ABSTRACT

Introduction: This research explores how emergency nurse practitioners (ENPs) become role proficient given experience variation and lack of role standardisation.

Aim: To understand how ENPs experiences in practice influence their feelings of role proficiency.

Methods: A hermeneutic phenomenological study was undertaken utilizing an interpretive standpoint. A two-phase approach was adopted with ten participants using a digital diary informing a semi-structured interview. A three-stage data analysis approach was applied.

Findings: Six themes emerged: the meaning of role proficiency, relationships, confidence, learning and knowledge, exposure and experience, and care. Models of proficiency and its development are presented.

Discussion: Proficiency is defined where confidence in the components that proficiency consists of and their application to each clinical presentation is required. Proficiency is a continuum supported by regulatory mode theory. Inconsistency of role understanding gives rise to three ENP groups, resistors, maintainers, and innovators.

Conclusion: Role clarity is required to establish a consistent culture within organisations founded on the voice of the ENP as captured in this research. This model of proficiency be incorporated in ENP role development for current and future ENPs

Key words:

Emergency nurses, Practitioner, Phenomenology, proficiency, capability, advanced clinical practice

1. Introduction

UK urgent care services provide approximately 25 million same-day patient contacts each year [1]. It is reported that Emergency Nurse Practitioners (ENPs) are less likely to refer patients on to other services, reduce waiting times, attract high patient satisfaction, provide a service as good as existing services, improve the patient experience and deliver good quality care [2]. Attendances to emergency departments continue to rise [3, 4], with much of the work now being taken on by practitioner roles. The discussion regarding regulation had moved on little in the UK until the release of the Health Education England framework for advanced clinical practice (ACP) [5] that seeks standardisation of the level of practice, rather than a regulatory process. The framework provides consistency and clarity of qualification alongside direction that is not currently present in ENPs. The need to define and clarify the process of moving nurse practitioners to the stage of competency [6] has become more apparent as the delivery of urgent and emergency care in England continues to change. The continuing demand for urgent care services and the impact on its staff underpinned by principles and standards of urgent treatment centres [7] and their further integration into systems, highlighted by the NHS medical director [8].

2. Research Aim

This study aims to explore and understand the ENP's practice experiences, and how these influence feelings of role proficiency from the position of the autonomous and clinically proficient ENP.

To approach the aim, three research objectives were proposed:

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

3. Methods

3.1. Study design

A hermeneutical phenomenological study to interpret the lived experience of ENPs was adopted. Phenomenology is the study of the lived world as is immediately experienced by the subjects [9]. Hermeneutic phenomenology shifts the commitment to examine phenomena from an interpretive, rather than descriptive, standpoint focusing on the contextual analysis of the data, rather than descriptions of it. Consequently, the interpretation of people's meaning-making activities is central in this research [10].

3.2. Sample, Setting and recruitment.

The purposive sample was drawn from a NHS Trust in the North of England operating a number of urgent care facilities centres in the region. ENPs were approached by email by the unit Matrons in which the sample population practised. Thirteen participants volunteered initially, three withdrew after further consideration. The selection addressed the goal of understanding proficiency as influenced by practice experiences of ENPs.

TABLE 1 PARTICIPANT DEMOGRAPHICS

Participants (n = 10)

Gender, n (%)	

Male	2 (20%)
Female	8 (80%)
Years as NMC Registrant, years	
Mean	22.8
Range	12-33
Years in ENP role, years	
Mean	9
Range	1-16

3.3. Data Collection

Data was collected in two phases, inspired by Bedwell et al [11]. Phase one, a digital audio diary captured by the participants whilst in practice, as close to the participant defined proficiency experience as practicable. Phase two was a semi-structured interview. Participants captured a diary on a digital voice recorder, focusing on experiences they considered related to proficiency, prior to the interview that followed. Diaries were transcribed and provided the structure of the interview, which focussed on the experiences participants had captured as proficiency and the practice experiences they felt influenced their role proficiency. The audio recorded interview was transcribed allowing text data immersion in line with the research methodology. Question examples can be seen in table 2.

TABLE 2 EXAMPLE INTERVIEW GUIDE

Tell me about how your work as a NP?
What do you understand by the term proficiency?
How do you experience it, what does it consist of or what are its components?
How do you feel about proficiency? Is it something you aspire to or have achieved, a kind of tangible thing? Is it something that you just have or does it need to be developed?
Asking for advice, how does this affect proficiency?
You spoke of gut feeling, how is gut feeling related to feelings of proficiency?

3.4. Analysis

Phenomenological data analysis seeks to extract meaning, understanding and the essence of the phenomenon under investigation. A three-stage approach was adopted [12] through naïve reading, allowing the text to speak to the researcher; structural analysis, conveying the essential meaning of the lived experience; and comprehensive understanding (interpreted whole); by summarising and reflecting on the themes in the context of the research question, allowing the researcher to be intimately embedded in the text and experiences of the participants.

3.5. Ethical considerations

Ethical approval for this research was given by the University ethics committee [DHCMonk250615]. NHS approval was also gained through the HRA [IRAS 195341]. Informed consent was obtained, confidentiality was maintained throughout.

3.6. Rigour

Data analysis was undertaken independently, validation was achieved with the assistance of the experienced supervision team. Continuous reflexivity was adopted to maintain awareness of how the researcher shaped the analysis and findings. This research follows the consolidated criteria for reporting qualitative research (COREQ) guidelines [13].

4. Findings

Six themes emerged from the interpretation process and are summarised in Table 3.

TABLE 3 SUMMARY OF THEMES

Theme	Title	Summary
One	The meaning of role proficiency	The meaning to the participants of proficiency in their role, leading to its definition.
Two	Relationships	Participants overwhelmingly indicated a struggle in relationships linking sub themes of their role, work self and Doctors.
Three	Confidence	Confidence plays a significant role in feelings of proficiency. Sub themes relate confidence to the professional-self, the personal-self, resilience and self-efficacy.

Four	Learning and knowledge	Subthemes are built on the perception of formal learning and knowledge, and common sense.
Five	Exposure and experience	Exposure builds proficiency with a lessening influence as experience increases.
Six	Care	Care is a central theme that threads through proficiency in its entirety.

4.1. Theme one: The meaning of role proficiency

'…proficiency is being good at your job' (P1).

The concept of proficiency was strongly associated with their role in its broadest sense as a job. Participants examined the concept more deeply, progressing to its component parts and their relationship.

'To be proficient, it means many different things. Being competent, accountable, responsible, working within your scope of practice. Having theory, understanding, and following guidelines and protocols... But that comes with experience as well. You don't just become proficient overnight ...' (P3).

Proficiency became about how these components were applied and understood by the ENP, how they constructed their feelings of proficiency using these parts. Proficiency became about the effectiveness with which they confidently connected and understood the components to move towards proficiency in their role.

'I don't think there ever is an end point. I think there's a point where you are [feel] proficient, but there's never an end point to developing your skills and what you know.' (P9).

Participants discussed proficiency as a continuum beginning before their ENP role, incorporating all their clinical experiences. It was seen as a lifelong process expanding beyond the confines of their current role, without end, an acceptance that proficiency perfection in all areas of practice was unrealistic.

'To me, proficient [sic] is a sort of, it's the next stage on from competence I personally think.' (P9).

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

4.2. Theme two: Relationships

The relationships theme is about how relationship experiences affected feelings of proficiency.

4.2.1. The role

'You don't know absolutely what's coming in through the door. It can range from where I am, from babies under 2s … and right up to 100 really …' (P10).

'why aren't they having that ability, why don't they have that knowledge and that competency to be seeing things that we're saying. You know, as an advanced nurse practitioner, we expect you to be seeing this, this, this, this and this.' P3

The perception of the ENP role varies significantly, driven by factors including workload, client group differences or location. There was frustration linking to role variability, directed at other ENPs or units who are perceived to be not practicing at the same level as the participant, routinely vocalised as 'seeing less' by participants, an inherently negative phrase to indicate units/ENPs not being able to manage as many conditions. This presented an unofficial hierarchy, with community units lowest and those co-located with ED at the top.

'But there's always a few without that extra training, theory, competency, assessment. Who will go off and do things anyway. And then it becomes a muddle to them because they're not really sure what direction they're going to go down…'(P3).

'And its, in any environment you've got two groups, in my experience you've got the two groups of people who just draw a line somewhere and … there's people,… that say it could be my business if I take advice from that person…' (P6).

Participants indicated the existence of those looking for solutions to resolve the gaps in role proficiency, and those who want to remain in the role as is, with firm boundaries of what they will or will not manage clinically. Participants noticed a consequence to this, P3 noting a situation where they perceived another ENP pushed the boundary too far.

4.2.2. The work-self

'I think sometimes for me I kind of walk away thinking … I knew I should have done that … I never thought of doing it like that. So I kind of, for me I give myself a little bit of a bashing.' (P7).

The work-self theme is about relationships with their self, in a work context by an apparent existential peering inward at the self from without. The work-self focuses on the desire to be the best and includes a personal understanding of abilities, a strong sense of responsibility, honesty with the self, a need to feel safe in decision-making and a strength in the recognition of weaknesses. P7 voiced the impact of being critical of the self, and the resulting negativity.

'And it's about how you manage it. Some days you manage it better than others.' (P5).

Recognition existed that, if unchecked, the examination of the self becomes counter-productive, reducing feelings of proficiency, rather than contribute to its improvement.

4.2.3. Doctors

'if anything it made me feel more proficient... and being in and around … junior Doctors ... understanding their need to question everything … and the fact that they've got to justify why they've taken a patient to the Reg[istrar]…' (P9).

Relationships between the ENP and doctors influence proficiency. The above example when making a referral and was met with what was felt excessive questioning. This focused on the doctor's perspective, their perceived insecurity and knowledge of the ENP role or the condition. This led to acceptance that the doctor had to question further driven by how

they had been instructed, their understanding of the ENP role, and their own learning. It was not seen as an attempt to frustrate or obstruct the ENP.

'…Consultants will say, "Well, you're probably doing that more than some of the SHOs.' (P3).

'… some Doctors don't see NP as proper clinicians do they? Lets face it, there's still a bit stigma with all that you know' (P2)

Examples are seen with variance of influence between doctors. A positive example is seen where a consultant indicated that the ENP is most likely the expert in a particular area, seeing more of the patient type or condition than the consultant. In contrast a consultant was short when asked for telephone advice. This is sometimes delivered dismissively and does not always result in advice however, the negativity associated with this example was deflected using a similar appreciation and understanding of the position of the ED department, and the affect this may have over the consultant similar to the earlier example.

4.3. Theme three: Confidence

The confidence theme is about how confidence impacts proficiency, practice and the person of the ENP.

4.3.1. The professional-self

'I think they have… more widespread training. So I think the doctors from a medical point of view should know a lot more than us.' (P5).

The perception of professional-self is what ENPs feel it should be and its reaction to negative experiences impacting confidence in the professional-self. ENPs measure how their professional-self should present against other individuals. The respectful comparison is against the medical profession who are perceived to have more knowledge and expertise.

'…and it's on your mind …, that can affect your work for a long time... And there's no debriefing sessions, there's no meaningful support… but the problem is that you have a difficult consultation and you have to move on to the next patient within minutes.' (P6).

Complaints negatively impact on confidence and its contribution to proficiency. This effect lasts well beyond work time, taking negativity beyond their professional-self into their personal-self and home life. Participants spoke of the negative impact of complaints, their sudden and often unexpected receipt, and the lack of formal mechanism to manage them on a clinical and professional-self level.

4.3.2. The personal-self

'*You might, kind of, withdraw. But nobody sees... I don't think a lot of people see themselves as being confident people. It's like people say, "Oh, you don't look too nervous there, standing up and talking in front of..." But inside you feel completely...*' *(P3).*

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

Confidence in the personal-self is an individual experience. There is a great deal of doubt in the personal-self, participants indicated that this drives their willingness to practice yet remains affected by issues experienced with the professional-self. A negative view of personal-self is typical amongst the group. Management of self-doubt is through a constant process of reflection, focusing on not allowing the personal-self to dominate and affect practice. It is kept separate from the professional-self, however participants outlined that this can be difficult. There is evidence that the personal-self is punished for errors that the professional-self makes. This punishment is felt as emotional responses, predominantly self-criticism, to the experience.

4.3.3. Resilience and self-efficacy

'…I think you've got to be able to recognise your own weaknesses and strengths.' (P10).

Resilience and self-efficacy is about systems employed to preserve participants and their effectiveness as an ENP. Participants take a position perceived as either quite negative and exposing or of strength and awareness.

'…I think you just develop it and keep it professional. Because otherwise you would be going home a complete wreck every night.' (P3).

Self-awareness and constructive criticism of the self is as an important aspect of proficiency, making a significant contribution to the development of resilience and self-efficacy. Participants attempt to limit negative experiences linked to the professional-self, to protect the personal-self, or minimise its effect outside the workplace. P3 spoke of the process and its potential effect:

'You don't want to. You know, oh God, I don't want to do that again. But you have to…' (P3).

Participants exposed themselves to an expected negative experience, knowing that their goal of the best outcome for the patient will be achieved. P3 spoke of experiences seeking advice from medical colleagues with whom they had repetitive negative experiences and developed a preference to avoid them for advice.

'I'll go back and get the information that I need and stand up and be an advocate for my patient. Because ultimately that's what you're doing it for, you know.' (P3).

The purpose or motivation for exposing themselves to suspected negativity was clear.

4.4. Theme four: Learning and knowledge

Learning and knowledge (L&K) is built on the perception of how formal L&K is gained and its application referred to by participants as 'common sense'.

4.4.1. Formal Learning and Knowledge

'Obviously you do have to have underlying and underpinning knowledge. And that comes … one with your [initial] training, two with extra training, when you come into this sort of role. Like... the university background.' (P5).

This concerns experiences of L&K that occur mainly in higher education, and how this links to feelings of proficiency. There is clear expression that formal knowledge attainment is a fundamental expectation and is the foundation on which proficiency is built. It was also clear that this knowledge acquisition process begins long before the ENP role.

'I think that you need that knowledge, you need that textbook knowledge in order to make the clinical decisions that you make and if you haven't got that, it's a problem.' (P2).

It was clear that formal L&K, referred to as 'textbook' knowledge by participants, is needed to be proficient. This formal knowledge is a part of a L&K acquisition process, rather than an end point to it and that there is a limit to knowledge related to the role. It was seen as not possible to know everything and that part of the formal knowledge acquisition process is developing a way to recognise and discover what is not known.

4.4.2. Common sense

'It's a combination of experience, confidence, prior knowledge and being able to put that together and think ... So gut instinct isn't really gut instinct, it's knowing you've got all these elements of proficiency that you pull together.' (P3).

Common sense is seen as the application of a lifelong learning experience to any given clinical presentation, and how this affects feelings of proficiency. Participant 3 discussed that common sense is constructed from knowledge and what has been learned, applied as a sense.

4.5. Theme five: Exposure and experience

'And once you've been doing the job for 10 years, there's this database in your head of 150, and you can't recall them all but it's just there in your head and… of each condition that you see and then you just know the alarm bells for certain groups of symptoms…' (P6).

Exposure builds proficiency with a lessening influence as experience increases. Each episode of experience is filed away in a system available for access as a similar episode is

experienced. As the number of exposures to a particular experience increase, each has a less significant influence on the experience of the ENP.

'Repetition doesn't make you a good ENP, repetition makes you see things that you get a built up a pattern process in your head, pattern of illness, pattern of fractures, pattern of this…' (P1).

Exposure is simply about how many patients are seen with any condition, accumulating clinical experience by the application of L&K. It is acknowledged that volume of patients does not on its own grow proficiency. It builds a practical applicable relationship between the L&K that has taken place and the practicalities of a patient presentation.

4.6. Theme six: Care

'because we're there for patients it's not about us, it's not about money, … it's about patients … If they're getting quality care on top of that it just makes the patient journey so much easier…' (P1).

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

4.7. The Proficiency Model

The constructed meaning of proficiency became about the effectiveness with which participants confidently connected and understood the components to move towards

proficiency. The key is motion towards the goal of proficiency and confidence in the components that drive the ENP towards their zone of proficiency (ZOP). The impact of components over time can be seen alongside a direction and growing magnitude as the ENP enters their ZOP for each component. The motion of proficiency and its components are independent, yet have a collective influence over proficiency, as represented in figure 1.

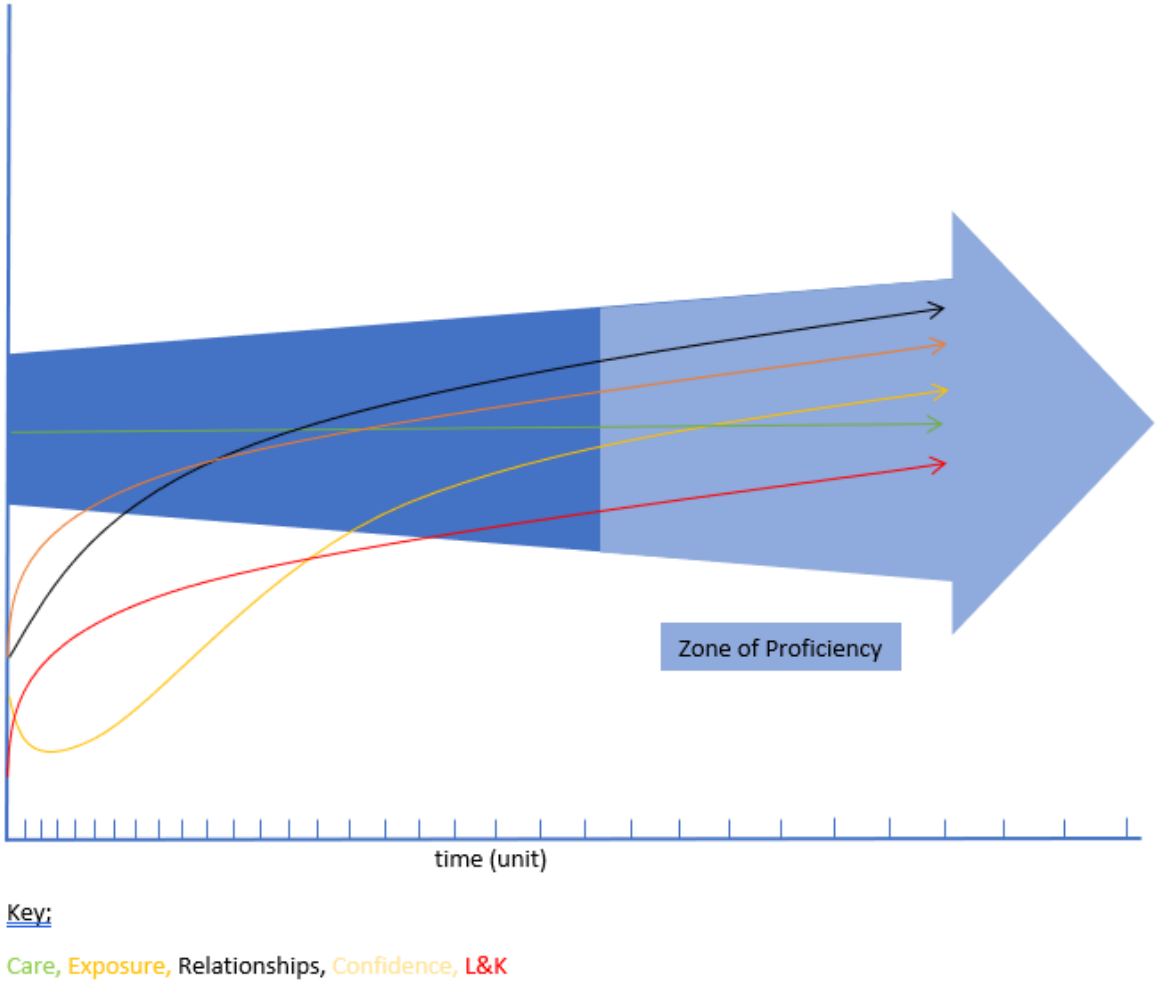

FIGURE 1 THE MOTION OF PROFICIENCY

The motion of proficiency is incorporated within the model of proficiency development seen in figure 2, where the components' relationship is seen to represent how proficiency is created in ENPs.

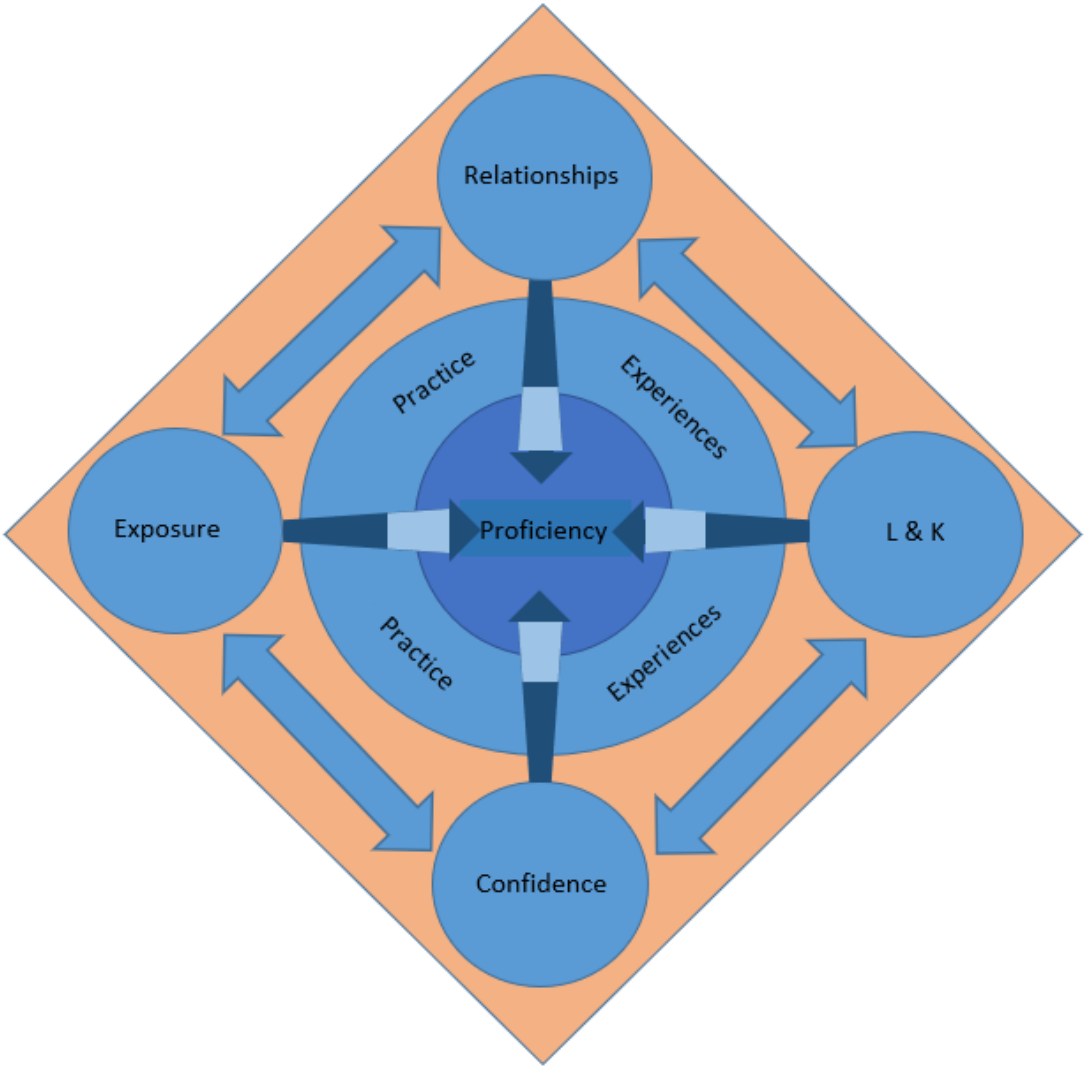

FIGURE 2 PROFICIENCY DEVELOPMENT IN EMERGENCY NURSE PRACTITIONERS

Proficiency is a dynamic notion, changeable, delicate, fragile even and not necessarily present for every situation. The model should be considered an ideal, regarding the nature

of proficiency as a continuum moving ever forward (figure 1), the diagram is unlikely to be as balanced as it is presented. The influence exerted by each theme upon proficiency varies in magnitude in line with how the ENP feels about their proficiency. The fragility of proficiency itself is considered as a bubble, vulnerable to influence by any of the themes. The four themes represented in blue circles are equally fragile, changing size depending on their influence over and the impact on proficiency at any given time. The influence of care, represented by the orange diamond, encapsulates and protects the development of proficiency, and the motivation to drive towards it, to such an extent that the absence of the influence of care leaves proficiency virtually unattainable for an ENP.

5. Discussion

The concept of regulatory mode theory goes some way towards assisting an understanding of the constant forward motion towards the goal of proficiency experienced by the participants [14]. This is represented by a sense of how the motion and confidence combine. The participants revealed two components that enabled them to feel that they were being good at their job. The concept of proficiency being a continuum and confidence in achieving connection and understanding of the fundamental components that construct proficiency achievement, particularly exposure and experience.

Regulatory mode theory conceives self-regulation of human behaviour as two distinct, yet inter-reliable, functions that give a sense as to how proficiency is experienced by the participants; locomotion and assessment [15]. Locomotion refers to movement from a current state towards or away from a desirable or undesirable state, typically representing a

change in state from one position to another. Assessment includes a measurement of the discrepancy between the current state and a desired end state, captured by the phrase doing the right thing, to establish which goal is the worthiest to carry out. Tension exists between the two positions, that in the case of proficiency serves to keep both the drive towards proficiency and the confidence in the components required to feel proficient in check with each other. The drive towards proficiency is kept in motion by exposure and experience to each clinical presentation. The assessment of confidence in the components is also checked by the exposure and experience each clinical presentation brings. Thus, the motion towards the ZOP and the confidence in the components required to get there are fuelled by the exposure and experience gained from each clinical presentation. Being good at your job, or proficiency, is not about knowing everything. It is instead about having the confidence in the components that proficiency consists of and their application to each clinical presentation. This leads to the proposed definition of proficiency:

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

Relationship issues have a significant effect on feelings of proficiency. They are associated with an inconsistency of role understanding, the expectation that the inconsistency of role understanding creates and, paradoxically, conflict between ENPs as to what the role actually is in the first place. This lack of role understanding continues to be seen between ENPs, registered nurse colleagues and medical staff impacting on collaborative practice

[16]. The lack of clarity and agreement on the role within the ENP group themselves is surprising. Three groups rise from the data, resistors, maintainers, and innovators.

Resistors actively oppose role development by placing barriers, such as citing lack of training or support as a reason to resist new patient groups.

Maintainers are happy with the role as they see it, including its value, usefulness, and their professional ability to perform the job. Maintainers continue to develop the components of proficiency to maintain their ZOP, but do not seek to develop the role itself further.

Innovators seek to develop the role beyond where they currently practice. This moves their ZOP further on, challenges the role itself and utilises the components of proficiency to do more for their patients.

Innovators seek to move role boundaries forward, which conflicts with the other groups. Maintainers find it hard to justify what they consider risky role progression. They are concerned that innovators go too far, being unable to complete care, considering it a risk-taking activity that compromises the integrity of the service placing expectations on other staff that they are uncomfortable meeting. Maintainers perceive innovators are operating beyond their proficiency, whereas innovators perceive that they are applying the components of proficiency for the benefit of patients.

Care has a central motivating influence on feelings of proficiency for ENPs given what is known about the common and naturally caring nature of personality types within the profession. It drives the ENP to be good at their job, to seek, maintain and improve confidence, to continue to manage relationship experiences and formulate appropriate

coping strategies. Care is the central motivational reason that drives the ENP towards proficiency.

6. Conclusion

It remains the reality that the role is ill-defined for the participants in this study. This leads to an inconsistency of role expectation that doesn't meet their understanding and, when measured against this understanding, results in feelings that either their role is undervalued, or unrealistic expectations are placed upon the role as they perceive it. It is recommended that clarity for the ENP role is provided to establish a consistent culture within organisations founded on the voice of the ENP as captured in this research.

It is further recommended that this model of proficiency be incorporated in ENP role development for current and future ENPs. This will establish the understanding that proficiency is a continuum, with established components that influence proficiency in a variable fashion, thus giving confidence and direction to both ENPs and those with whom working relationships are established.

7. Conflict of Interest statement

No conflict of interest is declared.

8. Funding Statement

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