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An exploratative study into the mentorship requirements of nurses working within advanced roles.

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Academic Thesis: Declaration of Authorship

I hereby declare that this thesis comprises my own original work and effort, that it has not been submitted in any previous application for a degree and does not exceed 22,000 words, exclusive of footnotes, bibliography and appendices.

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Abstract

This work investigates the mentorship requirements of nurses in extended roles. The aims and objectives were to develop a greater understanding of advanced practice and the mentorship requirements senior nurses had when transferring into advanced practice roles. The data provided from a focus group and multiple interviews found that many new advanced nurse practitioners have destructive transitional anxieties when new to post. The complex interprofessional relationships that exist within extended paradigms are explored, concluding with a model that may assist in creating comprehensive mentorship and support for new advanced nurse practitioners. The findings on the need for advanced nurses receiving mentorship are all original contributions to nursing knowledge.

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Finally, I would like to sincerely thank my mother. Mrs C has always maintained unshakeable faith in my ability and that all would eventually be well. On reflection this was no mean feat as many others had their doubts or reservations: including me.

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Introduction

Within this dissertation new knowledge has been generated that should increase the understanding of advanced practice issues for the nursing community as a whole. The aims of the study were simple, to develop a greater understanding of the mentorship requirements of nurses working within advanced roles; and to identify potential models that could be developed to assist in the mentorship of advanced nurses new to post. The research was designed within the phenomenological paradigm in a hope to uncover depths of feelings associated with a transition from a traditional nursing role into an advanced practice role. The research produced far more than could have been expected from the initial aims, the transcripts highlight complex interproffessional relationships, organisational influences, educational requirements, transitional anxieties and expectations that build a picture of how a nurse feels when adopting a new advanced role. It concludes with a model of advanced nurse practice mentorship that ensures that both the art and science of nursing combine to create truly advanced nurses.

Structure

This dissertation is constructed as a series of chapters.

Following the introduction chapter one offers an overview of current evidence and issues pertaining to advanced practice. The literature is provided to contextualise current situations within advanced practice, mentorship, and to justify this study. This is however an explorative study and it is hoped that theories will emerge from the data rather than pre-conceived findings. The methods applied for the literature review are explained within the chapter.

Chapter two focuses on the methodology that was employed within this research study. The rationale for chosen methods of data collection is explained, as is how the participants were selected, and how the data was subsequently analysed. This study is creative in its usage of mixed methods, a focus group was used to gain insight into the research question, the findings were then analysed. Questions from the focus group

findings were then developed to ask in interviews with other nurses that were not present at the focus group. This approach enhanced the validity of findings, and lead to a themes being constantly reevaluated throughout the text.

Chapter three presents the findings from the focus group and an analysis of the data. The transcripts from the focus group are heavily drawn upon to facilitate an explanatory framework whilst articulating individuals' thoughts and feelings. The findings are subsequently related back to supporting or conflicting evidence within the literature review to improve the critical nature of this work.

Chapter four will contain the findings of individual interviews further exploring content that was uncovered within the initial focus group. Themes within the focus group will be further explored until data saturation is achieved. The data is then reviewed, themes identified and critiqued.

Chapter five will present the conclusions drawn from this study. The chapter will suggest the common difficulties that Advanced Nurse Practitioners (ANPs), face when they make the transition from general nursing into advanced roles; and what mentorship they appeared to require. The chapter examines evidence from both phases of the research and develops a model within which new starters in advanced practice could be mentored.

Chapter six forms recommendations for advanced nursing practice, practitioners, and mentorship to be used by the nursing community. The limitations of this work are also examined, as is how this work could be expanded on in the future.

Background

The first Nurse Practitioner roles were developed in North America in the 1960s and in the UK in the 1980s (Gardner et al 2006). In Canada the earliest roles related to supporting General Practitioner Doctors (GPs); due to the massive expanse of the country, it was necessary intersperse GP's with advanced nurses that could diagnose, treat and refer patients on appropriately. Whilst in the USA 'advanced' nursing was initially linked to a form of specialisation predominantly in anaesthetics or midwifery (Bigbee, 1996). The UK again developed the concept from specialist roles, nurses in a

particular area developing a deeper knowledge, or more advanced ‘skill-set’ to care for their caseload of patients (Gardner et al 2006).

The number of nurses working in advanced roles is almost impossible to calculate, as there is no register of advanced practitioners as yet. Even if a register is developed for advanced practitioners it is still unlikely to reflect the true number of all nurses working within advanced roles, as many may not have reached the level of ‘ANP’ to register but may still be working in advanced roles. Castledine (1998) stated that in the early 1980s, there were only 353 nurses in England and Wales termed as nurse specialists (Castledine, 1998), by 1989 Wade & Moyer had determined 1016 officially designated CNSs (Wade &Moyer, 1989). The pinnacle of advanced nursing is considered to be that of consultant nurse, and in 2001 plans for a 1000 of these posts had been developed (Moore, 2001). Therefore, it is fair to assume, as these posts top the advanced nurse practice continuum there must be thousands of nurses working at different levels within advanced roles.

Chapter 1

Review of Literature

To gain insight into the issue of mentorship for advanced nurse practitioners, it is necessary to split the two concepts for the purposes of reviewing the literature. This was a forced decision as an extensive literature review found very little relating to mentorship of *advanced* practitioners. There was however, literature relating to mentorship albeit predominantly for unqualified nurses or staff nurses newly entering the profession.

It is useful for the purpose of this research to determine what 'advanced' nursing practice is, and how this differs from traditional nursing roles to highlight the need for an examination of ANPs mentorship requirements. If it is possible to distinguish differences in practice between ANPs and general nursing staff it is logical that further mentorship may be required as nurses take on expanded roles. Within this review knowledge from the literature on mentorship/advanced practice will be collated and critiqued. Examining these concepts separately should allow them to be fully explored before co-joining them, and synthesizing new knowledge.

A literature review was completed in order to inform research design, identify problems in the research proposal, and ensure that the data that was collated would build upon, or at least relate to previous work (Bell, 1999). The review of the literature also provides the reader with background knowledge of 'advanced practice'. As the study develops findings from the research process can be compared back to current literature to determine similarities and differences (Burns & Grove 2005). Journal databases were used as the starting point for the literature search as it allows efficient access to vast amounts of information (Fitzpatrick & Montgomery 2004). Electronic journals were accessed via Ovid on line and CINAHL databases, these date back to 1984 through to the current day; their advantage is that they can allow access to full texts from any location, and that their content is usually most current (Gash, 2000). The keywords "advanced practice"; "nursing" and "mentorship" were used initially and resulted in around 6,000 articles. To refine the search further a more advanced search was adopted using '+' within the searches i.e "advanced+ nursing"

"Nursing + mentorship" and finally "advanced +nursing + mentorship" which gave only one response. The same words were applied to the library catalogue to collated textbooks related to advanced practice. Texts or journals that were over ten years old were at first excluded; however, it soon became apparent that more contemporary authors were often referring back to the original works. It was for that reason that these original texts were sought, read and included. The abstracts of various articles were read online, if they seemed to fit the work being undertaken the full article was taken. A 'snowballing' type method described in sampling was the applied to the literature. If a particular author had written an article that seem particularly pertinent, or highlighted other sources that could be beneficial; these journals or texts would then be sought. Finally the same keywords that were used for a search via the Internet of current policy documents relating to advanced practice via the Department of Health website.

Towards a definition of advanced practice

The problem of *'how many'* Advanced Nurse Practitioners there are is compounded as there is no conclusive definition of what an ANP is, or the standards required to be one. What defines an ANP varies, but even more confusing is how 'ANP' is used as an umbrella term over Clinical Nurse Specialists (CNS), Nurse Practitioners (NP), Advanced Nurse Practitioners (ANPs) and Nurse Consultants (NC) (Hamric 2000). Advanced nurses accept that there is a plethora of titles in existence and that the lack of standardisation of what an ANP, essentially is, or needs to possess educationally or experientially to function, is leading to the misunderstandings and misconceptions (Coombes, 2008).

The American Nurses Association in 1995 suggested that there are three basic characteristics that distinguish 'advanced' nursing from basic nursing practice: specialisation or provision of care for a specific population of patients with complex, unpredictable, and/or intensive health needs; expansion or acquisition of new knowledge and skills and role autonomy extending beyond traditional scopes of nursing practice; and advancement, which includes specialisation and expansion (ANA, 1995).

Authors of this period all tended to agree that clinical practice was the primary focus of advanced nursing practice (Ackerman et al 1996, Dunphy & Winland Brown 1998, Hamric 2000). However, they also felt that implicit characteristics of an ANP should be innovation, orientation to practice, and the ability to synthesise new nursing knowledge, whilst simultaneously delivering evidence based care. Great emphasis was placed on demonstrating a great breadth and depth of knowledge, suggesting that advancement involves more than just experiential knowledge, but also requires levels of critical thinking and analysis (McGee & Castledine, 2003). Most models have common themes regarding advanced practice: Manley (1997) identified four integrated sub-roles related to direct and indirect domains of expert practice, education, research and consultation for the advanced practitioner/consultant nurse. The Strong Model includes five domains for acute care nurse practitioner roles; direct comprehensive care, support systems, education, research, publication, and professional leadership (Ackerman et al 1996).

The Scottish Executive (2008) have recently adopted the user-friendly definition of advanced practice given to us by The International Council of Nurses (ICN). The council states

"Nurse practitioner/Advanced Practice nurse is a registered nurse who has acquired the expert knowledge base, complex decision making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A masters degree is recommended for entry level" (Castledine & McKee 2003 pg 147, Para 5).

The Scottish Executive (2008) also decided to simplify the concepts stating that a nurse can be an advanced 'specialist- or generalist'. This rejects the notion of earlier authors that 'expert' or 'advanced' nurses had to be specialists. Rather they state that it is the level at which a nurse is practicing that determines whether they are advanced or not. A nurse therefore can be 'advanced-specialist' or 'advanced-generalist'; the key is not what job or title they have, but whether they have the educational and experiential evidence to prove they are indeed advanced!

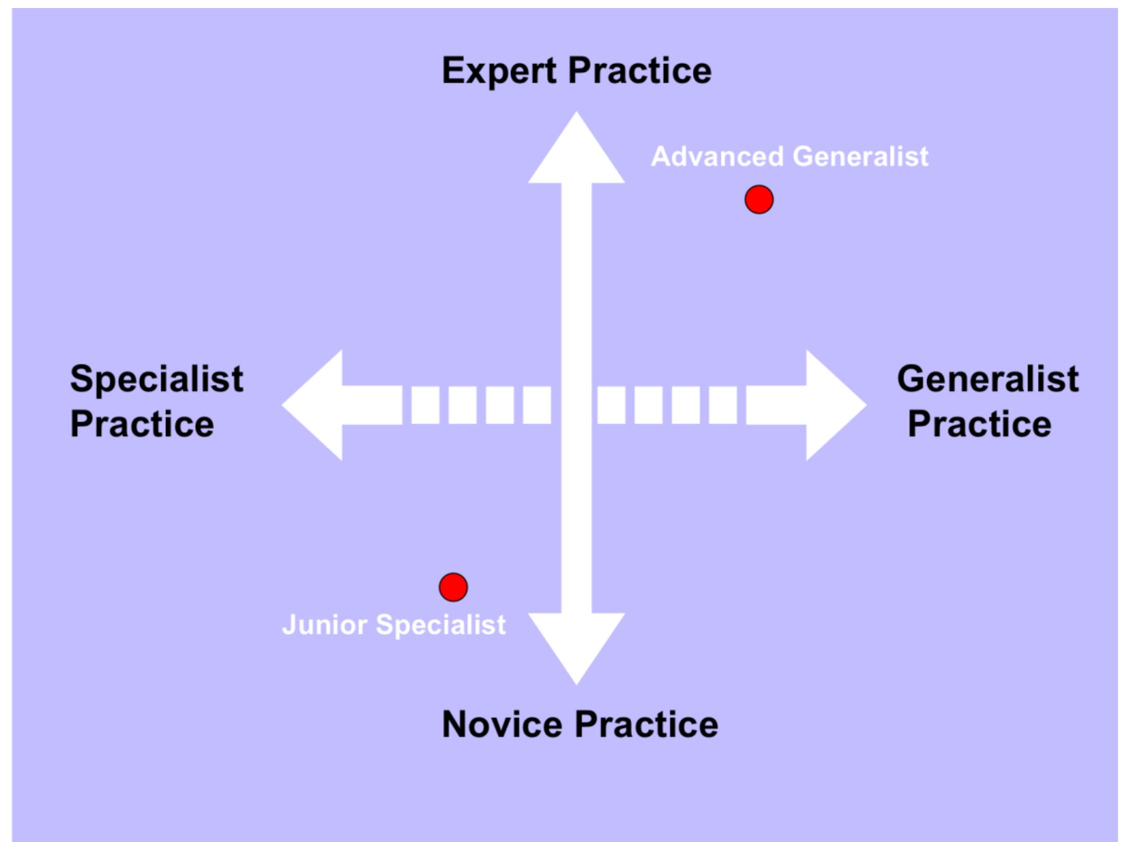


Figure 2. Relationship between Specialist and Advanced Practice

(CNO, 2008, pg 14)

This diagram forms a pictorial guide to how nurses can position themselves on the advanced nursing continuum. It shows that you could potentially be a junior specialist, possibly new in post with relatively little experience within the 'Specialist-Practice' paradigm or 'Advanced-Generalist' with Msc education etc. The key to this concept is appreciating that specialist or generalist titles are irrelevant, the issue is how proficient and capable the individual practitioner has become within their role to denote whether they are 'advanced'.

The Scottish Exec add further to understanding with the following diagram:-

Figure 1.

Scottish initiatives to support the Nursing Career Framework

This diagram shows that all nurses, at all levels, essentially should have the ability to progress up through the ranks. At the base of the diagram is the 'Support Worker-Level 1', which could be an unqualified nurse, or a nurse cadet. Progressing up to 'Registered Practitioner' at level 5, which signifies registration entry level, on to 'Consultant Practitioner-Level 8'. The blue boxes to the right all indicate other initiatives that run alongside this one involved in facilitating the transition between the various levels.

Benner & Tanner (2000) described progressive movement from novice to expert, highlighting specific competencies or skills at each stage. However, just focusing on particular skills or situations in which the 'expert nurse' performs, has been sighted as a weakness of the work done by Benner (1984) (Sutton, 1995). Benner (1984) failed to describe the individual in this process, or their ability to transfer their advanced knowledge to other situations. Thompson et al (1990) argued that expertise didn't necessarily have to form outward behaviour or actual performance; moreover that the expert nurse could share their knowledge, and manipulate it to suite whatever job they were employed within.

This is highly relevant to the discussion of ANPs, and the whole 'advanced' practice debate. Benner (1984) felt that nurses needed to build up their knowledge base that there were no short cuts, and that expertise took years to achieve. However, modern thinking contends this, as the Scottish Exec's 'flying start' blue box relates to another

initiative held by the NHS Education for Scotland for highlighting gifted and talented nurses, pushing them to create portfolios early on that maximise their potential. These sentiments are echoed in earlier work *Modernising Nursing Careers: Setting the direction* (DoH, 2006) and the Chief Nursing Officers *10 Key Roles (2004),* where it was acknowledged that nurses may well want to take different career pathways, some possibly wanting to "climb up a ladder of increasing responsibility and higher rewards" (Robinson, pg 2, 2007). Within *10 key roles (2004, CNO)* the Chief Nursing Officer for England stated that nurses would need to be ordering more diagnostics, prescribing, referring and discharging. Since these roles were labelled "key" in 2004, it signified that nursing leaders were expecting more of the nursing workforce. All of the ten roles were expanded, possibly advanced, and many of them would require additional training and education. The most recent Department of Health guidance is *Towards a Framework for Post-registration Nursing Careers* (Doh, 2008). This suggests five pathways that post-graduate nurses may wish to follow *(appendix1),* that there is an inherent need for practice to be standardised, and that skills and competencies should be aligned with roles and responsibilities. Interestingly the work also aligns progress through various academic gateways, and job titles with agenda for change banding (pay).

Education

The literature provides intriguing debate about how advanced nurses use knowledge in practice, specifically, about the 'science vs art' question. The job of nursing requires scientific (empirical) understanding but arguably also more tacit/humanistic knowledge and skill (Elson et al, 1995). Benner et al (1999) discuss a duality with good clinicians drawing upon scientific evidence, and the ability to use reasoning to develop the best account of a clinical situation (Benner et al, 1999). Pearson and Peels (2002) advocate that advanced nursing practice can be simplified to three principles, experiential knowledge, theoretical knowledge and clinical implementation of these high standards to produce high standards of clinical performance (Pearson & Peels, 2002). If an 'advanced-nurse' is to posses a level of skill, above that of a general nurse, then it also has to be accepted that it will take extra training to achieve this. In time it will be necessary to *prove* that an ANP has a differing skill set to that of a general nurse, therefore some form of certification will be required.

Rafferty 1996 stated that education is a potent force in professionalising a group of caregivers and improving standards (Rafferty, 1996). However, some ANPs in extended roles do not have the ratified certification that proves their competence within a particular job. Predominantly due to the fact that as the drive for ANPs increased, nurses from senior nursing positions naturally moved across into these roles without receiving further training (Atkin et al 1994). For some, clinical experience was viewed as better than, the alternative academic orientation of post-graduate learning. However, the literature would suggest that ANPs require both clinical experience as well as academic foundations to fully achieve 'advanced' status.

Internationally, requirements to gain the title of ANP differ; many countries agree that a master's degree program for advanced practice is the best way to ensure credibility (Davidson, 1996, Atkins and Ersser 2000; van Soeren et al 2000). It then becomes increasingly difficult to agree upon what the content of master's programs should be, for whom, and in what circumstances does education work (Wilson and McCormack, 2006 cited in Jones, 2006). Gardner et al 2006 found that practitioners all preferred masters modules that specifically suited their job, particular interest was shown in pathophysiology, and pharmacology; nurses were predominantly engaged in subjects that historically were outside of traditional nursing practice. In the Netherlands the concept of NP relates to completion of a two-year masters degree, in America the CNS came from acute medicine, with NP's practising in the community a title holding less prestige and recognition but still requiring first level education (Knaus, 1997, Bryant-Lukiosius 2004, Carroll, 2002).

Nursing within the UK is set to become 'all-graduate' by 2013 (Doh, 2009a) and this will heavily affect the discussion over whether masters level education represents the bar for advanced practice. As nursing adopts degree level education at point of entry, then for nurses to prove they have the credentials to practice within an advanced job they are likely to need masters education. Previously degree level education or holding a degree was evidence enough of further learning; however, with more academic institutions offering a greater number of degree programs, and with the development of pre-registration masters courses, nurses working in advanced roles have work to do.

Now, yet further strides in education are coming to fruition with educational programs such as the Doctorate of Nursing Practice. This is an American example of a professional doctorate in clinical nursing practice, designed to equip nurses with the same skills as primary care doctors (Coombes, 2008). Similar programs can now be seen in postgraduate university programmes within the UK, with nurses already in possession of Masters education looking to extended their knowledge yet further. If we refer back to the continuum presented by the Scottish Executive (2008) we may find a 'consultant-practitioner' may need to have a professional doctorate or PhD in the future. These jobs will be at the pinnacle of the clinical profession, and therefore it seems to make sense that they will be educated to the highest level achievable.

Regulation

Trusts often pay practitioners to competently practice, whereas the profession assumes more of advanced nurses, expecting them to be teaching, researching, managing and leading as well as actually doing their job. Subsequently, many advanced nurses are finding it difficult to fully achieve all that is required to be considered an ANP. With fellow professionals, other nurses and most importantly patients starting to ask questions about ANPs competence, one looks to the regulatory body of nursing the Nursing and Midwifery Council (NMC) for clarification on standards.

Initially, in 1990 the UKCC (precedent to the NMC) suggested that nurses operate at three levels, primary, CNS and NP. CNS nurses were required to be educated within their specialist area to first-degree standard. In 2004 the NMC stated that nurses wishing to sign the new higher level sub-section, would need to be educated to masters level and that other competencies would have to be assessed on a three yearly basis (NMC 2004). The document also stated that nurses without masters level education would have to prove their knowledge against the standard attained by masters graduates should they already be in an advanced role. The NMC suggested that a sub-section of the register could be created. This was to address the fact that the only people in place to oversee quality and competence were ANPs line managers, who may not have an understanding of what is expected of a nurse at this level (Castledine & McKee 2003).

However, the subsection of the NMC register for advanced practitioners as yet has failed to ever materialise. This was primarily due to the white paper *Trust, assurance and safety: The regulation of health professionals* (Doh, 2007). This paper sought to re-evaluate the practice of regulation, and impart greater powers to the Council for Health Regulation Excellence to oversee how professions regulate themselves or revalidate.

The Council for Health Regulation Excellence (CHRE) overarches all of the major health professional regulatory bodies; its aim is to drive up standards for health professionals, encourage greater consistency in regulatory practice, and shape future developments in the regulation of healthcare professionals. The NMC placed the sub-section of the register on hold as it awaited the CHRE's investigation into advanced practice for health care professionals.

The Council For Healthcare Regulatory excellence published their work: *Advanced Practice: Report to the four UK Health Departments* in July 2009 (CHRE, 2009). The document states that the council were:

"Unconvinced that much of what is often called 'advanced-practice' represents such a significant shift in the nature of practice that it is inadequately controlled through current arrangements" (CHRE, 2009, pg 9)

The CHRE (2009) also suggest that it is the responsibility of the separate regulatory bodies, employers, and practitioners to ensure that safe practice is delivered. They state that it is the employer's responsibility to:

"…Assess the fitness for purpose of employees and job applicants with regard to specific competences required for a given job. Employers-not regulatory bodies- are in a position to determine this by considering the specific roles and responsibilities the professional will be taking on" (CHRE, pg12)

And that: -

"…Robust organisational governance arrangements provide the most effective means of controlling for risks to patient safety from an individual professional's practice" (CHRE, 2009)

It seems therefore that great emphasis is placed on the employer controlling what roles the practitioner is competent to do, how competent they need to be, and how often this needs to be revaluated.

For the individual practitioner the advice is: -

"…As a registrant, a professional must abide by the duties laid out in their regulatory body's core Code/Standards documents which make clear that they must only practise where they are capable of doing so safely and effectively" (CHRE, Pg12)

Which in the case of nursing places the ANP back to where they started from within the *The Code: Standards of Conduct, Performance and Ethics for nurses and Midwives (2008).* It is possible that the CHRE were overly ambitious in their attempt to recommend what 'advanced' was in so many varying contexts, and ultimately this resulted in a document that did little to change the status quo. The NMC had to hold the development of a sub-section of the register for 'Advanced Practitioners' as they awaited the report from the Commission for Health Regulatory Excellence (CHRE 2009). However the CHRE (2009) report struggled to differentiate between subtle evolution of roles, taking on slightly extended tasks, and advanced practitioners taking big leaps into unchartered territory. The document gives examples of specialist dentists taking on extra work underpinned by extra certification, or GPs with secondary specialist interests, but these examples are not comparable to the advancements occurring nursing. Whether the implausibility of trying to define 'advanced' across so many boundaries, or the practical application of revising a multitude of constitutions influenced the CHRE is questionable. Potentially most concerning is that the CHRE report also placed the responsibility of assessing fitness to practice on the individual employers, which was exactly the opposite of what the NMC was trying to do before it. It also seems ill advised as Woods in 1999, found that ANPs felt that organisations were not in touch with 'advanced practice'.

However, the CHRE's task was to determine whether practice was safe and whether the regulation in place was sufficient; not to define 'advanced' in the varying contexts. Without doubt had they suggested that practice was advancing beyond the remit of current regulation, a logistical nightmare would have ensued. As one would imagine that all of the independent regulatory bodies would have to align as to what 'advanced' was and what competencies were required. If we link this to most of the

current thinking that 'advanced' represents a level of practice, it has to be considered in the context of the individual profession. CHRE were therefore destined to struggle as each profession has very different starting points, which in turn means different ideologies of what constitutes advanced practice!

Unfortunately gaining the respect of fellow professionals, and public confidence requires expansion to be managed correctly, and there is little evidence of the NMC adequately controlling the situation as yet. Whilst the current NMC code of conduct may *cover* work that is done by advanced practitioners due to its generalist guiding approach, it does not necessarily represent or regulate ANPs adequately. As the NMC has no definitive definition of what an advanced nurse practitioner is, or who should be considered 'advanced' the title is open for abuse. The NMC will therefore have to re-evaluate its position on 'advanced' practice itself, and determine whether a subsection of the register is required. ANPs are currently left with a problem; an individual may well be a competent expert practitioner, who has completed first degree, masters degree or even doctorate with multiple years experience within their field. And yet, they are not seen as different in the eyes of fellow professionals or laypersons to any other nurse with the title 'nurse-practitioner'. The generalist guidance the *The Code: Standards of Conduct, Performance and Ethics for nurses and Midwives (2008)* gives us may mean that it can capture work that ANPs do, but that does not mean it sufficiently represents it. A difficult question to answer is whether ANPs should remain on a nursing register at all, if their job has become so far advanced of what 'general' nurses do. If the knowledge, skills, requirements and practices have changed so much, is even a subdivision of the register enough?

Interprofessional relationships

The profession itself is partly responsible for adding to the melee through highlighting its dissatisfaction to nursing's position within the health profession hierarchy (Rodney and Varcoe, 2001). With feelings of powerlessness and detachment from clinical/organisational decision-making, the profession has urged nurses forward to gain greater influence and credibility in specialist and practitioner roles (Hamric et al., 2000), creating a division between 'traditional' nurses and ANPs. Tensions have been

extended as some believe that ANPs are abandoning their traditional positions and discrediting that which was previously held as sacred within the nursing profession (Gottlieb, 1994). General nurses are said to reject 'elitist' roles as they weaken the identity of the profession as a whole by predominantly using reductionalist approaches to care. Kitson's (1996) article *Does nursing have a future?* highlighted how nursing was losing its identity by focusing to greatly on the scientific elements of healthcare, not core nurturing values (Kitson, 1996).

Advanced nursing roles remain high on many of the developed countries agenda; nurse practitioners are said to be playing vital roles in improving health care through improving access to services (O'Keefe and Gardner, 2003). Further studies have shown that nurse practitioners improve patient satisfaction and enhance team approaches to health care delivery (Litaker et al 2003, Gardner and Gardner 2005). However, many posts were created in response to a shortage of doctors; the need to reduce junior doctor's hours; cost containment in health and service provision; and the need to improve access as a whole to health care services, not necessarily, a true quality perspective (Horrocks et al 2002; Harris and Redshaw 1998).

Traditionally, nursing gained credibility and professional status by closely following the medical profession (Gerrish et al., 2003). However, the drive for professionalisation and reduction of medical hours has meant that nurses have crossed boundaries further than previously expected. This has clearly caused friction between professions with some medical staff claiming that advanced nursing roles are tokenistic, or that in the rush to create such roles insufficient training has been provided to facilitate safe practice (Paquette., 2006, Smy 2006). Moreover, it has meant that nurses in some cases have taken the simplistic cases away from medics leaving them with predominantly more complex workloads, which unsurprisingly some do not welcome (Sibbald et al, 2006,).

Coombes (2008) has alluded to some of the concerns that doctor's raise with regards to advanced practice. A consultant within the article suggests that: -

"To work nurse endoscopists need clarity, support and feel a member of the medical team- have lunch with us for example" (Coombes, 2008, pg 661)

Probably a free one; another consultant who wished to remain nameless felt that: -

"There is a big difference in what nurses do if they see something. For example, if doctors see a stomach ulcer, they will decide on treatment and treat the patient. But nurse endoscopists will refer back to the consulting physician. Once you have the technical skills you have to apply them. Just sending the patients back is unhelpful…" (Coombes, 2008, Pg 661)

It seems that power relationships play a part in how other professions view nursing, and that all professions will attempt to protect their boundaries in the face of new challenges to its position within a hierarchy. However, healthcare should be moving on, there is now greater emphasis on the benefits of multidisciplinary interventions, and teaching for the benefit of patient outcomes (Cranberry & Flemming, 2009).

Wood's (1999) performed a longitudinal study over two years between 1996-1998, involving five separate case studies, into the training of new advanced nurse practitioners. Wood's (1999) used a variety of methods to collect data, these included: interviews with the various case study informants at various stages, observation of clinical practice during and following ANPs educational preparation; and documentary evidence from development diaries. The reader is informed that Wood's (1999) used grounded theory and analysed data using constant comparative analysis, which is advocated by Glaser & Strauss 1967. Unfortunately, we are not told whether all of the ANPs, managers and medical consultants are from the same NHS trust, or whether this was a multisite enquiry. The publication does not acknowledge any limitations but purports to examine "the issues faced by advanced nurse practitioners in the UK…." (Pg1, Woods, 1999). Which is a bold claim as the number of case studies is also low (5), from possibly one site, which may well affect both the reliability and generalisability of the study. However, the study is of benefit as it examines the interprofessional relationships between all of the major stakeholders ANPs, Medical staff, Nurse educationalists and Managers. Wood's (1999) study also provides useful insights that may well be applicable in other trusts, and is particularly valid in its examination of organisational governance and its influence on developing ANP roles.

Wood's (1999) found that practitioners start in advanced roles with an idealised stance with regards to advanced practice, which may be attributable to their 'novice'

status within the new role. It is accepted that medical staff often are amongst the most powerful stakeholders in a hospital environment, in the Woods (1999) study one consultant said

"They [ANPs] should concentrate on the clinical side so that they get into the job…. I suggest that they should spend 80% of their time on clinical matters". (Woods, 1999, pg 5,)

An ANP within the same study stated that:

"…. They [managers and senior medical staff] felt it [the orientation of the ANP role] should be 90% clinical duties and 10% of the time on other things. And we don't see it like that at all. We want to do other things, we're not just here as replacements for junior doctors. If it's going to be like that I'd rather not bother, thank you very much." (Woods 1999, pg 5,)

Both of these examples show how the view of managers and medical colleagues suggest that an ANP was supposed to be spending between 80-90% of their time working clinically. It is indicative of the fact that they did not appreciate other 'non-clinical' components of advanced nursing such as research, teaching, managing or leading. Resolution did seem to occur whereby it seemed the participants within Wood's (1999) study settled within their advanced roles. They had accepted how they had come to fit within the organisation, and were less frequently challenging the way in which they were working. It seemed from other comments that were made within the research that they still harboured frustrations over possible developments:

"If they want they could employ me on a supernumerary basis on the ward to make a big impact here. Or, they could employ me to work throughout the hospital or even on a trust wide basis, where I could go and run outreach clinics…but they're not doing any of that. Nobody here has any vision" (Woods, 1999, Pg 7,)

Regardless of whether medics or indeed nurses supported the expansion of nursing roles into advanced paradigms: its happened. Over the last ten years with greater opportunities for nurses, at different levels within health care, nurses have expanded their practice (Mills and Pritchard 2004).

MENTORSHIP

The origin of 'mentorship' comes from; Homer's Odyssey in which, Mentor, a wise and trusted friend of Odysseus takes on rearing of his son whilst he is away (Barlow, 1991). The image depicted is that of an older and wiser male, taking responsibility for a younger males learning and development (Andrews & Wallis 1999). The term mentorship has been applied to other professions for considerable time, but only really began to be recognised within nursing literature since the early 1980's (Anforth 1992, Donovan, 1990). The concept of 'nursing mentorship' came from North America to the UK, again it; -

"Slipped into the folklore of nurse education almost unnoticed, and quickly became part of the educational language of the eighties and nineties "(Burnard, 1990, pg352)

The nursing profession then created more definitions of 'mentorship' then can be possibly necessary. Wilson-Barnett et al (1995) found that terms such as 'mentor', 'assessor' and 'supervisor' were all used interchangeably in the 90's. The majority of the literature relating to mentorship dates back to this period, when Project 2000 (diploma-level practice) was first implemented. Project 2000 saw supernumerary status for pre-registration students, to emphasise educational rather than service-led nature of clinical practice (Kilcullen, 2007). During this time it was felt that student nurses, spending more time in the classroom, would need to address the 'theory-practice' gap by working with competent mentors (Northcott, 2000).

'Mentors' in this sense were, and still are; qualified nurses that assess pre-registration nurses in clinical practice, often 'signing-off' practice booklets to determine competence in a particular area. The role of these mentors is to enhance the clinical experience students receive, providing students with appropriate guidance and support in the clinical environment (Andrews & Roberts 2003, Ali & Panther 2008). The NMC has specified what is required to be a mentor of pre-registration students; they expect the mentor to have been on the same part of the register as the student they assess for at least 12months, and to have completed an NMC-approved mentorship course (Ali & Panther, 2008). Mentors should be able to support the student in meeting continual professional developments in accordance with *The Code:*

Standards of Conduct, Performance and Ethics for nurses and Midwives (2008) (NMC 2008).

The NMC (2006) suggested eight mandatory competencies that 'mentors' should have: -

⇒ Establishing effective working relationships.
⇒ Facilitation of learning.
⇒ Assessment and accountability.
⇒ Evaluation of learning.
⇒ Creating an environment for learning.
⇒ Context of Practice.
⇒ Evidence-based practice.
⇒ Leadership.

(Adapted from Nursing and Midwifery Council, 2006)

Great attention is paid to the 'mentor' being competent to mentor students, predominantly because these 'mentors' are actually doubling up as 'assessors' to determine whether the 'mentee' is competent or not. Avoiding the temptation to dissect the semantics of nursing terminology, there is an underlying principle that seems to be missed within this widely held view of mentorship. That is that a professional mentorship relationship should be *chosen* by both parties involved to be most effective. Nurse leaders should *want* to be a mentor; they should have an interest in teaching a particular protégé (Schaffer et al, 2000). Potential protégés should exhibit positive qualities to attract mentors to spend time with them developing their career. To gain the support of these experienced nurses the mentee should be hardworking, willing to learn, and anxious to succeed (Schaffer et al, 2000). This is important as almost all authors concerned with mentorship of nurses concur that the relationship between Mentor and Mentee is key (Ali & Panther, 2008, Andrews & Roberts, 2003, Schaffer et al, 2000, Andrews & Wallis, 1999, Northcott, 2000). Mentors are expected to possess characteristics such as: -

"Friendliness, a good sense of humour, patience, effective interpersonal skills, approachability and professional development abilities" (Ali & Panther, 2008, Pg 37)

Pre-registration student nurses often get their mentor allocated to them; they have little or no choice in who mentors them whilst on placement, and its only when or if problems occur alternative mentors are sought. Pre-registration student mentors tend often to be staff nurses who have students allocated to them amongst their already

challenging workload (Earnshaw, 1995). This is a significant challenge for these mentors as they are expected to balance teaching with patient care, they are to flex up or down depending on the student's ability, they may have multiple students at one time, and personalities may clash (Bennett, 2003, Moseley and Davies 2008, Mills et al 2005).

The Advanced Practice Mentor (APM) has the opportunity to be different, and possibly more fulfilling. This is because the aims of such mentorship could be different, as Northcott 2000 alludes to: -

"The best work-based mentor is the work-based peer who acts as a host and goes out of their way to help the more junior colleague to grow" (Northcott, 2000, Pg3)

Power relationships could well be different, in that the APM could be chosen by the advanced nurse practitioner, which would be the reverse of how a pre-registration student is 'allocated' a mentor. It is likely if the mentee chooses the mentor, they may work together, respect each other, and get on well.

"Mentors are sometimes described as 'knowledgeable friends'. As with any friendship, this relationship requires mutual respect and a commitment from you both" (Bennett, 2002, Pg2)

There is no insistence within the literature that a mentor *has* to be an assessor. In fact there is suggestion that being an evaluator of competence detracts from the supportive benefits of mentorship (Northcott, 2000). However, what is clear is that the 'mentor' is supposed to be facilitating and supporting a journey of enlightenment, insight and understanding; enabling the mentee to practice with competence and advanced skills (Kilcullen, 2007).

Rather than guidance of what a mentor *should* do within the literature, there is more suggestion of what they *could* do (Northcott, 2000, Kilcullen, 2007, Andrews & Wallis 1999): -

⇒ **Listen**- to everything particularly unease
⇒ **Provide** structure- help colleagues with time management
⇒ **Encourage** – when times gets tough
⇒ **Advocate** – allies are usually welcome
⇒ **Share** – their own experiences

⇒ **Celebrate** – success and achievement
⇒ **Set tasks and Signpost**- to help meet personal goals
⇒ **Confront –** with ideas, creating conflict and reflection that concludes with learning
⇒ **Agreeing standards**- High, but achievable
⇒ **Role modelling**- those standards
⇒ **Mirroring**- back to the student to help them see new ways of working

(Northcott, 2000, Pg 2)

Different mentees will have different educational or support needs. The mentor should be able to assess each individual, and provide the help that the individual requires. In the case of pre-registration students, the mentor-student relationship has pre-defined duration, the placement may only be for 12 weeks. This does not mean that a relationship cannot last longer than this but it is unlikely that this will occur. Some authors suggest mentor relationships lasting between 6 months and 2 years are possible, depending on other factors such as job progression or career changes (Andrews & Wallis 1999, Hunt & Michael, 1983).

It is probably most useful to appreciate the phases of mentorship, to gather when it is best that the relationship ends. There will be fast, and there will be slow learners regardless of the level that is being taught. Some ANPs will have a propensity for 'advanced' practice and therefore measuring the mentorship requirements in time is ineffective. Unlike undergraduates; ANP mentorship would not necessarily have time boundaries at all, it may be the case that as the relationship is more dyadic, it will end when it needs to end.

Mentorship is said to have three distinct phases to it according to Ali & Panther 2008:

"Initiation, working and termination phase"
(Ali & Panther, 2008, pg37)

In the initiation phase student and mentor get to know each other, they work closely to support each other, influencing the development of the relationship.

The second phase is that where the mentee gains the most from the relationship, a sense of trust and closeness should occur (Ali & Panther 2008). Morton-Cooper and

Palmer (2000) state that this is an active phase where the intensity of the relationship moves to that of common understanding, and solid partnership. During this phase the student gradually becomes more independent, taking on greater responsibility, and asking for help less frequently. As the student becomes increasingly confident and self-reliant the relationship moves towards the termination phase.

The third and final phase is the termination phase. Where if the relationship has worked well a supportive and friendly relationship follows. However, if the relationship ends negatively the both parties can be left with feelings of negativity. It is suggested that all mentorship relationships go through these stages even if some of the time the transition between stages is unnoticeable.

Whether discussing pre-registration students or ANPs, the aim is to get the protégé to a level where they can be released from the need of that particular mentorship. The mentee may now need to move on to a different mentor with different skill sets or even greater knowledge.

Woods (1999) suggested that during the development of advanced nursing roles there is a transitional period from experienced nurse to ANP. It is suggested that a practitioner is required to 'reconstruct' their practice and professional frame of reference. If the job requires a greater level of assessment, it may be the case that the practitioner has to develop new ways of going about that. Nursing has held 'holistic' principles of care close to its core for many years; however, the requirements of the advanced role may mean they need to adopt reductionalist approaches to succeed in their new role. Essentially they may challenge their core values, or develop new ways of approaching problems.

By conducting this research it is hoped that useful insights can be found with regards to advanced nursing and mentorship. It is accepted that the content of educational programs will be more complex for ANPs, and that they should have greater awareness or standing within their trust; but this does not mean they will not require support in their new domains, or with the work advanced practice brings.

Chapter 2

Methodology and Methods

The purpose of this chapter is to detail the methodology that was used within this research project. This will include the rationale that was used to determine which methodology was most appropriate for this research question. The sampling method, interview techniques and data analysis will also be explored.

Ethical considerations and approval.

Ethical approval for this study had to be sought via three independent ethics committees. The first of which was the De Montfort University Ethics Committee, the second ethics approval committee belonged to an acute trust in the East Midlands (EMT), and the third; and final committee was the Leicester, Northamptonshire & Rutland Ethics Committee (LREC).

EMT ethics approval was necessary as the researcher chose to interview staff working within his trust, within their own working time. It was therefore necessary that the EMT committee ensured that they would come to no harm during the study, and as they were to act as the 'sponsor' of the research, that the activity was valid. Following EMT ethics review, and approval, the project was passed on to LREC. Only once LREC and DMU ethics committees had agreed that the study was appropriate was it possible to commence fieldwork. *(The various forms and supporting information can be found in the appendix 2,3,4,)*

EMT & LREC ethics committee required a completed 'Integrated Research Application System' form (IRAS). This form is accessed online; it has a predetermined format and variety of click button options to complete. The form can be used for a variety of research topics from Randomised Control Trials of medications through to qualitative works done for academic purposes. The form manipulates itself as certain options are chosen, to provide the researcher with differing boxes or tick circles to complete. *(See appendix 4)*

Ethical approval is designed to safeguard the participants as it ensures their interests and rights are maintained, whilst also ensuring that they are not disadvantaged by their involvement in the study (Denscombe, 2002, Burns & Grove 1999, Watson et al 2008). It can also ensure that the research project itself is justifiable, designed well and constructive (Bassett, 2004, Bell 1999). The Helsinki declaration first developed in 1964 and then regularly amended supports this philosophy in that it states that research should be considered carefully, to ensure no harm comes to participants, and if it becomes apparent that harm can occur through the research it should be ceased immediately (Oddi & Cassidy, 1990). Similar ideals are apparent within the Nursing and Midwifery Councils Professional Code of Conduct; to which the researcher must adhere to being a registered practitioner. It states confidentiality as well as informed consent and doing no harm as mandatory requirements (NMC 2008).

There is a pre-existing relationship between the researcher and the participants as the researcher works within the trust where the study is conducted. It was therefore essential those relationships were not compromised in anyway, and that no coercion was employed within the research process.

Key ethical principles as defined by Denscombe (2003) were followed throughout this research process *(see appendix 5)*

Consent

Consent within this study could be withdrawn at any stage and at anytime, without any justification. Participants were assured that they would never be coerced into taking part or continuing with the study if they did not wish to. All potential participants were shown the presentation introducing the study *(appendix)*, and were given the "information for participants" *(see appendix)* and were asked to complete a consent form *(appendix)* prior to taking part in the study. The information for participants form includes the declaration that: -

> "If you do not wish to participate in the study you need not express an interest. Only individuals who have agreed to be contacted will be invited to participate in the study.

> "If you chose to withdraw from the study at any time, you may do so. All records of your involvement will be destroyed."

The following extract is from both the IRAS form, and information that was given to participants.

> "You are free to withhold or withdraw your consent to participation at any time and will not be asked to justify your decision. Regardless of whether you participate or not, you will be treated no differently either by the staff of EMT or by the researcher at any point or in the future." (IRAS Form 08/H0402/133/ appendix Pg 10)

Sampling

Within this study the researcher selected participant's to be included from a pre-determined group of Advanced Practitioners. This was achieved by presenting the aims of the study at the 'Advanced Nurse Practitioner Forum'. This is a group where all nurses seen to be advanced practitioners meet for monthly meetings. Membership to this group is determined by job description, it is assumed that all nurses that attend this group are working in advanced roles be they CNS or NP's.

The sampling strategy was therefore purposeful; the aim was to gain concentrated insights from a group of advanced nurses (Creswell, 2005). A purposive sample is a group 'hand-picked' by the researcher; this was undertaken because it was necessary to gain shared views of ANPs. Selecting a random group of nurses would not have provided the insights required on the research topic or generate meaningful discussions (Jennings et al 2005).

The size of the sample was kept to six participants for the focus group; and seven for interviews this was partly due to time constraints and financial implications of a greater sample population. However, Wolcott (1994) suggested that researcher preoccupation with large sample groups came from quantitative studies, or an intention to appease funding bodies. Banister et al (1994) also claimed that having too large a number of participants within qualitative enquiry might lead to meanings being lost or not respected. The overriding issue was to get good descriptions from people who had first hand experienced of the topic (Holloway & Wheeler 2002).

A presentation was developed that explained the nature of the study, and what would be expected of participants should they consider taking part. Those that wished to consider involvement were given the participation information sheets, with consent forms attached *(Appendix 6,7,8,9)*. These forms were then signed, and placed in a box if the ANP was interested in participating and being contacted to attend for either the focus group or interviews. The ANP's that expressed an interest by returning the form were the initial sample frame.

ANP's agreeing to participate also had to meet *all* the criteria below:

Table 1: Inclusion / exclusion criteria for participation in research study.

Inclusion Criteria	**Exclusion Criteria**
• Be a Registered Nurse • Currently practising in Nursing • A Senior Nurse that has a job title in keeping with 'Advanced Practice'. • Have given written consent to participate in the study • Have an understanding of the aims of the research study and be able to articulate their thoughts	• Nurses not currently practising in England (this includes midwives undertaking Adaptation / Return to Practice programmes within the university) • Nurses working independently or for private organisations • Nurses who are directly managed or supervised by the researcher during or prior to the research period • Nurses who decline to take part in the study

and responses	

Having expressed interest, participants were then contacted to ensure that they understood the study as far as possible. The consent forms that were signed were then checked with them, which produced a written record of involvement in the study. It also systematically ensures that participants are both willingly and knowingly involved in the study (Berg, 2001).

Methodology and Rationale

> "Methodology is the theory behind the method, including the study of what method one should follow and why" (Van Manen 1990 cited in Koch, 1995, pg 3).

To determine which methodology is most appropriate one has to first decide upon the nature of the research (Lathlean 1994). The aim was to gain greater understanding into what mentorship requirements ANP's had, if any, and how they felt these could be provided. It was therefore a study that needed to explore the feelings and perspectives of nurses, valuing their thoughts and presenting them as the work progressed. Using participant experiences in this manner facilitates *inductive reasoning*, which moves from the participant's specific experiences to generating wider more generalised statements by grouping findings together (Chinn & Kramer, 1995).

Because greater understanding of feelings and beliefs regarding mentorship and advanced practice were sought, a qualitative study was recognised as the most appropriate methodology (Corbin & Straus, 1998, Denscombe, 2003, Holloway, 2001). Achieving this aim required an inductive rather than deductive approach, as currently there is a paucity of literature regarding the mentorship of ANP's. The intention was to explore nurse's thoughts and develop new understandings from data presented within this study.

The original intention was to conduct this study within the Grounded Theory paradigm; however, upon further reading it became apparent that Phenomenology had

many benefits that could be exploited within this work. It is essential that this work justifies its methodology, and that throughout this chapter; discussion of methodology is underpinned by sound philosophical understanding.

Originally, the concept of phenomenology can be traced back to Descartes, the French philosopher and mathematician (1596)-(1650). The whole philosophy came from Cartesian duality, the idea that a mechanistic view of the person can be achieved separating mind from body (Koch 1995). Edmund Hursserl (1859)-(1938) who is often hailed as the father of phenomenology then further expanded Descartes work. Ultimately, Husserlian phenomenology is concerned with the 'meaning' of human experience; it seeks to provide a systematic view of mental content. It acknowledges that a person's knowledge, understanding, intentions and actions originate in the mind (Wimpenny & Gass, 2000). Phenomenological enquiry seeks to break knowledge and feelings down into their constituent parts, thereby allowing the researcher to study the 'essence' of any phenomena (Koch, 1995). It aims to take the beliefs of the participant out of the 'real-world' to examine them more fully. The aim is to study the essences of thought and feelings in isolation to ensure that true understanding is achieved (Paley, 1997).

Some authors advise caution when using phenomenology; as thanks to Martin Heidegger, a Nazi; and a former student of Husserl, some difficulty can be found in separating phenomenological concepts and fascism (Ott 1993 cited in Holmes 1996). Heidegger became a mouthpiece for the Nazi regime, and an ultranationalist who never condemned Nazism or the human misery that it caused. Heidegger associated phenomenology with fascism, which goes against all of the humanist principles on which nursing was founded. Holmes 1996 states

> " Nurses cannot, I believe, tolerate any theoretical or philosophical position which so clearly encourages appropriation by, or association with fascist political affirmations" (Holmes, 1996, pg 9)

Which the researcher believes any nurse would agree upon, however, Holmes 1996 does continue to say

> "I believe we are entitled to selectively scavenge his [Heidegger's] work for what we believe is useful to us, keeping a weather-eye on the assumptions and

> consequences of the principles and techniques we choose" (Holmes, 1996, pg 9)

The individual can manipulate frameworks of knowing for the purposes of the individual. Heidegger used Phenomenology to dehumanise that, which was occurring to individuals. The researchers aim is to merely observe a phenomenon, and improve understanding, for the purposes of good. It is for these reasons, and for the general applicability of 'bracketing' that the researcher chose to use a Husserlian, not Heideggerian, model of phenomenological enquiry.

Husserlian phenomenology would suggest that the researcher should just present the facts and let them 'speak for themselves' (Walters 1995). By participants validating that which is written, and only pure facts being presented not interpretations, the reader can decide on their own meanings from the research. The transparency of work including the steps taken in analysis increases the value of work, even if another researcher did not produce exactly the same descriptions; the work is not therefore 'invalid'. It just means that there are other descriptions that are plausible for readers to examine and interpret (Webb, 2001).

Phenomenology is widely accepted as a difficult and complicated concept to understand, but as a nursing approach, it has grown considerably over the past 20 years (Wimpenny, 2000). This could be due to the fact that a hallmark of genuine phenomenological enquiry is just to describe that which is occurring (Kohak, 1978). Emphasis is placed on description of experience, really trying to understand that which is being observed, and presenting that to the reader. Nurses using qualitative methodologies that pursue understanding as their main goal genrally struggle to prove how rigour can be achieved and maintained (Sandelowski, 1986 cited in Koch 1995).

Reflexivity, bias, and relationality

Oiler in 1982 sought to examine problems with qualitative research in terms of both 'validity' and 'bias', whilst establishing that knowledge gained can be worthwhile without being replicable and generalisable. Phenomenology seeks to improve validity through a variety of measures, but primarily through its reductionalist approaches to social science. 'Validity' is generally accepted as meaning that the research tests what

it actually set out to test (Jasper 1994). It is suggested that this can be achieved by including the participants at a variety of levels during the research process; this facilitates 'inter-rater' reliability. The feeling is that if a team approach is taken to the research, with participant involvement, then no one person interprets everything.

Within this project the researcher allowed participants the opportunity to review their transcriptions prior to the data being used for this very reason, this affords the researcher the opportunity to clarify beliefs and positions before the data generation phase (Parse et al 1985 cited in Koch 1995). The researcher will also provide excerpts from transcriptions so readers can judge 'correctness' (Walters 1995).

Husserl did approach the question of bias by suggesting both 'bracketing' and ' phenomenological epoche'. Epoche was a term used by Greek academics to suggest a suspension of judgement (Walters 1995). This concept is central to phenomenology, and is often represented by 'bracketing', which is the idea that a researcher's premises and suppositions can be suspended through the research process. Both Shultz (1972) and Taylor (1995) identify the difficulties in suspending belief, they acknowledge the great difficulty in 'bracketing'; pushing presuppositions aside and allowing 'true' phenomena to be revealed. Knack (1984) and many other authors would agree that there is no such thing as 'value-free' social science, appealing to the notion of 'objectivity' but suggesting that bracketing can enhance rigour.

The concept of 'bracketing' seems synonymous with general theories of reflexivity, which has been described as

> "The researchers' active engagement with their own self awareness to identify the impact of their own personal values and positions on the research process and the data collected" (Reed 1995)

This suggests a high level of understanding as feelings and biases are sought to allow them to be suspended. The notion of relationality is particularly important within this work, as it addresses power and trust relationships between participants and researchers (Hall & Callery. 2001). Being employed within the trust meant participant information leaflets had to clearly state that participants, are free to partake, or not to,

without any consequence. It is an acknowledged phenomenon that participant responses can be dependant on the nature of the relationship with the researcher (Marchant & Kenney 2000).

Working within the EMT meant that participants knew the researcher, which, is why it was necessary to remain mindful of the 'halo' effect. The 'halo' effect is a term coined by Holloway (2001); it refers to respondents aiming to please, showing themselves in a more positive light to the 'expert' interviewing. It was hoped that this again would be countered by 'transparency' of findings, and allowing readers to see excerpts of text. The guarantee of anonymity is also hoped to prompt nurses within the research to be as open and honest as possible, giving true accounts of how they think and feel.

Methods

Within this work a two-stage approach to data collection was adopted. This was designed to optimise the data collection; and to provide analysis at separate stages, generating a 'narrative thread' throughout the work (Norrie, 2004). The principle was to complete a focus group, analyse the data; and then use this to inform the generation of an interview schedule *(Appendix 10, 11).* It was hoped that this would generate theory at each stage of the process. The aim was to fully examine the phenomena, by allowing stage one to inform stage two, then investigating the net findings together in the concluding chapter. Ideally it may be possible that data *saturation* will be reached, which means it is likely that no further information may be found to alter the emergent theories (David & Sutton 2004).

The first stage of the research process was to collate a focus group of the consenting participants. A focus group is:

> "A group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of the research" (Powel & Single 1996, p.499)

A focus group was used as it is recognised as a particularly useful method when trying to explore people's thoughts, knowledge and experiences (Kitzinger 1995). It is thought that focus groups provide the opportunity to highlight (sub)cultures, values

or group norms. It is suggested that by analysing the operation of humour, consensus, dissent and examining different types of narrative used within the group, the researcher could identify common themes (Hughes & Demont, 1993). This is seen to be particularly useful in the early stages of the data collection where a wide range of data is required to inform the next stage of the research process (Vaughn et al 1996).

Focus groups are also a tool to enhance validity according to Webb (2001) who states that

> "The method [focus groups] has a high level of face validity because what participants say can be confirmed, reinforced or contradicted within the group discussion"
> Webb (2001) pg 4.

Higginbottom (1998) also concludes that issues of rigour are addressed by focus groups as data can be fed back to participants for 'member checking' increasing validity and plausibility. Focus groups encourage participants to speak using the "safety in numbers factor". People, who may have been less vocal in an interview, may well contribute intermittently in a focus group (Kitzinger 1995). This should be juxtaposed with the fact that participants do not have complete confidentiality within the focus group. As other members see and hear what they think about the topic, this was addressed by promoting an open and 'safe' environment for participants to respond. When group dynamics work well the participant's work alongside the researcher, often taking the discussion to places that were not expected.

A small focus group consisting of six ANP's was set up; the size of the group was designed specifically to create an environment where each member felt comfortable to input in a natural and spontaneous environment (Bloor et al 2001). The venue of the focus group was a seminar room within the researcher's trust, accessed expressly for this purpose.

The second method adopted within this research was that of semi-structured interviews. The interviews followed an initial focus group to facilitate the development of an effective interview guide. Topics that were established at the focus group stage would be reviewed and explored further at interview.

Interviewing is seen as synonymous with qualitative research regardless of which methodology is being used (Wimpenny, 2000); although it is often considered to be the main method of phenomenological investigations. This is primarily due to the fact that it provides the opportunity to explore participants' descriptions, illuminating and gently probing their experiences (Jasper, 1994). The researcher as an individual is hugely important within the interviewing phase of the research project. Jasper (1994) states

> '…the researcher using a phenomenological approach needs to develop specific research skills to enable him/her to get the "lived experiences" without contaminating the data' Jasper (1994) p.311

This fits with the ideology of 'bracketing' but is countered by Polit & Hungler's (1991) perspective that the subjective judgement of the researcher is valuable in phenomenological based research. What is definite, is that the researcher needs to have developed interview skills, or needs to learn them (Seidman, 1991). Wimpenny 2000 suggests that over-zealous, too directive or inexperienced researchers may result in the loss of interesting directions or rich data. Again authors suggest that the researchers should be naïve about the research topic, but skilled in the application of research for best results. In the case of this study and being inexperienced it was thought best to adopt a semi-structured approach to the questioning, because this allowed the opportunity to ask the participants similar questions. To ensure that certain issues and topic areas were covered without direct questioning (Holloway & Wheeler, 2002). An interview schedule was therefore developed, to expand on the data gained from the initial focus group, and pursue concepts highlighted within the focus group (appendix?). The interviews were not overly rigid, and predominantly used open-ended questions, which allowed participants the opportunity to develop their ideas and speak widely on the topic (Denscombe, 2003, Kane et al, 2001).

Dictaphones were used to capture all of the data from the focus group, without interfering with the dynamics of the group. Some individuals may have been reluctant to speak openly or commit their beliefs to tape, which, may mean they require greater reassurances that their anonymity, confidentiality and disposal of tapes were guaranteed. There were no identifying features on tape labels; they were labelled 'focus group', or interview 1, 2, 3 etc. Removing any identifying features helps to maximise the confidentiality for participants (Berg, 2001). The audiotapes were then

transcribed; the reliability of analysis is highly dependant on accurate transcription (Peräkylä 1997).

The researcher then reviewed the data, and all participants were given transcripts to ensure that they agreed with accuracy. Once accuracy had been established the taped recordings were then erased and disposed of. These steps were established to encourage transparency throughout the research process, and went some way to acknowledge the researchers responsibility to be truthful in both the analysis and presentation of data (Finch, 1984).

Analysis

The purpose of data analysis, according to Banonis (1989), is to preserve the uniqueness of each participants lived experience while permitting an understanding of the phenomenon under investigation (Banonis 1989). Listening to the participant's verbal descriptions, then reading; and rereading transcriptions of the data ensures that the researcher becomes immersed within the data. It then becomes possible to find common themes within the data, highlighting these and grouping themes together. The researcher then aimed to link these themes together to try and ensure that all lines of enquiry were exhausted.

Colaizzi suggested seven steps to facilitate phenomenological data analysis for the researcher: all of which were undertaken. Transcriptions were cut and clustered into themes that were then further explored. *(see appendix 12 for Colaizzi steps)*

The intention within the research was to find themes, not based solely on quasi-quantitative approaches placed upon qualitative data. In other words just because certain phrases may have been mentioned more often, attention was still paid to quieter more subtle views of quieter group members. Data such as this is sometimes labelled as 'deviant', but should be reported regardless of whether it fits with the researcher's overall theme. Carey (1995) pointed out that counting frequencies was inappropriate unless questions were directly asked to gain numerical value, and both Robinson (1999) and Kitzinger (1999) agree that it is not appropriate to give percentages when evaluating focus group data. Such techniques do not fit within

Phenomenology, where the aim is to appreciate differences, and gain an in depth view of participant experience. The researcher will aim to highlight interactions within the focus group, whether that is humour or conflict; it is hoped that these subtexts may also be examined.

The ultimate aim within phenomenological analysis is to reduce data down; to get to the 'essences' of what has been uncovered. To present the reader with the essence of the research, as clearly and effectively as is possible (Paley, 1997). Within this study the author has taken excerpts of both the focus group, and interviews; presenting them within the findings chapter should aid validity through understanding.

Chapter 3: Focus Group.

This chapter will present the findings of the focus group; the aim was to develop understanding on 'advanced' practice, whilst also examining views that ANPs have on mentorship. It was intended that the focus group would highlight areas that could be further explored within subsequent interviews, the second stage of the research. Themes that emerged from the analysis are presented using the practitioners own words, and are grouped along the lines of an explanatory framework.

The focus group consisted of six nurses working within advanced roles at the trust, from a variety of directorates. Tom had previously been a ward manager overseeing a large unit within another trust; David also had been a charge nurse before becoming a clinical nurse specialist a year later. Becky, Ann, Gillian and Patricia had been ward sisters that then were then promoted into advanced roles. The experience within their advanced roles varied from six months, to six years; all were either Agenda for Change Band six or seven nurses. *(Please see appendix 13 for table of findings)*

Transitional difficulties/New skill sets

All of the participants had very different experiences, with regards to the transition from being a senior nurse to an ANP, even though they all had been sisters or charge nurses previously. It appeared that the individuals that were joining an established team of advanced practitioners had a smoother transition than those that were starting new roles. Tom had a

> *"Pretty comprehensive package including a certificated anticoagulation course"*

A senior nurse within the department, who had already established the 'advanced' role, led this; whereas Patricia's job was developmental, it had just commenced to bring the trust in line with national service frameworks, therefore Patricia had

> *"Nothing in place… [Having to] work my own induction out"*

Patricia had been given a job description for the new role but felt

> *"That doesn't automatically translate into you coming in and knowing what to do…there was a lot of trial and error"*

It seemed that the transition regardless of which directorate, came with similar issues, as the role had changed, the requirements of the practitioner changed also. This caused frustration, as the ANPs often felt that they initially lacked direction. Ann said

> *"I worked on the wards for 23 years… you go in and do A, B, and C, and you get through your day…when you go into a office because its quite alien to most nurses, you sit and think, well what am I supposed to do now?"*

This perspective was supported:

> *"Nobody tells me what to do in a day; and yet the buck still stops with us" (Gillian)*

The lack of preparation prior to starting the advanced role in some cases, and subsequent lack of support whilst new in post causes great stress, Gillian stated

> *"One day you're this person [a Sister], and then the next day you're that person [an ANP], in that role, hence you should know absolutely everything! Because you have this uniform on its expected you should know!"*

The focus group agreed that whilst they were experienced nurses, the role that they had taken on had taken them into new paradigms of working, making them essentially in some ways a beginner again. Tom said that

> *"I went from being in charge, to not being in charge at all… people think you're fine and you can just get on with it, if you're not shouting for help, people perceive you to be fine...you are therefore sort of isolated in that respect, people don't support or help you because they don't understand your role"*

Many found that the lack of clarity within their new role, and a variety of expectations placed on ANPs by staff and patients alike were too ambitious at an early stage, often making them feel like they were failing

> *"My lack of experience, meant that I was not as effective as someone with more experience… my initial transition was extremely stressful, because the decision making process is at a higher level" (Tom)*

"…[Patient's think] she's got a different colour on, therefore she must be clever, and therefore she'll look after me" (Gillian)

"Its difficult because when they [patients] come into hospital, we set them up for their entire experience in the hospital, that's a lot of pressure" (Becky)

These statements reflect the exceptionally high standards of practice the ANPs sought to deliver, but on occasion these standards could be destructive,

"If I don't know something, I probably beat myself up more than anybody else" (Gillian)

"…You can feel a pain in the backside if you ask for support, or advice, or guidance" (Tom)

It was interesting to note that whilst the majority of the group had been involved in teaching, and considered it integral to their job, none had performed any research. Becky however had conducted many audits

"Most of the audits I do are for the service managers…figures and times, keeping tabs on how long it takes for people to be seen etc. It helps in getting better doctor cover, but my actual job is the least developed part of my job…."

Becky gave the impression that rather than the emphasis of audits being directly involved in nursing or patient care; they were more concerned with activity, or the business side of the unit.

Science vs. Art

With current attention being paid to 'advanced' practice dictating a level of skill, it was thought to be useful to determine whether the ANPs felt that they gained their recognition or banding from their scientific knowledge, or advanced interpersonal knowledge, and which of these they felt was most important to possess.

"I think you still need both…definitely, because you're not working in a team, you're usually seeing your patient on a 'one to one' basis, your art of nursing has to develop even further'"(Ann)

Tom felt that advanced practice required high levels of both skills, he described using advanced 'tacit' skill, which, is the knowledge gained through experience. It is described as knowledge that is s difficult to teach, or disseminate, but involves an

experienced nurse making many discretionary judgements on a given situation (Price, 1999).

> *"It's the combination that makes you advanced, and its your experience that gives you that tacit knowledge…it enables you to break down the science into bite sized chunks for patients that require education. Its knowing the right descriptors, and all those good things that put people at ease, knowing when to use what, and when to withdraw" (Tom)*

Becky also commented on the differences in approach between ANPs and medical staff

> *"I think that we have a more holistic approach, that you might not get from doctors, we break a lot of life changing news to people" (Becky)*

Tom felt that whilst 'scientific' knowledge can be imparted to new staff or ANPs, advanced tacit knowledge took a greater amount of time to perfect

> *"Empathy is the touchy- feely stuff which is only gained with experience" (Tom)*

Interprofessional relationships

The belonging that ANPs felt with general nursing seems to be affected by the transition into advanced roles, leaving them yet further isolated. Rather than actual animosity most of the focus group felt that it was understanding of their role that caused problems

> *"I don't think its friction, I just don't think they understand what our job is" (Gillian)*

Patricia, felt that the uniform being a different colour to senior sisters created misunderstandings, all specialists wear the same uniform although they perform very different roles

> *"When you have this uniform on its so far away from what they [S/N's] do they don't understand what we do" (Patricia)*

Although both Gillian and Ann had both worked within the trust for many years as sisters prior to becoming ANPs, both felt that after changing their role they were increasingly isolated.

"I worked with a lot of nurses for many, many, years and then suddenly they treated me like I wasn't one of them anymore…it can be quite solitary, your role suddenly changes and then peoples perceptions of you change overnight " (Gillian)

"Your no longer included are you?" (Ann)

It seemed as if both Ann and Gillian were suggesting that their identity within the nursing hierarchy had been compromised

"*You don't seem to be in anybodies club any more do you? No ones but your own?" (Gillian)*

In order to try and re-establish herself within the nursing teams, Gillian often attempted to perform 'basic' nursing care, to re-establish her identity as a nurse. She felt that general nurses liked to see specialists continuing with general ward work. However, although she made effort, she was still not fully accepted:

"Sometimes I'll give them a hand, make beds and do washes, but when its time for tea, they will go off and have one but they wont make me one… I know that's a really daft example but it makes you feel like its me and them now" (Gillian)

With regards to medical staff there were fruitful insights into how ANPs and junior doctors work together. There were several examples of how the ANPs had closer collaboration to junior doctors than nursing staff. At the time of the focus group new junior doctors had just taken to the wards

"With the change over of junior doctors, your role kinda changes, to help them along…maybe this is their first time in medicine, maybe they really don't know which question to ask first" (Becky)

Gillian described differences in how ANPs and Staff Nurses viewed junior doctors

" Staff nurses can just go "oh god new junior doctors are coming, what a nightmare" and yet, you know, I feel a little bit protective of them, because in a sense I have empathy with them... Staff Nurses certainly can be a bit abrasive to them. When I go to the ward, and say I'm Mr X's specialist practitioner, they go oh, thank god. They really do lean on you. I support the junior doctors huge amounts" (Gillian)

The interaction however with consultants was variable Ann felt that

"We've got some really supportive consultants"(Ann)

While in complete contradiction Tom felt that

> *"We get very little consultant support"*

Becky offered a position of interacting with whichever consultant was best positioned to help with the problem at hand, as in her role she was well antiquated with all of the medical consultants at the trust

> *"If I had a medical problem [with a patient], I would decide which consultant would be best to deal with it…and then speak to them" (Becky)*

This implies a good working relationship as Becky felt that she could contact any consultant at any time for help or advice. However, it seems that as with any other relationship, building productive partnerships takes time, and many felt they had to prove their competency prior to acceptance. Gillian gave an example of a clinical scenario whereby she diagnosed a difficult to differentiate surgical problem, and subsequently got a patient admitted to a ward via her consultant

> *"It increases you credibility with the consultant when you do something pretty clever…you then feel, yeah, I did alright there" (Gillian)*

This supports Wood's (1999) study, which suggested that good clinical work was what consultants valued most highly. However, this work has also brought attention to the fact that ANPs feel that 'general' nurses like to see ANPs doing practical nursing basics; therefore the practitioner feels obliged to balance 'advanced' tasks such as being a competent diagnostician with general nursing duties in order to seek acceptance from all parties.

Mentorship

When asked what they would want from mentorship, they highlighted again their need for confirmation that they were doing well

> *"It would be useful to have a mechanism whereby you can meet up with someone on a one to one…see where you need to go, give you some goals, get some constructive criticism" (Tom)*

> *"I've been in the job for 18months, and not yet has anyone sat me down and said your actually doing the job right, because I was put in the job and no ones told me I'm doing it right" (Gillian)*

It was clear that five of the six participants had not received an induction package that had satisfactorily integrated them into their new role. This was sometimes as a result of the job being new, isolated or developmental, but often it seemed that not enough *time* was attributed to the practitioners needs.

> "*In my case I had a week with my manager, and then she was off for two weeks so it was kinda sink or swim!" (Gillian)*

Tom gave the example of how his time to mentor new ANPs within his team was severely impaired by his clinical caseload

> *"We have no time in our working week to develop staff. If you develop staff it takes precedence over patient care, and there is just no lea way in our working week for that…. You have to crowbar it in, like I'm here today but I'm very conscious that my colleagues will be struggling with all the patients they are currently seeing" (Tom)*
>
> *"Same here…how much time you need, depends on the individual" (Becky)*

The group made a point of stating that to get mentorship, or access to support, they needed to go out and get it themselves

> *"If you're really passionate, there is someone out there that will listen to you. It's not encouraged, or if it is, because work is choc a block you have to do that first…then whatever comes is a bonus"(Tom)*

Patricia also found that

> *"Clinical supervision is there if you go and get it, it's not offered" (Patricia)*

One participant felt that the only opportunity to get mentorship came when participating in post-graduate studies at a local university

> *"…formal education is a way to get it [mentorship], then you get time" (Becky)*

Not all experiences were the same; some of the group seemed to be more actively involved in making mentorship happen. Patricia gave the example of a colleague that had joined her in her role from another trust

> *"There's a huge difference in how I've been mentored when compared to my colleague. When she started her consultant mentored her; for the three months*

before she arrived I really had no clinical supervision at all. I guess if I really needed it I could have gone out and got it" (Patricia)

However, Patricia had been active seeking out the support she required and had organised

"…Monthly meetings with my manager, just to go through problems. Now its in the diary for half an hour, or if it's a big issue, it might be an hour once a month…. if there are problems we discuss it together, and then we will go to a consultant, if its medical, If its service development we'll go to a line manager"(Patricia)

Ann also had positive experiences

"I've felt very supported…from all members of the team, and I know that it will be ongoing" (Ann)

To address the issues of a lack of mentorship, ANPs seemed to develop support networks within their roles

"Our line manager has been running the clinic for nine years, has become very competent, confident, and is seen as a font of knowledge in our department…if we have a problem we go to her…but now its moved on, we tend to mentor each other" (Tom)

Tom had been in the advanced role for six years, and identified that as he had become more 'advanced' within his role he had offered support back to his initial mentor when she needed it. Whilst still in the same job they have gained different experiential knowledge, which means they now can effectively help each other out with a diverse set of problems. Gillian also gave an example of how ANPs create their own support networks

"Our mentorship is with each other...there's only four of us… our mentorship is with each other, upstairs, we do support each other a lot, because there's a lot expected of us" (Gillian)

The ANPs had developed their own ways of dealing with things, but when asked what would happen if they were a new practitioner, new to the trust, without any pre-existing networks of support, the participants acknowledge the difficulties this would cause

"I don't know where you would go, I suppose you would go to your line manager to begin with, but if you've been in a little while you find your own ways of coping" (Becky)

All participants looked at each other, raised eyebrows, produced a range of sighs and said

> *"You wouldn't have a clue where to go" (Gillian)*

This is of great significance as with the posts previously mentioned many emerged through new service requirements. In most of the cases the ANPs came from within the trust, but had they come from elsewhere it seems they would have the same isolation and pressure with even fewer options of support.

David was a lone worker in his speciality and had no colleagues doing the same job; therefore he got what he considered mentorship from a nurse working abroad. He was forced into this, as there was no one locally equipped to help him with particular issues related to his speciality. He got his mentorship

> *"Externally, with other specialists on a national level, at one point I asked a bloke in New Zealand for advice…[when asked if that could be effective] if they've got the experiences that your looking at in terms of if they have been there and done it, then yeah, use a telephone" (David)*

Of greatest significance is the fact that David was open to mentorship, advice, and support from any suitable source, not that the source in this case was in New Zealand. He put in effort to foster external links to improve his understanding, and care that he delivered.

How would they improve mentorship?

The focus group felt that the first step was to give people the tools of the job, and whilst this seems crude actually inhibits new starters from working effectively, Becky said

> *"Give them the functional tools, passwords etc, supernumaracy, time, then plenty of structure, more individual assessment from then on…You wouldn't expect a newly qualified nurse to step up take on new things and new roles and just move on, you need time to step up" (Becky)*

The basic requirement of resources was termed as 'practical support' within Bryant-lukosius & Dicenso (2004) but also acknowledged the essential requirement of being equipped to do the job. Tom felt that giving new ANPs an opportunity to call on you

whenever they felt it necessary was key, but also alluded to the fact that the new ANP needed to identify their own areas of need. Tom said he would offer

> *" Open accessibility, as your dealing with people who have worked within senior roles, once you have passed the formalities of passwords, you have almost got to let them touch the water themselves, see what it feels like before they come screaming out asking for support [with humour]" (Tom)*
>
> *"I'd sort of leave them but let them know where I am, let them sort of make the agenda, but put some structure in there too" (Tom)*

Gillian again felt that the new ANP would predominantly require a period of reassurance and guidance.

> *"I would sit them down and tell them when they had done a pretty darn good job" (Gillian)*

Focus Group Analysis

Just as was examined within Davies et al (1991) work with pre-registration nurses, the ANP staff that did not have a mentor felt they were 'hanging about' or 'tagging along' when they first started in their new role (Davies et al 1991). The ANPs also displayed a similar anticipatory fear of not performing well enough associated with being new. In fact they seemed to place even greater expectations on themselves, feeling isolated, and like underachievers as they felt that they were expected because of previous standing as a senior nurse to be able to perform in the new paradigms; but equally felt paranoid that asking for help would show weakness. Whilst Woods (1999) did suggest that the transition from nurse to ANP was Omni directional, and that competing expectations arose from developing new roles, at no stage was a clear picture of how this affected the practitioner provided. Northcott (2000) suggested that 'established practitioners' should only *at times* seek assistance from a mentor as they prepare for promotion; however, this study found that ANPs were *'established'* in their previous role *not* the new ANP one. It was often wrongly assumed that their previous experience would give them greater confidence in their new role, but in essence, ANPs share similar anxieties to pre-registration nurses.

Hamric et al's (2000) findings are supported within this work; there do seem to be divisions being created between ANPs and 'traditional' nurses. Although, rather than this being because of the ANPs rejecting their previous roles, it seems that general nurses don't understand their role entirely. In fact all of the participants highlighted how important it was to maintain the 'art' skills of nursing, and also how they required advancement of these skills to perform in their role. They were equally as passionate about 'core' nursing, as advanced science, and gave examples of how both complimented each other. This challenges both Kitson's (1996) and Gottlieb's (1994) work, as these ANPs still had clear affinity towards basic nursing care, they did not reject 'basic' nursing in any form. It may be more than the perception that ANPs are "too posh to wash" that causes problems, it could be jealousy, as one participant said even after doing washes etc, she was still not made to feel welcome or like a member of the team. The ANPs displayed greater empathy and understanding towards junior doctors than other nurses; they seemed to understand what it was like to do a role similar to theirs, and the pressures associated. All nurses support junior doctors when they first start, it is not exclusively ANPs that support new staff, but it is interesting how close a bond ANPs, and junior doctors develop. Which possibly highlights a disparity whereby the ANPs support junior medics; but consultants do not always support ANPs.

The focus group as within the literature used 'mentorship' and 'clinical supervision' interchangeably, but in essence they all wanted greater support from senior staff. Competing time demands were given, as a barrier for not receiving mentorship, they, and their potential mentors were always too busy with clinical work to facilitate development. This competition between clinical duties and other areas of advanced practice, was also demonstrated within Irvine et al 2000, Sidani et al 2000, and Bryant-lukosius et al 2004 work, where it was suggested that clinical work took such priority education, research and leadership activities took a back seat. In the focus groups ideal world they wanted 'accessibility' to an individual who would be there for them when they needed it.

Conclusion

It seemed superficially that some of these ANPs were a disadvantaged, disillusioned, and often disenchanted bunch. However, closer examination does show how whilst they are working in new paradigms, they use their advanced skills and communication to get things done. These ANPs had fostered peer support within their teams; some even negotiated a time allocation with their line managers on a monthly basis; if necessary they would call on not just *a* consultant, but *the* medical consultant they feel best positioned to help them with a given problem. This is not indicative of a suppressed work force, but one that has confidence to use the whole organisation to achieve a given goal. The experience and reputation that these ANPs gained whilst working as sisters or charge nurses may increase expectations of them; but also gives them pre-established networks that help them in their daily duties.

Limitations

Group dynamics did seem to be integral to the focus group; one participant often overshadowed others, to address this dysfunctional characteristic questions were directed to participants that were not so active (Webb, 2001). The concept of 'member checking' suggested by Higginbottom (1998) was proven as whilst not always speaking, quieter members were often using non-verbal signs such as nods to indicate that they were in agreement to whoever was currently talking. Unfortunately, on some occasions some members digressed to elaborate examples of their working lives, it was difficult due to inexperience, to stem these; which meant that time to discuss actual issues was lost. Many of the ANPs had to leave the room for short periods of time to answer various 'bleeps' or 'pagers' whilst this supported concepts regarding practitioner's time for research, it meant constantly having to go back and explain where the discussion had headed.

Within questions designed for the focus group great emphasis was placed on determining what challenges ANPs faced, partly, as it was hope that it would create a foundation for the *'who, what, where, when and why'* they needed mentorship, if they actually did require it. However, whilst the focus group gave greater understanding to the pressures felt in transition from nurse to ANP; clarity regarding mentorship requirements was not achieved. The aim of the interviews will therefore be to illicit more precisely how to facilitate mentorship for advanced nurse practitioners, with

particular interest in what skills they feel the new ANP requires; how to develop these, and who is best placed to mentor new ANPs. Questions have been specifically designed to also highlight whether existing models of mentorship for pre-registration nurses work for ANPs, or whether ANPs require a different kind of mentorship *(see appendix7).*

Chapter 4: Interviews

Interviews were conducted with seven ANPs from the trust who had not been present at the focus group, these were held in locations found to be mutually conducive for both parties. As with the focus group, discussion opened with what the participants felt when they first started in their roles, and how their roles had been developed. The aim was to learn about what mentorship the participant's actually required, by whom, when, and for how long. A comparison was sought with how these practitioners felt with their situations, and how they felt when newly qualified. To determine whether research that has already been conducted into mentorship for pre-registration nurses can be applied to ANPs or whether new models are necessary.

How the organisation interacted, supported, and developed ANPs was also discussed; as it seems that greater responsibility for regulation is now placed in the hands of individual employers. *(please see appendix 13 for table of findings)*

New Changes and Challenges

As with the focus group the interviews provided insights into what new ANPs find most difficult with in their new role. The participants were directly asked what they found most difficult and their responses were diverse.

> *"I found good quality letter writing and patient summaries most difficult at first, that and how to communicate with senior consultants or GPs. Your interaction as a charge nurse is very different to when you are a Clinical Nurse Specialist".* (Alan)

Nicola felt that it was new interpersonal relationships or environments that were most challenging: -

> *"Board meetings were all really new to me, we deal with a lot of boards and committees, and how you deal with that, I needed to learn…It all comes down to interpersonal skills and communication, and I think that not everyone is good at that".*

Christine and Alan also felt that,

> *"The interpersonal stuffs the hardest at first, the science you just need to go away and learn, but to get things done, requires the ability to influence and lead"* (Christine)

> *"My interpersonal skills had to improve, and fast"* (Alan)

To Christine the 'science' and 'autonomy' was straight forward, but to others the expectations of a greater clinical knowledge early on proved to be the most difficult thing to grasp, and where they needed most help.

> "*I think my lack of clinical training was the worst aspect, it was just to go off and learn it, nobody did any competencies with you…Then it was just go off and do it!! But I didn't get proper-guided training. We were placed in a position to take over from doctors but if you look at their training and our training, we just weren't ready for it"* (Alice)

Christine supported the ideology that good clinical knowledge creates a greater rapport with medical colleagues

> *"If you don't have the science, how are they [doctors] going to trust you? You buy your credibility through showing your stuff. Once doctors see that you are clinically competent then that trust begins to grow, I always proactively manage such encounters"*

Christine's experience was different to others, as she had completed a degree within her specialist field *before* she actually got the post as a specialist . She and her consultant had approached the trust for funding for her post, after she had gained the necessary qualifications. This meant that she had more confidence

> *"After eight years working with stroke, then doing extra training, I was very confident in my role. I felt that I could meet the expectations, I got the uniform, and it wasn't a problem. I never felt that I could not meet the expectations placed on me"*

She had the support from her medical lead from the start, and was critical of those that did not fully prepare for their advanced role before taking it on.

> *"My consultant pushed and pushed for me to get into this role, we both wanted it to succeed so much… I can't understand people who take on an advanced role without having training before it."* (Christine)

She felt that others lack of preparation created misconceptions over advanced practice

"Because some CNS staff don't have the knowledge they let the rest of us down, certain ones in this hospital just walk round, they don't have the knowledge and they've given us a bad name, so when people first meet us they go oh god here's another specialist nurse…I know a lot of them, and they haven't done enough training, that's frightening" (Christine)

The role of the organisation within the transition was criticised on several occasions, the ANPs seemed to depict many situations where their role was changed several times, early on whilst they tried to establish themselves

"The biggest problem with the role was the role itself. It was new and no one understood what I was supposed to be doing, this created a degree of scepticism, whether the role was important enough to lose a senior nurse over" (Alan)

Alice's start was equally as unsettled,

"Because it was a new role, it kept changing. I felt very much like, well, what am I going to be doing this week? Will it be the same next week? It was all very airy-fairy to begin with"

Clive found the transition to be

"A big learning curve, the first day we started four of us sat in a office and went right, what we going to do. We developed the service ourselves; we didn't get any support. I thought the then service development team could of got involved, but at the time we got nothing"

Organisational influences

ANPs felt that the organisation did not fully appreciate or understand their role, which reflected much that was found in Wood's (1999) study. Whilst the organisation or managers had clear expectations and aims for ANPs few knew how to achieve them, or what support ANPs needed in fulfilling their role.

Joshua stated

"The organisation had identified what they wanted, like reducing pressure ulcers… what they didn't have was a framework in place to deliver it"

Christine felt that the managers were just not positioned with enough information or knowledge to effectively oversee her service

> *"All they do [managers] is tell you what they think, what they feel, they don't wanna listen. They want to tell* ***you****,* ***your*** *job, without knowing actually what you do! I don't think that our line managers know about our services. They know what they want, but nothing on a wider scale"*

Katrina supported the ideology that managers were not fully appreciative of advanced issues or what advanced practice could do for the organisation

> *"I think the organisation pays lip service to advanced practice. It seems like a good thing to have..."*

The ANPs were acutely aware of their personal 'figures'; how they were able to prove their worth to the organisation itself through numbers. Some welcomed audit, and thought that it highlighted the work they did, whilst others felt that the methods used were to crude.

> *"They [managers] look at how many bed days I save. Normally my patients will stay for seven days, but they have a multitude of medical problems, alcohol is just one of the issues. If I sort out a detox package etc I may prevent readmissions but its difficult to prove, because they may just show up again. I really struggle sometimes to evidence that my service makes a difference"* (Katrina)

Joshua felt that the organisation did not fully appreciate the implications of targets that they had set

> *"The organisation wants me to drop the incidence of pressure sores by 10% in twelve months. So that means anyone who is involved in pressure care needs to be brought up to speed, so that's, what, one thousand two hundred nurses! How can I get at one thousand two hundred nurses in six months, when only four turn up at each session I teach? That's a lot of sessions."*

Christine thought that audits proved her worth, and could show useful quality variants when she was not working.

> *"I prove my worth via audits, if our patient's aren't getting scans or their aspirin on time we can show the difference through audit…If you look at the weekends when I don't work, there is a sudden drop in quality"*

ANPs that worked in isolation all felt that absence through holidays, sickness, or even just days off caused problems.

> *"If I go on holiday or am sick there is no one to cover my service, no one at all. Like a lot of the other specialist nurses… I think that devalues the work we do"* (Katrina)

Christine highlighted how her absence was noted at a senior level,

> *"The operational director said what happens when Christine's not here, and was told nothing. At the time I was forced not to take holiday because there was no one to do my clinics, it put me under huge amounts of stress. The service is no where near as good when I am on holiday, so many things aren't done"*

The limitations of a service resting on one person rather than a team seemed very apparent. A question over whether this meant that their service was a luxury or essential for patients was logical; if a service could go missing for seven weeks a year or indeed at every weekend did the trust really need it?

> *"All I know is if it was one of my relatives coming in, and they received the service that is available when I'm not here. I'd go ballistic."* (Christine)

An effort was also made to ascertain whether the ANPs or managers had started a process of succession planning in their area of specialty, but most commonly nothing was in place.

> *" There is no where for me to go here now, no chance of further promotion"* (Clive)

Joshua stated that even with his notice period there would still be problems replacing him

> *"I have to give three months notice, but that's probably not enough, not to find a replacement get them in, and teach them how this place works, the various systems"*

Christine also stated that

> *"There is no one to take my place, no one up and coming. When I get some more money I am going to try and take a band six on, to train up for when I leave"* (Christine)

Mentorship

The discussion in the focus group highlighted transitional anxieties, and that mentorship may be required. It also showed that different ANPs required help with different issues, but key to this research was who, what, where and when worked for them in order to conceptualise a model for advanced practice mentorship.

Not every ANP thought mentorship was a essential requirement,

> *"I don't think I do need it much [Mentorship], but then maybe I am deluding myself. If I want it, I know how to get it, when I was doing the course [MSc] I did have a coach, but I don't have anyone at the moment"* (Katrina)

Katrina also felt that

> *"Mentorships not seen as such a positive thing with ANPs, clinical supervision was all a bit mid-nineties, and it seems to have dropped away again now"*

Most ANPs did state that they required mentorship, and had gained their clinical knowledge from a medical consultant; many had established good working relationships and indeed received vast input from their clinical tutors.

> *"I think the best clinical mentor would be one of the doctors, from a clinical examination point of view, you just need to pick which one you get on best with and then just get on with it"* (Alice)

Christine also felt that her medical consultant had been very valuable

> *"My mentor has been my consultant. He has been key to my progression. He was the one pushing me on saying you've got to do it, you have to do it; Its easy to sit back and just get your band"*

Nicola was one of the only ANPs that was from an established, experienced team, she felt that her lead nurse could educate her clinically

> *"The lead nurse for infection control is best placed to mentor me, we are a close knit team and she knows all there is too know about our roles. We are lucky though, as our consultant is also a director at the trust, we get on well everyday, and she fills any gaps we have"*

Clive cited how joining a team now would be easier for new ANPs

> *"For new starters now it would be much better, because we now have the knowledge to pass on to them"* (Clive)

Interestingly, there was further suggestion that the educational or mentorship needs of ANPs are not always clinical; they may also be 'political'

> *"In terms of clinical, I speak to a consultant that works at another trust, because he is an expert within my field. But for me there is also a political kinda mentorship, the how to get things done- who do you approach"* (Katrina)

Within Clive's interview he added

> *" Its not just about clinical skills. You need someone to help you in the organisation, you need someone who knows the trust and knows how to set up a service"*

Joshua felt that in order for ANPs to achieve their goals, they needed to learn new advanced skills to manage themselves in new paradigms

> *"Mentorship should include how you behave in certain situations. More of the art than the science, you need to be assertive to be an ANP, you've got to do it. I needed someone to push me to that"* (Joshua)

Medical consultants alone were not best positioned to provide all of the knowledge that new ANPs required, they did not posses the same level of 'political' or leadership/managerial knowledge as senior nurses

> *"Managerially was where I lacked the most support, the consultant just couldn't give me that managerial knowledge. That's just not what he does"* (Christine)

It seemed apparent from the focus group, and earlier questions that if an ANP was to be able to perform within the advanced role proficiently, more than one mentor may be required. However, there were views for and against this proposal

> *"I think that you could have more than one mentor. I think that it may well work, however, for continuity's sake, it may be best just to start with one"* (Alice)

Alan had experienced multiple mentors

> *"I think you certainly can have more than one mentor. I did. Somebody coming into an established team can get mentorship from a senior member"*

Participants suggested different mentors for different situations. What exactly they wanted from, and how often they wanted the mentorship itself again became difficult to elicit. Structure and 'time' were both common themes as with those questioned in the focus group.

> *"I think a guided, structured, programme would be the best sort of mentorship, one with time, time to actually learn and settle in"* (Alice)

Alice also felt that to begin with the new ANP should meet regularly with their mentor,

> *"I think you need to be meeting weekly, at least to begin with, if not, certainly monthly. It's going to be very different from what you were doing before."*

The majority of other participants felt that you should be able to meet up with your mentor when necessary. They warned that if you were unable to 'off load' troublesome experiences that would be counterproductive

> *"I think that you need to have access all the time, they [Mentors] need to be accessible at all times, even if it's just for a phone call. If you've got something eating away at you…you need to deal with it quickly" (Christine)*

Alan again offered the impression that mentorship was lost within busy schedules

> *"Things like clinical supervision and mentorship are very fragile in the face of day to day working."*

Although whilst he felt that the opportunities for mentorship were scarce he was the only participant to actually suggest what sort of things should be brought to a mentorship meeting.

> *"People should bring an experience to the table... Take something to the supervisor, you then can together pick it apart, you can dovetail it with research through a reflective model. You can then go on to develop a plan of what to do about it. That revolves around the skill of the supervisor, and them possessing the knowledge to facilitate that service"* (Alan)

ANP Vs Staff Nurse Mentorship

The majority of literature relating to mentorship regards either pre-registration students, or newly qualified staff; it was thought to be beneficial to draw comparisons between the two situations. If there were obvious similarities it may be that the same models suggested for newly qualified nurses would work for ANPs.

Nicola could see the similarities,

> *"There is a generic core that, yes, applies whether you are a new student nurse or a new ANP"*

ANPs found themselves more isolated and with great expectations, which proved to be the difference in the eyes of participants between them and staff nurses.

> *"I think that you are more isolated. As a new staff nurse you have anxieties and expectations placed upon you, but you are also supported more. The more senior you are you get less support and greater expectations"* (Alice)

Christine stated that organisation culture supported new staff nurses and that people knew what could and should be expected of them.

> *"When you are a new student nurse, there are loads of other students nurses around you. There are loads of people in the same boat. You work for many hours with the same people in the same area. When you're a specialist its ten minutes here or there, never enough time to develop the same level of friendship"*

As a senior nurses the individuals themselves had been exposed to organisations, and to nursing for longer, so they had time to develop ways of knowing.

> *"A difference with ANPs and students is ANPs know* ***how*** *to get hold of the information they need. Independently, they have developed the systems to access information"* (Joshua)

In selecting a mentor ANPs were seen to be in a far better position then pre-registration or newly qualified nurses, although, being able to choose your own mentor did still come with constraints.

"When I was a student, I remember getting stuck with a mentor I really couldn't stand, I really didn't like, that doesn't happen when you're an ANP" (Christine)

Whilst having the ability to choose a mentor was a great bonus afforded to most ANPs; a problem was that the people who would be chosen were often very senior, very busy individuals.

"What is hard as an ANP is that the people you'd like to chose as a mentor are always a lot more senior. They tend always to be busy, and have very little spare time for you. Where as a newly qualified or pre-registration nurse, there is usually someone suitably qualified to help and work alongside you" (Nicola)

Networks

The reliance that ANPs have on networks was apparent in the focus group; ANPs questioned how a new starter to the trust would manage without pre-established networks. Understanding these networks was important, as they seemed to provide a form of mentorship in the absence of formalised support.

Many ANPs cited how important networks were to them,

"I think that they [networks] are very valuable, it's much better to work together. You get to bounce off each other, use another persons knowledge" (Alice)

Clive also felt that having networks made a ANPs work much easier,

"If you didn't have the networks you would have to do everything the hard way! You need to develop support networks… I think that it's hugely useful to share ideas with each other."

Nicola appreciated the difficultly a new ANP to the trust would have if they did not formulate a support network.

"You would need far more mentorship if you did not have a network, or if you haven't worked here before…you need to know how a place works"

Christine felt that the best way to get fellow staff onside was to promote your role at ward level first before trying to expand to other areas.

"If I went to another trust I would go to the ward area first, that's where you first develop networks."

Communication and self-promotion were a recurring theme, Alan suggested being as proactive as possible with 'networking',

"Saturate people with information, use the trust magazines that go round. It isn't easy but you need to get half hour slots in senior meetings, do drop ins at lunch times or after work. Get known." (Alan)

Joshua was an example of an ANP who had joined the trust from the outside; because he knew the job he was going into and had prior experience within that speciality; he could foresee where he would needhelp. Whilst he didn't know the names of the individuals he would need, he knew what jobs they would be doing.

"I had a good awareness of the people I actually needed to make things happen. I had a list of people I needed to get onside, not names, just titles or departments."

Nicola felt that networks were not a 'given' and in all cases the practitioners had to go out and develop their networks. She felt that networking was crucial it was a support system but also informed ANPs *how* to get things done.

"You have to fly your wings, you're an advanced practitioner, you're going to have to speak to people, and it's the nature of the job. People are willing to help, if you're willing to ask for it. People don't come to you, you have to go to them." (Nicola)

Analysis

This chapter commenced with one ANP '*Katrina'*, stating that she felt that she did not require mentorship. Unfortunately, due to a word counts it was not possible to give full demographic details of each participant. *Katrina* would meet all of the recommendations within the literature suggesting what an 'Advanced' practitioner should be (ANA, 1995, Ackerman et al 1996,Castledine & McKee 2003 Dunphy & Winland Brown 1998, Hamric 2000). The excerpts of her interview depict the confidence and great understanding she had of advanced issues; she seemed unconcerned with mentorship because she had reached a level where she was comfortable in her paradigm. At first it seemed that this ANP detracted from the rest of the work as she felt that mentorship was not required, but she actually underlined a level of ability that all advanced practitioners should aim for. That is without

discrediting any other participant, but no other gave a sense of such breadth and depth. On reflection the greatest loss is the fact that *Katrina* works in complete isolation, she has no team and does not have a responsibility to teach other ANPs. Undoubtedly the patients she serves felt the benefit of her experience and knowledge, but one cant help feeling the trust and profession is not making the most of this asset.

The organisation is key within advanced practice, especially as the CHRE have placed the regulation of 'advanced practice' firmly into their hands within the paper *Advanced Practice: Report to the four UK Health Departments (2009)*. The aim of questioning participants regarding the organisation, and succession planning, was to determine what grasp the organisation had of advanced practice, and practitioners needs. It was also hoped that if succession planning could be found that the trust was enabling staff nurses to expand and progress towards a position as an advanced nurse practitioner in keeping with the model the Scottish Exec (2008) suggested. Unfortunately, ANPs did not depict an organisation that fully understood the roles ANPs were undertaking. As in both Wood's (1999) and Coombes (1998) study the organisation seemed to know what it *wanted* from the practitioners but not *how* to get the best from the individuals employed to do the job. Many of the ANPs had started their own services with only a few guidelines, and criticised the fact that managers did little to support them from the start. The transcripts show that ANPs were also in positions where if they were on leave or were sick no one was in the position to take over from them. ANPs felt devalued by this, they felt it made them seem a 'luxury-good' in the trusts economy; creating uncertainty in their future as spending is likely to be cut. One ANP gave examples of how clinics closed in her absence; stroke patients would not receive CT scans, correct medications, or co-ordinated nursing care in a timely manner when she was away. This was not just when she was on holiday, but after five o'clock, or at weekends; creating a disparity in the quality of service delivered by the trust.

Evidence of succession planning was sparse and primarily only demonstrable in the larger teams of ANPs. This suggested that a stepladder like approach to gaining an 'Advanced' practice title after starting as a staff nurse depicted by the *Scottish Executives (2008) Nursing Career Framework* was some way off; and that should a particular ANP leave the trust, quality would again drop until a replacement was

found. The lack of succession planning, and whole services being dependant on single individuals is not reflective of an organisation that has full control of its development. It also highlights the gap between the idealist stance of policy makers and that, which is actually occurring within trusts.

The ANPs did not effectively suggest how they wanted to be mentored; only one participant offered that using a reflective model to aid these encounters would be beneficial. A problem reflected within the literature review, as other authors found it difficult to precisely determine what needed to be involved in mentorship and therefore only suggested what *could* be included (Northcott, 2000, Kilcullen, 2007, Andrews & Wallis 1999). The ANPs stated that they could choose the person, or persons they wanted to mentor them, many seeing the potential benefit of having various mentors for the various elements of their new role. As suggested in the literature, these relationships were more likely to work as mentor and mentee chose each other (Ali & Panther, 2008, Andrews & Roberts, 2003, Schaffer et al, 2000, Andrews & Wallis, 1999, Northcott, 2000). Unlike pre-registration nurses the ANPs could choose their mentors, but because the mentors would normally be very senior nurses gaining access to them was often problematic. Moseley and Davies (2008) suggest mentors are often expected to balance too great an amount because mentorship itself is an added task, this fact is exacerbated for ANPs as the number of people suitably positioned to mentor them is much less than for pre-registration nurses. How often and for how long the ANPs felt they would need to be mentored for was dependant on the individual. The ANPs wanted mentors that were accessible when they needed them rather than having predefined weekly or monthly meetings; they appreciated that leaving problems unresolved for too long was destructive.

In the absence of mentorship the ANPs had developed their own networks for support, often this was not limited to the direct team they worked with but extended to other professionals. They gave examples of how to gain a network, and how that network would then increase an individual's ability to function in their new role. The emphasis was for the ANP to go and get the network they needed, some knew what they needed before they started, and therefore targeted people they needed to know early on.

Conclusion

ANPs gave examples of a diverse range of problems they encountered when starting their new roles. This highlighted how their mentorship would need to be equally diverse and personalised for it to be effective. Interestingly, although they gave very little direct insight into how they wanted to be mentored; they did feel that it might be necessary to have more than one mentor, as they split their areas of need loosely into clinical, leadership, and research components.

The ANPs did not appear too favourable of the organisation itself, and generally felt there were a multitude of misunderstandings between primary stakeholders. They felt that too often their work was judged through 'numbers', and that the quality of their work was not often captured or appreciated. A lack of succession planning, and the fact that when certain ANPs were on holiday complete services folded meant another lottery for attending patients.

Christine and Katrina proved education to be integral to becoming an ANP. They were the only participants to have gained qualifications in their speciality prior to undertaking the role as an ANP; this gave them greater confidence when commencing their new posts, and gave them the skills to meet demands of the post. Unlike every other ANP that found the transition from Senior nurse to ANP difficult, those with prior education adapted in a more efficient manner.

Limitations

Some participants were very keen to get their opinions across, as they knew that the trusts board would be receiving a copy of the findings. In places this detracted from data as it felt that they were trying to make a 'political' statement probably only pertinent to their own area of work. Occasionally participants seemed to overstate or were too personal with some points, and therefore conversation transgressed to lengthy examples of how they were disillusioned; an inability to quickly regain focus on the task in hand resulted in wasted time. In complete contrast were some participants who clearly did not want to say too much continually displaying non-

verbal signs such as looking at the tape recorders with suspicion. The resulting hesitancy was equally as challenging to deal with, as the intention was not to lead participants in their answers.

Concluding analysis

The nursing profession finds itself perpetually under review; with many influential bodies contributing opinions on what is best for the future. As the Prime Minister launched the commission of *'Future of Nursing and Midwifery'* in March 2009, concluding in March 2010 involving twenty of the professions foremost leaders, again nurses wait for what will be asked of them in the years to come. The chief nursing officer in 2004 stated that advanced roles were "key"; *Modernising Nursing Careers: Setting the direction* (Doh, 2006) also suggested advancement and leadership were requirements. Whether the expansion of nursing duties was due to nursing's thirst for professionalisation, a more dependant case load of patients requiring more technical skill, or simply due to a reduction in junior doctors hours is academic: as the expansion *has* occurred. It is pertinent to acknowledge that other professions do not use the word 'advanced' there are no 'advanced' lawyers or accountants, but there are specialists within both; using the term 'advanced' within nursing leads critics to suggest advanced practice devalues general nursing or the profession itself. However, the aim of this research has been to continually challenge the rhetoric; nursing has *had* to evolve, and will continue to do so, and it is most likely that practices considered 'advanced' now will become accepted nursing duties with the addition of time.

Within this study the organisation was criticised for not fully appreciating the roles that ANPs were undertaking or the pressures that they faced. ANPs were critical of how they were constantly expected to generate figures for the work that they were doing. They even stated how the development of such figures took time, and detracted from the clinical work that they could deliver. Examples were given of how crude using numbers alone as a method of assessing their worth were given; but the concept of measurement is contemporary since the *Next Stage Review: a High Quality Workforce (DoH 2008)* suggested that a way to measure nursing outcomes was required. The subsequent Kings College London *State of the art metrics for nursing: a rapid appraisal (2008)* report highlighted the difficulties involved with metrics but also that metrics were a necessary quality indicator for trusts of the future. Interestingly the report stresses how good nursing care can result in tangible, and

demonstrable quality outcomes for patients achieved by nurses. The report offers nursing the potential opportunity to prove its worth, and use quality outcomes to underline that good nursing care improves patient outcomes. However, the participants felt that the reports *they* were producing were crude in nature; and that the trust was more interested in *how many* rather than *how well* ANPs dealt with their clientele.

ANPs criticised the fact that entire services relied on one person being at work to deliver them, or that whole services folded when individuals were on holiday; and the subsequent affect that had on quality. Little evidence was found of succession planning, if some ANPs left the trust then their would be no natural replacements, they were training no junior nurses in the skills required to fulfil their position. This makes the ideals proposed in *Supporting the development of Advanced Nursing Practice* (CNO Scotland), 2008 of nurses that progress through the ranks, or those with exceptional ability being 'fast-tracked' some distance from being actualised.

ANPs within the study echoed that which was found within the Woods (1999) as they felt that doctors, managers, and fellow nurses alike all poorly understood their roles; and that poor definition exacerbated this. Within the data some ANPs stated that general nurses in some cases believed that ANPs rejected general nursing roles as found by Gottlieb (1994) and Kitson (1996); although this study challenged that as all ANPs valued their nursing roots; and felt that without both 'scientific' and 'artistic' development they would never be truly advanced. If it is the case that ANPs do value nursing roots, and do still value and perform general nursing duties then the misunderstandings within the profession need to be addressed. A number of doctors within the literature review were critical of advanced nursing practices, and yet this study did not support that finding, not only were many consultants said to be productive mentors for ANPs; ANPs themselves could empathise with junior doctors and often supported them in their new roles. This research did highlight previously unchartered tensions between ANPs, primarily, because the more qualified practitioners would criticise those with advanced roles but without the educational certification to underpin their position for devaluing 'advanced' titles.

Throughout the literature, NMC and governmental publications there are many opinions of what constitutes advanced nursing, what roles nurses should have, what

education they require, how they should be regulated, and what value or quality of service they can deliver. Yet within the literature that asked so much of advanced nurses there were no examples of what help or support ANPs may require, or what support would be provided with in their new roles. This research showed that there was a hugely diverse range of needs; many found that the lack of structure and organisation during their transition was a cause of great stress. Those that were developing new services were given a job to do and told to do it as they saw best. A conflict exists within ANPs behaviour as many did seem to be outgoing, educated, and vocal senior members of staff, and yet many still seemed to lack inner confidence. The majority of all ANPs in both the focus group and the interviews, all suggested that they needed reaffirmation that they were actually doing their job well. They described working in isolation, and making difficult decisions in the face of adversity without always-suitable opportunities to offload. When new in post ANPs displayed very similar traits to newly qualified nurses in that they too harboured deep transitional anxieties. The primary difference between staff nurses and advanced nurse practitioners found within this work was the level of expectation; ANPs were generally expected to be able to perform expertly on day one of transition. New staff nurses start on a ward amongst many other nurses, they have less expectations, more potential mentors and a nursing culture that wants to support them. New staff nurses have many challenges but those challenges are recognised by every qualified nurse as they had similar experiences. In contrast new ANPs at present find themselves in a new paradigm of working; the skills they require may also be new, and the cross-transferable skills they have will need to be extended. There are far fewer people positioned to support them in their new roles, understanding of their roles is poor, expectations are higher and they are rarely get the benefit of working on ‘a’ ward or working within ‘a’ team.

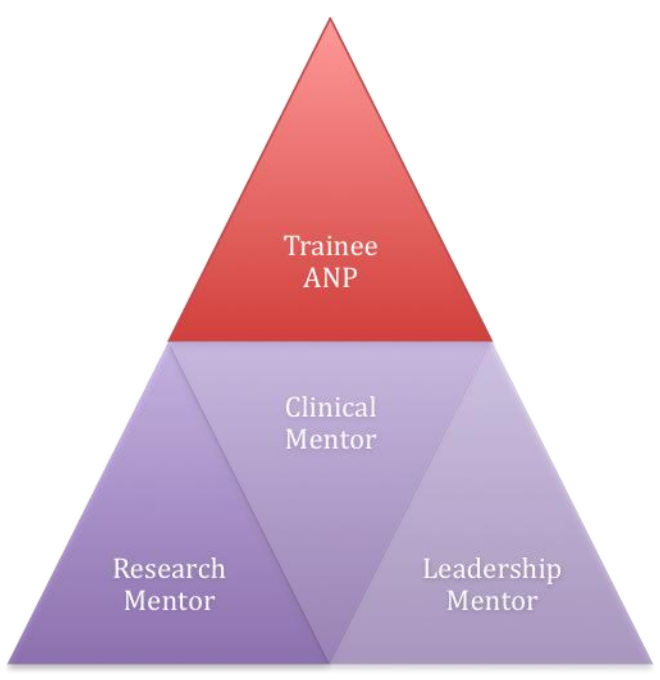
This study found that in the absence of mentorship ANPs developed their own networks of support, which was not a finding within the literature review: for ANPs in an established team this was a natural occurrence, for others the networks had to be developed. The extended network meant that they were able to seek those with knowledge they required and use it in any given situation. The majority of ANPs had worked within the trust for many years prior to becoming advanced nurses, and felt that without networks they would cease to be effective. The reliance on a good

networks led ANPs to seriously doubt whether a new starter in a new advanced role, in a new trust could be effective.

This research makes a contribution that may beneficial for this trust, NMC, and DoH, which is the development of 'Supervisors Of Advanced Practice' (SOAPs). Clearly, this is a concept taken from midwifery but with good reason; midwives have been autonomous practitioners for far longer than general nurses, and the lessons they have learnt should be employed. SOAPs may not be able to ensure competence, as supervisors of midwifery do, as the range of advanced roles would be too extensive (NMC 2008a). However, SOAPs could be ANPs with a desire and the skills required to mentor new ANPs, they could teach and support with the initial transition. From an organisational point of view they would provide benefit as rather than experts working in isolation such as '*Katrina'*; their knowledge and skills would be disseminated. Trusts could nominate several SOAPs within their organisation who could mentor new ANPs, or as the data suggests, be *available* for new ANPs when they needed it.

This study has provided new unchartered insights into why ANPs require mentorship. Sadly, an exacting formula for how mentorship should be delivered was not achieved; this was due to the fact that the needs of each individual were so inherently different. Similar problems were faced by all of the authors within the literature search as many suggested what *could* be included in mentorship rather than what *should* be included (Northcott, 2000, Kilcullen, 2007, Andrews & Wallis 1999). However, the study did show that many nurses working in advanced roles did require mentorship, support and guidance when new to post. The great variety of issues and anxieties ANPs had were neither constructive or conducive for staff development or patient care. ANPs felt that the people best placed to teach them clinically were medical or surgical consultants within the trust, but they also acknowledged that to be successful as an advanced practitioner required more than clinical knowledge alone. A 'political' ability was required in order to shape or justify new services, present in board meetings, and succeed with the complex leadership issues and interpersonal challenges advanced practice presented. The new ANP also required support in gaining further educational certification, as well as conducting and understanding research. Therefore there

seemed to be a triad of educational requirements for the new ANP to succeed in their new role. These were clinical, leadership, and research.



Mentorship Pyramid for New ANPs Chessum 2009

This model is designed to show how new ANPs would benefit from mentorship from various mentors if in a newly developed role working in isolation or one that does not contain an experienced consultant nurse or senior ANP. Clearly, consultant nurses will have a high standard of leadership, clinical, and research skills to have obtained their role and in which case the new ANP working with a consultant nurse would not need to follow this model. However, the great majority of new ANPs will not have access to a consultant nurse or work with an individual that has all such skills, and therefore should seek to enlist support from experts within each dimension of advanced practice. The clinical mentor could well be a medical/surgical consultant who would provide the required clinical education and observation in practice; a lecturer may improve understanding of research within an MSc course and finally a nursing leader be it a senior nurse, consultant nurse or matron could provide the new ANP with the essential *how* to get things done within any given organisation. The model aims to show that all mentors within this model are equal; service users and fellow staff respect ANPs that are good clinicians and that underpin their practice with research, but if the ANP does not have leadership skills to unpick the politics of

organisations or interprofessional relationships, their ability to improve care delivered will be reduced.

The model does have limitations as many ANPs already struggle to get access to one mentor due to their busy schedules, let alone three possibly separate mentors. It therefore does require the profession, and the organisation to change its culture to further appreciate the need for mentorship of new advanced practitioners. Ensuring that support time for mentorship is factored into job descriptions. Increasingly high demands are placed upon nurses working in advanced paradigms; and therefore the profession has a responsibility to ensure that similarly high levels of support are made available for new ANPs.

If the most original and significant contributions this study has achieved is to highlight ANPs passion for basic nursing care, increase interprofessional understanding and highlight the need for ANPs mentorship: then it was a job well done. Ultimately nursing needs to take control of *nursing's* future, not governments or individual trusts. Nurses have to be proactive, pre-empting needs of the future; and then tailoring their education and professional expansion in a controlled fashion. Only then will nurses, fellow professionals, and the public fully appreciate the potential the nursing workforce has to improve the quality of care delivered.

Chapter 6

Limitations and Recommendations

Recommendations/Further work:

⇒ The NMC needs to seize the initiative, and in conjunction with the Department of Health agree upon the requirements for 'advanced practitioners'. A sub-section of the NMC register for masters level advanced nurses should be developed to ensure that fellow professionals and the public further appreciate advanced nursing roles.

⇒ The NMC, DoH, Scottish Exec and 'Skills for Health' team need to get together with foundation trusts and ensure that senior managers and directors understand changes in nursing practice. The success of 'flying start' or a system where cadet nurses can progress through to consultant nurses is highly dependant on organisations facilitating the ascendance through the ranks. Better workforce planning is required from organisations; they should investigate their current workforce and decide early how nursing advancement can help to provide quality care. Then take proactive steps in training staff to become advanced practitioners, giving them support and time to learn. This will improve the care delivered at ward level but also ensure that if an ANP were to leave, a successor could be found in a controlled fashion. Advanced practitioners also have a responsibility to begin to look amongst their more junior colleagues for signs of potential, and work to develop those individuals.

⇒ All parties need to appreciate that there are multiple stressors involved with becoming an advanced nurse practitioner from a senior general nurse. It is essential that the major stakeholders in advanced nursing appreciate the benefits that effective mentorship could have for these nurses, and that as the government, profession and employers ask for

increasing amounts from nurses, they should provide equal amounts of support. In the absence of a senior ANP in the team or consultant nurse, the original mentorship model suggested within this research may facilitate a smoother path to advanced practice, whilst ensuring high quality care continues to be delivered.

⇒ The concept of SOAPs should be investigated at greater length within other work.

Limitations

1. This study was an unfunded masters project, and therefore was only undertaken on one site and only questioned ANPs themselves. The data would have been enriched by a multi-site enquiry that allowed the opportunity to examine organisational culture with regards to advanced practice, and contrast how ANPs had been mentored within a variety of trusts. The study would also of benefited from speaking to other stakeholders involved in advanced practice other than just nurses alone, it would have been valuable to interview managers and doctors as Woods did in the 1999 study; this would have been useful to gauge how far advanced practice had evolved in ten years.

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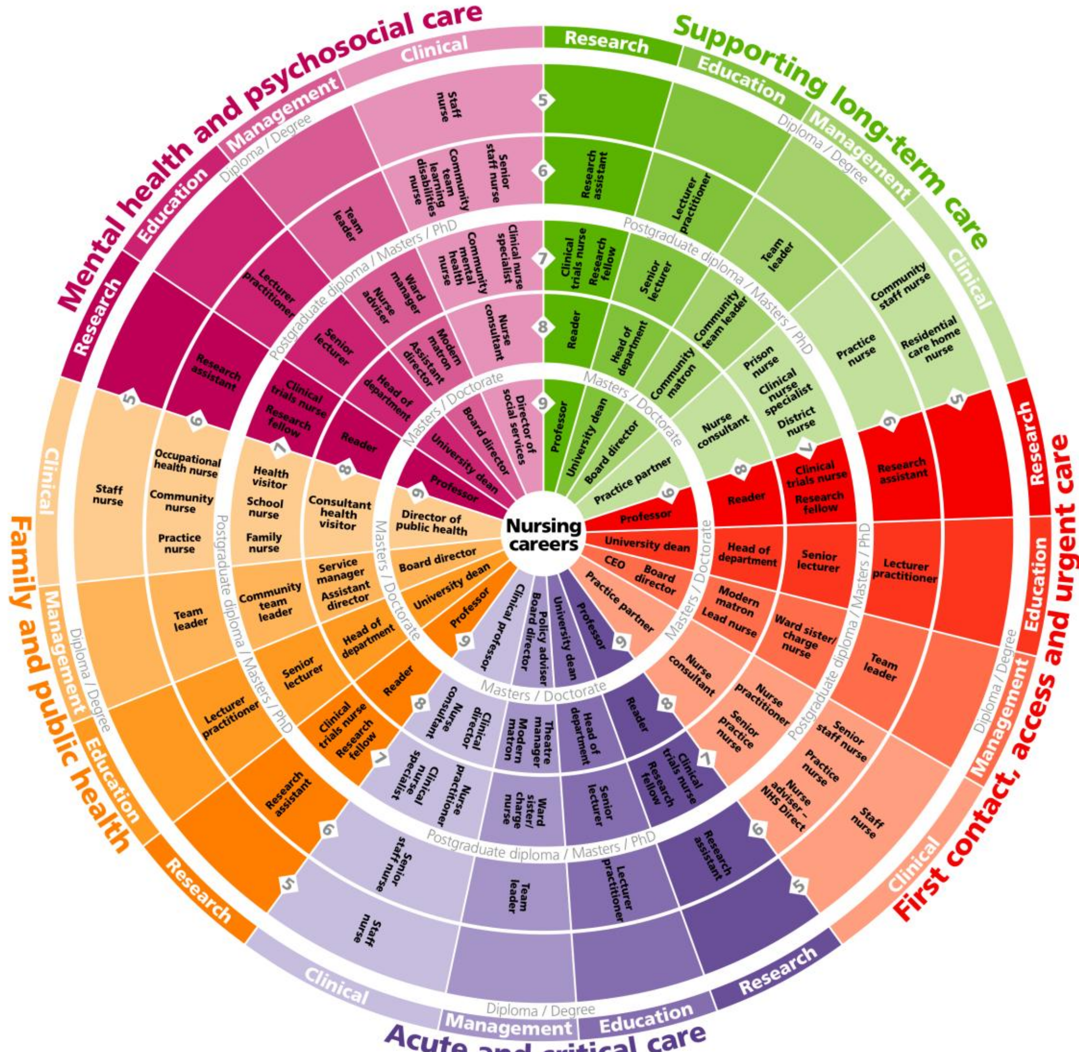
APPENDIX1

Care for your future in nursing

NHS

Nursing offers so many opportunities for professional development, personal satisfaction, education and achievement. Whether you're just starting out or planning your next career move, the potential is wide-ranging and ever-changing. For more information, visit **www.nhscareers.nhs.uk**



Find your own career path

Nurses no longer work mainly in hospitals. Your career could take you into people's homes, community clinics, workplaces, schools, prisons, nursing homes and rehab centres. You could provide care in many different pathways, from public health to critical care, and help children, young people, adults or older people to manage their physical or mental health. And you might work beyond the NHS in social care or for a private company or charity. Wherever your career takes you, the emphasis will always be on promoting health and illness prevention.

Move up and around

Once registered as a nurse, you've already reached level 5 as a healthcare practitioner on the NHS Career Framework. You will undergo preceptorship to develop your confidence and soon become a preceptor or mentor yourself. As you progress, you might move into management, research or education, or else become a clinical specialist.

- Level 5 – Practitioner
- Level 6 – Senior practitioner
- Level 7 – Advanced practitioner
- Level 8 – Consultant practitioner
- Level 9 – Senior leader.

Focus on education and achievement

Throughout your professional development, you'll be supported by the right education and training – with early opportunities for postgraduate achievement. This will equip you to work with doctors, physiotherapists, pharmacists, radiographers and others – including managing and delegating care to healthcare support workers and assistants. You will also be able to refer patients across the healthcare system and take part in shaping policy and practice for the future.

Develop your skills

Build on your skills as a practitioner, partner and leader as you progress from your first job potentially right up to the executive board. Your core competencies will always include:

- Autonomy and accountability
- Advocacy and negotiation
- Assessment and referral
- Decision-making and clinical skills
- Managing complexity
- Caseload management
- Care pathway co-ordination.

For more details, visit **www.skillsforhealth.org.uk**

De Montfort University, Faculty of Health and Life Sciences Research and Commercial Office

APPLICATION FORM FOR ETHICAL APPROVAL OF A RESEARCH PROJECT (INCLUDES GUIDANCE NOTES)

GUIDANCE FOR COMPLETING AN APPLICATION FOR ETHICAL APPROVAL OF A RESEARCH PROJECT

The Faculty Ethics Committee requires those partaking in research activities to consider the ethical and safety implications of their work and where necessary apply for necessary ethical clearance from within our Faculty and from external bodies.

Safety aspects relate to specific issues in addition to the normal H and S and COSSH requirements (eg: use of radioactive sources, lasers, biohazards, including microorganisms, tissue culture etc). Researchers (staff and students) should contact their line manager, project supervisor, research centre manager for guidance. The Faculty Ethics Committee Chair is Professor Paul Whiting, H.25I, extension 8283.

The ethical approval form is essential to planning a piece of research activity. Application forms completed by UG, PGT students must be returned to the relevant administrative or academic staff involved with the particular module. Application forms completed by PG Research students or staff should be returned to the Faculty Research and Commercial Office, room H.036, e-mail HLSRO@dmu.ac.uk.

FORMS MUST BE SIGNED
PLEASE USE ORDINARY LANGUAGE AND AVOID JARGON

Title of proposed project/research activity – include module title where appropriate

An explorative study into the mentorship requirements of nurses working within advanced roles.

As part fulfilment of MSc in advanced nursing practice.

Start date for the project:……………………….. Expected end date for the project…………………

Researcher's/Student's Name and contact details

Peter Chessum,
Medical Nurse Practitioner,
Kettering General Hospital,

Kettering,
Northants

Module Leader's, Supervisor's Name or Project Director's contact details.

Dr Peter Norrie
Senior Lecturer
School of Nursing and Midwifery
Charles Frears Campus,
pnorrie@dmu.ac.uk
201 3914

Brief Description of proposed activity and its objectives

This research proposal has been submitted in part fulfillment of an MSc in Advanced Nursing Practice. The main aims of the project are to develop greater understanding into the mentorship requirements of nurses working within advanced or extended roles. Whilst also learning more about what support systems for senior nurses exist within an acute trust in northamptonshire at present. It is hoped that findings may well identify possible models that can be used in other areas to mentor nurses moving into advanced roles.

The work will take a Phenomenological approach, as currently there is a paucity of literature pertaining to mentorship of advanced nurses. Initially, the researcher intends to organise a focus group for nurses working within the advanced paradigm. The sample will be selected from the 52 nurses currently working with job titles that suggest advanced practice. The sample will be taken from Kettering General Hospital NHS Trust following concurrent IRAS approval being confirmed. A presentation will be delivered at the 'Advanced Nursing Practice Forum' on the research and subsequent information sheets will be provided (included within). Volunteers will then be sought at this juncture and consent gained via forms included, the aim will be to gain circa 4-6 participants for the study.

Following on from the focus group a set of semi-structured interviews will be undertaken until the researcher is satisfied that data saturation within this set has occurred. The data will then be transcribed and a copy of the transcript given to the participant to review and alter as determined to be necessary. This data will then be reviewed, with the hope of rather than only producing descriptive data, the researcher may be able to identify models of mentorship that may be beneficial to other nurses or managers working in a variety of clinical settings.

All of the data will be transcribed into computer files. All data will be held on a password-protected computer kept within a locked office. Any paper documentation that is generated through the research will be kept in a locked cupboard until completion of the study is confirmed and then will be subsequently shredded. Results from the research will hopefully be published within a nursing journal and fed back at the RCN 'Advanced Practitioners' conference at Aintree in September 08'.

Ethical Issues Identified	How these will be addressed
A Small number of participants may have a relationship with me prior to involvement within this project.	Research subjects will be made aware that this project is in association with a MSc and in no way connected to their employment within the NHS trust. Participant's are able to decline the offer of taking part in the study, and may also withdraw from the study without prior explanation.
Maintaining confidentiality.	Data will be anonymised with each participant being assigned a code held on a

	password-protected computer. All data collated will be destroyed on completion of the study.
To do no harm.	It is not expected that this study will cause any harm or distress. However, it may be possible that this process may unearth distressing or issues of bullying. Participants will be given contact details of counselling through the NHS trust should this be applicable. A written copy of "dignity at work" will also be available should it be required.
Members of the focus groups are qualified healthcare workers; they are employed solely within the NHS. It is important that support from the employers is gained.	To ensure that the trust supports the research taking place the researcher has completed the IRAS form (included). This is the trust's requirement to confirm ethical approval of research conducted within KGH.
Consent.	Consent will be sought by voluntary participation, Information sheets and the ability to withdraw from the study at any given time without prior explanation.

To which ethical code of conduct have you referred to?
For example British Sociological Association, ESRC, British Psychological Association

Nursing and Midwifery Code of Professional Conduct: Standards for Conduct, Performance and Ethics (2004).

How have the requirements of those involved with the research whose first language may not be English been addressed?

All potential respondents are senior nurses working as registered health care practitioners. Many will have undertaken both Degree and Masters level courses, therefore will be able to converse and write in English.

List of accompanying documentation to support the application:

(1) A copy of the Research proposal Yes □

(2) The details of arrangements for participation of human or animal subjects or material, (including recruitment, consent and confidentiality procedures and documentation as appropriate) Yes □

(3) A copy of all the documentation provided to the volunteer to ensure the clarity of information provided Yes □

(4) Copies of appropriate other ethical committee permissions (internal or external) or supporting documentation Yes □

(5) A list of proprietary drugs or commercial drugs to be used in the proposed investigation including formulation, dosage and route of administration and known adverse side effects N/A

(6) A brief one page curriculum vitae for each applicant, including recent publications Yes □

(7) Other Documentation:

Signature of researcher/student date

Signature of project director /supervisor(s) date

	DISSERTATION PROPOSAL FORM			
1	**Postgraduate Programme:** MSc Advanced Nursing Practice			
2	**Student Name: Peter Chessum**			
	Tel No (home):	**01536 713875**	Tel No (work):	**01536 491177**
	Tel No (mobile):	**07717492231**	e-mail:	
	Address ***(for mailing all dissertation correspondence):*** **5, Gibbons Drive, Rothwell, Kettering, Northants NN14 6HS**			
3	**Employer/ Sponsor/ Location/ Job Title:-** **Medical Nurse Practitioner/NHS/Kettering.**			
4	**Dissertation Supervisor Name:** **Dr Peter Norrie**			
	Tel No:		e-mail:	
6	**Working Title:- An explorative study into the mentorship requirements of nurses working within advanced roles.**			
7	**Summary Statement** of research proposal with two to three primary text(s)/ sources stating the idea/ research focus or question to be explored (What I am going to do): Within this research it is the student's intention to examine the mentorship and support nurses feel they require as they extend normal nursing boundaries. To achieve this a view of how advanced nurse practice developed is appropriate, highlighting the fact that many advanced positions were created in reaction to an increased service demand in a particular area. The literature suggests that nurses were placed in extended roles before being fully qualified to do so; rather more frequently a senior nurse in the right place at the right time gained an ANP job (Mantzoukas 2007). Managers, organisations, even the NMC have yet to fully underline what is required of ANPs; and most work revolves around demonstrating competence to others rather than establishing support systems and proper training for ANPs. It is hoped that within this work extended roles can be viewed from a nursing perspective, highlighting the various needs nurses have to function within advanced roles.			
8	**Research Objectives.** (Why I am going to do it) **To Develop Greater Understanding of Advanced Nursing Practice** **To further explore the mentorship requirements of nurses practicing in extended roles.**			

9	**Proposed Research Methodology** Indicate with clarity, precision and accuracy. (How I am going to do it) This research will take a Phenomenological approach, within the qualitative paradigm. This particular method has been chosen to ensure that concepts come from the data collected and are systemically worked out in relation to the data gathered during the research As previously mentioned, whether Advanced Nurse Practitioners are in control of their own development or supervision is questionable. The student will initially organise a small focus group of nurses working within advanced roles. The focus group will discuss mentorship, highlighting potential themes or streams of thought in relation to mentorship. Following the initial focus group further interviews will be organised with a greater degree of control to elicit deeper insights into the feelings of practitioners. The benefits of the initial focus group will be the opportunity for practitioners to share their opinions and thoughts, whilst simultaneously allowing the collection of data from multiple sources at the same time (Berg, 2001). Focus groups historically have also often been used to explore attitudes and needs of staff; more confident participants break the ice for the shyer amongst the group (Bell, 2004). Such groups allow examination of (sub)cultures or norms as co-participants provide mutual support for each other allowing deeper insights into behaviour and feelings. Moving on from the focus group, the intention will be to organise a number of semi-structured interviews with practitioners, who may not have attended the focus groups to ascertain whether feelings gleaned are more widely applicable. Loosely structured questions will be developed from thematic analysis of early group work, to form the basis of questioning and free discussion. Design such as this facilitates theoretical sampling in that the initial sample is drawn then extended in the light of emergent theory (Denscombe, 2003).
10a	**Work Programme (Complete 10b & 10c overleaf giving a detailed plan for reading, contacts, research, analysis and writing up). Use this space for relevant contextual information to enable clear understanding of your proposed programme.** (When and where I am going to do it) The initial focus group is to be established at Kettering General Hospital, held within the postgraduate centre in one of the seminar rooms. The student's intention is to chair the group with a set of predetermined prompts to use as and where necessary. However, in order to gain insight into the understanding ANP's have of mentorship these will only be offered up should it be necessary. Preparation for the focus group will be achieved by pre-reading on both focus group management and mentorship through structured literature reviews. To aid in the collection of data I will seek to enlist a scribe to take notes during the focus group, due the problems created by multidirectional sound; crude sound recording equipment is thought to be less effective. However, within subsequent interviews tape recording equipment will be used and then transcribed in full.
11	**Intended Outcomes, relevance to employment, etc** **Publication of research findings within appropriate nursing Journal.** **Completion of MSc programme.**

Outcome of Ethical Approval Form Review **(if applicable)**	**A ☐ B ☐ C ☐ D ☐**
Outstanding issues or comments	
Confirmed Submission Date ** Following agreement of the submission date this deadline is binding	

This form should not be signed until outstanding issues are resolved.

Dissertation Supervisor ____ **Student** ________________________________

Module Leader/ Panel Member __________________________________ **Date** ___________________________________

Appendix 3

Further Information or Clarification Required LREC :-

1. **What is the study looking for?**

   Advanced Nursing Practice is poorly defined at present. A further aim of this study is to explore 'Advanced nursing' within the context of this study. It is hoped that through asking participants about what support they require they may also allude to the types of work that nurses are undertaking. The nursing profession needs to understand nurses working in sometimes-marginalised positions, possibly in isolation. Hopefully, this may aide the professions acceptance of such roles and informs the wider public about the changing nature of nursing.

   The justification for this research is predominantly due to a complete lack of research having been conducted with regards to advanced practice, and mentorship. Within nursing literature there is evidence of approaches to mentorship or clinical supervision but these are normally always tailored towards new nurses, just entering the profession.

   It seems both strange and arrogant to believe that even experienced nurses moving into new paradigms of work aren't again in someway 'beginning' again, requiring support, mentorship and further training. The researcher's aim is to understand the problems with transgressing from a senior nursing role into an advanced practice role, and how mentorship may play a part in facilitating this change more effectively.

2. **A topic Guide should be created for the focus group to be used as a starting point.**

   Please see attached topic guide for the focus group. It is acknowledged that the focus group serves to inform the researcher on appropriate questions for the second stage of the research→ interviews. Therefore, it was suggested that

rough guide for the focus group be created, with the questions for interview being submitted at a later date as an amendment. (see attachment for focus group guide)

3. **As Above.**

4. **The committee requested confirmation on the storage of data.**

   The information gained from this study will be held on password-protected computers within the researchers trust. Laptop computers will not be used within this study, and all data will be encrypted, and stored securely within a locked office.

5. **The Committee required further clarification on who was transcribing the data.**

   The researcher now intends to transcribe the data personally. As this will increase the time spent familiarising himself with the data, which hopefully should improve understanding within the research.

6. **The committee suggested that I may wish to use the ANP forum to feed back the results of the study to participants and fellow ANP's.**

   This will be done. Following the research it is the researchers intention to do a formal presentation of findings to the ANP group.

7. **The committee wanted to know whether GCP training was a requirement to consent staff and whether the training has been undertaken.**

   With regard to this question the researcher contacted Demontfort University for further clarification.

   Dr Norrie felt that, as this was neither a clinical trial nor was I introducing an IMP; ICH GCP training would be unnecessary. It is felt that the training delivered within the Research

development module of the MSc would suffice for consenting purposes for this work.

Professor Denis Anthony also supported this.

8. **The committee requested clarification regarding the number of participants that are expected and how dropouts would be replaced.**

   The researcher appreciated the advice given by the panel with regards to drop out rates. In response to this the number of people invited to the focus group meeting will be raised from **4** to **8** participants. This should mean that even if a few people do not attend, there should still be enough participants for the focus group to go ahead.

   The interviews will be arranged more personally in that once the participants have been selected for the interview stage a mutually conducive date can be arranged for the interview to take place.

9. **See attached revision of Participant Info V3**

   The researcher has manipulated the Information Sheet as required by the LREC board.

10. **See attached revision of Participant Info V3**

N.B the researcher **will** always be the person who is obtaining consent from the participants. As there are no other persons involved with the collection of data.

The NRES consent form has been placed on KGH headed paper as requested, referencing the information sheet V3.

Appendix 4

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
A study into the mentorship requirements of advanced nurses (V.2)

1. Is your project an audit or service evaluation?

○ Yes ◉ No

2. Select one category from the list below:

○ Clinical trial of an investigational medicinal product
○ Clinical investigation or other study of a medical device
○ Combined trial of an investigational medicinal product and an investigational medical device
○ Other clinical trial or clinical investigation
○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
◉ Study involving qualitative methods only
○ Study limited to working with human tissue samples, other human biological samples and/or data *(specific project only)*
○ Research tissue bank
○ Research database

If your work does not fit any of these categories, select the option below:

○ Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	○ Yes	◉ No
b) Will you be taking new human tissue samples (or other human biological samples)?	○ Yes	◉ No
c) Will you be using existing human tissue samples (or other human biological samples)?	○ Yes	◉ No

3. In which countries of the UK will the research sites be located?*(Tick all that apply)*

☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland

DRAFT

Appendix 5

Ethical Principles

These principles were upheld throughout the study:

I. The participants were always safeguarded; this included maintaining their dignity and ensuring that they came to no harm from their participation in the study. This was achieved by meeting participants at a venue and time that suited them, and by ensuring that all participants were aware of what would be expected from them prior to commencing the study. This was ensured by detailed participant information and a presentation to potential participants prior to commencing the study.

II. The study was submitted to two separate ethics committees, and both had to agree on the final format of the study prior to it being commenced, thereby ensuring that its ethical principles had been examined rigorously. Ethics committees did suggest changes, which were performed and various versions of either form were made and then re-reviewed.

III. The researcher should always be honest, avoiding misrepresentations of data collated; the researcher should always be truthful and the methodology should be transparent. This was achieved by ensuring participants understood methodology used prior to consenting to the study. Transcripts of their interview/focus group were emailed to the participants, for their approval, to check the accuracy and give them an opportunity to address any issues they felt necessary.

IV. Participants are free to give their informed consent to take part in the study. (Denscombe 2003)

Appendix 6

Participant information sheet.
(VERSION 3 14/1/09)

INFORMATION SHEET FOR PARTICIPANTS

An explorative study into the mentorship requirements of Nurses working within advanced roles.

Researcher: Peter Chessum (Msc Advanced Nursing Practice student)
Supervisor: Dr. Peter Norrie (Programme leader BSc nursing, senior lecturer)

Contact Details: Peter Chessum
Clinical Decisions Unit
Kettering General Hospital
Rothwell Road
Kettering
NN16 8UZ

Tel. (01536) 491177
E-mail: Peter.chessum@kgh.nhs.uk

Invitation Paragraph

You are invited to take part in a research study that aims to explore the aspects of mentorship, within KGH trust, that enables advanced nursing practice. It is hoped that the findings of this study will help inform nurses when developing a working culture that supports advanced nursing practice. Participants within this study have been selected due to having a job description that suggests advanced levels of nursing practice. From the sample group highlighted, that provide consent; six staff will be randomly chosen and asked to take part in the study.

If more people volunteer then are required for this study then participants will be randomly selected. If you are chosen to partake in this study you will be contacted in writing to inform you of the date of the focus group, and subsequent interviews.

Very little is currently known about mentorship per se, especially within the advanced paradigm. The aim of this study is to explore what mentorship means to advanced nurses and what support these nurses require to facilitate better working practices.

If you agree to participate in the study it will have no impact on your working at Kettering General Hospital. There is no personal benefit for you from taking part in this study. However, the information you provide may produce valuable insight into

the work of practitioners on advanced boundaries, and the support systems they require.

Peter Chessum is undertaking the study, he is a Medical Nurse Practitioner and final year MSc Advanced Nursing Practice student, and this study will be submitted as part of his dissertation. He will have outlined the parameters of the study with you prior to you receiving this invitation.

1. What is the purpose of the study?

The purpose of the study is to try and explore, with advanced nurses, aspects of mentorship within the clinical setting. The findings will be reviewed and explored to try and determine common themes.

2. What will be involved if I agree to take part in the study?

You will be asked to take part in either an interview or small focus group. The conversations that take place will be taped and transcribed. You will be given a copy of your transcript and asked to confirm its accuracy.

3. Will information obtained during the study be confidential?

All information acquired during this study will be anonymised and entirely confidential. You will not be personally identified in the study data, report or conclusions. The data collected within this study will be held on a NHS computer, password protected and encrypted.

Nurses have a professional obligation to report unsafe practice: this cannot be overlooked if scenarios of concern are identified in the course of the study.

4. What if I am harmed by the study?

It is anticipated that you will not come to any harm as a result of your participation in the study. The study does not involve any physical contact; it is your views, opinions and reflections on experience in practice that are being sought. However, there may be issues that you wish to discuss in more detail following the interview. Were this to occur, you would be provided with information so you may access counselling services provided by KGH Trust. These services are accessed via the Occupation Health department at KGH, who can be contacted through the hospital switchboard on (01536) 492000.

There are no special compensation arrangements in place for this research study.

5. What are the potential disadvantages of taking part in the study?

The study will involve a time commitment from you of approximately one hour.

It is expected that there will be no other disadvantages from participating in this study.

If you do not wish to participate in the study you need not express an interest. Only individuals who have agreed to be contacted will be invited to participate in the study. If you chose to withdraw from the study at any time, you may do so. All records of your involvement will be destroyed.

6. **What happens if I do not wish to participate in the study, or wish to withdraw from the study at a later time?**

You are free to withhold or withdraw your consent to participation at any time and will not be asked to justify your decision. Regardless of whether you participate or not, you will be treated no differently either by the staff of KGH trust or by the researcher at any point or in the future.

7. **What happens if there is a problem?**

Provision has been established for counselling should this study unearth a work related issues that causes distress. Participants are also free to withdraw from this study at anytime without explanation if they feel it is causing distress.

If any other problem or concerns related to this research study occur, participants are encouraged to relay these back to KGH R&D committee via the address below.

8. **Who has reviewed this study?**

Three separate ethics committees, KGH Research and Development Committee, Demontfort University Ethics Committee; and Leicester, Northamptonshire & Rutland Research Ethics Committee have reviewed this study prior to it taking place.

Thank you for taking the time to read this information sheet and for considering yourself for involvement in the study.

This application has been supported by the KGH Trust Research Committee, the chair of which, Dr Gwyn McCreanor, can be contacted via:-

Linda Lavelle,
Research Co-ordinator,
Quality Governance Team,
1st floor Thorpe House,
Kettering General Hospital,

NN16 8UZ

Appendix 7

Contact details pro-forma

Contact Details

(VERSION 3 14/1/09)

An explorative study into the mentorship requirements of Nurses working within advanced roles.

Researcher: Peter Chessum (Msc Advanced Nursing Practice student)
Supervisor: Dr. Peter Norrie (Programme leader BSc nursing, senior lecturer)

Contact Details: Peter Chessum
Clinical Decisions Unit
Kettering General Hospital
Rothwell Road
Kettering
NN16 8UZ

Tel. (01536) 491177
E-mail: Peter.chessum@kgh.nhs.uk

Please complete your contact details **ONLY** if you are happy to be contacted to take part in the study.

Name ______________________________

Address ____________________________

____

____

____

Tel. ______________________________

email ______________________________

Appendix 8

Centre Number:
Study Number: 08/H0402/133

CONSENT FORM

Title of Project: An Explorative study into the mentorship requirements of nurses working within advanced roles

Name of Researcher: Peter Chessum

Please initial box

1. I confirm that I have read and understand the information sheet dated 14/1/2009 (version3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that my interview will be recorded, and that I will be given a copy of the transcript to approve of prior to its inclusion within this research. ☐

4. I agree to take part in the above study. ☐

Name of Participant　　　　Date　　　　Signature

________________________　　__________　　_____________

________________________　　__________　　_____________

Researcher　　　　Date　　　　Signature

When completed, 1 for patient; 1 for researcher site file;

'AN EXPLORATIVE STUDY INTO THE MENTORSHIP REQUIREMENTS OF NURSES WORKING WITHIN ADVANCED ROLES'...

A

- The aim is to develop greater understanding
- How did you come to be an ANP?
- What does 'mentorship' mean to ANP's?
- What sort of 'mentorship' would ANP's say they require?
- Do nurses working in advanced or isolated roles feel supported?

WHAT IS REQUIRED?

- Well, thats up to you.
- The research is split into two stages, you can do either part or neither part...or both.
- Part 1 Focus Group (4-6 nurses) for about an hour.
- Part 2 Interviews, 30-40 minutes of your time.

WHAT'S IN IT FOR US?

- Sadly, no cash. However, this study is supported and underpinned by KGH research committee, so we can use work time. Providing you can free yourself for max 1hr.
- I hope to improve the understanding the profession has of advanced roles, and what ANP's require, if anything as support.
- You get to do some good.

HOW ARE WE PROTECTED?

- Confidentiality will always be maintained. All records will by anonymised and destroyed on completion.
- Transcripts will be returned to participants for their approval/ 'sign off' prior to being used.
- No harm is expected to come from this study, however, KGH occupational health, are ready to support if needed.

WHERE DO WE SIGN..

- Please pick up the 'information for participants' sheet, which is attached to consent forms, and participant details'
- Read these as they explain more then, if interested please place the completed forms in the internal post.
- If selected I will then contact you directly to organise mutually convenient times for the focus group/ interviews.

Appendix 10

Guide for Focus Group: Areas for Exploration.

1. From what background did you enter into Advanced Practice?

- Work area.
- Training prior to commencing 'advanced' role.
- Demands from the transition.
- What are the differing demands, and how have you adapted?
- Do you feel that your job is more 'science' than 'art'?

Literature suggests that many nurses in 'advanced roles' came quickly into extended roles as a result of service need, rather than organised role development this is to be explored

2.What do Advanced Nurse Practitioner Understand of Mentorship?

- Explicit or implied understanding?
- Ethos
- Differentiation from Supervision?
- Support
- Expectations
- Sub-cultures.

3. What do you think about Mentorship and your role within it?

- Have you worked in any different areas and received it
- How did the culture differ there
- Were expectations discussed - interview / induction / preceptor or mentor allocated?

4. What does Mentorship in practice mean to you?

- Expand - Yes / No - how
- How would you like to be mentored in practice
- By whom- and why would you chose that individual?

5. If you had a specific issue related to advanced practice within your role or otherwise whom would you speak to?

- How would they gain access?
- How often does this occur?
- When does this occur?

6. Do you often work in isolation?

7. If so, other than your yearly IPR when do you speak to colleagues about issues?

8. How would you improve the Mentorship where you work?

Appendix 11

Guide for Interviews: Areas for Exploration.

1. From what background did you enter into Advanced Practice?

- Work area.
- Training prior to commencing 'advanced' role.
- Were you already employed within the trust?

2. How did you find the transition from Senior SN to ANP?

- Acceptance.
- Support.
- Expectations.
- Sub-cultures.
- Feelings.

9. What Knowledge or skills are required to be an effective ANP?

- Scientific
- Artistic/Interpersonal
- Tacit knowledge
- Experiential or taught
- What is the most challenging skills to learn.
- Where do you need most help when starting in a ANP role.g!!!

10.What does Mentorship in practice mean to you?

- Expand
- How would you like to be mentored in practice
- How often do you feel it would be necessary to meet?
- By whom- and why would you chose that individual.
- Could you use more than one mentor if required?

11.Who in your view is best positioned to mentor you?

- How would they gain access?
- How often does this occur?
- When does this occur?

12. How valuable are your own networks of mentorship or support?

- How was it developed
- How do you use them in practice
- What benefits do they give you

7. How does the mentorship requirements of ANPs differ from those require by newly qualified nurses?

Blank canvas how would you mentor a new ANP

Appendix 12

Colazzi, seven steps to data analysis.

i. Read all of the subject's [*sic*] descriptions (conventionally termed *protocols*) in order to acquire a feeling for them, and to make sense of them.
ii. Return to each description and extract from them phrases or sentences which directly pertain to the investigated phenomenon; this is known as *extracting significant statements.*
iii. Try to spell out the meaning of each significant statement; these are known as *formulated meanings*.
iv. Repeat the above for each description and organise the aggregate formulated meanings into *clusters or themes.*
    a. Refer to these clusters of themes back to the original protocols in order to *validate* them.
    b. At this point, discrepancies may be noted among and/or between the various clusters; some themes may flatly contradict others. (The researcher is advised by Colazzi to refuse the temptation to ignore data or themes, which do not fit.)
v. The results of everything so far are integrated into an *exhaustive description* of the investigated topic.
vi. An effort is made to formulate the exhaustive description of the investigated phenomenon in as unequivocal a statement of the *identification of its fundamental structure* as possible. This has often been described as an essential structure of the phenomenon.
vii. A validating step can be achieved by returning to each subject, and, in either single interview or a series of interviews, asking the subject about the findings thus far.

(Colaizzi, 1978.)

Appendix 13

Summary of themes Focus group and Interviews

Phase of research	Theme	Evidence
Interviews	ANP to ANP tensions	Within the Interviews some ANPs criticised the fact that other ANPs were not performing at a level, or did not have the accreditation to be called ANPs.
Focus Group + Interviews	'Time'	Various pressures placed on ANP time meant that mentorship was rarely delivered unless the individual organised it.
Focus Group + Interviews	Different approaches to Mentorship within the organisation.	Quotes from participants showed a variance from 'pretty extensive' to 'nothing at all' with regard to mentorship.
Focus Group	Tension between ANPs and General Nurses.	Poor understanding of ANP role causes misconceptions, ANPs felt excluded from nursing teams.
Focus Group	Science Vs Art	Participants gave examples of how it was necessary to possess both advanced scientific knowledge and tacit knowledge to succeed in ANP role.
Focus Group + Interviews	Transitional Difficulties + Heightened Anxiety	Multiple examples of anxieties created from high expectations of new ANPs, with little experience in advanced paradigm.
Interviews + Focus Group	Potential Mentors	Many participants suggested that multiple mentors could be used and that rarely one mentor is sufficient to cover all the aspects of advanced nursing practice.
Focus Group + Interviews	Support Requirements	Many participants gave insights into their need

		for 'affirmation' that they were doing the job well with constructive criticism of how to improve.
Interviews	Education	Both participants that had educational training prior to commencing their ANP posts, found transgression into advanced roles 'easier'.
Focus Group	Empathy and Support for Junior Doctors	ANPs understood the expectations and pressure place on new junior Doctors due to role similarities.
Interviews	Organisation	ANPs felt that the organisation/managers did not appreciate their role, or fully understand their needs. There was little evidence of succession planning, and some services ceased when an individual was sick or on leave.