview. You have the right to ask for the audiotape to be turned off at any time during the interview.

The interview will be held at a location that is convenient to you. Immediately following the interview I will make some notes. I will transcribe the tapes myself and return to you a transcription copy for you to review prior to moving on to the next stage of the research process. I will again return to you a copy of my findings toward the end of the study for further review. At the end of the study you will be given a copy of the thesis for your own personal use.

You may withdraw your participation and/or information that you have imparted at any stage in the process with no questions asked. Further you may decline to discuss any particular issue that may be brought to the fore during the interview

The data you provide will not be used for any other purposes or released to others without your written consent. The finished material will not use your name and no opinions will be attributed to you in any way that may identify you or any other person you refer to.

All reasonable steps will be taken to ensure confidentiality, however you are to be made aware that this may be difficult to ensure with such a small group involved in the project.

All data collected will be kept in a secure location for duration of ten years in keeping with Massey University and the Wellington Ethics Committee guidelines. Following this time frame the material you provide will be either destroyed or archived, you have the choice of disposal to be indicated on the consent form

Ethics approval for this study has been obtained from Massy Universities Human Ethics Committee and Wellington Regional Ethics Committee.

If you are willing to participate, please sign the attached consent form and sent it back to me in the pre-paid envelope. If you require any further details or clarification about my research study please feel free to contact my supervisor or myself at the above contact details.

Yours
Mark Davies BSc(Hons)

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Committee Approval Statement:

This project has been reviewed and approved by the Massey University Human Ethics Committee, WGTN Protocol 04/7. If you have any concerns about the conduct of this research, please contact Mr Jeremy Hubbard, Acting Chair, Massey University Campus Human Ethics Committee: Wellington, telephone 04 801 2794 ex 6358, email J.J.Hubbard@massey.ac.nz

Appendix C

Literature Review Matrix

Author/s	Year	Setting	Subjects	Research design	Results	Conclusions
Cole F & Ramirez E	1999	ED Dept's	NP's	Quantitative data postal survey	Validation of educational Programme	Ongoing development required for the ENP Programme
Cole F & Ramirez E	2000	ED Dept's	NP's	Quantitative data analysis pilot study	ENP's order less diagnostic tests than other providers of health care	ENP's provide equivalent if not better cost effective care as other providers of health
Dolan B et al	1997	ED Dept's	NP's	Questionnaires, interviews & focus groups	NP's role appears to be developed in response to reduction in junior Dr's hours	Issues around training remain, further evaluation re; cost effectiveness of NP's needs evaluating
Freij RM	1996	Minor Injury Dept	NP's & SHO's	Retrospective date analysis	No difference in the ability of NP's & SHO's requesting and interpreting x-rays	Appropriately trained NP's at least as competent at SHO's regarding ordering and interpretation of x-rays
Lindely-Jones M & Finlayson BJ	2000	ED dept's	Nurses	Descriptive study of postal survey	Staff (excluding some medical & radiography) & Patients rated system highly	Development of protocols for experienced nurses to request x-rays suggested. Pitfalls of same to be evaluated
Lindely-Jones M & Finlayson BJ	2000	ED Depts	NP's	Prospective randomised control study	Nurses requested fewer x-rays than SHO's with greater percentage of positive findings	Nurse requested x-ray system reduces waiting times without compromising quality of care and service provision
Mann CJ et al	1998	ED Dept's	NP's & SHO's	Retrospective data analysis	NP's requested less x-rays than SHO's using same protocols	NP's are just as effective as SHO's when using same protocols to request x-rays
Marsden J	2003	Conference	ED Nurses	Partially structured questionnaire	Variations in role and preparation for the role exist	Role needs coherent development, with an emphasis of ongoing education
Meek SJ et al	1995	ED Dept's	Charge Nurses	Postal survey structured questionnaire	Training, prescribing and radiology resistance to the role	Use of NP's in ED dept's is predicted to rise significantly.
Meek S	1998	ED & Minor Injury Dept's	NP's & SHO's	Comparative study	NP's compared favourably with SHO's when interpreting x-rays	NP's who interpret x-rays do so to the same standard as SHO's
Salt P	1997	ED Dept	ED Nurses	Prospective observational study	Nurses were able to appropriately identify patients needing x-rays	Nurses are able to safely apply the Ottawa ankle rules without missing acute fractures
Tachakra S & Deboo P	2001	ED Dept	NP's & SHO's	Retrospective comparative study	NP's & SHO's manage many patients to a comparable level	As usage of NP's rise they will need to manage more types of patient presentations
Tye C	1998	ED Dept's	Senior nurses	Postal survey structured questionnaire	36% currently use NP's with a further 33% intending NP use	Formal NP services are in use throughout the UK with a predicted upward trend
Tye C & Ross F	2000	ED Dept's	NP's	Semi-structured interviews	Consensus on benefits of role with some degree of ambivalence	Need for ongoing audit of role effectiveness
Walsh M	1999	ED Dept's	NP's & ED nurses	Retrospective quantitative data survey	Formal recognition and continuing education are identified needs	Appropriately targeted resources are required for both NP and ED nurse continuing education

Appendix D

Interview Guide

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Interview Guide

This guide is not intended to be followed in a structured manner. The bullet points are for reference only and relate to issues that pertain to the phenomena under study. It will be the respondent who mainly dictates the direction of the interview, with minimal intervention from the interviewer.

Example of a lead in question at the commencement of the interview:
How have you found your own personal transition into this advanced nursing role within the emergency department?

- Personal transition to the role
- Personal experiences
- Professional experiences
- Personal relationships
- Professional relationships
- Ambitions
- Anxieties in relation to the role
- Future of the role
- Your future within the role

Appendix E

Research Subject Matter Data

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Discussion subjects generated from interviews:

Accountability
General development of the nurses role in ED
Gender issues: pregnancy, promotion etc
Lax practices in the past prior to ACC HDC
Publics awareness of their rights
Knowledge, research, rational, evidence based practice
Time in post vs. knowledge, skills, effort
Waiting times for lower acuity presentations: workload up
Treading on medical toes
Power struggle Drs vs. nurses
Medical resistance to the development of the role: paying lip service
Maxi nurses mini Drs
Drs happy for nurses to do certain tasks, IV lines etc
Team work
Skill level Drs vs. nurses
Extended role skills of the past are now routine skills for the ED nurse
Different practices between ED's in relation to what PCN's do
Education: area specific. Masters level
Formal basis for skill acquisition: accreditation
Theory vs. skills required for NP role
Nursing council: what they require for NP status
Many nurses practice at an advanced level already
Medical opposition, especially ED spec Drs
Nurse opposition to the role
Mistakes: Drs vs. nurses how they are dealt with: Drs cover up nursing polices itself to severely
Radiographer/radiologist opposition
Changing hospital culture to accept NP role
Change: the change phenomenon

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Need for cognitive dissonance in other health professionals

Who teaches the NP's? Drs or Nurses

Mistakes. Who, what, why, when ACC med mis

Drs numbers down

Change of practices over time in the ED

The future: NP's/generalist nurses

Pay Mia Carrol @ 2003 ED nurse conference states NP's on 80-90.00 $

Analogous roles- junior Drs and NP's

Decision making: Drs make the decisions nurses do the practice, will this be the case with NP's

What do NP's offer that is different to Drs

Empowerment/power

Past experience shapes what is to come, what direction an individual takes

Nurses responsible for innovative practice in ED's CPAP, Vents etc

Other NP's specs working within ED ie. Paeds NP's

Individual scope of practice: how, what, where, when how do you define?

If scope too narrow what are they giving up: minor injuries vs. major trauma for example

Knowing oneself in the role: strengths/weaknesses

Skill level/leadership

Self reflection in terms of practice

Difficult transition, anxiety, scary, self doubt

Constant learning/professional development

Responsibilities up

Other peoples expectation of you in the role

Recognising limitations and doing something about it

Support from colleagues on the floor

Resources available; work environment, equipment etc

Hospital systems and their effects on the way ED's are run

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MAU SAU

Support in terms of transition to the role

Lack of funding

Liasing with other further up the hospital hierarchy

Education-theory-practice-experience

Communication with peers

Peoples perception that we are going away from nursing; mini Drs maxi nurses!

Academia scares people

Just a staff nurse

Nurses being negative toward each other both professionally and socially

Pay/salaries

Inadequate funding for education

Archaic systems

Too much admin

Unsupportive management as perceived by those on the floor

Rosters

Morale down

Staff turnover up

Great potential for the role

Drs: trusting relationship with some

Already working in an advanced capacity without the recognition

Drs/nurses: them and us

Experienced nurses practice on a par with if not better then junior medical staff

ED great place to work, could not go back to the wards

Colleagues in other areas do not realise they extend of the RN's role in ED let alone NP's

Relationships with other HP's need to improve

Nurses development in ED seen as a threat by other HP's

Nurses have just been doers without any EBP, now with research BP seen as a threat by other HP's

Break down barriers

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Accountability, responsibility HPCA Act

Empowerment, emancipation, change

Advanced study, accreditation

Specific nationwide programme development for nurses coming into ED, recognised by other HP's

NP seen by some as an elitist concept, it is something everyone can aim for: ED cong 2003 Brian Doolan

Publics perception of nurses has not changed not aware of nursing profession moving on, not seen by the masses as a profession

Nurses need to become politically aware

Anger toward the system and government

Nurses not always on the same page as each other

Expected to work outside of contracted hours without added benefits or pay

Appropriate courses: TNCC, NZRC etc

Want to provide a good service, unable to do so

Working short (staff)

It's a hard job

People leave yet they love the job

Anger and frustration at self, others, system and govt

Moving into a senior role can de-skill an individual

Problems with skill mix senior in charge vs. junior on floor

Family vs. work commitments

Unable to practice at full potential due to system

Education of junior nurses

Throwing new staff in at the deeep end

No recognised career path unlike medics

New people perceive they are not supported

Mistakes happen: med mis

Role models

Nurse/patient ratios: PCN vs. NP role

Unsafe practice due to numbers, skill mix etc

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New equipment, drugs, practices

Chaos: unstructured work environment to outsiders

High turnover of staff

New Drs every 3-6 months-studies comparing NP's with SHO's

Nurses orientate and support junior Drs; not recognised

Junior Drs put into compromising situations, nights etc

Nurses taking the lead in resuses

Conflict with junior Drs in terms of EBP

Must keep pace with change/hospital systems have not

Media and their effect on hospitals: SARS etc

Reflective practice

Primary health care attendees up in ED, public education required

Effective education ie NZRC

Advent of the NP role will empower individuals to use their skills

NP training and accreditation? not like that of the UK: care across the board not just minor presentations

Support needed, NT for example has already met resistance

Decreased waiting times, stress down, patient satisfaction up

Grey area: maxi nurses mini Drs

Will NP's practice along the lines of medical model

International recognition of the NP qualification

Not just the money

Might have to leave nursing to advance career or at least nursing on the floor

Work load increase in recent years

Education: research ' masters level

Pay

Management not valuing nursing staff

Nurses negative attitude to each other

Publics attitude toward nurses compared to medical staff (Drs handmaiden etc)

No public awareness of NP CNS role

Waiting times

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Legalities: Mistakes Nurses V Drs

Safety in relation to the development of the role

Right people in the role

Nurses own perception of where they stand in comparison to Drs

Cognitive dissonance in relation to undertaking further education

Use of the internet in day-to-day practice

Time for others to accept the NP role: Drs, Nurses, management etc

ACC: Medical misadventure: nurses signing off

NP: formalising a form of patient care that has gone on for years

Family issues: support ect

As a senior from another area had to learn a lot coming to ED

Wide range of presentations

Need to build confidence

Need good communication skills at that level

Advanced ED courses TNCC etc

Masters level study important at this level

Need experience to go with above

Latest research & techniques

Nurses are already working in an advanced capacity in ED

Restricted practice due to tradition

Nurses themselves are driving forward

Nurses interested in advanced practice networking throughout the country

Barriers: Drs Radiographers/radiologists requesting x-rays?

Analysis of blood tests should be part of our role

Frustration at limited practice due to traditional barriers

Decreased waiting times PT satisfaction less steers

Ankle assessment

Access to education/funding

GP referrals, need for MAU/SAU

System needs changing as it is it causes problems

Nursing council requirement for NP role? APL for ENP and other prior qualifications

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International perspective

Financial considerations for those attending ED

Primary health care problems

Cultural considerations ie refugees

Public perception: do not know or necessarily care about NP's

Public education needed to promote the role

Patient choice

No need for conflict between Drs and nurses

Resistance to development of the role from other nurses, OT's and physios

Need to break down the barriers

Research based practice ie Ottawa ankle rules

Holistic care by NP's/more time with pts

Role needs to be set up properly nationwide, standards etc

Development of related services ie minor injuries, nurse led clinics like UK

Integrate other specs into ED ie GP service other NP's from different areas

May leave ED ie teaching or ITU/CCU

Skill level up/ need broad base

More expected of senior nurses

Have become more global in outlook

Nursing shortage of experienced staff

Very challenging/scary

Political environment

Financially not recognised yet expected to do more

ED is speciality in its own right

Individuals bring skills to the area

Recognise our own weaknesses and address them

Acuity of presentations up

Constant pressure of work/education

Masters level do we need it?

EBP/rational for what we do

Many pts do realise nurses capabilities

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Senior nurses on par with SHO's

Nurse prescribing

More holistic outlook/time for pts

Health promotion in the ED with NP role up

Staff numbers down

Follow up care important

Mistakes, media Med Mis ACC HDC

Do we need medical back up for the role

Medical opposition

Need to prove competence: cognitive dissonance in other HP's

Other HP opposition: radiologists/radiographers in/out of hospital

Networking with other disciplines

Empowerment/emancipation

Experience gained in different ways

Not allowed to do anything/just a nurse

Progression has to be a transparent process

Nurses having to prove themselves a sad indictment of the profession

Nursing degrees count for nothing not respected by other professions

Change the title nurse

Public perception, Drs handmaidens, do not understand the role or concept od NP's

Need public education

Drs make mistakes and get away with it, nursing council comes down hard on nurses who make mistakes

Worried about missing something

Nurses support each other

Media effects ie CCH meningitis case

Accreditation

Not just a nurse

Not sure of personal future