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# **Self and identity of emergency nurses who pursue higher education in Ireland**

A thesis written in fulfilment of the requirements for the degree of  
Doctor in Philosophy (Education)

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## **Declaration**

I declare that this thesis has not been submitted as an exercise for a degree at this or any other university and it is entirely my own work.

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Catherine Jane Greene

August 2022.

## Summary

Higher education is a significant feature of contemporary nursing practice. The nursing profession has witnessed significant professional, political, and educational reform over recent years, both nationally and internationally. These reforms have been largely in response to changes in the broader healthcare and economic landscape. Additionally, working in increasingly complex and varied environments, coupled with changing patterns of health and illness, requires that nurses are appropriately educated. While nurses have found themselves with limited opportunities over recent years, irrespective of educational attainment, orientation to higher education has been consistent, particularly among emergency nurses in Ireland. Interestingly, there is no requirement by the professional regulatory authority in Ireland for registered nurses to participate in educational activities in order to maintain professional registration. While the literature has broadly considered decision-making strategies and experiences among the general nursing population, no study has explored these factors among emergency nurses.

This study employed a narrative inquiry approach to explore the influences, decision-making, and experiences of emergency nurses who have pursued higher education and took the theoretical stance that these areas could not be fully understood without being illuminated by the concepts of self and identity. This thesis supports the well-established claims of promotional and educational opportunities, and patient care outcomes as reasons for pursuing higher education. While these have been credible driving forces in the uptake of higher education, this study also demonstrates that emergency nurses' personal mandates in terms of self and identity are more influential and enduring in the decision to participate in higher educational activities. It is envisaged that the results of this research will be important in the understanding of why and when emergency nurses engage in higher education, thus leading to a greater knowledge of how higher educational opportunities can be focused for this group of nursing professionals.

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## **List of Abbreviations**

ABA – An Bord Altranais

A&E – Accident & Emergency

ADON – Assistant Director of Nursing

ANP – Advanced Nurse Practitioner

CNM1 – Clinical Nurse Manager 1

CNM2 – Clinical Nurse Manager 2

CNM3 – Clinical Nurse Manager 3

CNS – Clinical Nurse Specialist

DoH – Department of Health

DoHC – Department of Health & Children

DoN – Director of Nursing

ED – Emergency Department

HEA – Higher Education Authority

HEI – Higher Education Institution

HSE – Health Service Executive

INMO – Irish Nurses & Midwives Organisation

IU – Injury Unit

IT – Institute of Technology

NHS – National Health Service

NMBI – Nursing & Midwifery Board of Ireland

RANP – Registered Advanced Nurse Practitioner

RCSI – Royal College of Surgeons in Ireland

RNP – Registered Nurse Prescriber

SN – Staff Nurse



## **Glossary of Terms**

An Bord Altranais (now Nursing and Midwifery Board of Ireland) – the regulator of the professions of nursing and midwifery in Ireland.

A&E / Emergency Department / Casualty – a treatment facility specialising in the emergency care of patients who present without prior appointment either by their own means or by that of an ambulance.

ADoN (Assistant Director of Nursing) – a registered nurse who supports the Director of Nursing and Hospital Manager in the provision of high quality and safe nursing services across the hospital.

Autonomy – the ability of the registered nurse to assess and perform nursing care for patients based on competence, professional expertise and knowledge.

cANP (Candidate Advanced Nurse Practitioner) – a registered nurse who enrolls on a programme of higher education in order to register as an advanced nurse practitioner. During their candidature, the registered nurse engages in on-going clinical supervision and education to develop the skills, competencies, and knowledge required to register as an advanced nurse practitioner.

Clinical Nurse Manager 1 (CNM1) – a registered nurse who is responsible for providing clinical and professional leadership to the nursing team. This role is responsible for ensuring that high standards of care is implemented and monitored in the provision of nursing care.

Clinical Nurse Manager 2 (CNM2) – a registered nurse, senior to the CNM1, who has a pivotal role in the co-ordination and management of activity and resources within the clinical area on a day-to-day basis. The main responsibilities include ensuring the delivery of safe quality patient care, resource management, service provision, staffing and staff development, facilitating communication and providing professional and clinical leadership.

Clinical Nurse Manager (CNM3) – a registered nurse, senior to the CNM2, who applies specially focused knowledge and skills to manage and lead a high-quality service for patients. The role encompasses key result areas including service planning in terms of needs analysis, activities, targets and priorities, ensuring the delivery of safe quality patient care and deployment of resources to include budgeting and workforce planning.

Clinical Nurse Specialist (CNS) – a registered nurse specialist in clinical practice who has undertaken formal recognised post-registration education relevant to their area of specialist practice. The level of practice of a CNS is higher than that expected of a staff nurse.

Collaborative Practice – occurs when healthcare workers from different professional backgrounds work together in the achievement of shared effective healthcare outcomes for patients of all ages.

Competence – the attainment and application of knowledge, intellectual capacities, practice skills, professional and ethical values required for safe, accountable, compassionate and effective practice as a registered nurse.

Health Service Executive (HSE) – the publicly funded healthcare system in Ireland responsible for the provision of health and personal social services.

Higher Education Authority (HEA) – an organisation which leads on the strategic development of the Irish higher education and research system.

Higher Education Institution (HEI) – a university or college that awards academic degrees or professional certifications.

Injury Units – an area used for the treatment of minor injuries that are unlikely to need admission to hospital.

Public Health – refers to the structures, processes and competencies required to monitor, protect and promote the health of a defined population.

RANP (Registered Advanced Nurse Practitioner) – a registered nurse who is educated to master's degree level and who has the competencies to be senior decision makers who undertake comprehensive advanced physical and / or mental health assessments of patients. They can interpret the results of assessments and investigations to make a diagnosis and plan and deliver care. This may also include referring or involving the patient to other members of the healthcare team as appropriate.

Reflection – a theoretical and practical concept that involves reviewing one's practice with a view to learning from experiences.

Resus / Resuscitation – an area within emergency departments dedicated to individuals who require urgent and life-saving treatment.

Site Accreditation – the development and accreditation of a healthcare site by an organisation to support the employment of advanced nurse practitioners.

Staff Nurse – registered nurse who is responsible for providing nursing care which involves assessment, planning, implementation and evaluation of nursing care to a patient group.

Triage – the process of prioritising patients according to their need for emergency medical attention.

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# **Chapter 1 - Introduction**

## **1.0 Background**

One of my earliest recollections from childhood was being aware of the importance of education. This stemmed from my parent's lack of higher education and their wish for me to embrace education. I remember the various educational milestones and transitions of my formative years. I recall sitting my entrance exam for secondary school, and the years spent preparing for the Intermediate Certificate and Leaving Certificate exams. I remember the excitement and anxieties associated with college and career choices with, perhaps, very little insight into the real world. I remember the despair when I realised that a third-level education was not an option for me due to the financial restrictions associated with my social background. I was heartbroken. I was a bright kid. I remember leaving home for the first time in 1994 to pursue a career in general nursing. It was not my dream but I had a point to prove. I owed myself the opportunity to progress and to be educated to a higher level irrespective of my social background. This awareness and determination have remained with me throughout my life.

My career in nursing has afforded me many rewards and opportunities. Two of the main privileges afforded to me have been the opportunity to work with a unique and diverse group of people, and the opportunity to further my education. Throughout my nursing career I have been inspired by and curious about how nurses, and more specifically, emergency nurses, have considered and managed their approaches to the pursuit of higher education. I was more than aware of the practical and professional benefits of higher education.

However, the impact of the economic recession was still permeating the healthcare system with the result that educational and promotional opportunities were quite limited. Despite these restrictions, emergency nurses continued to pursue programmes of higher education. In addition, there is no requirement by the professional regulatory to undertake educational programmes in order to maintain registration. So, with these factors in mind, why were emergency nurses continuing to pursue higher education? Was there something more personal, fundamental, and enduring underpinning their decision-making?

With these questions in mind, I decided to explore emergency nurses' decision-making strategies and higher education experiences in further detail. The aim of my research was supported by asking the following research questions:

- What powers govern the decision to pursue higher education among emergency nurses?
- Does higher education inform an emergency nurse's sense of self and identity?

- What are emergency nurses' experiences of higher education?

## **1.1 Chapter Summary**

### **1.1.1 Chapter 2 – The Context Chapter**

The purpose of the second chapter is to place the research into a social and historical context. This chapter provides an overview of the history of nurse education in Ireland and details the reform of nurse education. It is important to provide some focus on the reform of nurse education as this has undoubtedly shaped how education has been perceived and approached since the introduction of the Diploma in Nursing programme in 1994. In addition, cognisance is given to the need for nurses to be responsive in meeting the evolving needs of the public as well as the changing patterns of health, illness, and wellbeing. It is also recognised in this chapter that pre-registration education alone is not sufficient in meeting the demands of the public and healthcare system. The area of emergency nursing and higher education in emergency nursing is also considered since this forms the basis of this thesis. It is apparent that EDs are an important component of the healthcare system with just under 30 hospitals in the Republic of Ireland offering a round-the-clock service. Underpinning these EDs are emergency nurses who, as part of the wider healthcare team, provide specialist nursing care to patients of all ages. The area of higher education in nursing is also considered in this chapter from both national and international perspectives with insight provided into the educational achievements of emergency nurses in Ireland.

### **1.1.2 Chapter 3 – Self and Identity Literature Review**

The third chapter of this thesis provides a review of the literature pertaining to the concepts of self and identity. It is a fundamental assumption of this thesis that self and identity form the basis for educational decision-making among emergency nurses. The chapter begins by illustrating the literature search strategy and then explores the concept of self and makes references to theorists such as Carl Rogers and Michel Foucault in interpreting the concept. The concept of identity is then explored. Again, I make reference to a number of theorists in an attempt to illuminate the concept appropriately with the research questions in mind. I refer to the work of Charles Taylor in order to understand how identity is structured. The work of Erik Erikson provides insight into how identity is developed across the lifespan. Finally, I refer to the theoretical underpinnings of identity, symbolic interactionism and social identity theory, as they form part of the construct that is proposed for self and identity in this thesis. In illuminating the concepts of self and identity, it is apparent that these concepts comprise of several facets and operate on both conscious and unconscious levels. In referring to both

concepts, a frame of reference has been provided from which to explore the educational decision-making strategies of emergency nurses.

### **1.1.3 Chapter 4 – Professional Identity Literature Review**

This chapter explores the concepts of professional identity as an extension of the discussion of the previous chapter. It provides an even more robust framework to address the research questions and analysis undertaken on the generated data. In this chapter I begin by discussing how professional identity is defined generally before considering how the concept is perceived within the nursing literature. I then explore how professional identity is formed generally before considering how it is formed within the nursing profession. To understand more comprehensively the factors that underpin the notion of being a professional, I examined the criteria normally associated with the term in addition to contemplating some of the surrounding controversies and contestations. Additionally, I also look at the concept of socialisation and professional socialisation since one of the most powerful agents in the formation of professional identity is socialisation.

### **1.1.4 Chapter 5 – Theoretical Framework**

The fifth chapter provides an overview of the theoretical framework underpinning this thesis. The application of a theoretical framework guided this study and focused the findings so that the research questions could be appropriately addressed. The theoretical foundations of this thesis are informed by the work of French philosopher, Michel Foucault, with his concepts of governmentality and disciplinary power providing the frame of reference. Informing the exploration and analysis of higher education uptake among emergency nurses, the ideas highlighted are not a complete summary of his work but rather an outline of the main theoretical ideas used in this thesis. I took an approach that was informed by Foucault's thinking which encourages the examination of how power in different groups and organisations operates subtly and on multiple levels to influence the behaviour of a population. Using Foucault's concepts of governmentality and disciplinary power as best interpretative frame, a rich theoretical framework was provided to understand emergency nurses' approach to higher educational decision-making.



### **1.1.5 Chapter 6 – Methodology**

This chapter outlines the research design underpinning this study. I begin by highlighting the tradition of qualitative research followed by identifying my philosophical position. I then explore the concept and application of a narrative inquiry approach as a basis to my thesis. I identify my position as researcher and illustrate how my theoretical assumptions and role of researcher have informed my thinking about the research process. I refer to the study setting and discuss the areas of population and sampling, eligibility criteria, and ethical considerations. I illustrate how the study data was managed and discuss in detail how trustworthiness and rigour was achieved. I also comprehensively describe the process of thematic analysis ahead of the presentation of findings.

### **1.1.6 Chapter 7 – Presentation of Findings**

In this chapter I identify the findings of this thesis. Each of the three research questions are identified and the relevant findings are detailed thematically according to each question. I also refer to new findings such as the influence of social background, timing, and departmental commitment as influencing powers in higher education uptake and completion. In answering the first research question, three themes emerged; challenging traditional social legacies, the desire for self-affirmation, and professional influencing forces. Within the participant narratives, issues such as social background, timing, educational development, security, and career advancement were identified as influential in underpinning educational decision-making. It is also apparent that forces relating to the self, personal identity, and professional identity were both enduring and influential regarding this decision-making. The second research question sought to ascertain if higher education informed an emergency nurses' sense of self and identity. It was clear, as detailed by participants' responses, that higher education impacted positively on their sense of self, identity, and professional identity. The final research question explored the experiences of higher education. Two main themes emerged from answering this question which included challenges of higher education and factors that maintained interest in the programme of higher education.

### **1.1.7 Chapter 8 – Discussion of Findings**

This chapter provides discussion of the thesis findings in relation to the thesis objectives with the inclusion of relevant supporting literature. It is apparent that the stories about higher education decision-making among emergency nurses within this study are powerful and multifactorial. While the findings generated in this study reflect data in other studies, I also describe the three new findings in the area of higher education pursuance among this group of nursing professionals. I reveal how emergency nurses are still influenced by the powers

arising from their social backgrounds and experiences associated with limited opportunities in their early years. I also reveal how commitment to the department, and the area of timing is significant particularly in relation to distraction and escape, and how this has been influential in underpinning emergency nurses' educational decision-making. I also identify the impact of higher education on sense of self, identity, and professional identity Finally, I describe the experiences of higher education as described by emergency nurses.

### **1.1.8 Chapter 9 – Conclusion**

This chapter provides a summary of the thesis and outlines the major findings of this research. I have also acknowledged the limitations of this study, provided some suggestions for further research areas, and provided a brief dissemination plan.

## **Chapter 2 - Setting the Scene**

## **2.0 Introduction**

Ireland has a strong reputation for producing highly qualified and competent nurses and midwives through provision of excellent programmes of education at both undergraduate and postgraduate levels. Over recent years, the country has witnessed significant trends driven by various socioeconomic factors, ongoing developments in healthcare, and professional issues that are unique to nursing. The subsequent ability of healthcare systems to address these trends is largely dependent on appropriately trained and educated healthcare professionals. In additional response to these trends, the educational system within nursing has undergone significant changes, particularly with the move of undergraduate nursing and midwifery education into the tertiary sector. Concurrently, the profession has also witnessed the emergence of specialist and advanced practice roles to assist with healthcare delivery. As a result, the availability and uptake of postgraduate nursing and midwifery education programmes have also advanced. In order to place this study into context, this chapter will begin by providing a brief overview of the history of nursing and nurse education in Ireland. This will be followed by a description of the reform of nurse education over the last 20 years. Finally, the concept of higher education, both from a general and emergency nursing perspective, will also be explored. I will begin by briefly exploring the history of nursing in Ireland.

### **2.1 History of Nursing and Nurse Education in Ireland**

Nurse education and training has witnessed significant change over the last century both nationally and internationally. While it is generally accepted that Florence Nightingale (1820-1910) was the founder of modern nursing, it is also important to consider some of the religious, gender, and sociopolitical perspectives that have influenced and shaped the development of the nursing profession in Ireland. I will begin by exploring some of the religious factors that have influenced the development of the profession.

#### **2.1.1 Religious Influences**

Historically, the Catholic Church played a formative role in the development of the nursing profession in Ireland. This is an important observation as Yeates (2009) claims that nursing had particular affiliations with female religious orders. These affiliations included both religious orders founded in Ireland and operating abroad, and those founded abroad and operating in Ireland. While the Catholic Church played an active role in the development of healthcare in Ireland, it also participated in the establishment of education, and poor relief services providing care for the elderly and those with mental health issues. The involvement of religious orders in public healthcare and nursing was predominantly undertaken by female

orders, such as the Daughters of Charity and Sisters of Mercy (Luddy, 1996). Prior to this, such duties were provided by lay women as religious orders were not permitted to leave convents. As these religious orders assumed these roles, Magray (1998, p.76) states that it allowed them to advance into public health nursing and the management of public and private hospitals, and hospices. Simultaneously, the Mercy Sisters, having returned from the Crimea in 1856, began providing nursing care in workhouse hospitals. This heralded the way for religious orders to found and manage hospitals (e.g. St. Vincent's Hospital, the Mater Hospital). This was not a new concept as Yeates (2009) claims that the influence of Irish female orders into nursing was part of a wider international trend where nursing communities occupied a central position in emergent healthcare institutions. Undoubtedly, this domination gave these religious orders authority over the education and training of nurses and, as Fealy (2005, p.101) observes, nurse training at that time was underpinned by the apprenticeship model, and it was in such hospitals that student nurses gained their experience and training. Until the twentieth century, religious domination still featured in healthcare provision and nurse education, however, over recent years, this control has diminished and, while some religious influences remain across the healthcare sector generally, the education of nurses rests with HEIs.

### **2.1.2 Sociopolitical Influences**

Sociopolitical influences have also underpinned the development of the nursing profession and nurse education in Ireland. Before considering contemporary political factors, the impact of Ireland's status as a British colony will first be briefly explored. It is a reasonable observation that Britain provided many employment opportunities to the Irish and global populations over the years. It is also a valid observation that Britain provided both nursing opportunities as well as an influence on the development of nursing in Ireland. Specifically, Queen Victoria's Jubilee Institute for Nurses provided district nursing training as part of a wider initiative in Britain to provide community nursing services. Yeates (2009) claims that in addition to being a key place of training for some Irish nurses, Britain also turned to Ireland for nurse labour to sustain its civilian and military populations. Yeates (2009) further claims that migration from Ireland to UK was partly facilitated by some general factors, including Britain being a popular destination due to easy access, and cultural and linguistic similarities.

Originally, the reform of nurse education in Ireland began in 1880 and involved the process of replacing untrained nurses of the servant class with middle-class lady nurses trained on the Nightingale apprenticeship model (Fealy & Harford, 2007). This reform led to the

introduction of the new system of modern secular-professional nursing which positively impacted on patient outcomes, and provided professional salaried employment for women. Based on an apprenticeship model, it allowed for the student nurse to assume the role of both student and salaried employee but outside the realm of higher education provision. Training for general nurses first began in St. Vincent's Hospital in 1834 under the auspices of the Irish Sisters of Charity (Scanlon, 1991, p.87). In 1950, the Nurses Act provided for the establishment of a national nursing board (An Bord Altranais) with responsibility for the education and registration of nurses, including responsibility for disciplinary procedures. General nurse training was conducted in hospitals based on the apprenticeship system over a three-year period, which continued until the transition to the third level sector in 1994. The global move from the apprenticeship model of nurse training to the tertiary sector heralded a significant move and elevated the nursing profession from its somewhat disreputable and medieval origins (Abel-Smith, 1960, p.127).

While it may be argued that the apprenticeship model offered much in terms of improved patient care, and career and educational opportunities, Scheckel (2008, p.159) claims that both the training needs of students and service needs of clinical practice environments were incongruent. It was becoming inevitable that, in order to meet these needs, the education of nurses would transfer to the university sector. At the time, many registered nurses undertook training for a second registration to increase their employment options and advance their career pathways. Robins (2000, p.43) states that in 1974 continuing education became a reality with the inauguration of the Faculty of Nursing of the RCSI. As a result various programmes of education were offered nationally and, with this advent of post-registration courses, it became increasingly apparent that nursing was moving away from the medical model of education.

By 1975, demands for further reform of the profession, in conjunction with the anticipated impact of European Union policies, gave rise to the establishment of a working party by the Minister for Health to review the education, training, and grading structures of general nurses (Robins, 2000, p.45). The Report of the Working Party on General Nursing (Department of Health, 1980), together with the 1985 Nurses Act, transformed the face of Irish nursing. The main features of this report included the introduction of common basic training, the reduction of the number of training schools, and the issue of university education for nurses. This report also recommended a review of grading structures and community nursing services. The introduction of a pilot diploma in nursing programme by University College Galway, following an arrangement with the Western Health Board in 1994, heralded the beginning

of a radical change within the system of pre-registration nursing education in Ireland. By 1998, similar arrangements had been implemented for all schools of nursing. This model of education increased the theoretical component of the programme with supernumerary status for students in the clinical setting. Supernumerary status means that students undertake clinical placements with a focus on the learning experience and are not considered part of the workforce. Pre-registration nurse education entered the tertiary sector fully in 2002 and is based on a four-year programme within higher education institutions. Undergraduate programmes of education have been in place for nursing (general, psychiatric, intellectual disability), and since 2006 for midwifery and the integrated children and general nursing programmes.

While the transition into the tertiary sector was widely welcomed and viewed as groundbreaking for the nursing profession in Ireland (Begley, 2001; Cowman, 2001), questions regarding the extent to which this was driven by intellectual interests were highlighted. McNamara (2005) claims that the drive towards all-graduate entry to the profession was mainly initiated by industrial unrest rather than professional or academic unease. This notion perhaps is supported by the industrial action undertaken by nurses in Ireland in 1999 regarding pay and parity. Interestingly, Baxter (2011, p.28) argues that by requiring degree level qualification and greater adherence to institutional policies, the nursing profession may lose the very type and genre of person it aims to attract. It may be argued that this idea perhaps stemmed from the notion that formal education was historically neither a prerequisite for entry into the nursing profession nor was nurse training based on a formal academic curriculum. Perhaps, it may be also be argued, that those who lacked education or who were unwilling to pursue formal education would be more committed to a caring role.

Since 1997, legislative changes mandated that all government departments and agencies produce a three to five year strategy. In response to this mandate, the Department of Health and Children (DoHC) have published many reform proposals through such strategies. One such document, 'Quality and Fairness: A health system for you' (DoHC, 2001) proposed a decade of reform in order to address the needs of the public and health service generally. O'Shea (2008, p.88) argues that this strategy underpinned many other strategies which are collectively referred to as the Health Service Reform Programme. This strategy set out a number of goals including better health for everyone, fair access, and responsive and appropriate care delivery.

The achievement of these goals demanded a competent workforce. Most importantly, from the perspective of the nursing profession, 'Quality and Fairness' provided a commitment to the future development of nursing as set out in the Report of the Commission on Nursing (Government of Ireland, 1998). The Report of the Commission on Nursing: A Blueprint for the Future was the most comprehensive and radical appraisal of the nursing profession in Ireland. It was established by the then Minister for Health, Michael Noonan, and sought to examine and report on the role of nurses. The Commission was also given scope to make recommendations for the development of nursing within any anticipated changes in the health service organisation and delivery. This was the first time that the development of nursing in Ireland would precede any national health policy or strategy (Wells & White, 2014). Key areas of focus arising from the Commission on Nursing included the professional development of nurses, career structures and promotional opportunities, and training and educational requirements. One particular recommendation was particularly significant for nursing in Ireland. This was the introduction of a four-year pre-registration degree programme to replace both apprenticeship training programmes and the three-year diploma pre-registration programme. Other key recommendations included the focus on the development of nurse and midwife prescribing.

Also arising from the Commission was the establishment in 1999 of the National Council for the Professional Development of Nursing and Midwifery (NCNM). Two key functions of the NCNM were the monitoring of ongoing development of nursing and midwifery specialities, and the support of health boards and other relevant bodies in the creation of specialist and advanced practice nursing and midwifery posts. The Council determined the appropriate level of qualification and experience for entry into these posts. The frameworks for the clinical career pathway in nursing and midwifery were established by the Council in 2000, using definitions and core concepts devised by the Commission on Nursing. While applications for CNS and CMS posts were processed by the NCNM, responsibility for the accreditation of ANP and AMP posts and registration has been with the NMBI (formerly An Bord Altranais).

More recently, the Office of the Nursing and Midwifery Services Director (ONMSD) supports the Health Service Executive in the development of advanced nursing and midwifery practitioner services throughout the HSE and HSE-funded agencies. Advanced nursing practice was formally established in Ireland in 2001. Within emergency departments, ANPs give emergency care for clients who present with unscheduled and undiagnosed conditions. The purpose of the ONMSD is to strategically lead and support midwives to



deliver a safe, high quality person-centred healthcare. The NCNM was disbanded in 2010 with some functions assigned to the nursing board. More recently, the Nurses and Midwives Act (2011) provides the legislative basis upon which the nursing and midwifery professions operate in Ireland.

### **2.1.3 Gender Influences**

Traditionally, patriarchal structures influenced how nurses were educated and trained. During this time, many male physicians loudly objected to the idea of an educated nurse (Kalisch & Kalisch, 2004, p.342). It was believed that educated nurses could challenge physicians' power and authority in hospitals, and that natural feminine qualities made a good nurse, not their educational achievements. In fact, Dorland (1906) cited in Ashley (1977, p.57) contended that nurses with too much knowledge were dangerous to patients. According to Reverby (1987), caring functions, typically provided by nurses, were considered to be mere extensions of the roles provided by wives and mothers, for which professional knowledge was not considered necessary.

The theoretical and practical knowledge received by nurses was historically influenced by the objectives of medicine where the 'medical model' focused on diagnosis and cure of physical disease and injury (Pearson, Vaughan, & Fitzgerald, 1996, p.17). However, the unsuitability of the medical model became apparent and added to the impetus for nursing's own distinct knowledge base. Pearson et al. (1996) contended that adopting the medical model approach depersonalised care and did not prioritise non-physical components of care. It was recognised that the development of nursing models as a means of formulating a unique body of knowledge for nursing was a significant advance within the profession and would offer appropriate frameworks to guide nursing practice and education. Indeed, the development of a unique body of knowledge is seen as a prerequisite for a 'profession'. This perspective has since evolved considerably over recent years as the discipline has gradually embraced other key characteristics of a profession, including formal educational requirements, codes of conduct, and role expansion. This will be explored in some further detail in Chapter Four.

Clayton-Hathway, Griffiths, Schutz, Humbert, and McIlroy (2020) argue that the development of professional status has been shaped by historic gender relations and the gendered division of labour. As a result, the perception of medicine as being suitable for men and nursing as work for women has left an enduring legacy from this social construction of gender roles. They claim that the concept of 'women's work' is based on essentialist notions

of gender which prescribe that men and women have different characteristics which are inherently biological. Clayton-Hathway et al. (2020) also claim that this belief has profoundly shaped the way work is valued in society and, because of its association with natural feminine attributes such as love, care and empathy, Ridgeway (2009) claims that these cultural beliefs about men and women exacerbate the issue of gender inequality.

More recently, Myklebust (2021) argues that gender segregation in the labour market is influenced by the notion that men and women have different skills and interests and are, therefore, suited to different occupations. The idea that women are more caring and have better social skills while men are perceived to be more technically competent with better managerial skills are widespread. As a result, Correll (2004) claims that such stereotyping influences young peoples' career and educational aspirations. Armstrong's (2002) study on gender issues in nursing found that male nurses were stereotyped both within and outside the profession as homosexuals, low achievers, and feminine-like. Harding (2007) reported that such stereotyping and stigmatising factors formed a barrier to patient care, deterred mens' entry into the profession, and played a major role in issues related to retention. These notions continue to persist, unfortunately, with Kearns and Mahon (2021) observing that the scarcity of men in nursing is somewhat attributable to an array of cultural, historical, economic, and political factors, not aided by rising entry requirements that do not correspond with remuneration packages. Statistics indicate that women account for 91.8% of the nursing workforce in Ireland (CSO, 2016). This is comparable to other countries where men account for 10.8% of the nursing workforce in the UK (Williams, 2017), and 11.7% in Australia (Nursing and Midwifery Board of Australia, 2017).

## **2.2 Higher Education in Nursing**

It is apparent and, indeed, inevitable, that pre-registration education alone is not sufficient to meet the demands of an individual's potential lifelong career in nursing. Pre-registration education cannot adequately prepare nurses or equip them with the required and ever-developing changes in knowledge, skills, competencies and, indeed, the healthcare environment to ensure effective delivery of nursing care, as they progress the professional lifespan. The Scope of Nursing and Midwifery Practice Framework (NMBI, 2015) states that it is essential for nurses and midwives to engage in continuing education following registration in order to develop new knowledge and competencies to not only practice effectively in an evolving healthcare environment, but also to maintain and enhance professional standards. While the NMBI may take this stance, it must be acknowledged that CPD is not a mandatory requirement for nurses in Ireland to maintain registration. Similarly,

nurses in countries such as Denmark, Germany, Sweden, Greece, and The Netherlands do not have to engage in mandatory CPD, and those nurses who choose to participate, do so of their own volition. With this in mind, the consequence of fully integrating nurse education into the university sector at undergraduate level is that programmes of postgraduate education have also subsequently been warranted and offered by universities and other higher education institutions. In addition, the evolving and complex nature of healthcare has called for the development of programmes specific to both general and specialist areas. As a result, there has been a steady growth in the number of nurses now undertaking both post-registration undergraduate and postgraduate level education. The 2016 Census indicated that 57% of registered nurses and midwives in Ireland held a third-level degree with 27.4% of this group holding a postgraduate degree (CSO, 2016). The Census also revealed that 17.1% of health and social care workers in Ireland are in possession of doctoral qualifications. More recently, the CSO (2019) revealed that 40.1% of those aged 18 to 64 years amongst the general population have a third level qualification in Ireland.

Statistics from the Higher Education Authority in 2017 reflect a mainly constant engagement by registered nurses generally with higher education in Ireland. While information is scant pertaining to post-registration educational attainment, there is some data available regarding higher education enrolments. Figures for the academic year 2017/2018 identify a total of 1,310 registered nurses (2%) were enrolled in programmes of higher education within universities, colleges, and ITs. In 2016/2017, there was a total of 1,424 registered nurses (2.2%) engaged in educational programmes while the academic year 2015/2016 saw a total of 1,157 registered nurses enrolled on educational programmes. From an international perspective, information reflecting nurse engagement and enrolment on higher education programmes was difficult to retrieve. However, some data was available regarding educational attainment amongst registered nurses. Figures from the United States suggest that 17.1% of the nation's registered nurses hold a master's degree and 1.9% a doctoral degree as their highest educational attainment of the 3.8 million registered nurses (American Association of Colleges of Nursing, 2018). In a report by the Nursing Council of New Zealand (2014) profiling nurse practitioners and registered nurses, more than 3,000 (5%) out of 58,000 nurses hold a Master's degree. In a review of postgraduate nursing and midwifery education in Victoria, Australia, Darcy Associates (2015) highlight findings from a 2009 survey indicating that 44.6% of Australian nurses and midwives reported a postgraduate qualification. In this review of postgraduate education, they also acknowledge that the extent

of postgraduate study uptake across the nursing and midwifery professions is unclear as national workforce data in relation to postgraduate education is not routinely collected.

Gerrish, McManus, and Ashworth (2003) suggest that the impetus for this development in higher education has come from three directions. Firstly, the reform of pre-registration education and the introduction of degree-level education has led to the expansion of continuing professional education programmes into the postgraduate arena. Secondly, the statutory professional bodies responsible for nurse education developed frameworks for post-registration education that sought to bring together professional development with academic development. Finally, the development of new nursing roles, particularly in the areas of specialist practice and advanced practice, has led academic nursing departments to develop higher education programmes orientated towards professional practice. The area of advanced practice particularly in Ireland has witnessed significant growth over recent years.

While educational reform and professional body influences are significant factors underpinning educational decision-making amongst nurses, various national and international studies have highlighted other considerations relevant to educational decision-making. Shahhosseini and Hamzehgardeshi's (2015) study identified the desire to update clinical knowledge and increasing clinical skills as the most important driving force of nurses' intentions to participate in higher educational programmes. Similarly, Mlambo, Silen, and McGrath's (2021) metasynthesis of the literature pertaining to continuing professional development among nurses illustrated how continuing education was perceived to be important for knowledge development, upskilling, and delivering evidence-based nursing care. Kinsella, Fry, and Zecchin's (2018) study surveyed the factors influencing postgraduate education among nurses and highlighted job security, job opportunities, professional improvement, and a commitment to providing high-quality care as noteworthy in educational decision-making. Similarly, Adriaansen, and van Achterberg (2008), and Macaden, Washington, Smith, Thooya, Selvam, George, and Mony (2017) identify job satisfaction, patient safety, and career development as significant forces in higher education uptake. Walter and Terry's (2021) systematic review exploring the factors influencing nurses' engagement with CPD, also highlighted areas such as the desire for professional progression and involvement in extended roles as significant forces in educational decision-making.

In earlier studies by Armstrong and Adam (2002), Cooley (2008), Dowsewell, Hewison, and Hinds (2002), and Whyte, Lugton, and Fawcett (2000), promotional opportunities, enhancement of clinical practice, personal achievement related to the acquisition of academic skills, the broadening of perspectives, and the development of advanced powers of reasoning were also cited as influencing factors for higher education uptake. There is also evidence that health service employers are promoting and funding nurses to complete higher degrees as a means of aiding retention, which has become, and continues to be, a global problem in the profession. Price and Reichert (2017) highlight how educational support can be an effective retention strategy for nurses, with this support coming in the form of financial support and scholarly time provision. This idea is also reflected in Mlambo et al.'s (2021) study where they state that organisational commitment for professional development initiatives can contribute to staff retention, and also for providing staff with the sense that they are valued in the workplace.

There are also studies that highlight decision-making influences which are underpinned by personal forces. Altmann (2012) describes personal desire in addition to the need for professional growth, and the influence of the working environment as significant powers in educational decision-making. Similarly, Reyes and Conde (2017) identify the interest to learn, pleasure and satisfaction in learning, and the sense of accomplishment as influential in nurses' decision-making strategies. They also highlight nurses' desires to embrace further education, develop a career identity, and to provide quality care. Pool, Poell, Berings, and Ten Cate's (2016) qualitative investigation sought to understand the factors influencing nurses' educational decision-making and revealed how the concept of self-esteem was an important consideration. The nurses in this study also identified the need to supplement educational gaps, contribute to healthcare improvement, and enhance knowledge, competence, and career opportunities.

Although little is known regarding the general impact and career progression of nurses with postgraduate degrees, the literature would suggest a positive correlation between higher education and patient care outcomes. Since successful learning can bring about both direct and indirect benefits through changes in attitudes, application of knowledge, it is anticipated that improved critical thinking and decision-making skills, and the ability to challenge treatment decisions would ultimately improve patient outcomes in addition to providing increased job satisfaction for nurses (Barnhill, McKillop, & Aspinall, 2012; Clark, Casey, & Morris, 2015; Cotterill-Walker, 2012; Ewens, Howkins, & McClure, 2001; Gijbels, O'Connell, Dalton-O'Connor, & O'Donovan, 2010; Ng, Eley, & Tuckett,

2016; Mlambo et al., 2021; Walter & Terry, 2021). Liao, Sun, Yu, and Li (2016) claim that the relationship between educational attainment and positive patient outcomes is clear, highlighting decreased patient mortality and reduced failure to rescue when there are nurses with higher levels of education.

Interestingly, however, Wilkinson, Carryer, and Budge (2018) claim there is no agreement as to the impact of increased educational attainment on the quality of care provided by nurses. Similarly, Abu-Qamar, Vafeas, Ewens, Ghosh, and Sundin's (2020) systematic review exploring postgraduate nurse education and the impact on the nurse and patient outcomes, suggests that nurses consider their educational attainments to have a positive impact on patient care outcomes. Abu-Qamar et al. (2020) claim, however, that this perception of the impact of knowledge and skills on patient outcomes is actually subjective, and does not provide sufficient evidence of patient care impact. Audet, Bourgault, and Rochefort's (2018) systematic review also sought to explore the relationship between nurse education and experience and the risk of mortality and adverse events in acute care hospitals. While they acknowledge that higher levels of nurse education are associated with lower risks of failure to rescue and mortality in these settings, they also highlight that few studies have considered the association between nurse education and the risk of other nursing-sensitive adverse events such as medication errors, falls, and nosocomial infections.

However, research undertaken collaboratively by the Schools of Nursing and Midwifery at Trinity College Dublin and University College Cork measuring the impact of cANPs and RANPs to service areas including rheumatology, respiratory medicine, care of the older person, and unscheduled care, highlighted how postgraduate education positively impacted on the patient experience (Office of the Nursing and Midwifery Services Director, 2020). This study indicated that 99.4% of patients surveyed agreed that the cANP / RANP provided high quality care. Narrative data from this study also revealed how patients articulated comprehensiveness of care, treatment and interventions provided by the cANPs and RANPs. Similarly, in a review of the impact of postgraduate education on nurses and midwives undertaken by the NMPDU HSE West and Mid-West area, nurses reported how they felt empowered to stand their ground on certain patient care issues as a result of participating in programmes of higher education (Nursing and Midwifery Planning Development Unit, 2020). In addition, higher education also enabled them to make good clinical decisions and introduce new initiatives based on the best available evidence.

### **2.2.1 Challenges Associated with Higher Education Uptake**

The experience of pursuing programmes of higher education is not without its challenges. There are several common themes identified in the literature which reflect the experience of registered nurses in the pursuit of higher education. Issues such as the desire to achieve the required academic level, self-doubt, IT abilities, and organisational and peer support are pertinent concerns among nurses and are reflected in studies by Clark et al. (2015), Johnson and Copnell (2002), Jones, Shaban, and Creedy (2015), Kinsella et al. (2018), Korte (2007), Macaden et al. (2017), Pool et al. (2016), and Webber (2004) Specifically, issues such as referencing in academic work, reflective practice, and digital competency can lead to a lack of confidence among students and a feeling of being inadequately prepared to meet both the required standard and demands of the educational programme. Other studies (Greenwood, Walkem, Mervyn-Smith, Shearer, & Stirling, 2014; Illingworth, 2005; Johansen & Harding, 2013; O’Keeffe, Corry, & Moser, 2013; Richardson & Gage, 2010) highlight the apprehension experienced by nurses in the return to higher education. Balancing competing demands can also be an area of concern for nurses where conflict can arise in maintaining the equilibrium between home, work, and the commitments of educational programmes (Clark et al., 2015; Gijbels et al., 2010; Walter & Terry, 2021).

Challenges related to the pursuance of higher education can also arise from the clinical practice environment and organisational structures. For example, studies by MacLellan, Levett-Jones and Higgins (2016), and Mannix and Jones (2020) on nurse practitioner educational experiences describe occasions where nurses were subjected to open hostility and where previously supportive relationships and friendships were lost as a result of pursuing advanced practice pathways. Support structures are a key consideration for emergency nurses when pursuing programmes of higher education. Organisational support can also be problematic for those nurses who pursue higher education with a mismatch often experienced between the support proffered to undertake study and the actual demands of the programme. Mlambo et al.’s (2021) study indicated that a supportive working environment is essential requirement for CPD uptake. Specifically, workplace camaraderie, moral support, and a good team spirit is highlighted to be of value for those considering and participating in educational activities.

It may also be argued that the impact of age, gender, and ethnicity can contribute to the challenges experienced by mature students in higher education. Richardson (2013) claims that age and gender can impact on the learning approaches adopted by older students where they demonstrate more desirable study behaviour than younger students. Richardson (2013)

suggests that this may be due to study intentions where older students pursue higher education for intrinsic interest and personal development reasons rather than for extrinsic reasons. Rubin, Scevak, Southgate, Macqueen, Williams, and Douglas' (2018) study sought to explore the effect of age and gender in predicting learning approaches and degree satisfaction. Participants in their quantitative study comprised a relatively balanced gender proportion across five faculties with an age range of 17 to 70, and found that age was a stronger predictor of deep learning approaches among women more than men. The study also revealed how older women were more satisfied with their degrees than younger women. While Rubin et al.'s (2018) study highlighted deeper learning approaches by women, they also reported greater surface learning approaches adopted by men compared to women. Interestingly, studies undertaken by Andreou, Vlachos, and Andreou (2006), Heikkila and Lonka (2006), and May, Chung, Elliott, and Fisher (2012) illustrate no identifiable gender differences in learning approaches among those who pursue programmes of higher education.

Challenges associated with ethnicity can also feature across educational programmes. Ireland is becoming increasingly multicultural with the number of foreign-born residents accounting for 17% of the total population (Hannigan, Villarroel, Roura, LeMaster, Basogomba, Bradley, & MacFarlane, 2019). Over recent years education providers have been encouraged to develop internationalisation initiatives within their institutions as a means of addressing the challenges experienced by international students (Markey, O'Brien, Graham, & O'Donnell, 2019). Markey et al.'s (2019) qualitative study exploring the experiences of Asian nurses undertaking an MSc Nursing programme in Ireland highlighted how language and academic literacies initially hindered learning experiences and academic progress. In my role as a postgraduate nursing programme lead, these are issues that often occur among the international student population. Shah and Ahluwalia (2019) explored the extent of differential attainment in medicine and identified that doctors from minority ethnic groups perform less well than their white peers across both undergraduate and postgraduate studies. While Shah and Ahluwalia (2019) claim that differences in performance may be attributable to language, prior academic performance, or examiner bias, they acknowledge that there is little empirical evidence to explain the variations in academic achievement.

### **2.3 Emergency Nursing in Ireland**

Up to recent years there was no nationally agreed definition of emergency nursing in Ireland. However, the Health Service Executive (HSE, 2018) formulated a definition reflective of international literature defining 'emergency nursing' and one which complemented the



international definition of emergency medicine. It states that ‘the emergency nurse accepts without prior warning any person requiring health care with undifferentiated and undiagnosed problems originating from social, psychological, physical, and cultural factors, and then leads, initiates and coordinates patient care.’ The key components of emergency nursing care include rapid patient assessment and assimilation of information; allocation of priority for care; intervention based on assessment; on-going evaluation; and discharge or referral to other sources if care undertaken independently by the nurse within specified guidelines.

Emergency Departments are an important component of the wider healthcare system. In preventing permanent impairment or implementing life-saving measures, these departments deliver urgent care to those with urgent medical, surgical or psychiatric conditions. As of October 2019, there are 29 hospitals in the Republic of Ireland that offer ED services on a 24/7 basis, one hospital offers a restricted spectrum 12/7 service and one site has a specialist emergency service (Department of Public Expenditure & Reform, 2019). In addition, there are 11 IUs and, together, these EDs and IUs make up the infrastructure of emergency care in Ireland. A well-coordinated system of care in each ED and IU will facilitate the provision of high-quality patient care that is standardised and easily accessible with high levels of effectiveness, efficiency, and accountability. An experienced and competent emergency nursing team is required to ensure the delivery of such services.

Emergency nurses work as part of a multidisciplinary team to deliver care to over 1.2 million patients across Ireland each year (Department of Public Expenditure & Reform, 2019) and provide complex nursing care and interventions to patients of all age groups who have acute and urgent illnesses and injuries. Emergency nursing has developed into a distinct specialist area of practice and since the ED is a gateway to the hospital environment, it is necessary for staff to have an extensive range of skills and resources to meet the demands of this particular patient cohort. In Ireland, there are currently 78 ANPs (emergency) who practice as key members of emergency care teams providing full episodes of care for patients whose conditions are unscheduled and undiagnosed (HSE, 2019).

## **2.4 Higher Education in Emergency Nursing**

Post-registration nursing education represents a lifelong learning process after completion of initial education leading to registration as a nurse. Post-registration programmes are planned learning experiences for nurses and midwives that lead to an academic award at levels 8 or 9 on the National Qualifications Framework. These programmes of education are designed to increase the competence of nurses and midwives to enhance professional

practice, patient safety, and the education, administration and research capacity of the nursing and midwifery disciplines (NMBI, 2015).

There is a comprehensive range of postgraduate educational programmes available in Ireland for registered nurses wishing to pursue a career in emergency nursing, and for emergency nurses wishing to undertake advanced clinical, management, and educational pathways. The availability of such programmes has stemmed from legislative and regulatory change which serve to improve services and standards of care, and to facilitate professional development of the individual nurse. For example, educational programmes are well-established in preparing suitably qualified nurses to prescribe medicinal products and ionising radiation within their scope of practice, and in accordance with the need of their local clinical setting. In addition to postgraduate educational courses, a range of short courses support emergency nurses' continuing professional and competency development. These courses provide for the development of competencies and skills to support practice specific to ED and include Pre-Hospital Trauma Life Support (PHTLS), Advanced Cardiac Life Support (ACLS), Paediatric Advanced Life Support (PALS), Neonatal Advanced Life Support (NALS), Advanced Trauma Life Support (ATLS), and Trauma Nursing Core Course (TNCC).

The number of emergency nurses holding qualifications in support of professional development is significant. Between May and September 2016, the Office of the Nursing and Midwifery Services Director (ONMSD) and the National Emergency Medicine Programme (EMP) collaboratively undertook a national survey to identify the education and training needs of nursing, healthcare assistant and multi-task attendant staff in Emergency Departments and Injury Units in acute hospitals in the Republic of Ireland. The survey was undertaken to meet the Health Service Executive (HSE) National Service Plan 2016 objective to 'provide clinical education to maximise the development of ED nurses' skills and competence to undertake advanced clinical assessment, interpretation and treatment in a standardised range of skills to improve patient flow, in conjunction with acute services (HSE, 2016, p.23).

The survey found that there was a total of 1,455 nurses working in EDs with a total of 271 clinical nurse manager grades. In terms of specialist roles within the ED, there were 76 registered advanced nurse practitioners, 15 advanced nurse practitioner candidates. There were a further 15 advanced nurse practitioner candidates. In terms of nursing staff qualifications, 526 nurses (36%) held a higher or graduate diploma in emergency nursing, with a further 67 (4.6%) of nurses working towards this qualification. Within this group of nursing professionals, a total of 95 nurses (6.5%) held a certificate in emergency nursing. A

total of 137 nurses (9.5%) held a Masters' degree with a further 39 nurses (2.6%) working towards qualification. Nursing management programmes accounted for 8% of qualifications held. At the time of the survey, a further (0.5%) were pursuing a management qualification. Prescribing qualifications accounted for 7.6% of emergency nurses' academic pursuits with these nurses holding awards in both medicinal prescribing and ionising radiation. More recently, a Certificate in Emergency Nursing was launched in 2018. This Level 8 Special Purpose Award was developed to provide nurses employed in EDs with an opportunity to pursue a short (six months) specialised educational programme. Based on a consortium of five ITs and commissioned by the ONMSD, this programme of education seeks to prepare nurses for progression to the Level 9 postgraduate diploma programme.

### **2.5 Higher Education and the Professional Body**

It is worth noting, however, that there is currently no professional regulatory requirement in Ireland for nurses and midwives to engage in higher education in order to maintain professional registration with the NMBI. Whilst the professional body advocates the need for nurses and midwives to engage in continuing professional development following registration in order to practice effectively and competently, it is not yet a condition for nurses and midwives to maintain their registration with Part 11 of the Nurses and Midwives Act (2011) still to be enacted. This is in contrast to countries such as the UK, Australia, and New Zealand where nurses and midwives must engage in a revalidation process to demonstrate achievement of both educational activity and clinical practice hours in order to maintain professional registration.

### **2.6 Statement of the Problem**

The area of higher education in nursing has grown significantly over recent years. Professional, educational, and sociopolitical influences have initiated much reform across both pre-registration and post-registration nursing education programmes both nationally and internationally. It is recognised that pre-registration education alone is not sufficient to meet the evolving healthcare demands of contemporary society and there has been a steadfast uptake in postgraduate study among nurses globally. Participation in programmes of higher education have largely been on foot of the desire for personal and professional development even when opportunities for career progression have been restricted. However, there is limited data both nationally and internationally regarding higher education uptake among emergency nurses. The general nursing literature pertaining to the area of postgraduate study identifies a number of common factors underpinning higher education decision-making and experiences of higher education uptake. There are

two interesting ideas regarding higher education uptake among nurses in Ireland. Firstly, there is no requirement by the professional regulatory body, Nursing and Midwifery Board of Ireland (NMBI), to engage in higher education in order to maintain professional registration. Secondly, figures demonstrate that engagement with programmes of higher education have largely been consistent despite the impact of the economy downturn and subsequent negative impact of on career prospects. In addition, the fiscal implications resulting from this recessionary period still impact negatively on the ability of some healthcare organisations to provide optimal support in terms of study leave allocation.

These issues led me to the assumption that there were more covert forces at play regarding the decision to engage in higher education. More specifically, I felt that the concepts of self and identity were both influential and significant in the decision to pursue programmes of higher education among emergency nurses. I wanted to ascertain if there was a connection between higher education uptake and the concepts of self and identity. Notwithstanding this assumption, I also anticipated that the common influencing factors already described in the literature would also be revealed in emergency nurses' stories of educational decision-making and experiences. My own experiences of participation in higher education as an emergency nurse also influenced the assumption that self and identity could play a role in educational decision-making.

## **2.7 Research Purpose**

The aims of this thesis were to explore the decision-making strategies of emergency nurses regarding higher education uptake through the lens of self and identity, and to explore the experiences of emergency nurses who have pursued higher education. A number of objectives facilitated the achievement of these aims and included:

- 1) To explore if emergency nurses' sense of self, identity, and professional identity influence higher education decision-making
- 2) To explore if higher education informs an emergency nurses' sense of self, identity, and professional identity
- 3) To explore other powers that influence emergency nurses' decision-making regarding higher education uptake
- 4) To explore the experiences of emergency nurses who pursue higher education

In order to address the research aims and objectives, this thesis addressed three questions:

- 1) What forces govern the decision to pursue higher education?
- 2) Does higher education inform an emergency nurse's sense of self and identity?

3) What are emergency nurses' experiences of higher education?

## **2.8 Significance of the Study**

This study aims to offer a contribution to the understanding of higher education decision-making and experiences of emergency nurses in Ireland. Research activity within this specialist area of nursing practice is lacking both nationally and internationally. It is essential to acknowledge the importance of higher education in nursing and particularly for areas such as ED where nurses are required to have specialist knowledge and skills to deal with a high acuity patient group. ED nurses, as a result, do have specific educational and support needs and understanding the decision-making strategies and experiences of this nursing group is necessary. Understanding the approaches to higher education decision-making and experiences of higher education uptake will be useful in developing strategies for future educational planning and in informing how HEIs and healthcare organisations can best encourage, promote, and support higher education uptake among emergency nurses.

## **2.9 Conclusion**

This chapter has sketched out the context for this study and has illustrated the nature of nurse education in Ireland both from undergraduate and postgraduate perspectives. It began by highlighting the history of nurse education and its subsequent reforms. This chapter has also explored the features of higher education generally and more specifically to emergency nursing in Ireland. It is apparent that the education system for both pre-registration and post-registration nurses has witnessed an exponential growth in response to multiple historical, professional, political, and healthcare trends. In doing so it has provided a frame of reference from which to explore the concept of higher educational decision-making and uptake among Irish emergency nurses. As the focus of this study is on decision-making through the lens of self and identity, it is appropriate to provide a review of the literature pertaining to these concepts. The next two chapters of the thesis will review the literature on self, identity, and professional identity.

## **Chapter 3 - Self and Identity Literature Review**

### **3.0 Introduction**

It was a fundamental assumption of this thesis that self and identity formed the basis of desire and decision-making in emergency nurses' decision-making relating to the pursuance of higher education. Additionally, it was also assumed that nurses are shaped and make decisions against a background of personal, sociocultural, and disciplinary structuring and actions. Using the concepts of self and identity as a basis for exploration was a significant approach to this study as since the recovery from the economic downturn, nurses' orientation to higher education has been consistent despite restrictions on career prospects and sponsorship opportunities. Concurrently, there is no professional regulatory requirement for registered nurses in Ireland to participate in educational activities to maintain professional registration. This may also suggest that self and identity are credible forces in educational decision-making and worthy of further consideration.

A review of the literature is generally considered to be a significant component of the research process. Steinert and Thomas (2016) claim that literature reviews describe what is generally known about a topic and can provide the background for a larger piece of work. In addition, they should be guided by a clear and purposeful question and convey the current state of a specific area, analysing and synthesising the available evidence and highlighting gaps and future directions in the field. Within the scope of this study, a narrative literature review approach was chosen to uncover a compact but concise interpretation of the literature on the concepts of self, identity, and professional identity in relation to higher education uptake among emergency nurses. A narrative literature review was chosen as unlike other literature review approaches, for example, a systematic review, it allows for the addressing and consideration of more than one research question. While it may be argued that subjectivity in study selection is a weakness of narrative literature reviews, Ferrari (2015) claims that the detail underpinning certain conceptual and theoretical issues could be lost in the restrictive rules of a systematic review and which would benefit more from the wider scoping that a narrative literature review offers.

This chapter examines the concept of identity and will begin by exploring the related concept of self, with a view to establishing its relevance to professional identity and professional identity in nursing. This chapter considers issues of definition, theoretical stances, and methods through which the concept of identity is constructed and communicated. Following this, in Chapter 4, a literature review will also be provided on the concept of professional identity. Since the literature review is a significant component of the research process, it is important to articulate the literature search strategy.

### **3.1 Literature Search Strategy**

The original search strategy to uncover literature pertaining to the concepts of self, identity, and professional identity commenced in January 2015 (see Appendix 1). An extensive electronic search of relevant databases was undertaken using the 'All Health Databases' option allowed for the accessing of AMED, CINAHL Plus with Full Text, MEDLINE, APA PsycInfo, and APA PsycArticles. The Philosophy database was also accessed and included Academic Search Complete, and the Philosopher's Index. Search terms were derived from my research questions and variations of these search terms were enabled using truncation and Boolean Operators. By applying these functions, I was able to retrieve papers specific to my research questions. When I first undertook the literature search, I sourced literature from 2010-2015 and this was to ensure that the most recent literature on the concepts of self, identity, and professional identity were retrieved. I then performed a literature search in 2021 to ensure that all recent and relevant literature was included in the review of the literature.

When searching for literature on the concept of self within the date range of 2010-2015, I initially retrieved a total of 6,620 results. Duplicate records were then removed leaving a total of 5, 867 results. I then applied eligibility criteria to further refine my results, thus ensuring the yielding of appropriate papers. I sought literature that was available in full-text formats only, written in the English language, with abstracts and references available. Any results which focused on the concept of self in relation to issues such as depressive disorders, body image, addiction recovery, neurological conditions, parametric and anatomical properties of the self, and maladaptive social self-beliefs were eliminated. Following this process, a total of 302 papers remained. In further refining the search results I then read the remaining papers' titles and abstracts to ascertain relevance and suitability with my research questions in mind. This process further refined my results to six papers. In addition, I also engaged in the process of hand-searching to further elicit relevant publications, and, indeed, textbooks to assist in both accessing seminal pieces of literature and formulating my review of the literature. Hand-searching required me to scan the content of the retrieved papers and allowed me to identify recent publications not yet indexed by databases. Hand-searching can also provide a means by which relevant studies can be identified even when much care is taken to ensure a structured approach to literature searching. This process yielded an additional six sources, papers and book chapters, bringing the total amount for this search to 11 publications. These publications consisted of six book chapters, three literature reviews, and two primary studies (cross-sectional and experimental designs).



I undertook a further literature search in 2021 to source any new or relevant material since 2015 relating to the concept of self for inclusion in this thesis, and this search yielded an initial total of 2,585 results. Using the same processes and eligibility criteria identified for the original literature search, I was able to refine the results to five papers. A further manual search elicited an additional three research papers and book chapters, bringing this literature search to eight results. The total number of research papers and book sources amounted to 19 within the literature review. The publications underpinning the literature review comprised a total of six literature reviews, six book chapters, four primary studies (cross-sectional designs), and three discussion papers. The majority of sources were derived from the United States, followed by the UK, Canada, China, Croatia, and Nigeria, thus ensuring a geographical representation of the literature pertaining to the concept of self.

When searching for literature on the concept of identity within the date range of 2010-2015, I initially retrieved a total of 18,333 results. Duplicate records were then removed leaving a total of 17,992 results. I then applied eligibility criteria to further refine my results, with the aim of yielding appropriate papers. I sought literature that was available in full-text formats only, written in the English language, with abstracts and references available. Any results which focused on the concept of identity in relation to issues such as identity disorders, sexual identity, identity associated with medical conditions, substance misuse identities, stigmatised identities (mental health, chronic illness, body integrity), identity crisis, and identity politics (religious and political affiliations) were eliminated. Following this process, a total of 1,980 papers remained.

In further refining the search results, I then read the remaining papers' titles and abstracts to ascertain relevance and suitability with my research questions in mind. This process further refined my results to 17 papers. In addition, I also engaged in the process of hand-searching to further elicit relevant publications to assist in both accessing seminal pieces of literature and formulating my review of the literature. This process yielded an additional five publications, and book chapters, bringing the total amount for this search to 22 publications. Almost half of these publications were book sources, with the remaining publications comprising of seven literature reviews, and four primary studies (qualitative and quantitative designs). I undertook a further literature search in 2021 to source any new or relevant material since my original search relating to the concept of identity for inclusion in this thesis, and this search yielded an initial total of 8,105 results. Using the same processes and eligibility criteria identified for the original literature search, I was able to refine the results to 17 papers. A further manual search elicited an additional three papers and book chapters,

bringing this literature search to four results. This search yielded 12 literature reviews, five primary studies (qualitative and quantitative designs), and four discussion papers. The total number of publications relating to the concept of identity amounted to 43 within the literature review. The majority of literature sources were derived from the United States, followed by the UK, Canada, and Australia.

The literature search on the concept of professional identity was also conducted within the initial date parameters of 2010-2015. When searching for literature on the concept of professional identity, I initially retrieved a total of 3,033 results. Duplicate records were then removed leaving a total of 2,895 results. The application of eligibility criteria to these results further refined my search and assisted with the yielding of appropriate papers. I sought literature that was available in full-text formats only, written in the English language, with abstracts and references available. Any results which focused on the concept of professional identity in relation to non-nursing professions, socialisation processes in non-healthcare settings, racial socialisation, racial ideologies, socialisation processes in adults with medical conditions (mental health and intellectual disability), and religious, spiritual, and political socialisation were eliminated. Following this process, a total of 586 papers remained. In further refining the search results I then read the remaining papers' titles and abstracts to ascertain relevance and suitability with my research questions in mind. This process further refined my results to 51 papers. In addition, hand-searching of these papers was undertaken to retrieve any further relevant publications and seminal pieces of literature relating to the concept of professional identity. This process yielded an additional four sources, papers and book chapters, bringing the total amount for this search to 55 publications. These publications comprised of 18 literature reviews, 17 books and book chapters, nine discussion papers, six primary studies (qualitative designs), and four governmental reports.

I undertook a further literature search in 2021 to source any new or relevant material since 2015 relating to the concept of professional identity for inclusion in this thesis, and this search yielded an initial total of 3,187 results. Using the same processes and eligibility criteria identified for the original literature search, results were refined to a total of 22 papers. A further manual search elicited an additional 24 publications. The total number of publications retrieved from this search consisted of 21 literature reviews, 12 primary studies (qualitative and quantitative designs), eight discussion papers, and five book chapters. The total number of publications pertaining to the concept of professional identity from both literature searches amounted to 101 within the literature review. The majority of sources

were derived from the United States, followed by the UK, Canada, Australia, Turkey, China, and Taiwan.

### **3.2 Overview**

The concepts of self and identity are inextricably linked within the literature (Holstein & Gubrium, 2000), and within any discussion on either concept, there is also reference to the other. Much ambiguity surrounds self and identity with both terms often used interchangeably. Regardless, the concepts of self and identity remain areas of high interest and significance in the humanities and social sciences. Oyserman, Elmore, and Smith (2012, p.70) claim that readers of literature pertaining to this area are still searching for the gold in vain. It has been long believed that the self is both a product of situations and a shaper of behaviour in situations (Oyersman et al., 2012, p.70). It may be argued that self and identity theories propose that people want to know who they are, their position in society and in the world, and how this knowledge can be used to make sense of themselves and others. It might, therefore, be assumed that individuals want to know who they are and how this self-knowledge may influence the personal and professional pathways they pursue. This line of inquiry was therefore worthy of consideration in ascertaining emergency nurses' educational decision-making.

### **3.3 Self**

Oyserman et al. (2012, p.71) state that in common discourse, the term 'self' often refers to a warm sense that something is 'about me' or 'about us' and includes both the actor who thinks ('I am thinking') and the object of thinking ('about me'). They further claim that the self can be considered primarily a memory structure such that the 'me' aspect of self has existence outside of particular contexts and social structures. In contrast, Oyserman et al. (2012) also suggest that the self can be considered primarily a cognitive capacity such that what constitutes the 'me' aspect of self is created inside of and embedded within moment-to-moment situations. Freshwater (2002, p.2) claims that the concept of a self by an individual is both a product of personal reflection and social interaction. Additionally, Freshwater (2002) contends that the self is also considered to be a by-product of the relationship between power and knowledge.

Individuals may also view their selves from distal perspectives. That is, people can consider themselves as actors buffered by others and situations; or they may consider what others might be observing about them, seeing themselves through the eyes of others (Cohen & Gunz, 2002). With regards to the emergency nurse, for example, advances in medicine and

technology, social circumstances, educational history, peer influence, and professional regulatory recommendations may be influential in the decision to pursue higher education. It may also be argued that these concepts also contribute to one's view of self also. Indeed, Wakslak, Nussbaum, Liberman, and Trope (2008) suggest that thinking about the self from a more distal perspective focuses attention on one's broader goals and values. Taking this perspective may also reduce emotional investment in the self, reducing both contemplation about the past (Kross, 2009) and perceived overlap between the self one is now and the self one will become (Pronin, Oliviola, & Kennedy, 2008). While these may be valid perspectives, it is appropriate to consider the influence of Carl Rogers who was one of the most important contributors to theories about the concept of the self. In his theory, Rogers (1959, pp.200-201) proposed two components of the self; the real-self, and the ideal self.

### **3.3.1 The Real Self**

To begin, it must be acknowledged from the outset that the term 'real self' may also be referred to as the 'true self', 'original self' and 'authentic self' within the literature. Notwithstanding, all allude on a fundamental level as to how we see ourselves and how we feel, think, and act. Rogers (1951, p.487) proposed that we all possess a 'real self' and this is underpinned by the need to actualise, and the need for self-regard and positive regard. Rogers (1951) was of the opinion that there is an innate and inherent quality in individuals which allows for growth, and the opportunity to seek new and varied experiences. The actualising characteristic has its roots in the areas of psychology and biology. The psychological aspect refers to how the recognition and development of potential makes individuals to be viewed as worthwhile, while the biological feature considers the forces which satisfy important basic needs. Grice (2007, p.561) argues that while the real self may be flawed, it is the self that feels most true to who we really are.

Schlegel and Hicks (2011) take a similar stance to Rogers and define the true self as a set of innate characteristics that the individual needs to discover in order to lead a fulfilling life. According to these perspectives each person possesses certain attributes and demonstrates authenticity when they behave in accord with those attributes. Strohming, Knobe, and Newman (2017) claim that the true self has a number of specific features. Specifically, the true self is a moral entity, the true self is good, the true self is perspective-independent, and the true self is cross-culturally stable. Additionally, in order to reveal the true self it is necessary to ascertain the changes to the self that affect an individual's identity the most. They further claim that it is moral capacities which are the most central component of an individual's identity. However, the true self is not solely perceived as a moral entity but also

as a ‘good’ entity. This perspective highlights how positive and desirable characteristics are more intrinsic to how an individual is viewed. The more positive a trait is the more likely it is to be seen as part of the true self. Strohminger et al. (2017) contend that the true self is also perspective-independent. This feature of the true self proposes that the judgements individuals make for themselves differ from the judgements they make of others. In making an assessment of others, individuals generally, and eagerly, consider that less-favourable information is more powerful and weighs heavier than favourable information. In taking this perspective, individuals see themselves in a more positive light, and according to Klein and Epley (2016), view themselves as superior to others.

However, Newman, Knobe, and Bloom (2014) argue that while individuals view themselves positively, they also consider the true selves of others to be good. The remaining feature of the true self, according to Strohminger et al. (2017), is one that reflects cross-cultural stability. They contend that the concept of the true self has little variance across cultures and that key characteristics of the concept are constant. Strohminger et al. (2017) argue that while some cultures may differ in their perceptions of what constitutes morally good actions and behaviour, they are similar in the belief that the true self requires individuals to act in a moral manner.

### **3.3.2 The Ideal Self**

The ideal self is a psychological component of the self which varies in consciousness among individuals and one that is personally and socially developed (Boyatzis & Akrivou, 2006). According to Boyatzis and Akrivou (2006), it is a core component of self-regulation and intrinsic motivation. The ideal self is comprised of three components, including a desired future, a sense of hope, and the individual’s core identity. The ideal self represents the individual’s desire to achieve goals and aspirations and provides the momentum to sustain the changes made personally, professionally, and socially. This component can be driven by one’s values, purpose in life, or perhaps their career aspirations.

Boyatzis and Akrivou (2006) claim that the emergence of one’s ideal self may appear as a surprise or as an epiphany whereby the ideal self instils in the individual the impetus to invoke intentional change. The desire to achieve goals and meet aspirations is underpinned by the sense of hope. They further suggest that hope may be viewed as both an emotional state and an experienced state whereby an individual has the ability to assess and judge the feasibility of that which is hoped and, as a result, any goals and aspirations will be met. The remaining component of the ideal self is the individual’s core identity which, as a relatively

stable entity, provides the foundation for enduring individual characteristics such as personal traits and social roles. This concept of the ideal self may not manifest itself early in life and may only reveal itself later in life. This may be attributed to the lack of established life experiences and awareness, and where the individual has only knowledge of their real self. It is only when the individual approaches early adulthood and beyond that awareness of the self is further developed and the sense of the ideal self is gradually revealed with ambitions and goals uncovered as life moves forward. Boyatzis and Akrivou (2006) also contend that once the force of the ideal self is activated, it directs all actions and decision-making towards deeper self-satisfaction.

However, Rogers (1961) claims that there are occasions where goals are beyond reach and this may result in a gap between the real self and the ideal self. This self is borne out of influences outside of one's immediate environment. He contends that this is the self which holds values absorbed from others, where a culmination of all those things that we think we should be, and that we feel others think we should be. Holding the values of others is not a conscious decision but, rather, a process of osmosis, to the extent that Rogers (1961, pp.170-171) claims that free choice is dominant in decision-making. Rogers (1961, p.174) further claims that individuals who are able to self-actualise are fully functioning. Fully functioning individuals are, for Rogers, well-balanced, well-adjusted, and interesting to know. In his later writings, Rogers (1975, p.151) referred to the fully functioning person as the emerging person. The concepts of the real-self and the ideal-self as influential in decision-making will be highlighted in Chapter 7 and will then be further discussed in Chapter 8. It will be made apparent how these perspectives are relevant in underpinning emergency nurses' educational decision-making.

### **3.4 The Concept of Self in Nursing**

This chapter has presented some of the literature illustrating the notion of self from both a general conceptual and theoretical level. Within the nursing literature the concept of self among nurses is apparent but primarily in terms of self-concept, self-esteem, self-awareness, and self-care in the course of professional nursing practice. Much of what has been written about the sense of self among nurses relates to the professional sense of self regarding clinical decision-making (Farcic, Barac, Lovric, Pacaric, Gvozdanic, & Ilakovic, 2020), self-awareness in the provision of nursing care and nurse-patient relationships (Jack & Smith, 2007; Rasheed, 2015; Younas, Rasheed, Sundus, & Inayat, 2020), and nurses' self-care in the provision of nursing care (Andrews, Tierney, & Seers, 2020; Farhadi, Bagherzadeh, Moradi, Nemati, & Sadeghmoghadam, 2021; Nwafor, Immanuel, & Obi-

Nwosu, 2015). In a quantitative study by Wu, Li, Cheng, Zhang, Du, He, and Lang (2020), the Self-identity Scale and the Cognitive Emotion Regulation Questionnaire were utilised to explore the concept of self-identity in relation to career success among nurses employed in an infectious diseases department and found that self-identity has a direct positive impact on career success of nurses. Wu et al. (2020) contend that having a positive self-identity can assist individuals to accept themselves and formulate clear career goals. Over recent years it has been suggested that nurses need to strengthen their sense of self-identity (Peterson, 2016; ten Hoeve et al., 2014) as it is claimed to be a significant factor in achieving career success (Dan, Xu, Liu, Hou, Liu, & Ma, 2018). It is not clear, however, in Dan et al.'s (2018) study if career success develops as a result of a positive sense of self-identity or as a result of education. Interestingly, within the literature, no study has attempted to address registered nurses' sense of self and identity at a personal level or specifically incorporated the concept of self as a basis for consideration relating to higher education decision-making and uptake.

### **3.5 Summary**

In summary, a number of facets surrounding the concept of self have been revealed. We can see that the individual self is underpinned by a real self and an ideal self both of which operate on conscious and unconscious levels. While the real self maintains a central or core value, the ideal self reflects the desire to achieve goals and usually only manifests itself in later in life. Within the literature, intrinsic factors for higher education uptake among nurses have been largely unconsidered. This study will incorporate the concept of self to illuminate the decision-making strategies employed by emergency nurses regarding higher educational pursuits. This approach is important as it will assist in understanding why emergency nurses optionally engage in educational activities during their professional lifespan.

### **3.6 Identity**

Since this thesis is also underpinned by a focus on identity, it is important that a general understanding and awareness of the development of identity is considered. The concept of identity is complex and one which has a vast range of conceptual meanings and understandings. In reviewing the literature on identity, much variation can be found surrounding the definition and meaning of the concept. At a most basic level, identity is comprised of characteristics by which an individual can be recognised either through meanings attached by themselves or others. Identity also defines our beliefs, values, behaviour, and conduct. It can also be conceptualised as a way of making sense of some aspect or part of self-concept (Stryker & Burke, 2000; Tajfel & Turner, 2004, p.8).

Turner (2012, p.331) claims that the concept has been used as a means to reconceptualise the self as the self is now viewed as a group of identities that can be invoked individually or simultaneously in situations. Jones and McEwen (2000) claim that our core identity reflects personal attributes while our external identity highlights characteristics such as race and gender. As a result, it can have an important impact not only on the way we feel, think, and behave, but it can also impact on what we hope to achieve in the future. Furthermore, identity can provide us with a frame of reference with which to interpret social situations and potential actions and behaviours as it signifies who we are in relation to and how we differ from others. Falck, Heblich, and Ludeman (2009) claim that an individual's sense of identity is influenced by considerations of social desirability. It may be argued that emergency nurses do not construct their identities independently, rather, according to Watson (2009), identity can be regarded as a fundamental bridging concept between the individual and the social world.

### **3.7 Identity Development**

In further illuminating the concept of identity, I turned to the writings of Erik Erikson and Charles Taylor to provide a broad understanding of how identity is defined and how identity develops across the lifespan. From Erikson's perspective, identity refers to a sense of who one is as a person and as a contributor to society which allows the individual to know their place in the world (Hoare, 2002, p.11). Erikson (1968, pp.22-23) incorporated a variety of terms including identification, identity formation, and development to illustrate the process of identity development across the lifespan. According to Sokol (2009), identity refers to the sense of personal coherence through evolving time, social change, and altered role responsibilities. Identity can also contribute to an individual's sense of wellbeing and provide growth and direction in one's life (Erikson, 1968, p.91). Identity is an established analytical frame through which one can understand a range of organisational settings and phenomena while bridging the levels from micro to macro (Alvesson, Ashcraft, & Thomas, 2008). They further claim that contemporary organisational studies on identity hold a vital key to understanding the complex, unfolding, and dynamic relationships between self, work, and organisation.

#### **3.7.1 Identity Development in Childhood**

Identity development is a significant component of childhood and provides the foundations for life. Fletcher and Lawrence (2018) claim that an individual without a solid identity basis may encounter issues in later life with relationships due to a lack of stable values, beliefs, and experiences. Erikson (1968, pp.96-97) states that identity begins at a young age as the



child develops awareness of themselves as a unique and individual being. As the child then grows, it will assume the characteristics of its parents or significant others. Jelic's (2014) qualitative study on identity development among pre-schoolers affirms this idea by citing family, the influence of peers, and cultural milieu as instrumental in a child's identity development. Sokol (2009) describes this process as identification where the child develops a set of expectations about what they want to be and do. As the child matures further, this stage is followed closely by the process of identity formation where the child no longer derives satisfaction from the attributes they have assumed from parents and the significant others in their lives. According to Erikson (1968, p.97), identity formation begins when the usefulness of identification ends and when continuity is required to build a basis for future development.

### **3.7.2 Identity Formation in Adolescence (Ages 12-24)**

The transition to adolescence from childhood can be a unique period of human development characterised by rapid physical growth, cognitive changes, and altered social relationships (Cherewick, Lebu, Su, Richards, Njau, & Dahl, 2021). Furthermore, these changes can significantly shape identity formation and gender norms, beliefs, and behaviours. There are several contributing factors to the formation of identity in the adolescent and early adulthood period. During this stage, new and enhanced physical abilities and cognitive skills are developed. In addition, during this period the adolescent will assume increased independence and levels of autonomy which lead to wider social interactions. These social interactions can also enhance awareness of their cultural and social position in society. Erikson (1968, p.127-130) claims that during the adolescent stage individuals can become morbidly preoccupied with how they appear to others, and it is the ideological potential of society that speaks most clearly to the adolescent who wishes to be affirmed by peers and inspired by worthwhile ways of life. Expectations and awareness of adult responsibilities are also recognised and assumed as the adolescent matures into adulthood. According to Erikson (1968, p.97), this allows the individual to explore vocations, ideologies, and relationships all of which provide outlets for expression, and the opportunity to assess personal attributes thus shaping their identity. Dahl, Allen, Wilbrecht, and Suleiman (2018) support this notion by claiming that adolescents actively build and shape their identities, values, behaviours and knowledge during this stage of their lives.

However, Kroger (2004) argues that with the nature of changing physical, cognitive, and social factors, some adolescents may experience a form of role confusion when the individual is unable to manage this developmental transition. If this occurs, role confusion

may ensue (Sokol, 2009). Role confusion can lead to a varying experiences of identity formation and according to Bosma, Graafsma, Grotevant, and de Levita (1994), it can cause the individual to seriously question essential personality characteristics, one's view of oneself, and the perceived view of others. Consequently, Sokol (2009) claims the individual experiences extreme doubt regarding the meaning and purpose of their existence, leading to a sense of loss and confusion. However, it may also be argued that this period in an individual's life may also present a key opportunity to promote positive platforms on which stable social, emotional, and behavioural processes can be developed and shaped, and which may also act as key drivers for development in later life.

### **3.7.3 Identity Development in Adulthood**

Erikson (1968, p.159) held that identity development does not end with its formation. Thus, identity development is both a normative period of adolescence and an evolving aspect of adulthood (Sokol, 2009). This developmental period seeks to establish and consolidate new goals particularly in the areas of education and career progression as adulthood approaches. Harker and Soloman (1996) claim that during this transitional period, it is common for individuals to amend their aspirations and values regarding goal attainment. Similarly, Sokol (2009) contends that identity related issues continue to emerge during middle adulthood where, according to Kroger (2007), it is not uncommon for individuals to re-evaluate, refine, and readjust career and social roles.

Eriksson, Wangqvist, Carlsson, and Frisen (2020) state that early adulthood sees the transition into long-term relationship and work roles, suggesting that an increased investment is required to sustain such roles. Their longitudinal study sought to explore identity development and maintenance across early adulthood and uncovered three processes of identity development including approach to change, story integration, and participation in a broader life context. In this study, participants demonstrated willingness to adjust their commitments even with no external pressures to do so. It had been previously suggested that changes in life circumstances can also cause a re-examination of identity issues (Waterman, 1993), however, this study demonstrated that changes to identity can equally be attributable to internal forces which drive the need to change. Such stability facilitates the strengthening of identity development across this particular group.

Kroger's (2002) study on identity processes in late adult adulthood demonstrates that identity development is just as significant in late adulthood as it is earlier in life, describing both stages as 'transitional times in the lifespan'. Mitchell, Adler, Carlsson, Eriksson, and Syed

(2021) claim that at this point in life identity integration is an important construct in adult identity development. Identity integration involves the merging of disparate parts of the self into a coherent whole. Mitchell et al. (2021) further claim that having an integrated identity enables adults to achieve goals and build important relationships which will also facilitate a smooth transition into the later stages of life.

### **3.8 Structuring Identity**

In *Sources of the Self*, Charles Taylor (1989, p.6) states that the major facets of modern identity include a sense of inwardness, an affirmation of ordinary life, an expressionist notion of nature, and epiphany. In the case of inwardness, individuals view themselves as creatures with inner depths. At first, these depths are viewed as ways to understand the good or as a way to approach God (Taylor, 1989, p.8). Now, however, individuals believe that they possess unique qualities which can only be found through introspection. Looking inward is no longer solely a path to God, but a path to the individual voice and the individual way of life (Taylor, 1989, p.8).

The second dimension structuring identity is the value attributed to ordinary life. This is significant as it was identified earlier in this thesis how nurses commit and make decisions shaped by personal and sociocultural factors. It was a fundamental assumption of this thesis that identity shapes individual and social behaviour. In recognition of this assumption, the concept of ordinary life is important. According to Taylor (1989, p.17), individuals are more willing to connect to what is valuable to everyday existence than to draw upon a larger cosmic order or a divine conception of history. This is relevant to nurses' decision-making as personal factors have a significant influence in the decision to pursue programmes of higher education. This is evident in this study's findings in Chapter 7 and in the discussion of findings in Chapter 8.

The third dimension of identity entails the Romantic conception of seeing nature as a moral source. Taylor (1989) states that:

“In the philosophy of nature as source, the inexhaustible domain is properly within. To the extent that digging at the roots of our being takes us beyond ourselves, it is to the larger nature from which we emerge. But this we can only gain access to through its voice in us. Finding that voice allows us to know nature and give it expression in our lives, for each of us has a nature to express. By looking inward we find that original path, that unique measure, that authentic core that makes our lives our own.” (p.44).

The fourth dimension of identity is epiphany. The notion of epiphany is genuinely mysterious and possibly contains the key of what is to be human (Braman, 1991, p.226). Furthermore, it identifies those sources which serve as the locus for one's authentic ideal. They are issued from the call of the 'world', understood as an independent matrix of meaning, from which our idea of what it means to be authentic is revealed. Braman (1991, p.228) claims that an epiphany discloses something beyond the individual and frees them from the mechanistic world, thereby empowering them to orientate their lives towards their authentic ideal. For Taylor, having an identity is not something that is optional, rather, it is a desire located deep within the individual allowing them to have a sense of orientation within the world (Braman, 1991, p.228). It was envisaged that taking this perspective would allow emergency nurses' decision-making to be revealed by illuminating the conscious and subconscious influencing factors relevant to their personal and professional mandates.

### **3.9 Theoretical Underpinnings of Identity**

Two primary philosophical frameworks underpinning identity are found in the literature and, more specifically, in the nursing literature: Symbolic Interactionism and Social Identity Theory. These will be discussed here as they form part of the construct that will be proposed for the understanding of the concepts of self and identity in this thesis.

#### **3.9.1 Symbolic Interactionism**

Symbolic interactionism (SI) is a framework that allows for the examination of how individuals interact, and how personal identity is created through repeated interactions with other individuals. Central to the concept of symbolic interactionism is the idea that individuals use symbols, such as language and gestures, to communicate with others (Redkina, Zakiryanova, Vishevsky, & Chernova, 2021). Visagie, Linde, and Havenga (2011) state that SI comprises of an individual-centred orientation that focuses on the development of the self and personality in addition to individuals' interactions. They further explain that it emphasises the subjective intentions and orientations of individuals in relation to their wishes, wants, and situations, in addition to their interpretation and understanding of symbols (Visagie et al. 2011). Symbols, especially words, are central concepts of the symbolic interactionist perspective. Symbols are socially created and used to represent shared meanings among members of societies and/or cultural groups (Burbank & Martins, 2009). Thus the symbols and meanings in a working group of emergency nurses will be shared within the group but may be quite different from other groups. As such, they are used

to communicate, are intentional and meaningful. Interaction occurs through the use of symbols.

SI has its roots in the work of philosophers such as John Dewey, George Herbert Mead, and Herbert Blumer. It was Blumer who developed the ideas of Mead and constructed three core principles; meaning, language, and thought. Meaning is central to human behaviour as individuals respond and act towards others based on the meanings they assign to other individuals and situations. Manis and Meltzer (1972, p.272) state that human beings are thinking beings and do not respond directly to events and situations but give meaning to these. Meanings are learned by human beings in the process of social interaction. Meaning emerges out of the ways in which other people act toward the person in relation to the thing for which meaning is being developed.

Language gives individuals a platform through which they understand meaning through symbols. Thought then modifies the interpretation of these symbols by using language in conversations (Smit & Fritz, 2008). Symbolic interactionism has a number of underlying principles. One such premise is the reflexive nature of human action. It assumes that human behaviour is not motivated solely by internal and external forces, but rather through meaningful, reflexive interactions between individuals. Reflexivity entails the capacity to use and respond to significant gestures such as language, symbols, and thoughts. As will be seen later, this is an important aspect of how emergency nurses are viewed and conceptualised in this study.

Symbolic interactionism does not ignore the influence of social norms and rules, but emphasises the individual's decisions and actions, which are explained within a set of predetermined rules and external forces (Farganis, 2008, p.102). The concept further posits that the individual and society are not separable; society can only be understood through understanding the individuals who comprise that society, whereas individuals can only be understood in terms of the society to which they belong.

Stryker (2001, pp.213-214) identified a number of principles which underpin the concept of SI. Firstly, behaviour is subject to a named or classified world and such classification carries meaning in the form of shared responses and expectations that grow out of social interaction. Secondly, symbols are used to assign positions in social structures. As a result, individuals or actors within the context of these social structures recognise each others' positions and expectations. Another principle identifies how these actors also name themselves and create meanings and expectations regarding their own behaviour. Finally, these expectations and

meanings form the basis for social behaviour whereby exchanges between actors shape and re-shape the content of the interactions in addition to the names and meanings used.

### **3.9.1.1 Application of Symbolic Interactionism**

The use of symbolic interactionism as the theoretical or conceptual basis for professional and social research activity is quite apparent within the literature. For example, symbolic interaction theory has been used to analyse leadership styles as a component of the subjective experience of diversity management (Visagie et al. 2011). Symbolic interactionists have also applied this perspective to a wide variety of issues in healthcare systems such as understanding classification systems, studying clinical trials, and studying the work setting itself (Clarke & Star, 2003, p.544). Within nursing, recent application of the symbolic interactionist perspective have focused on topics such as ageing (Rozario & Derienzis, 2009) and relationships between nurses and families (Lowenberg, 2003). At practice level, it has been used in studies on how nurses construct their practice identities (Deppoliti, 2008).

More recently, Willis-Hepp, Hrapczynski, and Fortner-Wood's (2019) study on adoptive parenthood utilised symbolic interactionism to explore decision-making, the transition to adoptive parenthood, and the adjustment required to family life. Using this approach allowed the researchers the opportunity to uncover how individuals interpreted and evaluated their experiences, generated individually or collectively, during decision-making processes. Goodall, Andre, Taraldsen, and Serrano (2021) also incorporated symbolic interactionism as their theoretical basis to provide insight into communication strategies and to explore how the use of technology could enhance interpersonal relationships amongst people with dementia.

### **3.9.2 Social Identity Theory**

Social identity refers to an individual's sense of who they are based on their group memberships. Social Identity Theory (SIT) is a particular approach to group processes developed by the social psychologist, Henri Tajfel. Tajfel (1970) proposed that the groups individuals belong to, for example, social class and family, were an important component of pride and self-esteem. SIT refers to an individual's self-concept in relation to their membership of social groups (Burford, 2012). The premise of SIT is that while some individuals see themselves as individuals, at other times they may think of themselves as members of a group (Brown, 2020). Schulz, Wirth, and Muller (2020) contend that social identity accompanies personal identity as components of the human self-concept and defines the self as a member of different social groups.

According to Haslam, Jetten, Postmes, and Haslam (2009), groups are not just features of the external world that provide a setting for behaviour. Groups also have the ability to shape our cognition through their capacity to be internalised and their capacity to contribute to the sense of self. Tajfel (1970) claims that through group membership, individuals can also be provided with a sense of social identity. Haslam et al. (2009) claim that the reason individuals are willing to embrace others in this way is that such groups have the capacity to enrich our lives in various ways. Brown (2020) contends that individuals prefer to see themselves in a positive light and, as a result, will seek positive distinctiveness in sourcing group memberships. Group membership is a source of personal security, social companionship, and intellectual stimulation. Furthermore, Haslam et al. (2009) claim that group memberships have advantages for individuals as they provide the basis for goal achievement and levels of agency that would be otherwise unattainable.

When people think of themselves as part of a collective, they are energised by different experiences or events than when they identify themselves as separate individuals (Ellemers, De Gilder, & Haslam, 2004). As a result, individuals are more likely to apply themselves to the collective effort and sustain their efforts on behalf of the group, leading to internalisation of group goals. Indeed, it may also be argued that efforts may also be sustained in achieving individual goals. Individuals are also assisted in orientating their behavioural efforts toward collective goals in line with an organisational commitment. In this study it will be apparent in Chapter 7 and Chapter 8 how emergency nurses experienced a sense of belonging and cohesiveness within the context of ED. It was also evident that being part of this collective was further enhanced when undertaking programmes of higher education, and how the achievement of academic pursuits was encouraged and sustained.

### **3.9.2.1 Social Identity Theory Process**

Tajfel (1978, p.87) identified three stages that underpin group-based social interaction, and these include categorisation, identification, and comparison. The first stage of the SIT process involves social categorisation. Social categorisation refers to how individuals organise social information by categorising individuals into groups. According to Ellemers et al. (2004), such categorisation which is based on salient features of groups, helps structure individuals' worldviews, assists them in making sense of the world, and also helps organise perceptions of self and others. Within groups, similarities become enhanced while differences with other groups become defined.

The second stage of the SIT process involves social identification. Social identification is the process by which information about social groups is related to the self (Ellemers et al., 2004). The categorisation of an individual's social context results in a social reality populated by several different groups. When an individual is assigned to particular social categories, this involves knowledge of belonging to the group and the emotional significance attached to membership of the group. Knowledge of group membership increasingly defines the self in terms of a range of social identities and, as will be demonstrated in the Findings and Discussion chapters, also defines the self in terms of opportunity, awareness of potential, and desire to succeed. This insight and awareness also has important implications for self-esteem. The third stage of the process involves social comparison. Social comparison is the process by which features and behavioural norms help to define the group in particular situations (Ellemers et al., 2004). Generally, these features are those that distinguish the group from relevant comparison groups (Van Rijswijk & Ellemers, 2002). With this comparative process, it must be recognised that groups may have the potential to evaluate themselves on the basis of socially acceptable and beneficial criteria, and assign themselves positive attributes and characteristics.

While SIT has received much attention over the years, Brown (2020) argues that as a theory of identity it fails to acknowledge the complexities of contemporary social groups. Brown (2020) offers a number of explanations for this assumption. Firstly, he argues that the search for positivity as the only motive for identity enhancement or restoration is rather fickle, and that individuals pursue group membership for other reasons such as outcome achievement or to reduce uncertainty within their social world. Secondly, in contemporary society identities are often multifaceted and, therefore, as an identity theory SIT cannot assume a single ingroup identity. Similarly, Korte (2007), in reviewing the impact of SIT on workplace training and development, proposes that a weakness of the theory lies in its disconnection between explanation and prediction, claiming that it is difficult to predict human behaviour in social settings.

### **3.10 Social Identity Theory, Social Background and Higher Education**

It is important to follow the discussions on the SIT process by acknowledging the link between, and significance of, social identity and social background. Manstead (2018) claims that the material conditions in which people grow up and live have a lasting impact on their personal and social identities. As a result, this influences the way they think and feel about their social environment and key aspects of their social behaviour. For some emergency nurses it was apparent that growing up and living under different social and economic



contexts from other emergency nurses bore influence on their thoughts and decision-making behaviours in later life.

Interestingly, data from the British Social Attitudes survey (Curtice, Phillips, & Clery, 2015) highlights that while there has been a dramatic decline in traditional working-class occupations, large numbers of UK citizens still describe themselves as being 'working class'. While some may question why this is of importance, Curtice et al. (2015) argue that this self-identification does matter. Manstead (2018) states that, traditionally, social psychological analyses of identity have not paid much attention to social class or socioeconomic status as a component of overall identity. In a study by Easterbrook, Kuppens, and Manstead (2018), it was demonstrated how respondents placed high subjective importance on their identities that are indicative of socioeconomic status. Furthermore, respondents attached as much importance to their socioeconomic identities as they did to identities such as gender and ethnicity.

Manstead (2018) claims that the selective nature of higher education involving economic and or qualification requirements to gain entry makes third-level institutions a high-status context. Therefore, working-class individuals who seek higher education programmes may be faced with working in an environment in which they feel out of place. This is compounded by Jerrim's (2013) study where it was noted that both in the United Kingdom and internationally, students at research-led universities are more likely to come from middle and upper class backgrounds than from working-class backgrounds. Chowdry, Crawford, Dearden, Goodman, and Vignoles (2013) suggest that while reasons for low representation of working-class students are complex, one factor is that many working-class students do not see themselves as feeling at home there. They see a mismatch between the identity conferred by their social backgrounds and the identity they associate with being a university student. This line of thought will become evident in the findings of this thesis whereby some emergency nurses expressed a sense of 'fraudulence' when not only discussing their place at university, but also with their career advancement as a result of having undertaken a programme of higher education.

The influence of parents' educational achievement is a significant consideration pertaining to higher education uptake. In a study by Nieuwenhuis, Easterbrook, and Manstead (2018), it was found that disadvantaged students, whose parents had low levels of educational attainment, scored lower on identity compatibility and this influenced educational decision-making upon leaving school. Children's aspirations can be highly ambitious and are

often unrealistic but they become more realistic as children get older (Croll, 2008). For most children, their occupational aspirations are higher than their parents' achievements (Kintrea, St. Clair, & Houston, 2011). Apart from social class, the main determinants of aspirations in children include gender and ethnicity along with circumstances, occupations, involvement and expectations of parents. Parents' income, aspirations and involvement have also been found to directly influence children's aspirations. Children from lower-income families aspire to less prestigious occupations (Croll, 2008) and also have less belief in their own ability (Goodman & Gregg, 2010) than their more advantaged peers. Family resources, both tangible and intangible, also influence children's aspirations indirectly by parents' involvement and aspirations. Parents with less time and fewer resources are less able to encourage their children's aspirations (Williams, Williams, & Ullman, 2002) and may in turn have lower expectations and aspirations for their children. When time, energy and resources are limited, grandparents may play a role over and above parents in helping children raise their aspirations.

Moulton, Flourir, Johshi and Sullivan's (2017) UK study highlighted how there was intergenerational social class transmission from parents' class to the child's classed occupational aspirations. Parents pass on a share of their class advantage or disadvantage to their children when they are growing up and as adults. The study showed that social homogamy is the norm in Britain. The parents' and the grandparents' social class were related within lineage, as well as cross-lineage, both between (grandparent) and within (grandparent-grandparent) generations. However, it will become apparent in this thesis that the concept of social background, including parental and wider family influences, was internalised for some emergency nurses and was a significant influencing force in the decision to pursue higher education.

### **3.11 Conclusion**

This chapter has provided a brief but comprehensive overview of the literature pertaining to the concepts of self and identity. It was a basic premise of this study that educational uptake amongst emergency nurses could not be fully understood without acknowledging the role of self and identity in decision-making. In doing so, this chapter highlighted the various philosophical stances which underpin both concepts. The seminal works of Carl Rogers, Erik Erikson, and Charles Taylor were referred to in the description and exploration of the concepts of self and identity. It is apparent from reviewing the literature on self and identity, that these concepts comprise of several facets, and operate on both conscious and unconscious levels across the lifespan. In referring to both concepts, a frame of reference

has been provided from which to explore the decision-making strategies of emergency nurses. It was also deemed appropriate that within the discussion of identity, a focus on professional identity should form part of this study's frame of reference. The next chapter will explore the area of professional identity and its relevance to emergency nurses' educational decision-making.

## **Chapter 4 - Professional Identity Literature Review**

## **4.0 Introduction**

This chapter will explore the concepts of professional identity, socialisation, and nursing values as an extension of the discussion of the previous chapter and to provide an even more robust framework to address the research questions and the analysis that was carried out on the data generated. The previous chapter highlighted the intricacies of the concepts of self and identity, and it may be argued that these two concepts also inform the sense of professional identity. The issues of professional identity, socialisation, and nursing values will be examined and their contribution explored regarding the construction of a model of a profession that will be later used as a conceptual platform to uncover the influencing factors of the pursuance of higher education among emergency nurses. I will demonstrate that the idea of professional identity is complex one and one that has been explored from many perspectives and across a broad range of literature. Additionally, little has been documented within the literature that explores the development of nursing professional identity through the pursuance of higher education.

I will begin by discussing how professional identity is defined generally and then how the concept is perceived within the nursing literature. I will then explore professional identity formation and its relevance to nursing before discussing the philosophical frameworks that underpin the concept. No discussion regarding professional identity is complete without considering socialisation. As one of the most powerful agents in the formation of professional identity, the concept of socialisation will also be explored.

An exploration of these key areas will assist in demonstrating not only how emergency nurses shape their decision-making regarding higher education uptake but also how engaging in higher education may contribute to emergency nurses' sense of professional identity. It will also form part of this study's analytical frame. I will now begin this discussion by exploring how professional identity is defined.

### **4.1 Definition of Professional Identity**

Definitions of professional identity are plenteous within the literature. Despite the various attempts to provide comprehensive and succinct understandings of the concept, Hensel (2014) claims that what constitutes the notion of professional identity often remains poorly understood. This is not aided by the competing definitions available where insights into the concept are based on a range of factors including one's personal, social, and professional circumstances. To begin, Schein (1978, p.46) takes a broad approach that professional identity is an enduring form of social identity where members of a profession differentiate themselves from members of other professions. Gecas and Burke (1995, p.51) also take this

broad approach by suggesting that professional identity is based upon the meanings individuals attach to themselves and the meanings attached to them by others. Similarly, Kogan (2000) claims that the concept is both individual and personal where individuals not only evidence their expertise and own moral frameworks, but also perform a range of roles which are determined by the communities and institutions of which they are members. Johnson, Cowin, Wilson, and Young (2012) take a slightly different perspective and suggest that professional identity is just a component of one's overall identity and is augmented by their position in society and interactions with others. While Johnson et al. (2012) contend that professional identity is just a component of overall identity, Adams, Hean, Sturgis, and Macleod-Clark (2006) argue that an individual's professional identity is actually more salient than their demographic identity.

More recently, the literature has offered different perspectives on the concept of professional identity highlighting the various contemporary forces and influences beyond the immediate professional working environment. For example, Browne, Wall, Batt, and Bennett (2018) claim that professional identity is an evolving process which is shaped by factors such as educational experiences, role-modelling, and the media. The reference to the influence of role-modelling is interesting as Gibson (2004) suggests that role models are important for the development of professional identity as they provide a source of learning, self-definition, and motivation. However, Weinberg (2019) argues that the influence of role modelling is slightly contentious and depends on the state of the mentee's sense of professional identity. If they are less experienced, their professional identity may be less well-defined and, as a result, role modelling can be useful in developing their sense of self and identity based on their past sense of self and identity. These insights and perspectives on the influence and impact of role-modelling relating to professional identity development are significant within the context of this thesis as it will be demonstrated later how the influence of emergency nursing colleagues contributed to professional identity development among the study participants, and how the decisions made to pursue programmes of higher education were, in part, attributable to these colleagues.

The impact of the media, and more specifically social media, has also contributed to how the concept of professional identity is viewed. It may be argued that with the advent of digital technologies, social media can play a significant role in the development of professional identities. Stets and Serpe (2016, p.16) claim that social media encourages individuals to formulate, verify, and enact both identity claims and multiple identities. Through the use of

these digital platforms and virtual environments it has been made possible for individuals to create professional profiles and engage with other like-minded individuals.

#### **4.2 Defining Professional Identity in Nursing**

I now turn specifically to the literature on professional identity in nursing. Despite numerous attempts at succinctly articulating the concept, it remains vague, poorly defined, and open to much interpretation within the nursing literature. This is noteworthy as the concept of professional identity does assist with the shaping of individuals at personal, professional, and societal levels. At a basic level, Nolan (1993, p.10) claims that it invites the thorny question of what it means to be a nurse and the strength of nursing's claim to be a profession, which has historically been difficult in nursing. While Stenbock-Hult (1985) claims that professional identity is based upon the individual's sense of self and identity within the context of nursing practice, Pullen (2006, p.69) argues that the sense of professional identity can also be developed through interaction with other nurses and through internalisation of the knowledge, values, and culture of the profession. While the literature has generally taken a broad and theoretical stance to understanding the concept of professional identity in nursing, only Oguisso and De Freitas (2016) offer a more focused approach by highlighting a key role of the nurse in their description of nursing professional identity stating that '...it seems clear that this profession's identity consists of the effective activity of providing care, which was converted into a technical and unique activity among all those performed by health professions, differentiating nurses from other professionals.'

It may be argued that some of the difficulties associated with a comprehensive understanding of the concept are somewhat attributable to an array of factors situated beyond the immediate control of nurses, both individually and collectively. Similarly, the vast range of roles and responsibilities assumed by nursing professionals may also contribute to the lack of a clear definition and understanding of professional identity. It will become apparent later in this thesis that emergency nurses experienced some difficulty in illustrating their understanding of the concept both on an individual level and on a conceptual level. It could be argued that perhaps nurses do not routinely contemplate their sense of professional identity unless they are considering higher education or actively engaged in programmes of higher education. It could also be argued that being affiliated with a professional body by virtue of their professional registration means that their professional identity has already been accomplished and established. From my own experiences, I did not contemplate by own sense of professional identity until I engaged with programmes of higher education and when embarking on my PhD journey. Interestingly, Kristoffersen's (2021) qualitative study

exploring nurses' professional identity and their intention to remain in the profession, revealed that the decision to remain in the profession by nurses was partly due to the notion of self-concept and the realisation that they were doing good for both patients and themselves. While positioning themselves as professionals with competence, they did not necessarily require the sense of professional identity or recognition for their competence.

Johnson et al. (2012) claim that several factors can alter the formation of nurses' professional identity, from the macro level of cultural and organisational change to the micro level of individual expectations and experiences. This line of thought will be evident later in this thesis when the study findings are presented and discussed specifically relating to the experiences of advanced nurse practitioners in the ED. Over the years specific factors relating to the difficulty in defining professional identity in nursing have arisen primarily from evolution of the nursing role. Fawcett (2003) highlights how the sense of professional identity began to erode with the move from 'hands-on' care as nurses started to embrace specialist and advanced practice opportunities mainly in response to professional, organisational, and governmental service improvement initiatives both nationally and internationally. Similarly, Dingwall and Allen (2001) contend that this sense of erosion and care fragmentation has been compounded by the need for cost-containment, and the resulting delegation of key nursing duties to facilitate the development of advanced roles. More recently, the profession continues to witness the rapid development of specialist and advanced practice pathways resulting in the reassignment of traditional nursing roles and responsibilities to other supporting healthcare staff.

There is no doubt that the image of nurses and the nursing role has changed in response to these professional practice developments. However, ten Hoeve, Jansen, and Roodbol (2014) claim that there is some incongruency between the public image and perception of the nurse's role and the actual reality of the professional role. It may be argued that due to the traditional association of the nursing profession with fundamental care provision, nurses are not always depicted as autonomous professionals with a sound educational platform. More than any other profession within the healthcare system, nurses have the distinct responsibility for the caring that patients receive. Such caring interventions can often be incorrectly perceived to lack complexity and significance and, therefore, have little relevance within the scope of modern nursing practice.

'Dirty work', however, may be one of the key roles that gives an occupation its charisma as is the case, for example, with the handling of the human body by the physician (Hughes, 1974, cited in Emerson and Pollner, 1976). Similarly, Hamilton's (2007) ethnographic study



of veterinary surgeons' sense of professional identity, demonstrated how the presence of dirt and animal waste can serve as a cultural symbol which can confer power and prestige that positively influences professional and social identities. Bolton's (2005) study also demonstrates how gynaecology nurses construct collective professional identity by celebrating a distinct form of dirty work. Interestingly, however, Vachhani (2012, p.37) claims that in the medical profession seniority is marked quite distinctly by distance from the bodily. Rafferty (1996) argues though that as long as nurses have the association with 'tea and sympathy', the possibilities of nursing achieving professional status may be restricted. Again, this relates to the idea that fundamental skills such as communication, respect, kindness, and compassion are functions that any individual can undertake which do not necessarily require formal education, training, or even recognition.

Anecdotally, this idea is somewhat reflected in my own contemporary experiences of nursing care provision where, as a registered nurse, I have participated in religious pilgrimages and in doing so I am referred to as a 'servant' in the undertaking of patient care activities during these pilgrimages. Similarly, student nurses who participate in nursing care activities assume the title of 'handmaid' during these pilgrimages. ten Hoeve et al. (2014) argue that nurses have not been given the due recognition for the skills they have by the majority of the public. The discipline of nursing has witnessed significant developments and growth over recent years with respect to professionalisation and role advancement. However, ten Hoeve et al. (2014) claim that this professional progress has not yet resulted in a public image that recognises the scientific and professional development and contribution of the nursing profession to healthcare and society as a whole.

#### **4.3 Professional Identity Formation**

The development of identity is both a personal and social process. In the previous chapter, I identified how Social Identity Theory (SIT) underpinned identity through how individuals view themselves as both independent beings who interact on the basis of personal characteristics and how they view themselves in terms of particular group memberships. Ohlen and Segesten (1998) state that professional identity is linked to an individual's sense of personal identity, self-esteem, and self-image. Glen and Clark (1999) also make reference to the sense of self and identity claiming that professional identity development requires self-appraisal and self-monitoring along with accepting responsibility for personal attitudes. The process of acquiring a professional identity is a multidimensional process that is strongly influenced by a number of factors including personality traits, life experiences, work experiences, and the socialisation of students into a profession. Nursing professionals create

the professional identity that is assumed by student nurses. As such, professional nurses are challenged to create a positive image of nursing, where nurses are proud of their accomplishments and contributions to healthcare. It will be apparent in the findings chapter of this thesis how professional identity has been formed by both personal and professional experiences. It will also be demonstrated how emergency nurses' sense of personal and professional identity further evolves on pursuing programmes of higher education.

#### **4.4 Professional Identity Formation in Nursing**

Professional identity formation in nursing may be underpinned by a number of factors, including the sense of self, social identity, and education. While the two primary philosophical frameworks discussed in the previous chapter, symbolic interactionism and Social Identity Theory (SIT), are relevant to the formation of professional identity, it is educational platforms which are most important in considering professional identity development. Maginnis (2018) states that education in nursing provides the natural and initial context for professional identity development, and the earliest form of formal socialisation into the profession. This begins with the pre-registration curriculum and extends into post-registration programmes as the nurse pursues further professional development. Cook, Gilmer, and Bess (2003) state that professional identity must be purposely developed early in the curriculum as an early and solid foundation of professional identity may promote future student success. The influence and impact of education on professional identity is noted throughout a nurses' professional lifespan, as pre-registration, graduate and continuing education all provide educational context for advancing nursing practice (Gregg & Magilvy, 2001).

At a fundamental level, students learn professional values and knowledge from theory and the clinical setting, all of which directly influence the development of professional identity (Arndt, Urban, & Murray, 2009). However, Apeso-Varano (2007) is keen to highlight that the education system straddles two important social institutions within the profession of nursing, education and workplace, and it is imperative that the theory-practice gap must be bridged in order to foster professional identity development and an effective transition to practice. The knowledge of nursing history within educational and clinical practice settings is also influential on professional identity development in nursing as Padihla and Nelson (2011) claim that nursing is influenced by concepts grounded in the past. Recognition of these influences is essential in professional identity development as it provides a basis for contemporary theory and practice development (Leishman, 2005). However, Madsen, McAllister, Godden, Greenhill, and Reed (2009) suggest that the relevance of nursing history

in professional identity development bears little significance in contemporary nursing curricula and argues that this is somewhat attributable to the move from hospital-based education, which instilled a sense of culture and history, to the current tertiary model. Madsen et al. (2009) also argue that history may be viewed as a luxury that has little significance in the preparation of the contemporary nurse. Interestingly, there is little available within contemporary nursing literature that considers and explores the influence, development, and enhancement of professional identity through the medium of higher education (Guner, Turhal, Ucuuogh, Tuncel, Akturan, & Keles, 2021).

#### **4.5 Relevance of Professional Identity in Nursing**

The literature notes several important functions of professional identity, such as benefiting the growth and practice of the nurse, defining practice boundaries, positively impacting on patient care outcomes, and working effectively in interprofessional teams. Additionally, it has also been described how professional identity influences retention, commitment to nursing, and job satisfaction (Allen, 2011). Frankland (2010) states an established professional identity is crucial for the advancement of professional nursing practice. Frankland (2010) further claims that a solid professional identity results in increased confidence in self and profession, an acquisition of cultural and social capital, and a sense of parity with other healthcare professionals. These are credible and valid points and later in this thesis it will become evident how issues such as personal and professional confidence, and parity with other healthcare professionals were both processes and outcomes regarding the pursuance of higher education programmes.

#### **4.6 Criteria of a Profession**

This section will examine the idea of a ‘profession’ and the criteria normally associated with the term together with some of the surrounding controversies and contestations. Exploring the criteria of a profession will allow for a more comprehensive understanding of the factors that underpin the notion of being a professional. It will also explore nurses’ own understanding of what it is to be professional and the aspects with which they attribute to being professional. In terms of the study focus, incorporating criteria of a profession within the frame of reference will assist in identifying whether awareness of these principles influences decision-making regarding higher education uptake or if participation in higher education contributes to the sense of some, or all, of these aspects of professional identity.

The notion of profession in nursing has had a troubled history, not aided by multiple definitions and characteristics within nursing literature. These troubles appear to continue today despite the modern profession of nursing meeting all recognised criteria of a profession

(Willetts & Clarke, 2014). These criteria include a systematic body of knowledge, professional authority, a regulative code of ethics and the existence of professional bodies and associations that control and monitor conduct and performance within the profession, and sanction of the community (Willetts & Clarke, 2014). These criteria, starting with a systematic body of knowledge, will now be explored further within the context of the nursing 'profession'.

#### **4.6.1 Systematic Body of Knowledge**

One of the first components of a 'profession' proposed by Willetts and Clarke (2014) is that of a systematic body of knowledge. Indeed, Butcher (2006, p.116) also claims that having a unique body of knowledge allows for the recognition and power granted by society to a fully developed profession and scientific discipline. However, the idea of a systematic knowledge base within the nursing profession has been subject to much debate over the years. The knowledge base underpinning the profession has been somewhat complex as it has historically drawn much of its knowledge and approach to patient care from various multidisciplinary sources in addition to relying on its own knowledge base which arises from tradition, personal and professional knowledge, and intuition, all of which are primarily embedded in clinical practice. In addition, nursing's knowledge base has also had to adapt in response to a changing healthcare environment, the complex nature of health and illness, and political and professional reform.

Carper's (1978) seminal work on nursing knowledge proposed four 'patterns of knowing' and is often used as an epistemological basis for nursing's knowledge base. These ways of knowing were applied to nursing knowledge, accepting the notion that knowledge acquisition occurs in different communities or cultures (Garrett & Cutting, 2014). Since the publication of Carper's (1978) work on nursing knowledge, White (1995) and Cipranio (2007) have proposed additional components including 'sociopolitical' (White, 1995) and 'synthesising' (Cipranio, 2007). Despite these suggestions, Carper's framework has been positively endorsed in the nursing literature (Garrett & Cutting, 2014).

The first pattern of knowing is empirical knowing which is the science of nursing. This pattern is factual, descriptive, and helps to develop abstract and theoretical explanations (Swift & Twycross, 2020). Nurses demonstrate empirical knowing on a practice level through the competent performance of activities supported by theory (Chinn & Kramer, 2018, p.27). This is underpinned by a firm grounding in appropriate theory and the understanding of the importance of theoretical knowledge as a basis for professional practice. Nursing theorists emerged in the mid-20<sup>th</sup> century to provide insights about nursing

practice and to guide research and goals for assessment, diagnosis, and intervention (Meleis, 2007, pp.9-10). Since then, the nursing profession has witnessed the emergence of theories, meta-theories, midrange theories, and conceptual frameworks, all of which have contributed to nurses' understanding of nursing. According to Maas (2006, p.7) the surge in development of nursing theories was related to the need to justify nursing as an academic discipline and for nursing to develop and describe its own knowledge base. Some of the main theories and nursing models include those relating to the theory of caring in nursing by Jean Watson, the science of unitary beings by Martha Rogers, the self-care deficit nursing theory by Dorothea Orem, and the Roy adaptation model by Callista Roy.

The second pattern of knowing is ethical knowing and this focuses on moral values. Ethical knowing allows the nurse the opportunity to consider the morals associated with treatment choices and goes beyond what is advocated by professional codes of conduct. Ethical knowing also includes the ability to evaluate motives, values, character, and norms. The next pattern of knowing is personal knowing and this refers to the knowledge we have of ourselves and how this knowledge influences our interactions with others. It also encompasses experiential learning.

Tacit knowledge is developed through experience gained by engagement in professional nursing practice. Carlsson, Drew, Dahlberg, and Lutzen (2002) propose that tacit knowledge and practice can be role modelled and displayed in practice delivery to future generations of nurses. Despite tacit knowledge being identified as a way of knowing, Hek and Moule (2006, p.14) claim that the lack of objectivity underpinning intuitive and tacit knowledge adversely impacts its standing as a credible knowledge base for professional nursing practice. As debates surrounding the value and role of intuitive and tacit knowledge in nursing practice continues (Whitehead, 2005), it should be acknowledged that intuition and tacit knowledge can inform the development of personal knowledge. Often experience is developed through observing role models in practice, and as such can be developed to include traditional and tacit knowledge (Moule & Goodman, 2008, p.25). Fawcett, Watson, Neuman, Walker, and Fitzpatrick (2001) claimed that aesthetic, personal, and ethical patterns were ineffable given the emergence of empirical literature particularly within evidence-based practice.

The final pattern of knowing as identified by Carper (1978) is aesthetic knowing. Benner (1984) suggests that nurses evolve into expert practitioners, using experience to develop aesthetic knowledge. While Benner (1982) states that expert nurses will use this knowledge or 'know-how' to identify and address individual patient needs, she does acknowledge that the expert nurse will also draw upon scientific knowledge to further support the delivery of

appropriate nursing care. Aesthetic knowing focuses on the nurse's perception of the patient and the patient's needs, emphasising the uniqueness of each relationship and interaction. Chinn and Kramer (2018, p.29) describe this as a way a nurse can formulate a sense of patients' needs and act on their behalf, taking into account nuanced information about their personality and previous experiences to orchestrate the most effective way of providing care.

Earlier I indicated that the nursing profession drew from other disciplines to inform its knowledge base. In contemporary nurse education, both at undergraduate and postgraduate levels, there has been an increasing emphasis on interprofessional education. This emphasis reflects the need to provide a holistic and collaborative approach to healthcare practice thus aiming for an improvement in patient outcomes and the provision of a holistic care environment. In addition, the inclusion of interprofessional education within programmes of education supports a more integrated approach to preparing nurses for interprofessional practice and collaboration. It can be argued that the willingness of a professional to learn about other professional roles leads to a broadening and enrichment of the knowledge required to collaborate with other team members.

However, Meleis (2007, p.17) warns that care must be taken to guard the identity and core values of individual disciplines in the development of knowledge. Thorne (2014) also argues that without clarity on what constitutes our core disciplinary knowledge base, we are at risk of losing our identity especially within the context of the current focus on interdisciplinarity. According to Fawcett (2007) nursing practice is based on unique nursing knowledge rather than knowledge developed by other disciplines. Unique nursing knowledge is evident in the many conceptual models of nursing and middle-range theories. Grace, Willis, Roy, and Jones (2016) contend that nursing disciplinary knowledge differs significantly from knowledge developed by other disciplines. They concede that nurses have shared and adapted knowledge and theories to meet their own disciplinary goals. It must be acknowledged that nurses care for the individual as a whole and, in doing so, rely on the knowledge base of other healthcare professionals. When I first commenced my general nurse training, I was introduced to the idea of patient assessment based on a nursing model which looked at the individual as a whole and not just their presenting complaint. In conducting patient assessments, it soon became apparent that input from other healthcare professionals was a reality. More recently, much emphasis has been placed on the idea of person-centredness, a concept originally developed by Carl Rogers. Adopting a person-centred approach to care will also involve the knowledge of other healthcare professionals.

Do we have a distinct knowledge base that we can claim as our own and upon which deliver holistic person-centred care to patients? I do not believe that we have an all-encompassing and distinct knowledge base yet like other professions, however, I believe we are making significant progress in accomplishing our own systematic knowledge base. As a profession we need to embrace and promote the efforts made by nurses, however small, in exploring the concepts and application of nursing practice, and the efforts made to improve individuals' healthcare experiences. Nurses need to be supported in undertaking programmes of higher education, particularly in an era when healthcare practices are rapidly evolving in response to changing nature of health and illness, and professional and governmental reform agendas. Similarly, it is irrelevant if nurses engage in local small scale quality improvement initiatives or engage in broader research activities. What matters is that knowledge is being generated at varying levels which will both enhance and consolidate the nursing knowledge base. In the meantime, nurses are faced with the challenge of bringing together knowledge and skills from other disciplines into alignment with, and to be informed by, nursing's goals and clinical practice environments.

#### **4.6.2 Professional Authority**

The second criterion of a profession to be discussed is that of professional authority. According to Meehan (2010), professional authority refers to the power, autonomy, intellectual and political influence afforded to nurses within healthcare systems. It is evident within the nursing literature that the terms 'authority' and 'autonomy' are often used interchangeably, however, Porter (1992) claims that professional authority cannot be secured without professional autonomy.

Ballou's (1998) concept analysis of autonomy identified that the nursing profession places a high value on the acquisition of autonomy as a requisite for professional status. Autonomy in nursing is defined as the power to determine what needs to be done in providing patient care, to act on one's assessments, and to accept accountability for those decisions (Ulrich, Soeken, & Miller, 2003). Autonomy refers to a nurse or midwife's ability to "make decisions within their own profession and their right and responsibility to act according to the shared standards of that profession" (Varjus, Leino-Kilpi, & Suominen, 2010). More recently, Pursio, Kankkunen, Sanner-Stiehr, and Kvist (2021) suggest that while the concept of nursing autonomy is multidimensional, two widely recognised categories of autonomy are clinical autonomy and professional autonomy. The NMBI (2015) state that professional autonomy arises from the ability to use knowledge and skills in such a manner that affords safe and effective care to patients and service-users. They also advise that there can be

individual levels of autonomy afforded to nurses and midwives which are dependent on various legislative, organisational, and individual factors.

In Ireland, nursing has undergone significant change in relation to the roles and responsibilities of nurses and midwives in response to health service restructuring and identified service needs (Coyne, Comiskey, Lalor, Higgins, Elliott, & Begley, 2016). In a discursive paper by Fealy, Casey, O’Leary, McNamara, O’Brien, O’Connor, Smith, and Stokes (2018), it is suggested that the emergence of specialist and advanced practice roles reflects nurses’ willingness to expand their scope of practice through enhanced professional autonomy, responsibility, and accountability. Attree’s (2005) grounded theory study on nurses’ perceptions on standards of practice highlighted that as professional practitioners who are accountable for their work, nurses expect to be primarily self-governing and autonomous, as well as being able to influence the factors affecting everyday standards of nursing practice. Conversely, in an earlier exploratory study by Flynn and McCarthy (2008) investigating the characteristic of the nursing practice environment, it was highlighted that Irish nurses are reluctant to take control over practice, due, in part, to disempowering policies and unsupportive attitudes from senior managers. Furthermore, local nursing philosophy statements in the participating hospitals made little or no reference to professional nursing itself or the creation of conditions to allow nurses to practice autonomously and control their practice setting.

#### **4.6.3 Professional Regulatory Body**

The third dimension of a profession encompasses affiliation with a professional regulatory body. Originally, the Irish Nursing Board (An Bord Altranais) was established by the Nurses Act 1950. It was re-constituted and its functions were redefined and expanded by the Nurses Act 1985. The Nurses and Midwives Act (2011), which repealed the Nurses Act 1985, states that the Board is accountable to the Minister for Health, the public, and the professions for providing and maintaining a safe, appropriate, and responsive system for professional regulation and guidance to nurses and midwives. Currently in Ireland the Nursing and Midwifery Board of Ireland is the statutory regulatory body which sets the standards for the education, registration, and professional conduct of nurses and midwives. The main objectives of the Board are to protect the public and to ensure the integrity of nursing and midwifery practice.

#### **4.6.4 Professional Code of Conduct and Ethics**

The fourth element of a profession that will be important in framing an understanding of nurses’ identity engaging in higher education is that of a code of conduct and ethics. The



new Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives (NMBI, 2014) forms part of the regulatory and professional guidance framework for the nursing and midwifery professions. It provides standards for the regulation, monitoring, and enforcement of professional conduct. The need for the development of a new Code reflects not only the requirements of the Nurses and Midwives Act (2011) but also the challenges nurses and midwives have faced in recent years, as well as the need to clearly define the principles, supporting values, and standards of conduct expected and required of the profession. The aims of the Code are to support and guide nurses and midwives in their ethical and clinical decision-making and their on-going reflection and professional self-development.

The Code also aims to inform the general public about the professional care they can expect to receive from nurses and midwives. It also aims to emphasise the importance of the obligations of nurses and midwives to recognise and respond to the needs of patients and families. Finally, it seeks to set standards for the regulation, monitoring and enforcement of professional conduct. The Code is based on five principles. These principles govern respect for the dignity of the person, professional responsibility and accountability, quality of practice, trust and confidentiality, and collaboration with others. Each principle underpins the Code's ethical values and related standards of conduct and practice and guides the relationships between nurses, midwives, patients and colleagues. The standards of conduct and professional practice follow on from these values and illustrate the attitudes and behaviours that members of the public have the right to expect from nurses and midwives.

#### **4.6.5 Sanction of the Community**

The fifth criterion of a profession is sanction of the community. The authority for nursing, as for other professions, is based on social responsibility. One of the principal pressures on public sector professional identities is that placed on them by the very public that they seek to serve. Under its terms, society grants the professions authority over functions vital to itself and, in return, the professions are expected to act responsibly, always being mindful of public trust. Nurses work in environments that are extremely complex, constantly changing, and subject to high levels of scrutiny through internal and external regulation. The HSE's (2012) National Healthcare Charter document states that the Irish health service is committed to promoting the well-being of patients and clients, and providing a caring environment where they are treated with dignity and respect. In addition, it aimed to inform and empower individuals, families, and communities to look after their own health and to influence the quality of healthcare in Ireland.

Similarly, the Strategy of the Office of Nursing and Midwifery Services Director 2012-2015 (Office of the Nursing and Midwifery Services Director, 2011) states that nursing and midwifery will continue to be a central pillar of Ireland's healthcare system and enhancing nursing and midwifery roles will assist in putting patients first and providing safe, high-quality care across the continuum of requirement. Placing the service user at the centre of care and actively seeking to identify and respond to their individual and collective needs and preferences, is a core element in the delivery of person-centred care (HIQA, 2013). This is the healthcare expectation being proffered by the HSE and allied subsidiary bodies to the general public. It recognises the nurse as central to healthcare delivery and grants the social contract. More recently, however, HIQA (2021) claims that there is no strategic platform within the Irish healthcare system on which the necessary focus for leadership and governance can be developed. Until this is achieved, it is anticipated that significant delays will be encountered in achieving the vision of integrated care.

Society recognises nursing as a profession which provides a valuable and essential service for the maintenance and promotion of health of the people. When nurses enter the profession, they enter into an unwritten contract with society (Kunene, Nzimande, & Ntuli, 2001). Nurses have traditionally been mandated to provide professional caring services that are of the highest standard. In an Irish context this has been made more explicit by the professional regulatory body which argues that nursing should be more responsive to society's needs and care delivered both autonomously and in collaboration with other healthcare professionals (NMBI, 2014). Nursing, therefore, is not mandated to be isolationist in ethos or practice, but rather part of a holistic and integrated support system for societal health needs (Ryan, 2008). This mandate from society also has a strong influence on how nurses regard themselves and how they view their professional identity within this context.

However, there is growing evidence from patients, the public, and nurses themselves that the profession has failed to provide quality basic nursing, or indeed, fundamental care, as consistently as needed (Kitson, Marshall, Bassett, & Zeitz, 2013). Reports of insensitive and incompetent practice assert that failure to assure these aspects of basic care often lead to wider patient safety failures and in some cases, an increased mortality rate (Kitson et al., 2013). Failure to deliver the fundamentals of care was identified in several reports and studies (Abraham, 2011; Francis, 2013; HIQA, 2013), demonstrating that most of the care missed on a regular basis is related to basic nursing care practices (Adamsen & Tewes, 2000; Kalisch, 2006). These reports have also initiated intense debates on the subject among nurses, other professional groups and public stakeholders (Francis, 2013; Keogh, 2013). In

the UK, the Francis Report (2013) highlighted deficiencies in the provision of basic care elements and supportive work environments within a system motivated by quantitative targets. In a European study by Ausserhofer, Zander, Busse, Schubert, De Geest, Rafferty..., & Schwendimorn (2014) into the prevalence of nursing care left undone, it was found that nurses' highest priority activities are those which, if omitted, are likely to have immediate negative consequences for the patient's physical health; their lowest are time-consuming activities or activities for which the required time-effort is difficult to estimate.

According to Kitson et al. (2013), there is international agreement that nursing is facing a series of challenges to the way it operationalises caring. These challenges can have an effect on how nurses view themselves and how their professional identity is shaped. There are ongoing tensions in producing caring, compassionate nurses in a contemporary healthcare context that tends not to value caring attributes, and places importance on such outcome measures such as waiting times and cost-effectiveness (Docteur & Coulter, 2012; Hollander & Prince, 2008). It may be argued that these tensions have arisen from local, national, and professional healthcare objectives where, for example, nurses have assumed extended roles in clinical practice environments, and, indeed, where the impact of nursing staff shortages have resulted in the contention that addressing fundamental care activities are not considered a priority in demanding clinical settings. In addition, it may also be argued that the access to and impact of educational opportunities have contributed to nurses' notions that the achievement of educational qualifications elevates them above the traditional nursing role. McNamara (2005) and Meerabeau (2004) propose the idea that nurses may be 'getting above their station' and they claim this notion stems from the advantages of accessing higher education opportunities. As a result of these opportunities Templeton (2004) declares that nurses are 'too clever to care' with Hall (2004) adding that nurses are now 'too posh to wash'. Franco and Travares (2013) claim that professional education and training have not kept pace with healthcare challenges, largely because of fragmented, outdated and static curricula that produces ill-equipped healthcare personnel. It is important for the nursing profession to recognise its contribution to this important mandate, and to be instrumental in transforming the aspects of patient care for which it is responsible. However, it must also be acknowledged that many in the nursing profession attain the provision of safe, appropriate and effective care, irrespective of their educational achievements, and in conjunction with the wider healthcare team.

#### **4.7 Contexts**

A distinctive feature of professional identity is its reference to work and the workplace. Beijard, Meijer, and Verloop (2004) claim that there is much emphasis on the ‘personal’ and an underestimation of the contextual side that plays a part in professional identity formation. An adequate understanding of nurses’ professional identity must also incorporate recognition of the diversity of contexts in which nurses undertake their practice. As suggested in the previous section, nurses work in extremely complex and evolving environments both in primary and secondary care settings and attaining a patient-centred focus can prove challenging at times. Despite such challenges, the work context is important for the development of registered nurses’ skills, expertise, and identity as nurses.

It is essential that an understanding of nurse professional identity should not be limited to areas such as academia, professional affiliations and graduate transition into the workplace. Rather, comprehensive and clear description of professional identity in nursing requires specific attention to the workplace settings where social actions underpin the demands of the nursing profession (Miro-Bonet, Bover-Bover, Moreno-Mulet, Miro-Bonet, & Zaforteza-Lallemand, 2014). As global healthcare systems have been subjected to financial constraints and reform initiatives, existing healthcare roles, including those of nursing, have responded by facilitating the introduction of new and evolving roles in order to address the demands of a contemporary healthcare service. On a local level within emergency department contexts, the need to develop a flexible and responsive workforce has been driven by the introduction of specific targets designed to meet the national policy agenda in emergency care. The work environment is not only significant for identity development, it can also influence nurses’ decision-making and approaches towards the uptake of both formal and informal educational activities.

#### **4.8 Socialisation**

This study sought to explore the influencing factors and experiences of emergency nurses who pursue programmes of higher education. A central tenet of this study was that an understanding of the efficacy of influencing factors and experiences can be gained only by way of an understanding of the manner in which these emergency nurses viewed themselves and their personal and professional identities. In the previous chapter, a framework was sketched for understanding how human beings come to a sense of personal self and in this section a similar task is undertaken to understand the construction of professional identity. One of the most powerful agents in the formation of professional identity is socialisation and therefore this section begins by exploring the idea of socialisation within professional

identity. It is argued that being a nurse is more than having a sound knowledge base and repertoire of skills, this being is shaped by the process of socialisation.

This section first sets out to explore what is meant by professional socialisation and the process of professional socialisation. To understand professional socialisation, however, it must be viewed within the wider concept of socialisation. Additionally, the concept of personal and professional values within nursing will be discussed and how these values may shape and inform their decisions to pursue higher education.

#### **4.8.1 An Overview of Socialisation**

Similar to the concepts of identity and professional identity, defining socialisation is not straightforward. There are many varying and competing definitions most of which describe a process whereby individuals acquire a personal and / or professional identity and learn the values, norms, behaviours, and social skills appropriate to their social and professional positions. Socialisation can be defined as the ‘process by which individuals acquire knowledge, skills, and attitudes that make them effective members of society’ (Weidman, Twale, & Stein, 2001). Chatman (1991) states that socialisation involves requiring the requisite knowledge and skills and also the sense of occupational identity and internalisation of occupational norms typical of a fully qualified practitioner. It may be argued, however, this definition of socialisation does not acknowledge that this process can begin while the practitioner is a student. Socialisation is the process during which people learn the roles, statuses, and values necessary for participation in social institutions. In most descriptions and analyses, socialisation is regarded as a lifelong process that begins with learning the norms and roles of the family and subculture, and making self-concept (Dinmohammadi, Peyrovi, & Mehrdad, 2013).

Baumeister (1996) concedes the importance of freedom of will which individuals themselves have, but on the other hand, admits that nobody can develop their identity by ignoring the socio-cultural context. In this sense, the person grows and change depends on the social systems of which they are a member. Within the literature, the concepts of socialisation and professional socialisation are often used interchangeably. The concept of professional socialisation will now be considered in some further detail.

#### **4.9 Professional Socialisation**

There are various definitions of professional socialisation in the literature. Much of the literature describes it as the process of internalising and developing a professional identity through the acquisition of knowledge, skills, attitudes, beliefs, values, norms, and ethical

standards in order to fulfil a professional role (Kilpatrick & Frunchak, 2006; Parsons & Griffiths, 2007; Price, 2009). Weidman (1989, p.296) claims that professional socialisation is a social process, which includes the formation of a professional identity, where students come to view themselves as members of a profession with the knowledge and responsibilities which attend membership. Weidman et al. (2001) also describe professional socialisation as a process by which people acquire the knowledge, skills and disposition that makes them more or less effective members of a profession. They further contend that it is a subconscious process whereby people internalise behavioural norms and standards and form a sense of identity and commitment to a professional field. This is perhaps the most comprehensive definition of professional socialisation. Professional socialisation may be described as a process and an outcome (Lai & Pek, 2012). When described as a process, it is the transmission of values, norms, and ways of seeing that are unique to the profession. When described as an outcome, it is the formation of a self-view as a member of a profession with the requisite knowledge and responsibilities. A closer look at each of these aspects will provide a more detailed frame to the concept of professionalization that can then be utilised in this thesis.

#### **4.9.1 Professional Socialisation as a Process**

Most definitions emphasise the process nature of the concept. In the literature, the socialisation process is described as complex and diverse (Mackintosh, 2006), unpredictable and uncertain (Howkins & Ewens, 1999), iterative and nonlinear (Price, 2009), involuntary (Dalton, 2008), inevitable (Mooney, 2007), dynamic and ever-changing (Kralik, Visentin, & van Loon, 2006; Price, 2009), and personal (Messersmith, 2008). The literature also suggests that the process has no specific pattern; it can move backward and forward, and its progress and activities are irregular and unpredictable (Howkins & Ewens, 1999). Professional socialisation, however, is widely regarded as an ongoing process and a facet of lifelong learning (Weis & Schank, 2002). The socialisation process is not linear; it has an integrated, dynamic, developmental, and flexible nature (Weidman et al., 2001). Moreover, this process is personal and varies from person to person. Additionally, professional socialisation is also seen as the subconscious internalisation of values, customs, obligations, and professional responsibilities, and it is an inevitable consequence of entry into any profession (Mooney, 2007; Tradewell, 1996). Professional socialisation, however, is the only periodic process of socialisation that continues throughout an individual's life (Page, 2004).

Taking these claims together, and in light of the evidence provided by the studies cited, the most salient and dominant features of the process of socialisation in general can be taken as a diverse and ongoing process of knowledge, values and skill acquisition whereby an individual internalises behavioural norms and standards to form a sense of professional identity and commitment to a professional field. It is these features which will be integrated later into the framework employed in this thesis to interrogate and analyse the socialisation aspect of the professional identities of emergency nurses.

#### **4.9.2 Professional Socialisation as an Outcome**

Zarshenas et al. (2014) claim that the ultimate goal of professional socialisation is to develop at least a semi-stable and partially durable professional identity that becomes part of a nurse's personal and professional self-image and behaviour. This goal, according to Zarshenas et al. (2014) is achieved through the exposure to multiple socialisation agents who are the individuals initiating the socialisation process. Socialising agents that nursing students encounter include clients, faculty, colleagues, other healthcare professionals, family, and friends. Indeed, these socialising agents are constant throughout a nurse's professional lifespan. The outcome of professional socialisation is to allow these individuals to communicate effectively. By interacting with different groups of people, students have the opportunity to learn different experiences from each other and subsequently contribute to professional self-development. As a result of professional socialisation, students' pre-set values are replaced with the values of the nursing profession. The change in one's values will subsequently result in a change in behaviour.

#### **4.10 Professional Socialisation in Nursing**

I now turn to the specific literature and previous analysis of professional socialisation in nursing. Professionalism is a fundamental concept in nursing and arises from initial education and training in the workplace, interaction, and interpersonal relationships throughout the professional work cycle. From the professional perspective, 'being a nurse' is more than just a series of activities and skills; it is, in fact, a part of the process of 'socialisation', which involves internalisation and development of professional identity (Zarshenas et al., 2014). Developing as a nurse is a sense of becoming, involving personal commitment and internalisation of values during the process of professional socialisation. There are various definitions of professional socialisation in the nursing literature, most of which describes it in the same way as the general literature treated above, as a process of internalising and developing a professional identity through the acquisition of knowledge, skills, attitudes, beliefs, values, norms, and ethical standards in order to fulfil a professional

role (Kilpatrick & Frunchak, 2006; Young, Stuenkel, & Bawel-Brinkley, 2008). These areas are evident within the narratives of emergency nurses in this study. Dinmohammadi et al.'s (2013) concept analysis of professional socialisation in nursing defined professional socialisation as a process with attributes of learning, interaction, development, and adaptation.

Specifically in nursing, socialisation begins upon entry into the nursing programme and continues with entry into the workforce. Professional socialisation is a critical aspect of nursing students' development which begins with entry into the nursing programme and continues with entry into the workforce (Marcum & West, 2004). Similarly, Sabanciogullari and Dogan (2015) assert that primary socialisation takes place through the undergraduate nursing curriculum while secondary socialisation evolves as nurses enter the working environment after graduation. It is both an intended and unintended consequence of the educational process and work experience (Nesler, Hanner, Melburg, & McGowan, 2001; Shinyashiki, Mendes, Trevian, & Day, 2006), and plays an important role in the development of professional identity. Students are exposed to various socialising agents and these agents convey norms and expectations related to their membership in the university and hospital community. Undergraduate and new nurses enter the profession with a beginning skill set, reflective of their education, coupled with preconceived values and ideas about the profession itself. It may also be argued that the socialisation process does not end on completion of undergraduate and pre-registration nurse training. Rather, it can be perceived as a process that evolves according to the professional occupational context. In this study, emergency nurses highlighted how the transition to the ED required the learning of new skills, knowledge, and values as part of the socialisation process. This area will be further highlighted and discussed later in this thesis.

Mackintosh (2006) claims that socialisation in the profession of nursing is an ongoing and interactive process by which the professional role is learned and the individual consciously and subconsciously seeks their sense of professional identity. Factors underpinning socialisation include the provision of comprehensive orientation and educational programmes, qualified role models, educational facilities, supportive educational and clinical environments (Mooney, 2007). In order to be socialised into a profession, one has to internalise the values and norms of the profession in their own behaviour and responsibilities. Internalising values of the nursing profession is paramount to professional development because such values provide a foundation for behaviour.



#### **4.11 Values in Nursing**

It has been highlighted how values contribute to the sense of professional identity and the process of professional socialisation. Since values feature in these developmental processes, exploring the concept is worthy of some consideration. It is a fair assumption that values can be found at the core of human behaviour and underpin actions and decision-making. They also provide a framework on which personal, social, and professional behaviour can be defined. Rassin (2008) suggests that a value is a preferred or desirable belief or attitude. Horton, Tschudin, and Forget (2007, p.717) propose that values reflect what is important and worthwhile. They further claim that while values define individuals, societal and cultural factors can also impact on how personal values are defined.

Values reflect our commitments and influence our perceptions, guiding our behaviour even if we do not articulate them to ourselves or others (Aroskar, 1995, p.84). They are standards for action preferred by practitioners and the professional group and can be used to evaluate the integrity of the individual and the organisation. Value formation has cognitive and affective components, including both intellect and feeling. They represent basic convictions of what is right, good or desirable, and motivate both social and professional behaviour. As a result, research regarding values is particularly helpful in providing ways to understand individuals' reactions to different situations. In addition, within the context of this study, consideration of emergency nurses' personal and professional values assisted in framing their perceptions of self, identity, and professional identity. Moreover, values were considered with the pursuance of higher education in mind.

##### **4.11.1 Personal Values**

Personal values are concepts that guide individuals during their life. Personal values will be developed through being influenced by family, culture, society, religious belief, and ethnicity (Blais & Hayes, 2010, p.108). Such concepts include benevolence, self-direction, and power. Personal values significantly influence preferences and beliefs on an individual level. Values that a person holds may determine their personal needs, social and cultural influences and interactions with significant others. Most only observe a few prominent values in their lives. They may be also unaware of the values that influence their behaviours. At the heart of understanding values and the meaning this has for nursing, is the acknowledgement by some authors that personal values can influence professional behaviour (Ingersoll, Witzel, & Smith, 2005; Whalley-Hammell, 2014).

#### **4.11.2 Professional Values**

The nursing profession is grounded in many personal and professional values. It is recognised that personal values can influence professional behaviour, actions, and decisions (Ingersoll et al., 2005; Whalley-Hammell, 2014). In addition, professional values reflect personal values and those values gained in nursing through the process of socialization (Shahriari, Mohammadi, Abbaszadeh, Bahrami, & Fooladai, 2013). In addition, professional values guide nurses' interactions with patients, the multidisciplinary team, and the wider community (Ilaslan, Geckil, Kol, & Erkul, 2020). According to Altun (2002), the prevailing values in nursing include aesthetics, altruism, equality, freedom, human dignity, justice, and truth. Farag, Weheida, and Badr's (2020) study on professional values and factors influencing their development highlighted how nursing students perceived caring, justice, and activism to be more important than trust and professionalism as nursing values.

The role that values play in nursing is expressed in the literature in various ways, including ways in which values are developed and viewed by nurses, and the influence of values on workplace satisfaction and culture (Ingersoll et al., 2007; Manley, 2004). Farag et al. (2020) claim that professional values form the basis of nursing practice and are essential to high quality nursing care, the development of critical thinking and communication skills, job satisfaction and retention. Lin, Li, Shieh, Kao, Lee, and Hung (2016) also claim that professional values can assist in rectifying some contemporary issues in nursing such as staff shortages. Maben, Latter, and Clark (2007) identified that nursing values are developed during nurse training and can be attributed to the many ethical codes and requirements imposed on students early in training. The authors suggest that core values, such as being ethically responsible and accountable, are important for the profession. Similarly, Ilaslan et al's (2020) quantitative study examining the professional values of nurses revealed that professional values are instrumental in the formation of professional identity and increase professional commitment. However, it remains unclear as to whether professional values influence the decision to pursue programmes of higher education.

Farag et al. (2020) state that the development of nursing values is a critical component of undergraduate nursing education. Posluszny and Hawley (2017) further state that incorporating professional values in undergraduate education so that nurses can provide ethical nursing care, support the image of nursing, and prevent moral distress in a healthcare environment that is both multidimensional and complicated. A study by LeDuc and Kotzer (2009) found that professional values were similar across three generations of nurses with a greater emphasis placed on professional values such as competence and collaboration

compared to societal values such as patient safety and advocacy. Whether there is a difference between personal and professional values, and what impact this may have on nursing practice and the decision to pursue programmes of higher education remains unclear. Watson (2002) offers some insight by suggesting that personal values play an important role in nurses' interactions within the workplace. If there is any conflict between personal values and organisational values, nurses can be challenged and tend not to follow a directive or requirement with which they disagree. Nurses bring with them both professional and personal values to their working environments, and while these values may certainly guide a nurse to maintain high professional standards and nursing care (Parvan, Zamanzadeh, & Hosseini, 2012), Drayton and Weston (2015) contend that the contribution or impact of their values on nursing practice remains to be fully elucidated. Similarly, it is unclear if professional values impact on educational decision-making.

The acquisition and internalisation of values espoused by the profession are central to professional development and provide for a common framework on which expectations and standards can be developed (Weis & Schank, 2002). Internalisation is the process of acceptance of a set of norms and values established by individuals or groups which are influential to the individual through the process of socialisation. It is within the nursing educational programme that a student develops, clarifies, and internalises professional values. The process starts with learning what the norms are, and then the individual goes through a process of understanding why they are of value or why they make sense, until finally they accept the norm as their own viewpoint and integrates the adopted values into their behaviour and actions. Farag et al.'s (2020) study also sought to explore the factors affecting nursing values development. One of the main factors identified was that of communication. Students cited respectful relationships with educators and hospital staff as important in the development of professional nursing values. Work ethic was also another factor observed in professional value development. Another influential factor related to the workplace where students cited nurse role models, including registered staff and nurse educators, and cooperation within the multidisciplinary team as influential in professional value development.

#### **4.12 Conclusion**

This chapter explored the concept of nurses' professional identity in terms of professional criteria, socialisation, and values. I began by exploring how professional identity is defined within the nursing literature. It is evident that within the nursing literature, the concept remains vague and poorly understood and not aided by competing definitions. I then

discussed professional identity formation and the relevance of professional identity to nursing. I also explored the criteria of a profession and the foundations on which the idea of profession is based. I then addressed the concept of socialisation within professional identity. It is evident that socialisation is a significant agent in the development of professional identity and therefore worthy of consideration within the context of this study. Since nursing is a discipline rich in values, I also explored the idea of personal and professional values as a component of socialisation and professional identity development.

This literature review has demonstrated a number of areas worthy of consideration which will form the foundation of this study. Overall, there is limited data, both on a national and international level, regarding both emergency nurses' perceptions of self and identity and their decision-making regarding higher education pursuance. Indeed, the impact of higher education on sense of self, identity, and professional identity is also somewhat lacking. Additionally, since values also contribute to the sense of professional identity, these will also be considered when exploring emergency nurses' sense of identity and influence in educational decision-making. These areas are worthy of further consideration given the current healthcare context with limited scope for upward mobility and with no professional regulatory requirement in Ireland to engage in higher education activities. In view of this, I would firstly like to explore emergency nurses' sense of self and identity. I would then like to ascertain if there is a connection between sense of self and identity with regard to emergency nurses' decisions to participate in higher education. I would also like to explore if engagement with higher education enhances the sense of self and identity. The next chapter will illustrate the theoretical framework underpinning this thesis.

## **Chapter 5 - Theoretical Framework**

## **5.0 Introduction**

This study explored the decision-making strategies of Irish emergency nurses regarding higher education uptake through the lens of self and identity. I have argued in the previous chapters that the concepts of self and identity are inherent and enduring forces which feature significantly throughout individuals' personal and professional lifespans. Additionally, further consideration of these concepts relative to decision-making was deemed to be appropriate particularly in light of the socioeconomic downturn in Ireland between the years 2008 - 2013. Arguably, the subsequent actual or potential fiscal repercussions may have impacted negatively on higher educational uptake given that further educational and professional opportunities on foot of higher educational attainment, was not guaranteed. However, as has been illustrated, engagement with higher education activities among registered nurse in Ireland has remained largely consistent over recent years. It may, therefore, be argued that the pursuit of higher education among emergency nurses could, in part, be due to the enduring forces of self and identity.

In order to illuminate these concepts and decision-making strategies more comprehensively, a theoretical framework was applied to this study. The application of such a framework both guided the study and focused the findings so that the research aims and objectives could be appropriately addressed. The theoretical foundations of this study were informed by the work of French philosopher and historian, Michel Foucault (1926-1984), and his concepts of governmentality and disciplinary power provided the frame of reference. Informing the exploration and analysis of higher education uptake among emergency nurses, the ideas presented are not a complete summary of his work, but rather an outline of the main theoretical ideas used in this thesis. In this study, I took an approach that is informed by Foucault's thinking which encourages the examination of how power in different groups, organisations, and institutions operates subtly, and on multiple levels, to influence the behaviour of a population. One of the key theoretical premises of my study was that power is significant in the educational decision-making of emergency nurses.

This chapter will firstly set out to explore the purpose and relevance of theoretical frameworks generally. I will then focus on the relevance of social theory application, and the central ideas behind modern social theory. I will then introduce Foucault as the theorist of choice in the development of an appropriate theoretical framework. From there, the concept of power, disciplinary power, and governmentality will be examined. I will then consider both the application of these concepts to this thesis and potential limitations of the Foucauldian approach.

## **5.1 Theoretical Frameworks**

Grant and Osanloo (2014) state that the theoretical framework is one of the most significant features underpinning a research study. Utilising such frameworks can assist in providing direction and even facilitate academic debate throughout the course of the study. In the case of this thesis, the application of a theoretical framework strengthened the study in several ways. Using a theoretical framework for this study allowed for the approach to data collection to be comprehensive with the research aims and objectives in mind and for the findings to be explored and revealed more meaningfully. I positioned the theoretical framework within the broader context of social theory and endeavoured to develop a framework for understanding the research problem. I will aim to clearly describe the concepts and theories that have underpinned my research. This included noting the key theorists in the area and the historical context that supports the formulation of the theory.

## **5.2 Appropriate Theoretical Framework**

The work of several contemporary theorists has been influential in the area of social theory. In choosing an appropriate theoretical framework for this thesis, theorists of diverse theoretical origin were considered. The work of Bourdieu and Foucault, for example, has been noteworthy in the provision of social and diverse interpretations of everyday life. This was an important consideration as the components of everyday life were an important factor in emergency nurses' educational decision-making. Bourdieu and Foucault's work mainly centre around the impact of the state on social structures. These social structures include the family, education, religion, health, and the law, all of which comprise the social structure of society. While Bourdieu's work deals mainly with class structures, the focus of Foucault lies with how power is exercised, with a specific focus on how power operates in areas such as asylums, hospitals, and prisons. Both Bourdieu and Foucault provide important insights into the process and application of power and insight into how power can shape the preferences and decision-making of individuals. Again, this was a key consideration in the development of an appropriate theoretical frame with the research questions in mind. While Bourdieu's theories are firmly grounded in a wide body of sociological research and across a range of social issues, the work of Foucault was considered to be more appropriate in underpinning this study theoretically.

## **5.3 Michel Foucault**

The writings of the French philosopher Michel Foucault underpinned the theoretical framework of this thesis. Specifically, I focused on two of Foucault's concepts, disciplinary power and governmentality, in illuminating emergency nurses' stories of

higher educational decision-making and educational experiences. The work of Foucault was chosen to underpin this study's theoretical framework for several reasons which I outline here. One of the most important reasons related to Foucault's description and understanding of how power works subtly in social life. This is particularly relevant in relation to how routine practices and ideas structure our personal and professional experiences, and sense of self and identity. Additionally, using Foucault's concepts of disciplinary power and governmentality provided a succinct platform on which to uncover the forces inherent in the underlying power structures of personal and professional life, and to explore how these powers shaped and influenced educational decision-making. Over recent years, the nursing profession has witnessed significant professional and political change and these powers not only influence individual decision-making but can also reshape both the educational and professional landscapes themselves. It is also apparent that Foucault's concepts, particularly power, government, and discipline, have previously been utilised in educational research studies (Fejes & Nicoll, 2015, p.12; Kopecky, 2012). I will now illustrate Foucault's concept of power.

#### **5.4 Foucault's Concept of Power**

The later works of Foucault, such as *Discipline and Punish*, present his understanding of power as an enabling force, rather than a force that is usually understood to be dominating and repressive in nature. This perspective is significant because power is usually perceived as being a negative force. Foucault's main focus within his notion of power was how power was exerted over individuals by systems and institutions, usually this power was exerted at the lower end of hierarchial systems. This is an important perspective as most emergency nurses in this thesis were employed at the level of staff nurse in the emergency department which would be considered at the lower end of the nursing hierarchial system.

With this in mind, the value of Foucault's approach is in his emphasis on the dynamics of power. It may be argued, however, that a potential limitation in using this approach is there may be a tendency to dismiss the broader or more generalised conditions associated with power structures. From an emergency nursing perspective, this could refer to the nursing professional regulatory body, management structures within healthcare organisations, or management structures at governmental level. However, it is apparent that Foucault's focus is directed at the routine and covert governing practices which are embedded in actions and behaviour among individuals.



### 5.4.1 Power

The concept of power is a significant feature of contemporary society and an unavoidable component of personal and professional life. It is one of the key concepts that appears in the works of Foucault. Dahl (1957) states that while power may be viewed as a relation among people and inanimate objects, it is specifically a relation among people. With this in mind, Turner (2005) claims that power has the capacity for influence and that influence is based on the control of resources valued or desired by others. Specifically, within nursing, power has been defined as having control, influence, or domination over something or someone (Chandler, 1992). This can be seen in a professional capacity where nurses, both knowingly and unknowingly, possess certain powers and control over patients and service-users.

While Weberman (1995) asserts that power may be linked to punishment, Foucault considers the concept in more positive and productive terms, whereby power can be exercised in a way that generates little conflict. This idea will be important in this thesis particularly when the forces underpinning decision-making will be highlighted. The finer forces of power, the forces that generate little conflict, are evident when emergency nurses, for example, cite the influence of other emergency nurse colleagues as significant in their educational decision-making. This will be further highlighted in the Findings and Discussion chapters. For Foucault (1979, p.194), power provides a constructive and positive platform, productive of opportunities, dismissing the notion of power as a solely repressive and negative exercise:

‘We must cease once and for all to describe the effects of power in negative terms: it “excludes”, it “represses”, it “censors”, it “abstracts”, it “masks”, it “conceals”. In fact, power produces; it produces reality, it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him [sic] belong to this production.’

Similarly, Kanter (1993, p.201) also illustrates the positive aspects associated with power, identifying it as ‘the ability to get things done, to mobilise resources, to get and use whatever it is that a person needs for the goals they are attempting to meet’.

According to Foucault (1990, p.92), power must be understood within the ‘numerous force relations within which they operate and which also constitute their organisation.’ Force relations are basic units of power found within social interactions and which influence an individual to behave in a certain way. In nursing, the nurse-patient relationship and

underlying interactions are the result of a variety of power sources, including clinical, personal, professional, and organisational. Clinical power is one form of power that is found at the core of the nursing profession and of individual nurses. The most significant legitimate clinical power that all nurses possess is their professional registration. Professional registration requirements provide the 'force' for nurses to practice. Nurses are compelled, through their professional registration, to provide safe and competent care based on acquired skills, knowledge and continuing education in accordance with a professional code of conduct and within a defined scope of practice.

St. Pierre and Holmes (2008) claim that nurses have portrayed several aspects of their work environment as oppressive describing situations of 'powerlessness, exploitation, marginalisation, and physical and interpersonal violence.' Similarly, Peter, McFarlane, and O'Brien-Pallas (2004) report perceptions of the workplace being dominated by 'medical or business values where nursing perspectives were marginalised.' Holmes and Gastaldo (2002) further contend that nurses perceive their practices to be shaped by economic and healthcare reforms and feel powerless when they intend to provide quality care but are required to support employers' strategic plans and keep the system running under almost any circumstance. However, within emergency nursing, the initiation of the HSE EMP presented a comprehensive and ambitious strategic plan for emergency care in Ireland. The EMP, launched in 2012, heralded a novel programme approach led by a multidisciplinary working group including Consultants in Emergency Medicine, Emergency Nurses and the therapy professions. Here, the ENIG provides a forum for emergency nurses to inform the nursing agenda at local and national level, contributing to the future development of emergency nursing services.

#### **5.4.2 Disciplinary Power**

The concept of disciplinary power concerns individuals and, indeed, nurses. Disciplinary power was a significant form of power for Foucault, one that is exercised over individuals to produce effects on aspects of their lives such as behaviour, attitudes, and conduct. Foucault (1979, p.7) states that "we are never dealing with a mass, with a group, or even, to tell the truth with a multiplicity, we are only ever dealing with individuals." Foucault (1979, p.11) further describes how discipline 'makes' individuals; it is the specific techniques of a power that regards individuals as objects and as instruments of its exercise. As previously highlighted, the intended impact of this type of power is not always negative in nature and, according to Hindess (1996, p.112), this form of power can help individuals achieve particular skills and new knowledge or to render them ready for instruction. Disciplinary

power trains and enhances individuals, utilises people's productive potential, makes optimal use of their capacities, and makes them more obedient as they become more useful (Foucault, 1977, p.170).

It was Foucault's belief that disciplinary power succeeded by utilising the 'simple instruments' of hierarchial observation, normalising judgement, and the examination (Foucault, 1977, pp.170-172). Foucault observed how these instruments were first used to make it more efficient to place prisoners under surveillance rather than to punish them. Foucault then found that these same principles also applied to the disciplines of education and healthcare. Hierarchial observation (surveillance) occurs when individuals are monitored through a 'gaze' which forms one part of the overall functioning of disciplinary power. Surveillance is hierarchial, implying visibility from above, with those of a higher rank observing those of a lower rank. The power of surveillance is its ability to normalise particular forms of behaviour that then become internalised, and, it may also be argued, standardised. The idea is that through constant observation, an individual can be encouraged or even coerced into doing something or to behave in a certain way. For example, mentoring and preceptorship systems in nursing serve as a way to create and maintain a particular knowledge base as the authority of the mentor or preceptor exerts power in delivering some knowledge whilst screening out other knowledge. Observation in the nursing profession thus occurs primarily through mentorship or preceptorship, with programmes of education, a code of conduct and ethics, as influential backdrops. Mentors and preceptors can create and track knowledge levels and productivity levels, establish the norms within the clinical setting, and monitor compliance in areas such as documentation and achievement of required learning outcomes. This 'gaze' applies not only to knowledge bases but also to policies regarding how nursing care is delivered both locally, nationally, and internationally.

Normalising judgement is considered an instrument of social control where the individual is both the subject and the object of power. The norm is established through disciplinary techniques. As a disciplinary practice, normalising judgement requires a comparison of individuals' behaviours in relation to a specific rule (Foucault, 1977, pp.177-178). At the centre of normalising judgement is a system of punishment whereby departure from the expected or correct behaviour is enacted. However, punishment does not specifically allude to physical actions. In this case, punishment can be a way of moulding attitudes and behaviours with the aim of normalising these behaviours. In nursing, this idea may be demonstrated through the use of a professional code of conduct. Professional regulatory guidelines are set out by the professional regulatory body to identify expectations for ideal

behaviour. As a technology of normalisation, the purpose is twofold. Firstly, this allows for the identification of anomalies and through this, behaviours can be normalised. Any contravening of a disciplinary code can invoke a punishment and, as such, is aimed at normalising individuals (Foucault, 1977, p.180). Secondly, it highlights the degree to which an individual can claim membership of a homogenous social group.

Examinations are a combination of hierarchial observation and normalising judgement. Foucault refers to this as ‘a surveillance that makes it possible to qualify and to punish’ (Foucault, 1977, pp.184-185). While he viewed the hospital as an ‘examining apparatus’, he was referring to the constant observation of the patient. In terms of education, examination allows for the ordering of knowledge and, if necessary, a process for correction, thus shaping the individual. This in turn will alter behaviour and encourage the production of specific behaviours and values that conform to a particular norm and, indeed, to a social group. It generates a documented record of progress and allows the students to be ‘described, judged, measured, and compared with others’ (Foucault, 1977, p.191). Power is demonstrated through knowledge and skills attainment. The format of a training programme is both a method of surveillance and a form of ranking.

The workings of these ‘simple instruments’ of hierarchial observation, normalising judgement, and the examination therefore ‘create and cause to emerge new objects of knowledge and accumulate new bodies of information’ (Foucault, 1980, p.51). Power does not need certain forms of knowledge. Rather, power acts at levels of desire for knowledge, for example, consideration of factors that influence decision-making. This line of thought will be evident when the findings of this thesis are highlighted and discussed. From his later work on disciplinary power, Foucault further developed his analysis of power, and defined his concept of ‘governmentality’ and this will now be explored in the following section.

## **5.5 Governmentality**

Governmentality is the second component underpinning this study’s theoretical framework. Foucault (1979, p.6) describes governmentality as ‘the ensemble formed by institutions, procedures, analyses, and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power, which has as its target population, as its principal form of knowledge political economy, and as its essential technical means apparatuses of security’ with, according to Morrissey (2013), the intention of making subjects governable. According to Nettleton (1999, p.99), the concept of government implies all those tactics, strategies, and aspirations of those authorities that shape beliefs and the

conduct of a population. Similarly, Dean (1999, p.18) claims it involves ‘a plurality of agencies and authorities, of aspects of behaviour to be governed, of norms invoked, or purposes sought, and of effects, outcomes and consequences.’

Rather than imposing the law on people, governmentality makes use of knowledge and expertise to educate and persuade a population towards particular behaviours aligned to government ambitions (Rose & Miller, 1992) and with the intention of maximising life (Lacombe, 1996). Varman, Saha, and Skalen (2011) also argue that governing is a feature of actors and institutions in addition to being a feature of the state. This is a particularly salient observation as the ‘actors’ in this thesis were emergency nurses and the ‘institution’ was the ED setting in a general hospital. Thus, as Dean (1999, p.19) suggests, to analyse government is to analyse those practices that try and shape and work through the choices, desires, and aspirations of individuals and groups. This is particularly appropriate for the lives and work of emergency nurses as they are governable subjects both within healthcare organisation settings and educational settings. The administrative and operational functions of these settings are based upon rules and regulations which the emergency nurse is subjected to, and adheres to, by virtue of assuming employment in an organisation and engaging as directed or as chosen with programmes of education.

In addition to governmentality entailing the development and use of technologies for governing the population, governmentality also refers to the deployment of techniques of the self. Dean (1994, p.196) argues that government of the self is located on the same plane as the government of others and the state. Foucault is one of the key figures in the 20<sup>th</sup> century regarding thought on the self and defines our ‘subjectivity’ as what we make of ourselves when we do devote ourselves to taking care of ourselves (McGushin, 2011, pp.134-135). Care of the self involves a trajectory towards the good and a life that is advantageous for the individual (O’Sullivan, 2010). In understanding this concept, it must be acknowledged that care of the self is understood as a personal choice and judgement made by the individual themselves and not as a result of external influencing factors (O’Sullivan, 2010). This understanding forms a key foundation of this study in exploring emergency nurses’ higher educational decision-making.

Foucault’s (1982) seminar on *The Hermeneutics of the Subject* illuminates his meaning of care of the self. Firstly, care of the self is ‘a certain way of considering things and having relations with other people’, it is an ‘attitude towards the self, others, and the world’. Secondly, it is a ‘form of attention, of looking’, ‘a certain way of attending to what we think

and what takes place in our thought'. Finally, and perhaps most importantly, it also names a series of actions or practices that are 'exercised by the self on the self' and 'by which one takes responsibility for oneself and by which one changes, purifies, transforms, and transgresses oneself.' It may also be considered a platform from which to uncover a truth that is otherwise hidden. In other words, the core or true self provides a basis from which intrinsic influencing factors within the individual are developed and actualised. It will be revealed later in this thesis how the desire to actualise the true self is enduring and remains a significant feature into adulthood.

Care of the self is what we do in order to form a relationship to ourselves. Taylor and Hawley (2010, p.136) state that subjectivity is not a state we occupy but rather an activity we perform. Subjectivity is not distinct from, but is rather formed in and through, relations of power. According to McGushin (2011, pp.128-129), Foucault calls this kind of subjectivity 'hermeneutic' or 'confessional' because it is formed through the activities of self-interpretation and self-expression. While confession means acknowledging, it also involves disclosure. The acknowledgement occurs when one discloses one's private feelings or opinions that comprises one's identity (Besley, 2005). McLaren (2002, p.152) states that confession involves a double sense of subjectification; one is compelled to tell the truth about oneself by institutionalised norms, but at the same time the individual, through this confession, constructs themselves and their identity through this articulation. Foucault (1990, p.21) states that by practising these activities we become a specific kind of self:

'The confession has spread its effects far and wide. It plays a part in justice, medicine, education, family relationships, and love relations, in the most ordinary affairs of everyday life, and in the most solemn rites; one confesses one's crimes, one's sins, one's thoughts and desires, one's illnesses and troubles; one goes about telling, with greatest precision, whatever is most difficult to tell... *Western man [sic] has become a singularly confessing animal.*'

However, Oliver (2010, p.64) argues that the subjective self does not exist because of the free will and autonomy of the individual. Rather, identity is created through systems of socialisation over which the individual has little control. However, this argument is not entirely accurate. While individuals may have little control over the origin and direction of socialisation practices in their early years, they do, however, have control and influence on socialisation during their adult years. Furthermore, as a professional group, emergency nurses do practice free will and autonomy, particularly within educational activities. This is

evident by emergency nurses who undertake educational courses that are not a compulsory professional regulatory requirement.

Rose and Miller (1992) claim that governing is as much about practices of government as it is about the practices of the self because the concept of governmentality deals with those practices that try to shape the desires and aspirations of individuals and populations. Here it is argued that governing is more concerned with enabling individuals to develop their potential. Power is also exercised in this way but it is more productive and enabling rather than constraining.

‘He has to take into account the points where the technologies of domination of individuals over one another have recourse to processes by which the individual acts upon himself. And conversely, he has to take into account the points where the techniques of the self are integrated into structures of coercion and domination. The contact point, where individuals are driven by others is tied to the way people conduct themselves, is what we can call, I think, government. Governing people, in the broad meaning of the word, governing people is not a way to force people to do what the governor wants; it is always a versatile equilibrium, with complementarity and conflicts between techniques which assure coercion and processes through which the self is constructed or modified by himself.’ [sic] (Foucault, 1993, pp.203-204).

## **5.6 Application of Disciplinary Power and Governmentality to this Thesis**

Cheek (2000, p.18) asserts that postmodern social theories have been strongly influenced by theorists such as Foucault. Postmodern thought allows the world to be examined from multiple perspectives in terms of class, gender, and other identifying group affiliations (Agger, 1991). According to Best and Kellner (1991, p.4), postmodernist perspectives reject the modernist notion of social coherence in favour of multiplicity, plurality, and fragmentation. In doing so, postmodern thought acknowledges the reality of multiple perspectives, voices, and views within individuals’ social worlds. This, according to Cheek (2000, p.20), has implications for research and researchers because if reality is made up of multiple perspectives then it follows that no single representation can hope to capture the truth of a social situation. Rather, through postmodern approaches, opportunities will be created to explore aspects of social situations that might otherwise have been taken for granted. Agger (1991) claims that Foucault supports the use of everyday experience and ordinary language to illustrate knowledge bases and argues that ‘every knowledge is contextualised by its historical and cultural nature’ which inevitably requires the researcher to identify ‘their own investment in a particular view of the world.’ As a result, the

importance of recognising how experiences and contexts can frame an individuals' view and experience of the world cannot be overemphasised. This will become evident later in this thesis when consideration is given to the participants' stories regarding their backgrounds, opportunities, and experiences both on a personal and professional level.

Using Foucault's concepts of disciplinary power and governmentality as best interpretative frame, provided a rich theoretical framework on which to understand emergency nurses' approach to educational decision-making. It is apparent from previous studies pertaining to higher education decision-making among the general nurse population, highlighted earlier in this thesis, that the principles of disciplinary power and governmentality, while not overtly articulated in terms of these actual concepts, were evident and operated on subtle levels in relation to educational decision-making. Since the area of higher education uptake among emergency nurses had not been previously considered, I wanted to understand if these principles were also pertinent factors in emergency nurses' decision-making. In addition, and with the concepts of self and identity in mind, I felt that underpinning my theoretical framework with the principles of disciplinary power and governmentality would enable for specific insights to be revealed regarding both the overt and covert powers at play regarding higher education decision-making. In addition, these concepts have also assisted in uncovering the experiences of emergency nurses as they have transitioned into and completed programmes of higher education. Since the area of higher education decision-making among emergency nurses was not previously considered or explored within the nursing literature, these concepts provided an appropriate framework from which to explore how this group of healthcare professionals perceived and experienced their higher education journeys.

### **5.7 Limitations of the Foucauldian Approach**

While the work of Foucault has underpinned the theoretical framework of this thesis, it is also appropriate, however, to consider some of the limitations of Foucault's theoretical assumptions. Kollosche (2015) claims that there is much fragmentality to Foucault's writings which is in keeping with the postmodernist notion. By this he means that Foucault did not generate a specific social theory, but rather developed and discarded his ideas according to how society evolved. With this in mind, it may also be argued that the problem with Foucault's approach is that there may be a tendency to overlook the more generalised conditions concerning power such as those which exist on a more broader scale and which may be as significant as the power forces operating on a smaller, more local level. Kollosche (2015) further claims that every scholar has 'his or her own Foucault' in



the attempt to develop an understanding of Foucault's theoretical stances. There has also been some criticism surrounding his interpretation of power. McNay (1994, p.104) is critical of Foucault's 'technical' perspective of the concept. While Foucault may be able to describe the complexities of power processes, these descriptions fail to highlight any proposals for improvement within social contexts. Additionally, Kollosche (2015) suggests that Foucault's theory of power is limited in what it can describe and suggests that other theories may prove more useful for the derivation of moral judgements and for a deeper analysis of learning.

## **5.8 Conclusion**

Through the lens of self and identity, this thesis explored emergency nurses' decision-making and experiences of higher education in Ireland. In order to provide a comprehensive understanding of these decision-making strategies, a theoretical frame was applied to this thesis. The theoretical foundations employed were informed by the work of French philosopher Michel Foucault (1926-1984). Using his concepts of disciplinary power and governmentality as best interpretative frame, a rich theoretical framework was provided to understand emergency nurses' approach to educational decision-making. Since one of the key theoretical premises of my thesis was that power is significant in educational decision-making, I took an approach informed by Foucault's thinking, whereby the notion of power was examined to understand how it both operates and influences the behaviour of a population and, more specifically, emergency nurses. The next chapter will identify the research methodology used to underpin this thesis.

## **Chapter 6 – Methodology**

## **6.0 Introduction**

In this chapter, I discuss the research design constructed to answer the research questions. I will begin by discussing narrative inquiry as the most appropriate methodological approach to answer the research questions underpinning this thesis. While I discuss briefly the tradition of qualitative research, I will describe how the narrative methods employed in the study answer the research questions and support the purpose of the research. I will also demonstrate the relationship between the theoretical frame constructed in the last chapter, methodological approach and methods used in my study within this chapter and build upon the foundations that have been laid out in previous chapters.

I will discuss the theoretical thinking and key conceptual ideas associated with the narrative methodological approach that will be utilised in the study. In developing my argument, I will lay the foundations for a justification of why I chose to undertake a narrative approach to study emergency nurses' sense of self and identity whilst undertaking higher education programmes. I will also demonstrate how I believe that this approach is linked to my own philosophical thinking. The approach to data management in terms of data collection and analysis will also be highlighted, in addition to a description of participant recruitment and ethical considerations. The areas of trustworthiness and rigour will also be identified within the discussion on data management.

The layout of this chapter is organised under a number of sub-sections and headings. I will begin by highlighting the philosophical assumptions within the context of qualitative research, and then concentrate on epistemological assumptions which will ultimately shape and enhance the approach to my research activity.

### **6.1 Qualitative Research**

Qualitative research methods provide a means by which human and social problems can be understood (Creswell, 2012, p.16). One of the main advantages of using qualitative approaches lies in its ability to allow individuals to be studied in their natural setting and for naturally occurring data to be collected. With qualitative approaches, the emphasis is on the meanings that individuals attach to their social worlds through description and the manner in which these meanings influence individuals' actions and behaviour. Qualitative researchers acknowledge that there can be multiple interpretations and perspectives of a situation or social realities (Bowling, 2014, p.370). With this in mind, qualitative researchers understand that multiple realities and interpretations form the basis of participants' social worlds and, as a result, general assumptions about the phenomenon under investigation cannot be made.

Despite the strengths of qualitative methodologies, there are some limitations to using this approach. Silverman (2022, p.11) claims that qualitative approaches can sometimes be dismissive of contextual sensitivities in favour of meanings and experiences. Rahman (2016) argues the issue of generalisability is a significant weakness of the qualitative methodology given the small sample sizes usually associated with studies of this nature. Miller (2010), however, argues that the lack of generalisability is a common misconception regarding qualitative inquiry. Sandelowski, Docherty, and Emden (1997) suggest that qualitative findings are not generalisable in the prevalent sense of the word. Rather, they argue that findings are generalisable in a way that is particularly pertinent to nursing education and practice where findings can be tailored to individuals in their unique contexts. In this thesis, however, the intention is to try to make a contribution to theorising about decision-making among emergency nurses rather than an empirical contribution to generalisation.

While there is increasing recognition of the valuable contribution qualitative research can make to nursing knowledge (Houghton, Casey, & Shaw, 2013), Rahman and Majumder (2014) claim that qualitative approaches have limited influence on both the use and discourse about healthcare evidence. They suggest that knowledge users continue to rely primarily on quantitative findings, particularly in acute care settings. However, Miller (2010) argues that qualitative research is no longer limited to descriptive studies that are used in strictly academic endeavours, or ancillary steps to 'real research'.

## **6.2 Narrative Inquiry**

There are several research designs that underpin qualitative research methods, one of which is narrative inquiry. Narrative inquiry is defined by Clandinin and Connelly (2000, p.49) as a way of understanding experience through stories lived and told. Narrative inquiry is a form of qualitative research that involves the gathering of narratives focusing on the meanings that people ascribe to their experiences, seeking to provide 'insight that befits the complexity of human lives' (Josselson, 2006). Like other forms of qualitative research, narrative inquiry focuses on life experiences, but uses the concept of 'story' to describe and analyse those experiences. Narrative researchers look for ways to understand and then present real-life experiences through the stories of the research participants (Creswell, 2012, p.502). The narrative approach allows for a rich description of these experiences and an exploration of the meanings that the participants derive from their experiences. By using narrative formats to present findings, researchers can access rich layers of information that provide a more in-depth understanding of the particulars of the participants' points of view.

In the latter part of the twentieth century, educational researchers such as Clandinin and Connelly have led the way in adapting narrative inquiry as a research methodology, concentrating predominantly on the personal stories of teachers. It is firmly based on the premise that, as human beings, we come to understand and give meaning to our lives through story (Andrews, Squire, & Tamboukou, 2008, p.3). Narrative inquiry is grounded in interpretive hermeneutics and phenomenology (Josselson, 2006). The primary concern of both is the understanding of the individuals' lifeworld experience and the meaning of language in the context of those experiences.

The purpose of narrative inquiry is to reveal the meanings of individuals' experiences as opposed to objective, decontextualized truths (Bailey & Tilley, 2002). Trahar (2009) proposes that there is more to narrative inquiry than just the uncritical gathering of stories. Riessman (2008, p.23) claims that the goal in narrative interviewing is to generate detailed rather than brief accounts. The knowledge gained through the use of narrative inquiry can offer a deeper understanding of the subject material and extra insight to apply the stories to their own context (Wang & Geale, 2015). Interestingly, Polkinghorne (1995, p.11) contends that it is often only retrospectively that we come to understand and give meaning to events. This was an area of particular interest during the data generation phase of the study as I explored the influencing factors surrounding emergency nurses' decision-making regarding higher education uptake.

Clandinin and Connelly (2000) offer the concept of a three-dimensional narrative inquiry space. The three dimensions of this metaphoric narrative inquiry space are the personal and social (interaction); the past, present and future (continuity); and place (situation). They write:

'Using this set of terms, any particular inquiry is defined by this three-dimensional space: studies have temporal dimensions and address temporal matters, they focus on the personal and the social in a balance appropriate to the inquiry, and they occur in specific places or sequences of places' (Clandinin & Connelly, 2000, pp.54-55).

The idea of working within a three-dimensional narrative inquiry space highlights the relational dimension of narrative inquiry. Narrative inquirers cannot bracket themselves out of the inquiry but rather need to find ways to inquire into participants' experiences, their own experiences as well as the co-constructed experiences developed through the inquiry process. This makes clear that, as narrative inquirers, inquirers, too, are part of the

metaphoric parade (Clandinin & Connelly, 2000, p.61). Researchers also live on the landscape and are complicit in the world they study.

Qualitative studies are often stereotyped as 'soft', in contrast to the 'hard' sciences (Gherardi & Turner, 2002, p.87), but narrative inquiry's soft data can illuminate hard realities (Bleakley, 2005). For example, Rich and Grey's (2003) study on black survivors of violence produced narrative accounts that gave dramatic insight into the lives of a socially marginalised population, rather than reporting on such incidences quantitatively. Similarly, Dillenburger, Fargas, and Akhomada (2008) adopted a narrative inquiry approach to explore personal accounts of violent experiences against the backdrop of Northern Ireland's sectarian and political conflict. Using this methodological approach allowed for the experiences of individual coping, psychological health, and social support needs to be highlighted and addressed in a way that quantitative approaches would not have uncovered. Additionally, it is anticipated that this research, in being able to highlight the range of issues faced by emergency nurses, will provide a range of insights and strategies to assist and enable other emergency nurses in their decision-making regarding higher education.

### **6.2.1 Rationale for use of Narrative Inquiry**

Narratives can help nurse researchers understand patients, nurse-patient relationships, and other issues such as personal identity, and the cultural and historical worlds of the narrators (Wang & Geale, 2015). It has already been highlighted in the literature review how nurses identify themselves personally and professionally, and how various contextual and social influences shape their experiences and decision-making. Using a narrative approach will allow for the uncovering of these deep and layered decision-making choices. The narrative approach also acknowledges human experiences as dynamic entities that are in a constant state of flux (Wang & Geale, 2015). This assumption is quite representative of the human experience, particularly in terms of the emergency nurse experience. This state of flux can manifest itself as socioeconomic structures, processes, and service-user influences that feature predominantly within the context of the professional role. The use of stories within this methodological approach can serve as a primary means for understanding the pattern of an individual life. Chou, Tu, and Huang (2013) assert that 'story makes implicit explicit, the hidden seen, the uninformed informed, and the confusing clear'.

Studies using narrative inquiry as a methodology are found in a wide range of disciplines. These include education (Clandinin & Connelly, 2000), sociology (Riessman, 2008) and social development (Daiute & Lightfoot, 2004). While Wang and Geale (2015) state that the use of narrative research within nursing is relatively new, Lindsay (2006) claims that the

discipline of nursing has well-embraced narrative inquiry. This contention is not entirely accurate as literature searches on narrative inquiry within nursing research activities indicate that the majority of narrative inquiry studies are only apparent from 2012. These studies include Hsu and McCormack's (2011) study on practice and service development needs within elderly care, Haydon and van der Riet's (2014) study on humour in nursing, and Law and Chan's (2015) study on communication among newly graduated nurses. Indeed, Casey, Proudfoot, and Corbally (2016) claim that narrative research in nursing has only flourished in recent years. A CINAHL database search retrieves a journal article by Gadow (1995) as the earliest result for the term 'narrative inquiry' in nursing literature.

Despite the dearth of narrative approaches to nursing research, nurses are well-placed to use narrative inquiry as the core of their professional practice focuses on their abilities to develop and maintain effective therapeutic relationships through listening, accurately hearing, and appropriately responding to what is being said or sometimes what is not being said. Nursing is familiar with narrative analysis, through the use of health and illness narratives, to gain an understanding of a patient's experience with an acute or chronic condition. Nurses often hear narratives from a patient or family member during the assessment or admission process. Indeed, narratives frequently form the basis of interprofessional exchanges and decision-making. Narratives can also be used as a basis for health promotion and educational activities.

A narrative approach was the methodology of choice in this study. As I have already indicated, I believed it was the most appropriate approach to use in order to acquire the calibre of answers required to address the research questions posed in this thesis. As an emergency nurse, I am well-placed to use a narrative methodology. My professional and personal relationships and interactions are based on narratives. Both narrative research and nursing practice involve the telling and hearing of a unique story, distinct in its content and plot. Elements of the story are likely to link the past, present and future, with the narrator eventually revealing the main point of the story at that particular time (Holloway & Freshwater, 2007).

Stories are essential in the development of individuals (Mishler, 1995) as they provide a structure through which identities are formulated (McMahon & Watson, 2013). This means that, according to Lieblich, Tuval-Mashlach, and Zilber (1998, p.7) 'narratives provide us with access to people's identity and personality.' Lieblich et al. (1998) further claim that identities can be shaped in two main ways; the stories individuals create about themselves as they experience themselves in relation to others, and the stories others tell about their

perceptions of the individual. Since the notions of self and identity are at the centre of this inquiry, it provided the most appropriate approach to understanding of emergency nurses' decision-making in the context of their personal, professional, and social lives. Additionally, through the adoption of a narrative approach, it ascertained and explored how the decision to undertake higher education programmes was linked to the concepts of self and identity.

### **6.3 Philosophical Position**

Narrative inquiry is embedded in the epistemological position of constructionism. Epistemology may be seen as theories of knowledge that justify the knowledge-building process that is actively or consciously adopted by the researcher (Pascale, 2010). Epistemology in general refers to the assumptions we make about the nature of knowledge and the world (Snape & Spencer, 2003, p.17). For Crotty (1998, p.8), epistemology is a way of looking at the world and making sense of it. These assumptions guide our decisions about topics, research questions, theories, methods, analyses, and conclusions and help us evaluate the knowledge contribution of public work. Examining the ways of our social locations shape our process of knowing 'can help us understand why certain questions get asked and answered, examine how values shape observation' (Pascale, 2010). With a given set of epistemological assumptions, conducting a qualitative study means that researchers try to get as close as possible to the participants being studied (Creswell, 2012, p.18). In practice, qualitative researchers conduct their studies in the 'field', where the participants live and work – these are important contexts for understanding what the participants are saying. The longer researchers stay in the 'field' or get to know the participants, the more they 'know what they know' from first-hand information.

Crotty (1998, p.9) states that constructionism supposes that meanings are co-constructed, subjective and interpreted into multiple realities. Crotty (1998) further explains that historically the epistemology of constructionism arose from a rejection of the objectivist view of the nature of reality, where the objectivist view supports the notion that reality resides outside of human consciousness and, as a result, meaning is discovered. Constructionism supports the notion that multiple realities and meanings emerge from an engagement process between individuals and their world with the result that meaning is constructed rather than discovered (Crotty, 1998, p.9). Williams (1992) claims that social constructionism is a branch of postmodernism and shares many tenets of the postmodernist framework including the assertion that the realities we construct are subjective and anchored within social contexts.



I take the position, as a constructionist thinker, that these ways of knowing and realities can only be understood and interpreted when beliefs, perceptions, and experiences are considered when exploring a phenomenon. Taking this approach means that understandings are subjective and individual in the attempt to understand the world. Bryman (2014, p.14) claims that the only way the social world can be understood is by gaining an understanding of how those who are involved have given meaning to the events under exploration. Furthermore, Ormston, Spencer, Barnard, and Snape (2014, pp. 15-16) state that ‘all meanings are a product of time and place...the researcher cannot capture the social world of another or give an authoritative account of their findings because there are no fixed meanings to be captured.’

I believe that reality, knowledge, and experiences are different for individuals as these factors are seen through individuals’ own perceptions and beliefs. With this mind, there are different ways of viewing and interpreting these realities and ways of knowing. In addition, what makes knowledge and ways of knowing subjective is the fact that it is influenced by various personal, environmental, and contextual perspectives. Findings from this thesis support this thinking as emergency nurses highlighted various factors specific to them in the description of their decision-making and higher education experiences. Emergency nurses constructed meanings in different ways as each had their own individual perceptions and experiences. Additionally, emergency nurses in this study were social actors. Views about reality are socially constructed and do not exist independently of human experiences and interaction. Finally, I believe that realities and ways of knowing are not fixed but constantly evolving.

#### **6.4 Study Setting**

This study took place in an Irish hospital. The hospital was originally built to serve as a workhouse in the 1840s before becoming a county hospital in the 1920s. A recent multimillion euro development of the hospital produced a new building which incorporates 243 beds and provides acute medical, surgical, and psychiatric services. The hospital serves a population of approximately 220,000 individuals. An important aspect of the hospital’s role is the provision of a 24-hour emergency department. The emergency department provides treatment for urgent medical problems. It also incorporates an injury unit where minor injuries or non-life threatening, non-limb threatening injuries are assessed and treated. The ED is staffed by 38 registered nurses in addition to medical, allied health professional, multitask attendants, and household personnel.

## **6.5 Population, Sampling, and Recruitment**

The population is the total number from which data can be generated (Polit & Beck, 2010, p.307). The study population is the selected representative group from the target population. The study population in this study consisted of registered nurses employed in an emergency department in Ireland. Purposeful sampling was chosen for this study in order to answer the research questions and address the study aims. In purposive sampling, the researcher recruits participants who have expertise with the phenomenon being studied by virtue of its being an integral part of their life experiences (Cohen, Mannion, & Morrison, 2018, p.223).

Sample size is determined by the desire to investigate the chosen topic fully, thereby producing rich data. As a result, much smaller numbers may be involved than in probability sampling (Higginbottom, 2004). Creswell (2012, p.324) suggests from five to 25 participants, while Morse (1996) contends that at least six participants are required for qualitative investigations. While there are several factors in determining qualitative sample sizes, Mason (2010) states that researchers generally use saturation as a guiding principle during data collection. In interviews, when the researcher begins to hear the same comments again and again, data saturation is being reached. This is a view also supported by authors such as Hill, Baird, and Waters (2014). However, Guest, Bunce, and Johnson (2010) suggest that while the idea of saturation is helpful at conceptual level, it provides little practical guidance for estimating sample sizes for robust research. Similarly, Saunders, Sim, Kingstone, Baker, Waterfield, and Jinks (2018) claim that in narrative research it is difficult to discern a role for the concept of saturation.

Prior to the commencement of this study, I sought ethical approval from both the hospital site and the University where I am registered as a PhD student. I received approval from both areas (see Appendices 2 and 3) and began the participant recruitment process in January 2017. I sent letters of invitation and participant information sheets (see Appendices 4 and 5) by the postal service to all registered nurses in the emergency department who had undertaken or who were undertaking postgraduate educational programmes at academic Level 8 or above. This ED is a small department and I worked there for 16 years. As a result, I had much familiarity with the participant group and their educational achievements. This was due to the fact that we worked closely and frequently together over many years, and also for the purposes of clinical area allocation, it was necessary in my management role to be aware of clinical skills and competencies held by ED nursing staff. Since I had that familiarity with the participant group, I was aware of the levels of study undertaken by these emergency nurses. I was aware that a number of these emergency nurses were apprenticeship

or diploma trained and had chosen to pursue Level 8 study before pursuing Level 9 educational programmes. Others at this level availed of Recognition of Prior Learning processes to secure places on Level 9 programmes. For those emergency nurses already in possession of a Level 8 qualification, their instinct was to pursue a Level 9 educational programme. It was also the case that the hospital would only provide financial support if emergency nurses pursued Level 8 or Level 9 nursing or healthcare-related programmes specific to their role in ED. Any further detail or clarification I required regarding their educational achievements, I sought during the interview process.

At this time there were 35 registered nurses employed within the unit; 14 of whom were employed in the capacity of clinical nurse manager, four of whom were advanced nurse practitioner grades, whilst the remainder of emergency nurses occupied staff nurse positions. Approximately 71% (n=25) of the emergency nursing staff held Level 9 postgraduate diploma qualifications; of this group, seven had been awarded Masters' degrees. A profile of participants may be found in the Appendices section (see Appendix 6). Nine participants had undertaken programmes of higher education whilst employed in other hospitals prior to commencing employment in the study setting. I included my contact details in the participant information sheet and 22 registered nurses indicated an interest in participation. Once an interest was indicated, I contacted each nurse individually by telephone through the ED to organise a convenient interview time. Data collection commenced in April 2017 and all 22 interviews were conducted at various times and locations at participants' convenience over an eight-day period.

### **6.5.1 Eligibility Criteria**

To support the concept of purposeful sampling in answering the research questions and addressing the study aims, a number of inclusion and exclusion criteria were applied in the recruiting of participants.

Inclusion criteria:

- Participants had to be employed as registered nurses in the emergency department since emergency nurses were the focus of my study.
- Participants were required to have undertaken or be currently undertaking a postgraduate programme of higher education at Level 8 or above in nursing or healthcare-related area, and relevant to their role in the ED. Since a number of the participant group were already diploma or degree trained, I therefore decided to focus only on Level 8 and Level 9 programmes of education. It was also the case

that for some of those participants who were certificate or diploma trained, they pursued Level 8 programmes prior to undertaking Level 9 programmes. There were other emergency nurses who were certificate or diploma trained who were accepted onto Level 9 programmes through Recognition of Prior Learning processes. Also, it was the case that for those nurses wishing to avail of organisational support to pursue programmes of higher education, financial and study leave support from the hospital was only offered to those emergency nurses undertaking programmes of education specific to their role in ED, and such programmes were within Level 8 and Level 9 categories. Organisational support was not available to those who wished to pursue programmes of education not related to their role in ED.

- Participants also had to be willing to voluntarily participate in the study. Voluntary participation represented a key ethical consideration and indicated that emergency nurses were not coerced into participating in the study.

Those excluded from participation included:

- Registered nurses in the emergency department who had not undertaken any programmes of study at Level 8 or above were not eligible to participate. Since the focus of my study was based on higher education decision-making and associated experiences of higher education participation among emergency nurses, those who had not undertaken such programmes were not eligible to participate.
- Registered nurses in the emergency department who pursued or were pursuing programmes of education not related to nursing or healthcare. The significance of this study lay in its importance to understand the approaches to higher education decision-making and experiences of higher education uptake in an area where specialist nursing and healthcare knowledge and skills are required to deal with a high acuity patient group.
- Registered nurses in the emergency department who were employed on a casual basis through external agencies as they did not have the same relationship with the hospital or experience with the department's clinical and educational culture.

## **6.6 Ethical Considerations**

Ethical issues are a significant consideration in research activity. Regardless of methodological approach, it is imperative that credence is given to this area of the research process since ethical research is essential in generating sound new knowledge or advancing an existing knowledge base. More importantly, there is a need to balance the advancement of knowledge with the need to respect human integrity, privacy, and protection from harm.

Warusznski (2002, p.152) suggests that qualitative researchers in particular can face several dilemmas including respect for privacy, establishment of honest and open interactions, and avoiding misinterpretation. Partasi (2013, p.115) reflects on the potential difficulties associated with personal relationships in narrative inquiry. This was a concern for me as, not only was I the researcher, but I was also known to the participants in my capacity as a former colleague and friend.

It is important to remember that what gives meaning and value to the narrative approach is how the researcher draws data from a relationship to the participant about significant and meaningful aspects of the participant's life. Josselson (2007, p.540) states that this relationship involves both an implicit and explicit contract. The explicit contract outlines the formal relationship and procedures between both parties while the implicit contract is influenced by the trust and rapport between the researcher and participant. Josselson (2007) also claims that in narrative studies, the participant reads the subtle interpersonal cues that reflect the researcher's ability to be empathetic and non-judgmental. This may allow for further self-revelation and maintenance of data integrity.

Traditionally, a principle-based approach to ethics has usually underpinned and dominated research endeavour where ethical practice assures the free consent of participants, protecting participants from harm, and maintaining confidentiality and privacy. These standards have formed the foundation of the ethical approach to this thesis. Whilst these basic principles, which are well-articulated internationally, govern the ethical treatment of human participants in research, Smythe and Murray (2000) claim that traditional ethical principles in research offer insufficient guidance to narrative researchers in respect of maintaining balanced perspectives. In addition, Plecshberger, Seymour, Payne, Deschepper, Onwteaka-Philipsen, and Rurup (2011) highlight how formal ethical review procedures provide limited guidance about the complex emotional and relational features of research. Whilst traditional standards have formed the foundation of the ethical approach to this thesis, McCarthy (2003) claims that increasingly attention has been turned to alternative approaches to describing and understanding the various elements of moral life.

One such approach to address these anomalies is the ethics of care approach. What distinguishes care ethics from traditional ethical approaches is its emphasis on response and social responsibility. Herron and Skinner (2013) argue that ethics of care is a central but often neglected aspect of the research process where concern in balancing complexities such as power relations are prominent. Lawson (2007) claims that there is a growing awareness

researchers should engage in care ethics as a means of ensuring more equitable relationships and actions in our work. Interestingly, however, Herron and Skinner (2013) claim little has been accomplished in determining how researchers can apply care ethics in the research process to develop more care-informed research relationships. Notwithstanding, they suggest that the concept of reflexivity is the most accepted method of fostering a care approach to qualitative research.

To this end, it was important that I considered the ethics of care approach in addition to the inclusion of general ethical principles. In this thesis, I adopted a dual approach to ethical considerations incorporating aspects of both the principle-based approach and the ethics of care. This approach was underpinned by the need to address the ethical requirements and standards of both the University and research site, with my responsibilities to the participants. I will begin my discussion on ethical considerations by outlining the traditional ethical principles which underpinned this thesis, beginning with the principle of free and informed consent, and refer to the concept of reflexivity later in the chapter.

### **6.6.1 Free and Informed Consent**

The principle of free and informed consent is widely acknowledged to be at the core of the ethical treatment of human participants in research. Informed consent means that the researchers have an obligation to provide participants full disclosure of all information relevant to the research process. Prospective research participants must give their free and informed consent to participate at the outset of their involvement in a study and maintain the right to free and informed consent throughout their participation. Smythe and Murray (2000) argue that informed consent may be problematic at times given the nature of narrative research. According to Josselson (2007, p.539), the essence of the narrative research approach requires the researcher to approach the participant in a genuine and respectful way if meaningful and valuable stories relating to significant life experiences are to be relayed. Josselson (2007, p.539) further contends that for good narrative research practice, this implies an implicit and explicit contract whereby the researcher has to be transparent about their interests in order to develop and maintain a research relationship with the participant.

In this study, free and informed consent was firstly highlighted in the participant information leaflets and then prior to commencement of the data collection phase. In the interests of assisting the participants to make an informed choice, participant information sheets were distributed to each participant two weeks prior to data collection highlighting areas such as the purpose of the study, expectations and procedures, duration of participation, risks and

benefits, planned use of collected data, and anonymity. The participation information sheet was provided to participants in advance of data collection to allow them sufficient time to consider and reflect upon the information provided, prepare any questions, and come to a decision about participation in the study. The participant information sheet also highlighted that participants could withdraw at any time up to the point of data anonymisation. It also included my contact details, telephone number and email address, should any further information have been required. Consent is something freely given by the research participant and may be freely withdrawn at any time. Consent was sought prior to the commencement of the interviews (see Appendix 7) and no participant withdrew their consent at any time during the study.

### **6.6.2 Confidentiality and Anonymity**

Given that qualitative studies often contain rich descriptions of study participants, issues pertaining to confidentiality are of particular concern to qualitative researchers. It can be a challenge for researchers to maintain these principles whilst presenting rich, detailed, and personal accounts of the social world and protecting the identities of research participants. Confidentiality entails the researcher's promise that personal and identifying information collected from research participants will be kept private and only disclosed to others on the condition of the participants' free and informed consent.

Issues relating to confidentiality and anonymity were first addressed when I sought ethical approval for my study from both the hospital site and the University where I am registered as a PhD student. I completed a standard application form for health-related research studies to gain hospital ethical approval. This approval was granted in late December 2016. I also applied for University ethical approval to the School of Education (Research Ethics Committee) and ethical approval was granted in March 2017. It was important that the procedures for ensuring confidentiality were addressed in the ethical approval applications. I clearly identified the procedures I planned to put in place relating to confidentiality and anonymity, and I sought clarification from my supervisor when completing the documents for the University Ethics Committee. Procedures regarding confidentiality and anonymity were then communicated clearly to research participants via the participant information sheet prior to the commencement of the data collection phase. The issue of confidentiality was again addressed when participants signed consent forms at the beginning of their interviews.

The concept of confidentiality is closely connected with anonymity in that anonymity is one way in which confidentiality is operationalised (Wiles, Crow, Heath, & Charles, 2008). It

must be noted, however, that anonymisation of data does not cover all the issues raised by concerns about confidentiality; confidentiality also means not disclosing any information gained from an interviewee deliberately or accidentally in ways that might identify an individual. It is evident within the literature the importance of anonymising research participants through the use of pseudonyms (Saunders, Kitzinger, & Kitzinger, 2015; Gibson, Benson, & Brand, 2012).

In this study, pseudonyms were used to anonymise participants; only I had access to the pseudonym key, and this key was kept in a locked cabinet in my home. Additionally, any references made to the research site, other hospital sites, and higher education institutions were anonymised. A copy of the interview recordings on a password-protected USB key was also kept in a locked cabinet in my home. A second password-protected USB key was submitted to the University as per ethical approval guidelines. Participant consent forms were also kept securely in a locked filing cabinet in my locked workplace office where only I have the key. Also, as per University ethical approval, raw data will be retained securely for 13 months after completion of the study. After this time, any hardcopy documents will be shredded and then placed into a confidential waste bin. Any data stored on electronic documents and recording devices will be deleted. All thesis work was undertaken on my personal computer which requires a password. Also, any folders on my computer that contained work related to my thesis were also password protected. All passwords were only known to me.

### **6.6.3 Protection from Harm**

The avoidance of harm is a general ethical principle that applies across research activities. Squire, Davis, Esin, Andrews, Harrison, Hyden, and Hyden (2014, p.107) claim that the potential risks invoked by narrative research have to do with the subtle and often unforeseeable consequences of both recounting an experience and the constructing of narratives about individuals' lives. Participants may also make themselves vulnerable in their own narrative revelations. One of the considerations for participants in narrative research is the potential for emotional impact, particularly when a participant has to recount an experience or event. Narrative research in this way can become intrusive even when participants respond positively to the researcher's account. In this study, one participant (Sue) became very emotional while recounting her family and social background. I provided her with water and tissues and offered her the opportunity to take a break from the interview which she declined. Hence, precautions are often necessary to protect the integrity of



participants' reputations and their ongoing relationships with others who figure in their stories.

### **6.7 Gathering Narratives**

Whilst interviews have long been used by qualitative researchers to generate data, Josselson (2006) claims that narrative inquiry does not privilege one method of gathering data. Interviews can be considered of less importance than the noting of events, feelings, hunches, and conversations (Clandinin & Connelly, 2000, p.61). Despite these considerations, the semi-structured interview was the data collection tool of choice in this study. Semi-structured interviews offer a more flexible approach to the interview process and afforded me the opportunity to interpret non-verbal cues through observation of body language, facial expressions, and eye contact, ultimately allowing me to probe and explore hidden meanings and understanding.

While the advantages of conducting pilot studies are apparent in the literature (Kim, 2010; Majid, Othman, Mohamad, Lim, & Yusof, 2017), I chose not to undertake a pilot study. I believed that when dealing with individuals' subjective experiences, it would have been difficult to anticipate potential responses and question adjustments as experiences and decision-making strategies would vary among emergency nurses. I believed that using a semi-structured approach would provide scope to deal with any unanticipated issues or responses, and I ensured that there was sufficient time between all interviews conducted. In addition, the literature pertaining to pilot studies in qualitative research is also not entirely supportive of the process and the usefulness of pilot studies is often questioned (Beebe 2007; Padgett, 2008). Similarly, Marshall and Rossman (2006, p.97), Morse (1997), and van Teijlingen and Hundley (2001) state that most qualitative studies adopt an emergent approach anyway and gradual improvements of interview schedules and questions emerge during the processes of data collection and analysis. This was the case for me as when I began my first interview with participant Alexandra, the issue of social background emerged despite this not being apparent in the literature pertaining to higher education and, as a result, I was able to adapt my interview schedule to include this as an area for consideration for the remaining participants.

The one-to-one interview is a social interaction, and the relationship between the interviewer and interviewee is of paramount importance in ensuring the process is successful (Ryan, Coughlan, & Cronin, 2009). Kvale (1996, p.326), however, cautions that although the interview may be seen as a conversation between two people, the relationship between those two people is not equal. Similarly, Trahar (2009) advises that the interview or conversation

should not be considered as a simple process, rather, it should be conceptualised as potentially problematic and complex. While it may be argued that power automatically lies with the researcher, Phoenix (1994, p.56) claims that power can fluctuate between the researcher and the research participant. This was a viewpoint that I was very much cognisant of as, although I am familiar with the social actors and research landscape, the shifting nature of power within the interview setting was a potential feature that required some consideration. To address any potential power imbalances, I began by providing the emergency nurses with detailed participant information leaflets identifying the purpose and procedure of the study with the accompanying letter of invitation which also identified that participation in the study was voluntary.

Once participation was confirmed, I contacted each nurse by telephone to arrange a convenient interview time and location, beginning the data collection process in early April 2017. I felt that providing the participants with the opportunity to decide on a time and location would assist in minimising any potential power imbalances. As it happened, the majority of emergency nurses chose to be interviewed in ED, and while some chose to meet with me during designated break times, others chose to meet me either immediately before or after their shift. A total of 22 semi-structured interviews were conducted over an eight-day period. Each participant was provided with a consent form that was signed prior to the commencement of the interview. An interview schedule (see Appendix 8) was used to guide the interview process. While an interview schedule may be used for predetermined topics, they allow for unanticipated responses and issues to emerge through the use of open-ended questioning (Tod, 2006, p.348). Most of these interviews were held in the hospital with three interviews held in participants' own homes. The interviews which were conducted in the hospital were done so at the request of individual participants. These interviews were conducted in an office within the emergency department. Most emergency nurses chose to be interviewed prior to commencement of their shift or having completed their shift. Some participants agreed to be interviewed during their allocated break times. In order to ensure privacy when conducting interviews with the participants, I arranged for interviews to be held in offices adjacent to the main ED area and at times that were convenient for each participant to ensure that any potential interruptions would be minimised. All office doors were closed throughout each interview so that conversations would not be overheard. On the occasions where I interviewed participants in their own homes, even though I believed I was not at any risk, I conducted interviews during daylight hours and I ensured that a family member or friend was aware of my location.

Interview duration ranged from 44 minutes to 92 minutes with a mean interview duration of 55 minutes. The grade of participants represented 48% staff nurse, 36% CNM2 and 18% RANP. Participants varied in age from 30 years to 58 years, with a mean age of 44 years. All participants had achieved a Postgraduate Diploma in Nursing (Emergency) with 36% holding a Master's level nursing qualification. All participants were female.

All interviews were audio-recorded and with the permission of the participants, I also wrote notes as required. These notes were usually prompts to remind me of a point that they made to which I wanted to return or to any point that I found particularly interesting or relevant. I began each interview with a very short statement explaining the purpose of the interview and thanking them for their participation. I then asked participants to relay information regarding their personal backgrounds and educational achievements before exploring their decision-making, their sense of self and identity, and their experiences of higher education. I used the interview schedule to guide me in ensuring that the participants were asked the same questions for consistency and to assist in addressing the research questions.

At appropriate junctures, I asked questions to elicit further information and clarification on certain points. I tried not to interrupt the flow of the story for a point made in passing but I would follow this up at a later point in the interview. There were some occasions where I repeated a point a participant made or rephrased it in an attempt to elicit further information. Occasionally I asked a question to follow up on an issue further or to probe more deeply. I tried to do this unobtrusively in order to elicit further information and not interrupt the flow of the story. At the end of each interview I informed the participants that I would provide them with a verbatim transcript in the weeks following the interview. The purpose of this strategy was to offer participants the opportunity to ensure that their narrative accounts had been accurately represented and to amend their narrative accounts as appropriate. The notion of responder validation is briefly explored in further detail in the 'Data Management' section of this thesis.

## **6.8 Data Management**

Data management is a complex but significant phase of the research process. Since qualitative research intends to generate knowledge grounded in human experience, it is essential that the process of data management and data analysis is articulated transparently in order to accurately reflect those experiences and yield meaningful results. If readers are not clear about how researchers analysed their data or what assumptions informed their analysis, evaluating the trustworthiness and rigour of the research process is difficult

(Nowell, Norris, White, & Moules, 2017). This section will identify the concepts of trustworthiness, rigour, and thematic data analysis in the description of data management.

### **6.8.1 Establishing Trustworthiness and Rigour**

In qualitative research, the underlying philosophy is that there is no single truth or reality and that the description of phenomena depends on our perceptions and interpretations of them. Therefore, according to Johnson and Rasulova (2017), the nature of reality is not unique or objectively verifiable but relative and is created by our interpretations of it. The ‘truth’ presented is then a result of the interaction between the researcher and study participant rather than simply of the research design. Since the truth is constructed by individuals under particular conditions and in a particular context, it cannot be generalised (Sandelowski, 1986). The principles of trustworthiness and rigour are ways by which researchers can demonstrate that their research findings are credible and worthy of attention.

Lincoln and Guba (1985) propose four criteria for developing the trustworthiness of qualitative investigations. These include credibility, dependability, confirmability, and transferability. This framework was adjusted in response to evolving conceptualisations and a fifth element, authenticity, was added (Guba & Lincoln, 1994, p.110). In the pursuit of trustworthiness and rigour, other frameworks were considered, such as Tong, Sainsbury, and Craig’s (2007) Consolidated Criteria for Reporting Qualitative Research (COREQ) framework. The aim of this framework is to produce a universal system of quality criteria for qualitative research. However, this checklist was not utilised in my research for a number of reasons. According to Treharne and Riggs (2014, p.61), the COREQ framework does not apply equally to all qualitative methodologies given its inclusion of concepts specific to grounded theory. In addition, they argue that adherence to a checklist may inhibit the methods of data collection and diversity across qualitative approaches, and constrain transparency by closing down on any discussions outside the realm of the checklist. These potential restrictions influenced my decision to underpin my thesis with Lincoln and Guba’s (1985) framework. I will highlight each element of this framework beginning with a discussion on credibility.

### **6.8.2 Credibility**

Credibility is viewed by Lincoln and Guba (1985) as an overriding goal of qualitative research. Credibility refers to confidence in the truth and interpretation of the data. Korstjens and Moser (2018) propose a number of strategies which may assist in addressing the concept of credibility. These strategies include prolonged engagement, and member checking. Additionally, other techniques such as peer-debriefing may be considered for the purposes

of enhancing credibility. Each of these were employed and I outline how this was done below.

Prolonged engagement was achieved in a number of ways. Firstly, my experiences from the clinical setting allowed for the sense of prolonged engagement to be achieved. I was familiar with the culture of this particular environment and I had developed relationships and rapport with the members of this culture. I was a member of this culture and had experience of higher education. This pre-existing knowledge of the environment coupled with the member rapport assisted in the facilitation and co-construction of meaning within this study. I also took significant time to immerse myself in the data. Through listening to the audio recordings and re-reading the interview transcripts, I ensured that I had familiarity with the research data. Secondly, I engaged in the process of member-checking, which will be described later in this chapter.

Understanding the significance of the interview site is important in devising a research plan and also to understand the potential power relations between myself as the researcher and the research participants. In addition, it was also necessary to consider any potential influence of location on the data retrieved. There is minimal guidance in the literature as to the implications or influence of different interview sites on data collection. In a study by Ensign (2006) exploring the perspectives and experiences of homeless young people, the influence of site location was not evident on participant responses. In my study, interview location did not appear to influence participant responses as all participants spoke freely and the findings among participants were largely comparable and consistent.

For those participants who chose to be interviewed at the research site, I ensured that the location was private and quiet which allowed for an uninterrupted experience. Time was allocated prior to the commencement of each interview for some brief general conversation which allowed rapport to be established with the participants. Participants were also derived from several nursing grades including staff nurse, clinical nurse manager, and advanced nurse practitioner which ensured that multiple person sources were achieved to meet data triangulation requirements.

Hadi and Closs (2016) describe peer debriefing as a method in which the researcher discusses the research methodology, data analysis and interpretations continuously throughout the research process with their peer who is not directly involved in the research project. Ideally, the peer debriefer should be a skilled researcher who can meaningfully question the researcher's interpretations, provoke critical thinking, and provide alternative

or additional perspectives and explanations. Hadi and Closs (2016) further claim that peer debriefing enhances credibility and trustworthiness by giving the researcher an opportunity to ensure that emergent themes are derived from the data and are sensible and conceivable to a disinterested debriefer. In this study, I sought the assistance of one of my University work colleagues who has significant experience in scholarship, research, and doctoral supervision. We frequently engaged in broad academic debate regarding my research and he also second-coded three of my interview transcripts (see Appendix 9) to ensure consistency among emerging codes and themes. This is also highlighted in the description of Phase 2 of my thematic analysis approach.

### **6.8.3 Dependability**

The second criterion in the framework is dependability which refers to the stability or reliability of data over time and conditions. The dependability question seeks to ascertain whether findings of an inquiry could be repeated if it were replicated with the same or similar participants in the same or similar context. Credibility cannot be obtained in the absence of dependability (Polit & Beck 2010, p.490). There are a number of ways in which dependability can be demonstrated and, in this study, I endeavoured to provide evidence of my decisions and choices regarding the theoretical and methodological issues. I have kept all interview transcripts, field notes, and a reflexive diary in order to demonstrate a clear audit trail.

### **6.8.4 Confirmability**

Confirmability refers to the degree to which the results could be confirmed or corroborated by others (Korstjens & Moser, 2010). Confirmability requires that the data collected represents the information participants provided and that any interpretations made by the researcher are honest and accurate. Korstjens and Moser (2010) state that researcher's interpretations of participants' accounts are rooted in the participants' constructions, and also that findings generated from data analysis procedures are also firmly grounded in the participants' perceptions. Although confirmability does not deny that each researcher will bring a unique perspective to the study, it requires that the researcher accounts for any biases by being upfront and open about them and use the appropriate qualitative methodological practices to respond to those biases. For this criterion to be achieved, findings must reflect the participants' voices and the conditions of the inquiry and not the researchers' biases or perspectives. Confirmability within this study was achieved through the process of reflexivity and peer debriefing which has already been discussed. I have endeavoured to make the research process as transparent as possible by clearly describing how data were

collected and analysed and I have offered examples of the coding process in the Appendices section (see Appendix 10).

### **6.8.5 Transferability**

The fourth component of Lincoln and Guba's (1985) framework is transferability. This refers to the potential for which findings can be transferred to or have applicability to other settings or groups. As Guba and Lincoln (1985, p.316) note, the researcher's responsibility is to provide sufficient descriptive data so that consumers can evaluate the applicability of the data to other contexts. The provision of thick descriptive narrative accounts within this study will allow individuals the opportunity to evaluate the extent to which the conclusions that are drawn can be transferred to other times, settings, situations, and people.

### **6.8.6 Authenticity**

The final component of Lincoln and Guba's (1985) framework is authenticity. Authenticity refers to the extent to which researchers fairly and faithfully show a range of realities. Authenticity emerges in a report when it conveys the feeling and tone of participants' lives as they are lived. When a text achieves authenticity, readers are better able to understand the lives being portrayed with some sense of the mood, feeling, experience, language, and context of those lives (Polit & Beck, 2010, p.493). Shannon and Hambacher (2014) claim that while authenticity is an essential component of qualitative research, there are few resources which illuminate it leaving the concept somewhat elusive to qualitative researchers. Nonetheless, they contend that researchers must engage in several processes to ensure that findings are credible and that the larger implications of the research are also considered. Lincoln and Guba (1985, p.320) propose five dimensions of authenticity when evaluating qualitative studies. These include fairness, ontological authenticity, educative authenticity, catalytic authenticity, and tactical authenticity.

According to Shannon and Hambacher (2014), fairness involves assessing whether all viewpoints are represented in a fair manner and this can be achieved when stakeholders are empowered to both have a voice and be part of the consensus building process. They further contend that authenticity is demonstrated when the researcher is able to demonstrate a depth of understanding that fairly represents these perspectives. Processes such as prolonged engagement, reflexivity, and member-checking are critical for ensuring fairness. These processes were achieved in this study and are described later in this chapter.

Ontological authenticity is determined by assessing the degree to which participants become more aware of the complexity of the social environment, and educative authenticity is

assessed by determining the extent to which participants experienced an increased awareness and respect for the viewpoints of others (Lincoln & Guba, 1985, p.308; Tracy & Robins, 2007). These two components are evidenced in participant narratives whereby participants are quoted directly in the findings and where statements were made indicating understanding of other participants. Additionally, personal and professional growth was also evident. Another strategy I employed to achieve authenticity was the use of field notes and a reflexive journal.

The final two components of authenticity, catalytic and tactical authenticity, are often difficult to evaluate as Nolan, Hanson, Magnusson, and Andersson (2003) claim that action towards change and empowerment resulting from engagement in the research process must be demonstrated. Catalytic authenticity is assessed by examining whether the research process stimulated action on the part of the participants or stakeholders. Tactical authenticity examines whether a redistribution of power among participants occurred. To address these two components, it is anticipated that the findings from this thesis will be disseminated appropriately in order to better understand the influencing forces and educational needs of emergency nurses who pursue programmes of higher education.

### **6.8.7 Rigour**

Qualitative research approaches may entail many challenges for both the researcher and the research process. One such challenge is the area of rigour. The measure of rigour is the clarity with which personal and relational subjectivity have been identified and revealed (Jootun, McGhee, & Marland, 2009). As a response, control of researcher bias has been emphasised as a way to ensure rigour, usually through reflexivity. Reflexivity is generally understood as an awareness of the influence the researcher has on the people or topic being studied, while simultaneously recognising how the research experience is affecting the researcher (Gilgun, 2008). At its most basic level, this may include raising researcher awareness of how their presence affects the research process and participants, as well as how the participants affect the researcher.

Ben-Ari and Enosh (2010) suggest that the impact of the researcher's presence should not be viewed as a problem, rather, it is an essential element of the co-creation of knowledge. Both the researcher and the researched shape the encounter, and the research becomes the collaborative construction of knowledge rather than the discovery of knowledge assumed to already exist (Probst, 2015). Reflexivity can function both as a control for researcher bias and as a tool for gaining new depth in research. Rolfe (2006) contends that the notion of reflexivity has become an increasingly popular means of supporting claims of reliability and



trustworthiness. Reflexive engagement, whilst planning, conducting, and writing about research, promotes an on-going, recursive relationship between the researcher's subjective responses and the intersubjective dynamics of the research process itself (Probst, 2015). In the next sections, I discuss how reflexivity was employed in this study.

### **6.9 Reflexivity and my role in the research process**

The term 'reflexivity' represents a new chapter in qualitative research but is often poorly described and elusive (Palaganas, Sanchez, Molintas, & Caricativo, 2017). Reflexivity takes account of the researcher's involvement in the research process and is defined as 'the process of reflecting critically on the self as researcher' (Lincoln & Guba, 2000, p.183). The process of reflexivity requires the researcher to be critically aware of the ways in which their own values and assumptions have affected the methodological design and processes, the interpretation of data and the conclusions (Patton, 2002, 567).

Reflexivity was employed in this study to enhance the quality of the research findings in terms of trustworthiness and transferability and also as a means of ensuring the ethics of care approach. Since the researcher is the 'instrument of data collection' within qualitative research (Mason, 2010), it is also vital that the influence of the researcher on the data generation and analysis is made explicit to ensure the trustworthiness of research findings (Pearson, 2004). Therefore, my role as researcher and the influence I may have had on this study are discussed throughout this thesis. The benefit of a reflexive approach within qualitative investigations, however, is contentious for some authors. Pillow (2003) warns that reflexivity is not a cure for the problems of representing someone else's reality. Similarly, Finlay (2002) claims that a researcher's openness does not guarantee that the voices of participants are faithfully represented. Additionally, Lynch (2000) claims that there is no inherent advantage to being reflexive nor does a reflexive approach necessarily bring the researcher closer to the meaning of a phenomenon. For this study, however, I believed that a reflexive approach would bring such benefits as clarity, richness, trustworthiness, and personal growth, which would serve to maintain the integrity of the research process and the quality of the knowledge being generated.

Reflexivity enabled areas such as subjectivity and positionality to be more transparent within the process. Reflexivity can be enhanced by using multiple researchers to encourage discussion about beliefs, values, perspectives, and assumptions during the research process (Patton, 2002, p.568). While there are not multiple researchers involved in this study, I have regularly engaged with my supervisor to openly share this work and to receive views and comments relating to any aspect of the study including my role and position (see Appendix

11). Koch and Harrington (1998) refer to this process as the ‘critical gaze turned towards the self’, examining personal position, identity and self.

In order to create a transparent audit trail throughout the research process, I maintained a reflexive diary throughout the research process recording a range of activities such as fieldwork notes and schedules and areas of concern and interest. My multiple roles in this research process included my role as a researcher, lecturer, clinical nurse manager, staff nurse, and my role as a student nurse was also considered and acknowledged. Additionally, my own characteristics, experience, skills, understandings, values and influences guided this study. In particular, I am aware of my ‘insider’ researcher status, given my experience of not only being a registered nurse employed in an emergency department, but also my experience of having been an emergency nurse who actively pursued higher education.

The approach to reflexive journaling was underpinned by Lincoln and Guba’s (1985) framework. My reflexive journal was composed of five different elements incorporating accounts of evolving perceptions, day-to-day procedures, methodological decision points, personal introspections, and a log of developing insights. My evolving perceptions were collated prior to meeting with each participant. Here, I documented everything I believed I would uncover from participants’ narratives to findings at the research site with a view to later discovering if my findings would be clouded by these initial perceptions or, indeed, if I would uncover new findings. In logging the day-to-day procedures, everything I accomplished regarding my thesis was documented and dated. It is important to state that I did not work on my PhD every day primarily due to work commitments but the days I worked on it, I described the progress, or not, made. I recorded my methodological decision points at various intervals throughout my PhD pathway. These entries reflected my decision-making in areas such as data collection and data analysis processes. Personal introspections highlighted my thoughts and feelings throughout, including the many episodes of frustration and self-doubt. In accounting for the development of my insights, I strived to highlight my learning mainly from a research development perspective. It also allowed me to become more aware of new findings from the retrieved participant narratives.

Within this research process, I also viewed myself as a social actor. Having worked as an emergency nurse in the research site and engaged in higher education activities throughout my professional life, I have also experienced the social world from the inside. An insider-researcher may be defined as someone who shares a particular characteristic such as gender, ethnicity or culture (Mercer, 2007). Bonner and Tolhurst (2002) identify a number of advantages of being an insider-researcher. These include having a greater understanding of

the culture being studied and having a rapport with participants that is conducive to the telling of stories. Additionally, Unluer (2012) claims that insider-researchers generally know the politics of the institution and how things “really work”. Furthermore, Smyth and Holian (2008, p.37) suggest that insider-researchers have a great deal of knowledge which takes an outsider a long time to acquire.

As an insider-researcher I had insight into the influences and realities that guided educational decision-making from both personal and institutional levels within the context of everyday life and I was able to relate to my participants’ experiences. This position as insider-researcher afforded me an advantage with respect to accessibility and to an understanding of the dynamics within the group culture. Additionally, I was aware of my own research agenda. I had a somewhat unique research position; I was a friend as well as a colleague with the participants, and we already had a history of sharing personal stories. My relationship with each of my participants was important to me, both personally and professionally, and there were places where my story intersected with theirs.

Although the advantages of this researcher position are well-documented, there may also be some issues associated with this role. Hewitt-Taylor (2002) propose that incorrect assumptions may be unconsciously made about the research process based on the researcher’s prior knowledge. However, Unluer (2012) affirms that educational research is concerned with human beings and their behaviour, involving a great number of players, each of whom brings to the research process a wide range of perspectives, including the researcher’s own perspective.

However, I was aware throughout that my position as an insider-researcher could create some tensions. While I knew most of the participant group well, I was particularly concerned that this may have impacted on the level of openness between us. It could have been the case that some of these emergency nurses may have assumed that my prior knowledge of their personal lives, the clinical environment, and my own experiences of pursuing higher education did not require them to fully disclose details of their personal and professional lives and, more specifically, details on their approach to decision-making and experience of higher education. My awareness of this helped me stay cognisant of colouring my findings by protecting their feelings or putting the most positive spin on what they shared. I am also an ‘outsider’ researcher as having since moved onto academic life in another country, I no longer work with these participants and personal interactions have been largely minimised. Dwyer and Buckle (2009) describe a ‘space between’ insider and outside researcher: ‘the intimacy of qualitative research no longer allows us to remain true outsiders to the experience

under study and, because of our role as researchers, it does not qualify us as complete insiders' (p.60).

As a narrative researcher, my responsibility is to formulate a story in a way that gives a voice to my participants, one that is truthful and congruent with their stories. I also have a responsibility to present their narratives in a way that weaves theirs together with the meanings I have uncovered in my work with them. My inquiry began with my own autobiographical narrative. This allowed me to attend to my own narrative and how my story potentially intersected with and impacted the stories and re-storying of my participants' experiences. By writing and reflecting on my story from the three-dimensional approach (time, place, sociality), I became aware of the crossroads of my experiences with theirs and I was better able to navigate the tensions of self-examination, both my own and that of my participants. While usually the entire narrative autobiography is not included in the final research text, Clandinin (2013) states that this narrative beginning 'can make visible [my] ontological and epistemological commitments' and how they impacted my research puzzle, my choice of participants, and my goings-on with those participants (p.89).

My autobiography allowed me to look at my existing relationships with my participants. In this narrative inquiry, I journeyed alongside the participants, experiencing with them their own stories regarding higher education uptake. I am not a subject of the study, my role within the context of this study is as a researcher, one who has experience of higher education uptake as a former emergency nurse. However, I was experiencing alongside my participants what was happening for them as they recalled their decision-making and experiences of higher education. The stories they told are not retrospectives about distant events; they are lived stories situated in the current lives of participants that were told as they were experienced. And I, as researcher, was 'part of the storied landscapes [I studied]' (Clandinin, 2013, p.82). Therefore, researcher bias was an issue of my own reflexive stance; I had to stay aware of my own stories and how they impacted my way of seeing the participants and how I identified and selected the threads of meaning that connected their stories.

This now concludes my discussion on how trustworthiness and rigour was achieved in my thesis. I will now further elaborate on the process of data management by identifying the framework that underpinned my approach to data analysis.

### **6.10 Data Analysis**

Data analysis is the process whereby retrieved data is reduced to illuminate a story and uncover its meaning and understandings. Broadly, it involves a systematic and methodical

process of arranging and synthesising data of various forms so that an understanding of the phenomenon can be generated. The use of analytical approaches such as content analysis and thematic analysis is frequently cited in the literature (Moule, Aveyward, & Goodman, 2017, pp.371-372; Nowell et al., 2017; Vaismoradi, Turunen, & Bondas, 2013). In this thesis thematic analysis provided the framework for data analysis and my choice of analytical framework will be further justified in the next section.

### **6.10.1 Thematic analysis**

Braun and Clarke's (2006) six-phase approach to thematic analysis underpinned the analysis of this study. Until recently, thematic analysis was a widely used yet poorly defined method of qualitative analysis (Braun & Clarke, 2012, p.57). This approach is rapidly becoming widely recognised as a unique and valuable analytical method in its own right. Thematic analysis is a method which systematically identifies, organises, and offers insight into patterns of meaning across a dataset. Through focusing on meaning across a dataset, thematic analysis allows the researcher to see and make sense of collective or shared meanings and experiences.

The main reason this approach to data analysis was utilised was due to its flexibility and accessibility. Thematic analysis provided entry into a way of undertaking research that otherwise seemed challenging and complex. It offered a way into qualitative research that taught me the mechanics of coding and analysing qualitative data systematically, which could then be linked to broader theoretical and conceptual issues. Additionally, the research area suited thematic analysis as the subject was experiential and exploratory. Content analysis was also considered as a means of analysing this study's data. Gbrich (2007, p.21) defines content analysis as an approach for examining large amounts of textual data to determine trends and patterns of words used, their frequency, and their relationships. While both content analysis and thematic analysis have many similarities, including the aim of exploring narrative material from life stories, Vaismoradi et al. (2013) claim that the main difference lies in the opportunity to quantify data using the content analysis approach. In doing so, if only the frequency of codes is counted to find significant meanings within the data, there is a risk of missing the context within the narrative accounts. In addition, they also argue that with content analysis a decision must be taken on whether to focus on either the manifest or latent content of the data. In contrast, thematic analysis allows for both manifest and latent content to be considered as part of the analytical approach. Since my intention was to provide a qualitative and detailed account of the narratives I retrieved, I pursued the thematic analysis approach.

While thematic analysis was the analytical method of choice, it must be acknowledged that the approach may be disadvantaged in some ways. Vaismoradi et al. (2013) suggest that thematic analysis is often poorly branded and does not hold the same acclaim as content analysis. Additionally, Holloway and Todres (2003) claim that the flexibility this approach offers can lead to inconsistency and a lack of coherence when developing themes from the research data. However, since I am a novice researcher, I believed this method would provide me with a structured approach to data analysis. I will now highlight how I applied Braun and Clarke's (2006) framework to my analysis of the retrieved data.

#### **6.10.1.1 Phase 1 – Become familiar with the data**

The first step of Braun and Clarke's (2006) framework required me to become familiar and engaged with the data. I began this process by listening back to the interviews I undertook on the same day with the participants. Any initial thoughts about the narratives or the interview itself I noted in my field notes and diary while the event was still fresh in my mind. I listened to each recording a second and a third time to ensure that I elicited all pertinent details. On occasion I found that by listening back to the interviews I gleaned further detail usually in the form of participants' tones. This process took approximately 70 hours to complete and was undertaken over a three-week period. I then began the process of transcription.

The first transcription of each interview was verbatim, including all utterances by both the participant and I as the researcher. Most of these were non-lexical utterances such as "yeah", "ok", and were used to encourage the participant to continue with their story and to indicate that I was listening to the stories they were telling. Places where the participant paused, laughed or cried were noted. Possible identifying information that was removed included participants' names, the university which they were affiliated with, names of hospitals where participants had been employed, geographical information and locations, and some specific family information. Participants were allocated pseudonyms to protect their identities. I also ensured that pseudonyms did not bear any resemblance to their original names. Where a university was referred to by name, I inserted [the university] in its place. Similarly, where the research site or other hospitals were alluded to, I inserted [hospital] in its place. The text was left in blocks relating to the event or topic about which they were talking, unless there was a significant pause. The sequencing was preserved. Where I made a comment or statement or asked a question, this remained in the transcript as this is part of the co-construction of the interview.

Since I wanted to ensure my immersion in the data, I undertook the transcriptions of all participant interviews myself. The transcription process took me four months to complete. Whilst this was a lengthy and often onerous process, it enabled me to get a sense of the emergency nurses' stories and how they were told. Since the trustworthiness of results is the cornerstone of high-quality research, the initial transcripts were sent back to each participant for verification. This provided participants with the opportunity to check whether the account corresponded with what they recollected they said during the interview. I chose to forward the interview transcripts rather than the interview analyses as I thought it would provide the participants with an opportunity to amend or reconstruct their original narrative through crossing out aspects of their stories they felt no longer represented their decision-making strategies or experiences relating to higher education uptake. In addition, I felt it was more appropriate for the purposes of trustworthiness to send participants their original narratives for consideration rather than my perception analysis of their stories. Since the 1980s, authors such as Lincoln and Guba (1985, p.242) advocate member checking as a means of enhancing rigour in qualitative research, proposing that credibility is inherent in the accurate descriptions or interpretations of phenomena. More recently, authors such as Birt, Scott, Cavers, Campbell, and Walter (2016), and Kornbluh (2015) recommend member checks, such as sending participants their transcript for review, as one of the recommended processes to confirm or enhance credibility in qualitative research.

The notion of respondent validation, however, is a contentious one within the literature. Thomas' (2017) narrative review of member check usefulness and appropriateness suggests that many qualitative research papers do not report using member checks. Additionally, he further purports that there is limited evidence to suggest that use of member checks enhances the credibility and validity of qualitative research. However, I believed that it was important to utilise the member-checking strategy in order to ensure an accurate representation of participants' experiences and perspectives. None of the 22 participants sought any alterations or amendments of the initial verbatim transcripts. All participants indicated that their transcripts were a true and accurate account of their stories and experiences.

During this stage of analytical process, it was essential that I immersed myself in the data to the extent that I was familiar with both the depth and breadth of content. Immersion involved me repeatedly reading the interview transcripts and reading each transcript in an active way and searching for meanings and patterns. I read each transcript three times before I commenced the coding process. This allowed for identification and shaping of possible patterns as I read. During this time, I was cognisant of how I engaged with analysing the

data, ensuring that I was honest and vigilant about my own perspectives, and pre-existing thoughts and beliefs. Using a reflexive journal, which I discussed earlier in this chapter, I noted my thoughts, values and interests as they developed through immersion in the data. Also at this time, I began to make notes on the transcripts and mark ideas for the coding stage.

#### **6.10.1.2 Phase 2 – Generating initial codes**

Once I had read and familiarised myself with the data, I generated an initial list of ideas about what was interesting about the data. This phase originally began by highlighting preliminary codes from the raw data followed by the development of more concise codes. Elliott (2018) claims that coding is a fundamental aspect of qualitative analysis in which researchers ‘break down their data to make something ‘. Similarly, Creswell (2013, p.156) states that ‘coding is the process of analysing qualitative text data by taking them apart to see what they yield before putting the data back together in a meaningful way.’ Coding provided me with a broad overview of the data and allowed me to simplify and focus on specific characteristics of the data in relation to my research questions. This was a crucial point in the analysis stage. Codes identify a feature of the data that appears interesting and refers to “the most basic segment or element of the raw data or information that can be assessed in a meaningful way regarding the phenomenon” (Boyatzis, 1998, p.63).

Coding was undertaken manually. I initially started preliminary coding of my data as field work progressed by jotting down preliminary words or phrases for codes both on my interview notes and then on the interview transcripts. As previously highlighted, the identification of these preliminary codes was also undertaken by an academic lecturer (peer debriefer), who was also familiar with the research questions underpinning my thesis, to ensure that there was consistency with my coding approach (see Appendix 8) whereby two interview transcripts were read and preliminary codes assigned. Barbour (2001) states that it can be useful to have another person cast an eye over segments of data and this is a valuable strategy in contributing to the rigour of a study.

Once all fieldwork was completed, I coded the data by writing notes on the interview transcripts and used highlighters to indicate emergent patterns. The number of codes is a question on which many scholars have a firm opinion. Friese (2014, p.83) advises that the number of codes should not swell into the thousands. Other figures gathered by Saldanha (2021, p.87) suggest a range between 50-300 codes; 80-100 codes divided into 15-20 categories, eventually grouped into five to seven concepts (Lichtman, 2013, p.108); or 30-



40 codes (MacQueen, McLellan, Kay, & Milstein, 2009, p.217). Creswell (2015) has a more modest figure in mind:

‘I try to code all of my text data (whether a small database of a few pages or a large one of thousands of pages) into about 30 to 50 codes. I then look for overlap and redundant codes and start to reduce the number to, say, 20 codes. These 20 codes then collapse further into about five to seven themes that become the major headings in my findings section of my qualitative report’ (pp.155-156).

In this thesis, I generated a total of 160 codes. In answering the first research question regarding the governing forces of higher education uptake, a total of 70 codes were generated. In the second research question where I sought to ascertain the impact of higher education on self and identity, I elicited 33 codes. The final research question which explored the experiences of emergency nurses generated a total of 57 codes. The next step of the analysis process involved searching for themes.

#### **6.10.1.3 Phase 3 – Searching for themes**

This phase of the coding process involves sorting and collating all the potentially relevant coded extracts into themes (Braun & Clarke, 2006). This stage began once I had collated all the coded material across my set of interview transcripts. This coded material highlighted the final codes identified across the complete dataset. In this stage I focused on data analysis at the broader level of themes, rather than codes. Before I attempted generating themes on a broad level, and with the research questions in mind, I organised the different codes into categories (see Appendix 11).

By developing categories I was able to impose a grouping system on the coded segments by collating similar data according to the specific research question. During this process, a total of 56 categories were identified. In first research question, 26 categories were identified in describing the forces the govern emergency nurses’ higher education decision-making. A total of 10 categories were generated in identifying the impact of higher education on sense of self and identity. The final research question yielded 20 categories in eliciting emergency nurses experience of higher education. These categories then assisted in the formation of subthemes followed by development of the main themes of this thesis.

One of the main advantages of the thematic analysis approach was that it allowed me to determine the themes with some flexibility. In doing so, and in order to have an overview and make sense of the emerging themes and connections, I devised several mind maps throughout this process (see Appendix 13). These mind maps assisted in the organisation of

my categories, subthemes, and themes, and were useful in displaying relationships between themes. In searching for and generating themes, I was mindful that as a novice researcher, I may attempt to explore and interpret every code equally which may not have been necessary or relevant in building an understanding of the phenomenon under investigation.

There were occasions throughout the coding process that certain codes did not seem to fit anywhere within the emerging categories and themes or they were isolated as concepts and would not have contributed anything significant or meaningful to the creation of categories and themes. In this case, I followed the guidance provided by Braun and Clarke (2006) and created a 'miscellaneous' theme to accommodate the codes that did not appear to fit within the themes. Braun and Clarke (2006) state that it is important not to abandon codes at this stage as it is uncertain as to whether the themes will hold, be combined, or eventually be discarded. King (2004, p.260) also advises that themes that seem somewhat relevant maybe become significant in the addition of background detail in the study.

#### **6.10.1.4 Phase 4 – Reviewing themes**

This fourth phase began with the refinement of the generated themes. During this phase I reviewed the coded data extracts for each theme in order to ascertain whether they formed a coherent pattern. It became apparent that some themes did not have enough data to support them or that data was too diverse. Indeed, King (2004) claims that inadequacies in the initial coding and theme construction can still emerge and various changes may be required to address any anomalies. It was apparent at this stage, that some codes had to be deleted and this primarily arose from the overlapping of codes or as already described, were isolated in the initial coding process. During this process, there were occasions where some separate themes formed one theme whilst others required further division, the same was also true of the category development procedure. This was particularly evident for the data concerning the first and third research question where themes generally merged and some sub-themes were disregarded. At the end of this process, I had a good idea and understanding of the different themes and the overall story they told about the data.

#### **6.10.1.5 Phase 5 – Defining and naming themes**

According to Braun and Clarke (2006), during this phase, researchers determine what aspect of the data each theme captures and identify what is of interest about them and why. In naming the themes, I endeavoured to allocate names that were succinct and gave the reader an immediate sense of what the theme was about. For each individual theme, I have conducted and written a detailed analysis identifying the story that each theme tells. This can

be seen in my discussion chapter. I discovered through my analysis and theme development that sections of data had to be included in multiple themes with some overlapping of themes. Whilst I invested considerable time to develop themes in order to produce credible findings, King (2004, p.264) suggests that themes should not be considered final until all of the data has been read through and the coding scrutinised at least twice. One of the difficulties I encountered was understanding where to stop the process of analysis and refinement. This is another issue acknowledged by King (2004) who admits that it is possible to go on modifying and refining definitions of themes forever and one of the most difficult decisions to make is where to stop the process.

#### **6.10.1.6 Phase 6 – Producing the report**

This final phase began once I had fully established the themes and I was ready to begin the presentation and writing up of my findings. Within the presentation of findings and discussion chapters, I have aimed to provide a concise, coherent and logical account of the data within and across themes. I have included direct quotes from the participants which I feel are an essential component of the final report. For some questions, I included more extensive passages of quotation to provide the reader with a flavour of the original text. In addition, excerpts from the interview transcripts were included as Braun and Clarke (2006) claim that extracts of raw data are useful in illustrating the complex story of the data whereby the reader may be convinced of the validity and merit of the analysis. King (2004) argues that if researchers simply report the codes and themes, the results will be largely descriptive and do very little justice to the richness of the data. In the next chapter, I have included several examples of direct quotes from participants and raw data excerpts under set themes and in response to the appropriate research question. I believe that within the presentation of findings, an overall story has been created about what each theme reveals about the area of emergency nurse higher education uptake. These findings will be further enhanced in the discussion chapter.

#### **6.11 Conclusion**

This chapter provided an overview of the research methodology underpinning this thesis. I began by outlining the tradition of qualitative research and I then focused specifically on the use of narrative inquiry as the appropriate research design. While I have indicated that narrative inquiry is a relatively new approach within nursing research, I have illustrated how I believe that, owing to the nature of its methodology and my professional background experiences, it was the most appropriate approach to answer my research questions and realise my study objectives. I have also clarified my philosophical position. Much

consideration has been given to ethical issues pertinent to my study and to my approach to data collection, management, and analysis. I have also detailed the concept of reflexivity and my role in the research process. The next chapter 'Presentation of Findings' will illustrate the study findings based on the research questions.

## **Chapter 7 - Presentation of Findings**

## **7.0 Introduction**

Having discussed the study's methodological underpinnings in the previous chapter, I will now present the findings that were generated through participants' own narratives in response to the research questions outlined at the outset. In answering the research questions, seven main themes were identified through the analytical processes previously described. The process of thematic analysis allowed for the generation of these themes in response to each research question. Each theme consists of a number of subthemes that represent participants' perspectives of their worlds and the nuances and complexities surrounding higher education decision-making. I have provided a table (see Appendix 14) which illustrates the themes and subthemes associated with each research question.

Data analysis on the first research question 'What powers govern the decision to pursue higher education?' identified three themes, 'Challenging Traditional Social Legacies', 'Desire for Self-Affirmation' and 'Professional Influencing Forces' and describes the personal, social, and professional powers that influence emergency nurses' decision-making regarding the pursuance of higher education. In describing these powers, three new findings pertaining to higher educational decision-making were revealed. These are the influence of social background, timing, and departmental commitment. Data analysis on the second research question, 'Does higher education inform an emergency nurse's sense of self and identity?' identified the impact of higher education on sense of self, identity, and professional identity. While this research question did not yield any new findings, the data analysed corroborated findings from previous studies examining higher education uptake among nurses. Finally, data analysis relating to the last research question 'What are emergency nurses' experiences of higher education?' also supported findings from previous studies.

Narratives were generated following semi-structured interviews with 22 emergency nurses conducted over an eight-day period in April 2017. I used pseudonyms to maintain anonymity for participants. Interview duration ranged from 44 minutes to 92 minutes with a mean interview duration of 55 minutes. The cohort of participants represented 48% staff nurse grade, 36% CNM2 grade, and 18% RANP grade. Participants varied in age from 30 years to 58 years, with a mean age of 44 years. All participants had achieved a Postgraduate Diploma in Nursing (Emergency). Of these emergency nurses, 36% held an MSc Nursing qualification. A total of 4% hold an additional graduate certificate qualification which is usually achieved when pursuing an advanced practice pathway. Emergency nurses in this study obtained their academic qualifications through attendance at six universities located in

the Republic of Ireland. It is important to state that nine of these emergency nurses had completed their programmes of higher education while employed at other hospitals and prior to assuming roles at the research site. This may contribute to this study's credibility and transferability of findings.

As I have already briefly indicated, while findings from this study support previous studies, they have also provided new perspectives and insights into the decision-making strategies of emergency nurses in relation to higher education uptake in Ireland and these are highlighted in the next sections. Influencing factors such as knowledge acquisition, security, and opportunities for career advancement reported in the literature from previous studies are also noted in this study. However, new findings such as the influence of social background, timing, and departmental commitment in decision-making will be illustrated in this chapter and explored in further detail in the following chapter. Similarly, the experiences of higher education will also be further described.

In answering the research questions, I have been mindful of the three-dimensional narrative space and, where appropriate, I sought insight into participants' backgrounds, past experiences, and future intentions in order to further illuminate their decision-making strategies, higher educational experiences, and plans for further educational activity. In addition, I have also been mindful of the significance of participants' stories in relation to my own background, decision-making strategies, and experiences of pursuing higher education, and at relevant junctures I have illustrated the resonance of participants' stories with my own story. In answering each research question, I will present my findings in order of originality and distinctiveness and, in doing so, I will illuminate the new and enduring forces which underpin emergency nurses' higher education decision-making in addition to highlighting the findings which are reflected in other studies. I will begin by addressing the first research question which sought to uncover the powers that govern higher education decision-making.

### **7.1 Research Question 1: 'What powers govern the decision to pursue higher education among emergency nurses?'**

The first research question sought to explore the powers that govern emergency nurses' decision-making regarding the pursuance of higher education. In Chapter Two, I highlighted my rationale for incorporating this research question into my study and I indicated how my own decision-making strategies and experiences influenced the development of this question. It is evident that the forces which underpin emergency nurses' educational

decision-making are multifactorial and represent both the personal and professional desires that drive emergency nurses to pursue higher education.

Three main themes were identified in answering this research question. These themes are presented in order of originality and are identified as ‘Challenging Traditional Social Legacies’, ‘The Desire for Self-Affirmation’, and ‘Professional Influencing Forces’. A number of subthemes were also generated by the analysis illustrating the finer forces that underpin and influence decision-making regarding higher education uptake. I will begin by discussing the first theme, ‘Challenging Traditional Social Legacies’, which will highlight the personal and social forces that influence educational decision-making. I am beginning with this theme for two reasons. Firstly, the concept of social background particularly is a new finding regarding higher educational decision-making in emergency nursing and, secondly, it was apparent that the concept of social legacy was an enduring and highly emotive influencing factor among this group of emergency nurses.

### **7.1.1 Challenging Traditional Social Legacies**

The issue of social background emerged as a new and significant force in emergency nurse educational decision-making. Participants in this study described the influential forces associated with their social background with specific reference to educational and occupational opportunities from both pre-registration and post-registration perspectives. The desire to challenge traditional social legacies presented itself in two forms; social background, and family influence.

#### **7.1.1.1 Social Background**

A new finding which has emerged from this study is that of social background as an influencing factor among emergency nurses regarding the decision to pursue higher education. This finding has not been previously uncovered in the literature pertaining to nurse higher education decision-making. It was apparent from these participants’ narratives that social background was enduring and continued to be influential in pursuing educational and career pathways. While I did not anticipate this issue as a potential influence in higher educational decision-making, I was cognisant of how this finding resonated with my own personal experiences of pursuing a career in nursing in the first instance and how it remained with me throughout my post-registration career.

Given that this finding was not prevalent within the literature on higher education in nursing, I considered myself fortunate that this influence was raised with my first participant, Alexandra. Having the issue of social background identified as an influence in decision-



making at the beginning of my data collection journey enabled me to consider it as a potential influence for the remaining study participants. Emergency nurses in this study articulated specific class-related influencing factors during the data generation phase, and the strength of emotion was very evident. Participants described how not only did the issue of social background influence their initial decision to enter the nursing profession, but also how it continues to infiltrate their decision-making regarding higher educational pursuits to the present day.

These decision-making strategies reflected my own personal experiences as my reasons for entering the nursing profession in the first instance were also based on the lack of opportunity, namely, the opportunity to pursue a university education, as a result of the limitations of my social background. In this study emergency nurses described limited opportunities during their early years as a result of their social background with the understanding that such limitations potentially compromised opportunities for further education upon leaving school. This is highlighted through participants' narratives describing the notion of social background as an influencing factor in the original decision to pursue nursing as a career.

Here, emergency nurses described in some detail how limited opportunities and financial restrictions associated with their social background influenced their original career choice. Kim and Alexandra, both advanced nurse practitioners, described the influence of their social backgrounds on the prospect of post-secondary education and how the associated assumption that third-level opportunities were not an option impacted on their career aspirations and pathways. Both highlighted the assumption that advancement into the unskilled job sector was a natural progression based on their social backgrounds. Additionally, the perceptions of their parents regarding educational progression were also evident.

Kim: "So I had finished school and I had come from a working-class family so there was never any encouragement to go and move into third level. It was always assumed that you would never, that, you know, I'd move on to be a secretary or something like that but the way I suppose my Mam and Dad looked at it was if they got me through secondary school that was an achievement. Purely nursing found me, it wasn't my decision to become a nurse. It was an opportunity to go to [country] and this is how I was going to get there and it wasn't really going to cost me anything other than my time, it was purely an opportunity."

Alexandra: "Nobody else went to college, kind of, none of us were really, it wasn't something that we kind of talked about at home, it wasn't something we kind of, eh, as kids we were pushed towards. I don't mean that in a bad way but it was just, it

was just a case of get a job after school. I don't think any of us filled out the CAO, it was just a case of get a job, earn your wages and that's kind of how you'll move forward. I don't think they [parents] ever saw how higher education could have been pursued. It was just that you needed a wage, you need to support your family and, yeah, it wasn't like, I don't think there was any malice in it but I don't think they even knew how to direct us."

Similarly, Natalie, also an advanced nurse practitioner, highlighted the impact of social background on educational and career opportunity decision-making. Natalie described how financial restrictions associated with her social background influenced the options available to her and her siblings upon leaving school. While the preference at the time was to pursue a college education, the decision for Natalie to undertake a career in nursing as an alternative to a third-level pathway would demonstrate achievement and success in light of social background. The desire to enhance sense of self and identity was apparent. Social background and the associated perceived limitations have been a driving force and a source of inspiration in Natalie's pursuit of higher education. Education was the platform by which Natalie sought to improve her life and social standing. Again, this resonated with me as Natalie's reasons for pursuing a career in nursing were similar to mine. My parents did not have the resources to enable me to pursue a university education. While they were encouraging of me to do well in life, this did not translate into tangible support. Like Natalie, I knew I had potential and I wanted a good job and the opportunity for further education but I was similarly restricted by the limitations of my social background. When I made the decision to pursue nursing as a career my parents were happy as nursing had that good standing in the community that Natalie described.

Natalie: "It was a fact that there wasn't many options out there at the time, you know, em, even looking back now. My sister is a nurse and she would say that she would have preferred to have gone into business studies or whatnot but there wasn't money in our house to pursue a college education, it was a case of get out and get something that you can work at, you know, a qualification as well. We would have been from what they would class as a social housing background. There was no money to go to college, you know, and I knew that filtered down. I was the last of four so I knew there wasn't going to be, it didn't have to be said to me, you know [laughs]. Also, nursing had a good standing in the community, you know, a job that could be perceived as being someone that had a nice job and had done well for themselves as well."

Clinical nurse managers, Sue and Joy, and staff nurse, Jane, also described the influence of social background upon educational and career decision-making. Here, financial and sociocultural issues were significant driving forces in the intention to improve educational and career opportunities. It was obvious that this was a very heartfelt and emotional issue

for Sue in particular and one that was still relevant and enduring as an adult. This was one of the most difficult interviews that I conducted as the restrictions associated with social background appeared to be still quite raw with Sue who became visibly upset and distressed when telling the story of her social background.

I felt concerned that I had placed Sue in an uncomfortable situation by recalling her family background and I did offer her the opportunity to take a break from the interview or to reschedule which she refused. This situation was also made difficult by the fact that Sue was on duty in triage that morning and I was concerned how the interview may impact on her ability to focus on her triage responsibilities. The other reason I felt somewhat uncomfortable during this interview was due to the fact that Sue was almost relaying my own story to me. While I felt I had a lot of resonance with participants such as Natalie, it was Sue's story which resonated with me on a much more profound level. In a strange way I almost felt like I understood my story, my experiences, my sense of self and identity, and my decision-making strategies more clearly through Sue's story.

Sue: "...we grew up in a council house. We would always have had good opportunities education wise, you know, as regards primary school and secondary school. It was because kind of my parents wouldn't have had a good education, they would always have pushed us towards it. We still, Mum and Dad still live, I'm going to start crying [starts crying], Mum and Dad still live in the council house that they just don't even like, they're still there, still don't have money but they still would, I'm sorry, but they always did their best for us and they, em, like we still live in the very same place, you know, people around us that wouldn't be ideal, you know."

Joy: "...I came from a terraced house and I came from nothing as far as they [school friends] were concerned. I didn't feel that I came from nothing. My Mum and Dad literally did everything that they could possibly do for me and I knew the limitations financially."

Jane: "There wasn't money there to put me through college."

#### **7.1.1.2 Family Influences**

It was also apparent in this study that family and family experiences played a significant role in the shaping of educational aspirations. The influence of parents features significantly with regard to the educational decision-making of their children, particularly in light of their own social backgrounds and associated opportunities. For these emergency nurses, it was also the lack of parental education that influenced the desire to pursue higher education. Parents generally, due to having similar social backgrounds and limited educational opportunities, did not have either the financial resources or the necessary understanding or knowledge of third level education processes to guide their children towards a university pathway.

My parents did not pursue formal education beyond secondary school. Both left school early to pursue employment. Their siblings also followed the same route and did not engage in education beyond secondary school. Similarly, my maternal and paternal grandparents did not pursue higher education. At the time, the focus was on securing employment in order to assist with the support of large families. Since my grandparents and my parents did not pursue further education or gain any qualifications, they were unable to either guide or support the journey into third-level education for their children. Despite their lack of education and educational opportunity, my parents were always encouraging of me to progress myself. Similarly, participants in this study were also keen to identify that parents were not always discouraging of their desires to break the social mould, in most cases parents simply did not have the requisite knowledge and skills to guide their children towards the idea of third-level opportunities. Instead, participants, such as Alexandra, found themselves being prepared and encouraged to repeat social history by surrendering to perceived social stereotypes through the finding of employment as a means of supporting themselves rather than pursuing post-secondary education.

Alexandra: “I kind of had this unspoken kind of thing that I knew not to say it to my parents because they didn’t know either and I didn’t want to make them feel bad, so I kind of just never talked about it, never discussed it. So it was just do ok in school, grand, but it wasn’t the end of the world if you didn’t so I kind of pushed myself more than anything, more than anybody else did.”

The reference to the ‘unspoken’ may be of some interest here. The notion of the ‘unspoken’ in this context referred to any potential conversations regarding her educational progression and subsequent career prospects. It was evident that Alexandra was conscious of the potential negative impact on her parents as a result of raising this particular issue given that her parents’ opportunities were also limited due to having the same social background. While Alexandra found herself being directed towards a similar social standing to that of her parents, she became actively engaged and self-directed in changing the course of social history and social standing through the pursuance of higher education. Again, this situation resonated with me as I chose to pursue a career in nursing to afford myself the opportunity to gain an education and professional qualification.

While participants such as Alexandra, Natalie, Kim, Jane, Sue, and Joy were not actively encouraged to break the social mould, Alison and Emma, both staff nurses, particularly described how the influence of their mother’s social background impacted on their decision to pursue higher education. Lack of parental opportunity coupled with a sense of opportunity for their children incited in these mothers a wish for both Alison and Emma to pursue higher

education. Additionally, both participants sensed that their attendance at university enacted their mothers' own educational and career aspirations.

Alison: "...my mother was never in a position that she was able to go to college. Like, you know, in those days they didn't have money and stuff and she would have had to work in the local supermarket and I suppose she wanted me to go to college whether it be, you know, to her it was like going to college and doing a course and getting a piece of paper."

Emma: "I always wanted to be a nurse, I think, from when I was about 12, you know. My mother always wanted to do nursing and she didn't have the opportunity because her parents died when she was very young, it was just herself and her sister."

Joy: "From I'd say third year, she [mother] would be looking at my results. I spent a lot of time with my grandparents, seeing how I cared for my grandparents and she basically said that I would make an ideal nurse and I then went to do work experience in the local nursing home and it appealed, it totally appealed. I loved the interaction with those little ladies and doing everything for them and they were just like sponges. It was a fresh face coming in and they just wanted to know you but for you to get to know them and to know their little quirks and that was lovely."

Participants also indicated parental influence and, more specifically, the influence of their mothers in educational progression. Gemma, Pauline, and Kerry described how their mothers influenced their educational and career trajectories. In the first example, Gemma, a staff nurse, described how she was encouraged to pursue educational activities beyond secondary level. In this case, Gemma was actively encouraged to pursue further education. While it may be argued that this encouragement arose as a result of her mother's own educational achievements, it proved to be somewhat of a restraining force in Gemma's desire to further her education.

Gemma: "I actually had a place to do nursing when I was 19, something my Mum kind of railroaded me down. Originally I wanted to do nursery nursing but she said that was for stupid people and she wouldn't let me do it [laughs]. My Mum was a teacher and she did her best to push me. I think she did her best to push me harder and to do better, she thought I was capable of doing better so I should be working harder. I think I just went through a rebellious stage and pushed back against her really, you know."

Similarly to Alison and Emma's stories, Pauline referred to how her mother and grandmother did not have the opportunity to complete their pre-nursing educational programmes but expressed the wish for Pauline to pursue and complete a career in nursing and enact their own aspirations.

Pauline: "I chose a career in nursing because of my mother and grandmother. So basically my Mum did a pre-nursing course the same as my grandmother which they

didn't really finish or complete but they wanted me to pursue and complete and finish nursing. They influenced me, I'm very obliging [laughs]."

Beyond the immediate parental influences, other broader familial factors were also at play in the decision to pursue a career in nursing. For example, Olivia, a clinical nurse manager, described the influence of her sister's career pathway and her father's ill-health as being pivotal in her decision to pursue nursing as a career:

Olivia: "Em, I suppose at the time I'd seen my sister who was a nurse and she was doing well and seemed to love it. Then my Dad has poor health as well and I was kind of always interested in how things worked as such. In school we would never have had any decent career guidance as such. I do remember going to a career guidance teacher and at the time I think I wanted to join the guards and she told me to do business. So I did a year of college in business and going back to maths, I was very poor and it was all financial accounting and mathematics and I was failing it miserably and then there was a newspaper article saying that they were recruiting nurses for training in England. I made the phone call, sat the interview and got the place."

Similarly, Michelle also described family influences regarding the decision to pursue nursing as a career. Michelle described the experiences associated with her sister's medical condition and observing the practice of the family GP as an influential force in her career decision-making.

Michelle: "Em, the first time I ever said I wanted to do nursing was the first, so my sister has epilepsy, she had her first seizure when I was nine and I said to the doctor that, he came to the house that night when she was having her seizure, he was our GP, I said 'if you make her better, I want to be your nurse' and ever since that, I wanted to do nursing, yeah."

### **7.1.1.3 Influence of Social background and Family on Higher Educational Decision-making**

As these emergency nurses began considering higher educational pathways, the influence of social legacy was still evident in the decision-making process. However, before this area is discussed, it is perhaps appropriate to consider the reasons behind pursuing a career in emergency nursing in the first instance. Exploring the rationale behind the decisions to pursue a pathway in emergency nursing will provide some further insight into the influences, desires and plans of this group of healthcare professionals. It will also assist in providing further understanding surrounding the personal and professional aspirations with the concept of higher education in mind.

Reasons for pursuing emergency nursing were varied among participants. Participants identified that the opportunity for learning influenced their decision to pursue a career in

emergency nursing. The prospect of working in a clinical environment where there was a 'buzz' appealed to some participants whilst working in a setting where you could make a difference and be part of a team that incorporated differing levels of patient and clinical acuity appealed to this group of healthcare professionals. Participants also identified 'chaos' as being part of the attraction of working in ED in addition to the high turnover of patients and working with a diverse staff group. The following transcript excerpts outline in some further detail the reasons this participant group chose to pursue a career in ED.

Ellen: "I think initially it was that whole buzz, especially resus and triage and all the things I don't like about it now but, you know, all that, the high turnover and, kind of, I suppose in a way, the drama of it. I used to love the trauma cases and the RTAs, the six patients in resus and the high turnover and you'd more time to talk to people as well, you know."

Sue: "I love the fact that you see people coming in at their worst and you can literally make them so better within hours and move them onto the ward for further treatment, I just love that. Em, you can make such a difference so fast down here, you know, whether they're an MI or they're a stroke, you know, the instant gratification I suppose. If they come in with a broken leg and you pull it, it's just brilliant."

Kerry: "I just liked to work in an environment where there is teamwork, I don't like to work alone, I enjoyed it. I was made to feel very welcome and I just knew the environment was something that I was interested in, I just got a buzz from it. I was learning so much. There was huge scope for learning and I was upskilling every day and it was fantastic and the, my colleagues were so willing to teach and I was willing to learn so it was a win-win for me."

Interestingly, participants (Alexandra, Holly, Natalie, and Sue) stated that they originally began working in ED by default due to the service needs of the hospital and following requests to be moved out of the ward environments.

Holly: "I was general relief so you'd be working in ICU, CCU or the emergency department and I spent a lot of time in the emergency department so then I asked for a post there and that's how it came, it came by default."

Sue: "Pure default. I wasn't happy on the surgical ward so I came down to the ADON and I said I didn't want to go back to the surgical ward so I asked her if I could go to ICU or A&E just to keep training and she put me down here, it's great."

While Holly and Sue actively sought positions in the ED, Alexandra and Natalie began their emergency nursing careers in an agency nurse capacity and found themselves in ED due to the service needs of the hospital. It is apparent that both struggled initially with their assigned placements but eventually became accustomed to the specialist working environment. This reflected my own experience as I was initially placed in ED due to service and staffing demands. Similarly to Alexandra and Natalie, I struggled initially with being placed in ED

due to my perception of the department being disorganised and lacking routine. In addition, I found some of the staff to be abrupt and unhelpful at times which did not help my transition into the department.

Alexandra: “We were moving down here and I just said I’ll do agency for a while and see how I get on. This was the first emergency department placement I did, it wasn’t a planned decision. I absolutely hated my emergency nursing placement. I was like ‘I can’t, I don’t know what’s going on, it’s too crazy’. It was the same kind of feeling when I ended up doing my first night here. I began to kind of thrive on it and it was kind of, I think, a thing of ‘yeah, you know, we can make a difference, you’re not going to make a difference on your own’, it has to be part of a collective input. But I kind of liked that challenge, I liked that idea of, you know, everyone working together and kind of feeling part of this big team.”

Natalie: “Nothing attracted me to it whatsoever. I was never an emergency department nurse, I’d stay clear away from it. I was like ‘oh Christ I can’t deal with that, there’s no structure, there’s no order, they could have anyone coming in and I was like I can’t do it’. But when I started working here you have to go where you’re put and I was like ‘ok, I’m just going to keep working, I’ll do whatever I have to do.’ I hated it, I hated it, I was terrified. Then after six months I loved it, I just, I don’t know, something clicked in me and I just loved it.”

It is evident from the above narratives regarding the decision to pursue a career in emergency nursing that emergency nurses cited the potential and availability of learning opportunities and upskilling as a reason for pursuing this specialised career pathway. These learning opportunities were both clinical and theoretical in nature. Once settled in the ED environment and appropriate clinical experience obtained, nurses in the ED sought to consolidate their clinical learning with appropriate theoretical learning, usually in the form of postgraduate diploma and Masters’ programmes of education. However, my findings relate and contribute specifically to emergency nurses and the field of emergency nursing, rather than the broader registered nurse population.

Within this group of emergency nurses, experiences from early educational and socioeconomic perspectives still featured and were prevalent for participants like Kim, Natalie, Jane, and Sue when it came to post-registration educational decision-making. The experience of having limited opportunities in their early years influenced their educational decision-making and desire to prove that success is attainable irrespective of social background. Additionally, the notion of family influence and social background continued to be influential in educational decision-making as the participants entered the post-registration phase of their careers. It was apparent that influencing factors and forces went beyond the traditional realm of knowledge acquisition and career advancement and were more fundamental and enduring in enhancing their sense of self and identity.



Sue: “Well going back to college was a massive thing as well, you know. I remember telling me cousin ‘I’m going to [University]’, that was massive you know. I told everyone, everyone who would listen to me I told, you know. Mum and Dad were so proud of me on my graduation day, you know.”

Kim: “I think, yeah, I think coming from a working-class family and I went as a day pupil to a boarding school, where I suppose they were all well-to-do and this feeling of being told, I remember my Mum being told that I was too laxadazical. I got grinds at one particular time and the grinds teacher told my Mum ‘God, it’s hopeless’ so it’s, you know, self-driven learning now, maybe I’ve a point to prove to myself now, you know.”

Jane: “It is for me. I wanted to do it. I suppose it’s to do with my upbringing. I’m the oldest. When Dad died we didn’t have much money. All my friends were either going to be teachers or doctors or accountants or whatever. There was nothing there and I knew I had to achieve something, I knew I had to better myself. I suppose it empowered me to go ahead and just find what I could be best at.”

Holly: “My mother would have said, em, my mother would have said ‘do your general and go on and do something else’ so it wasn’t acceptable that I just had one course so I suppose I was influenced that way.”

Natalie: “I didn’t feel that I was an academic person and I think that probably stems back to when I was younger, you know. Like, do your schoolwork, do well at it but, you know, maybe this is your social standing, you know, don’t go rising above it and my mother and father, they were great, you know, they were grafters and I don’t think they grasped that you can rise above where you’ve come from, em, and definitely I think the challenge that I put myself through it and excelled at it to be honest...it gave me that inner fight to make yourself a better person, you know. That little voice that was saying ‘oh you’re useless, don’t be doing it [laughs]. And I think that stems from your upbringing a little bit as well, you know, ‘I can do it, look I have done it.’ It opened my mind up to education. It does make you perceive to be someone as well, you know, of note really.”

Participants were keen to identify the finer and more personal powers at play relating to the concepts of self and identity in the decision to pursue higher education. For me this was a key influence in my decision to pursue higher education post-registration as I still felt the need to prove that I could progress and be afforded opportunities both professionally and academically despite my social background. Similar to my participants, while my real self and identity remained grounded in my social background, my ideal self wished to realise my goals and aspirations. It was evident in the telling of their stories that participants’ core sense of self and identity from their early years was still prevalent and a significant driving force in the desire to elevate and enhance their traditional social background legacies. It was apparent that such legacies impacted negatively on these participants to the extent that they felt the need to ‘better’ themselves and ‘having a point to prove’ in their later years. While the notion of clinical upskilling and betterment is apparent in the literature, the concept of

betterment from a social perspective as a result of higher education pursuance is a new finding within higher education decision-making among emergency nurses.

For some participants such as Natalie, however, parental support and encouragement was not always readily afforded regarding postgraduate study. The need for support and encouragement was important given that there was an element of self-doubt regarding the decision to pursue higher education. While Natalie acknowledged that her mother's viewpoint may not have been necessarily unfavourable, it ultimately did not prove to be a barrier in decision-making:

“I really didn't believe in my ability again, you know, to be academically bright, em, and my mother was alive at the time and she was like ‘oh, what are you putting yourself through that for, don't do that’, you know. I suppose she didn't want to see me overstretching myself but I would have liked for her to have supported me more and encouraged, you know. Like education is good, but no. So I suppose got a bit stubborn then and I thought ‘well, I'll show her as well’ [laughs], you know, so yeah, I went off and applied and got accepted onto the A&E postgrad in emergency nursing.”

Similarly, while Alexandra also described the concept of self-doubt, this proved to be somewhat of an influencing factor in her decision to pursue higher education.

Alexandra: “...that little voice in your head saying, you know, you're just going to give up, you can't do it, you can't do it and I'd be like, em, you can do it. So it was probably I argue with myself more than anything else. That kind of sustained me cos everyone else around me had this idea that I was great, that I was really clever and I'm like they're all crazy and any day now they're going to realise I'm as dumb as two short planks and the façade will be gone, that I'm not clever that, you know, I've just happened to fall into these things and I happen to be able to pass them by some strange mystery. But that was the thing, it was just kind of that trying to push myself going, yeah you know, you're a big old failure, yeah, no I'm not, that constant inner argument.”

The participants who identified a working-class social background achieved several postgraduate academic qualifications which has led to additional professional registration mainly in the area of advanced practice. While this drive and determination has served them well from a professional and educational perspective, interestingly, two of these participants still identify as being working-class. Both Alexandra and Natalie describe being on the margin of two social cultures. While both participants made reference to social mobility and the desire to rise above their familial social background through the platform of education, both were hesitant in acknowledging the impact of education upon their current social standing and made broad claims about their current social standing through self-perception and the perceived insights of others. It was apparent that, in keeping with the concept of

Social Identity Theory, the sense of working-class association was internalised. I also still consider myself to be working-class despite my educational and occupational achievements.

Alexandra: “Society might consider me middle class I’d say but I’d see myself as working class. I can’t hide from my roots.”

Natalie: “I don’t feel my social status has changed but I sometimes feel that other people perceive me in a different light.”

### **7.1.2 Summary of Theme Findings**

In the narratives presented so far, it is evident how social background influenced these participants original decision to pursue a career in nursing. For some participants, the desire to dispel the myths surrounding social background is important, highlighting how it is possible to elevate oneself from a particular social background. Drawing upon one’s social background can assist in the pursuance and acquisition of both choice and an enhanced social standing. This theme has demonstrated how the influence of social background is a new and enduring finding which continues to feature in higher educational decision-making among the study participants. It is apparent that the issue of familial socioeconomic status has been, and continues to be, influential among emergency nurses. The next theme to be discussed in answering the first research question is ‘Desire for Self-Affirmation’.

### **7.1.3 Desire for Self-Affirmation**

The desire for self-affirmation was the next significant theme which emerged from participant narratives regarding the decision to pursue higher education. Within this study, emergency nurses cited forces such as timing, self-worth, and self-fulfilment as influential in their decision-making. Although not the main reasons for higher education pursuance, these forces were meaningful and relevant nonetheless among this group of nursing professionals. I will begin by describing the issue of timing with a particular focus on the areas of distraction and escape as these are original findings within educational decision-making. I will then describe the area of self-worth within the context of decision-making.

#### **7.1.3.1 Timing**

Within the theme ‘Desire for Self-Affirmation’, the first sub-theme which emerged was that of timing. For emergency nurses, the issue of timing was influential in the decision to pursue higher education. Timing arose from two perspectives; the right time in life either personally and professionally, and a new finding concerning distraction and escape was also uncovered. In the stories relayed by emergency nurses, ‘distraction’ referred to the focus on higher education instead of other aspects of their lives while the notion of ‘escape’ provided these emergency nurses with a medium to forget about problems or issues in their lives. While

they were not the main cited reasons for pursuance of higher education, they were significant in terms of originality and depth of feeling, nonetheless. The reasons for distraction and escape were based on both personal and professional factors and included escape from family life and escape from professional life. Participants gave honest and emotional accounts in their descriptions of the need for personal escape. For Jane and Jennifer, both staff nurses, the engagement in higher education provided a means by which to escape from the stress of home life and work life.

Jane: "...there were other factors coming into my life in the last eight years because of the recession so there was a lot there and I needed to reduce my stress levels..."

Jennifer: "I knew it was going to take me from the stress of work life and the stress of home life."

Similarly, participants highlighted how the pursuance of higher education provided a distraction from personal issues. The impact of a bereavement and associated family dynamics were influential in Natalie's higher education decision-making. The prospect of engaging in an educational programme was anticipated to alleviate some of the stress associated with personal circumstances.

Natalie: "I had a void in my life I suppose after she [mother] had died because I had looked after her as well and even though she was in hospital the last three months, it was a huge undertaking and the dynamics of the family were hard as well at the time. I think after she died, before she died I suffered with depression, I got depressed and worked through that and then after she died I said 'right, you have to pull yourself together, you have to have a plan.'"

Unlike Natalie, Kim did not cite distraction as a reason for pursuing higher education. Rather, the process of engaging in higher education provided her with a distraction during the process of bereavement.

Kim: "When my Dad died, I wanted to get out of my own state of grief so it was a welcome distraction to take me away from where I was."

Similarly, for Alexandra, pursuing higher education provided distraction and comfort generally in adult life. She noted that engagement with education in childhood also provided her with distraction and this continued through to post-registration educational activities.

Alexandra: "I definitely continued to find solace in education but also maybe as a distraction from real life in relation to higher education. I always kind of found solace even when I was in school, I found solace in that kind of work."

Having highlighted the areas of distraction and escape, I will now focus on personal and professional timing as decision-making forces. Personal timing was significant for

participants as it was deemed to be the most appropriate time in their personal lives especially since childcare and domestic responsibilities had lessened. Here, participants Holly and Viv describe how they could devote time to study once their children became older. Additionally, Viv highlights how the issue of maturity and decreased parental responsibilities assisted in her educational decision-making.

Holly: “It was a good time in my life. My children were at an age where I could devote time to study.”

Viv: “The timing was good as they [children] weren’t little tiny tots running around the place and then I was mature as well. You’re a little bit more secure in your life as well, you’re more mature and you’ve done a lot in life. You come to a stage where this is my time, it’s your space, it’s yours to make what you want out of it, like that was my time to do what I wanted to do.”

The concept of professional timing was an important consideration for some participants. These participants stated that it was the right time in their professional lives to commit to further education for a number of reasons. Firstly, the decision to undertake a postgraduate diploma in emergency nursing was based on the time they had served in the ED. University requirements, and in some cases local hospital requirements, dictated that registered nurses must have a certain amount of both post-registration experience and ED nursing experience prior to commencement of the course.

Sue: “When I went on to do the graduate diploma in emergency nursing, I was here two years and two months at the time. I felt like I was here a long time and I still didn’t know it all. I felt out of my depth and I didn’t like that and I said right, I need to do this, you know, because of the line of work.”

Alison: “Well, I suppose when I started working in ED, I suppose I was there two to three years before I’d undertaken it [postgraduate diploma] and part of that, there were a few other girls that had done it so I suppose like observing them, their competency areas, I wanted to be able to have that knowledge base and know the rationale of how to manage things.”

### **7.1.3.2 Self-worth**

The desire for self-worth was the next most significant power pertaining to the desire for self-affirmation that governed emergency nurses’ decision-making regarding higher education uptake. Self-worth refers to the sense of one’s own value or worth as a person rather than basing a value on their worth on external actions or forces. Emergency nurses declared the need for self-worth as a reason for pursuing higher education. This subtheme was underpinned by two categories where emergency nurses cited recognition of potential by self and others, and the need for self-fulfilment as influential in their decision-making. Within the category of recognition of potential by self and others, some participants identified that

recognition of their own potential and while others described recognition of potential by others as influential in their educational decision-making. Again, while not the main reasons for higher education uptake, these forces were significant nonetheless within this participant group.

Recognition of one's own potential and recognition of potential by others was a modest finding among participants both in terms of aspiring to meet the needs of academic programme requirements and the overall achievement of academic credentials. In discussing recognition as an influencing force, participants also acknowledged other factors in their narratives. Recognition of own potential was identified by participants in the decision to pursue higher education. For Gemma, the decision to pursue higher education was based on recognition of her own potential in addition to her own personal need and value. While the majority of participants acknowledged the quantifiable benefits of higher education (knowledge development and enhancement, skill acquisition, promotional and educational opportunities), Gemma also took the opportunity to disclose the covert benefits that resulted from her engagement with higher education when discussing her own potential to undertake a programme of higher education.

Gemma: "I knew there was something more in me, you know, self-fulfilment I suppose. I felt as though, I'm not regretting that I hadn't done it sooner, I felt it was in me, I wanted to do it. I think for me, I think it, I suppose I was, not stuck in a rut but, you know, but to me it kind of, not opened up the world to me again but it gave me a new lease of life, an interest in the world outside my four walls I suppose."

Clinical nurse manager Emily also acknowledged her own potential in describing the factors that influenced her decision to undertake higher education. Here, Emily also indicated the other contributing factors to pursuing higher education such as her desire to learn and her desire to remain in the ED setting. In pursuing higher education, Emily felt that her position in the department would be secured, in addition to consolidating her sense of self-worth.

Emily: "I loved the learning, I loved the difference. I felt at the time I was good at it, that it suited me. So with that in mind, you know, I felt it would secure me, that I wanted to broaden my knowledge and increase my learning. If I was going to be a shift leader I had to have something behind me to back me so it was an opportunity for me to, you know, achieve more in my role and it also gave me some feeling of self-worth."

Participants also described how the recognition of their potential by others was influential in their educational decision-making. This is a new finding regarding higher education uptake and has not been previously described in the nursing literature. In this case, recognition of potential was offered by the department manager. This recognition then translated into active

encouragement by the manager to apply and pursue the specialist emergency nursing programme.

Natalie: “I think a huge factor was the clinical nurse manager 3 at the time. She probably recognised my potential, em, and she kept encouraging me to go and put me forward, you know. She said ‘you need to do it, you need to do it’.”

Molly: “The ED managers at the time really encouraged me to do it. I guess they saw some potential in me plus I knew that I would have to do it as some point.”

The idea of self-fulfilment was closely followed by the concept of self-worth as a reason for pursuing higher education. Participants made reference to this area when describing the powers that influenced educational decision-making. Within the area of self-fulfilment, participants identified various factors such as ‘bettering themselves’ personally and professionally, ‘doing it for themselves’, and having a genuine interest in pursuing higher education. In addition, participants identified the need to be someone of value as a reason for pursuing higher education while some participants identified themselves as being questioning and inquisitive. Participants also referred generally to the concept of self-worth in describing educational influencing factors:

Jennifer: “Just for myself as well, I wanted to better myself.”

Ellen: “I suppose on a personal level I just wanted to be a better A&E nurse

Gemma: “I think it’s easier to study if you have a genuine interest in something. I like to know, I have an inquisitive nature, I like to know the ins and outs of everything. I had this vision of going on to do public health and that’s where I wanted to be, that vision has changed now but at the time, so it was, it was all about, not bettering myself but I suppose it was in a way, yeah. I definitely have a sense of self-worth that I would never have had before and like, you know, I am a nurse, I’ve worked hard to get my qualifications.”

Natalie: “I definitely wanted to be a better nurse and a more qualified nurse, em, and a huge thing was to be able to give good care to patients.”

Similarly, Joy also describes a sense of fulfilment from a professional perspective having completed a programme of higher education. This fulfilment arises from her expertise in the clinical area and her ability to nurture new members of staff.

Joy: “...like this is my area. This is where I have, this is my home, it’s my expertise and I get great pleasure out of teaching different aspects of what I have learned and to other new staff that arrive. And that gives me, what do you call it, fulfilment. I feel like I’m doing my job, what I’m meant to be doing.”

#### **7.1.4 Summary of Theme Findings**

This theme has demonstrated how the concept of self-affirmation is a significant power among emergency nurses' educational decision-making. It has been revealed how forces such as timing, self-worth, and self-fulfilment are meaningful and relevant for this group of healthcare professionals. While the majority of findings are reflective of other studies, the issue of timing, with a particular reference to the need for distraction and escape, is a new finding in higher education decision-making. I will now consider the third theme underpinning decision-making which uncovers the professional influencing forces underpinning decision-making.

#### **7.1.5 Professional Influencing Forces**

The third theme which arose in answering the question 'What powers govern the decision to pursue higher education among emergency nurses?' was that of professional influencing forces. While all emergency nurses identified the influence of professional forces in their higher education decision-making, the majority of the professional influencing forces articulated are already well-represented in the literature on nurse educational decision-making.

The professional forces which underpinned emergency nurses' decision-making broadly included educational development and advancement, work context, security, and career advancement. More specifically in this study, emergency nurses ranked the desire to further their knowledge, the opportunity for promotion and progression, the influence of colleagues and admiration of their competencies, and the impact of working in a diverse clinical environment as the most influential in their educational decision-making. These findings were followed to a lesser extent by references to other influencing factors such as the desire to be clinically competent in ED and provide appropriate care, feeling left behind, the desire to remain in ED, and management support. While these findings have already been reported in the nursing literature, this study uncovered the concept of commitment, specifically departmental commitment, as a new finding relating to decision-making. I will begin by firstly discussing commitment as a new finding within decision-making and I will then highlight the remaining findings as identified in emergency nurses' narratives.

##### **7.1.5.1 Commitment**

Within the context of this study, the notion of both professional and departmental commitment was articulated as an influencing factor in the pursuance of higher education. In detailing this area, emergency nurses described the sense of commitment to emergency nursing and commitment to the ED. The sense of departmental commitment is a new finding



which has emerged from this thesis in relation to educational decision-making influences. For participant Kerry, the sense of departmental commitment was fundamental in the decision to pursue higher education. In describing this commitment to the ED, Kerry described how once she acknowledged her commitment to the department, she then sought to avail of educational opportunities in order to consolidate this commitment.

Kerry: “First of all I had decided that I was committed to the unit. I wasn’t looking to move out of the unit so I thought if I’m committed to the unit, why not be the best I can be in the unit. I thought I had upskilled as much as I could clinically so therefore I thought, well not fully, but I thought now I need to take it kind of a step further and actually, you know, learn about the gold standards, understand why I’m doing things, em, and I thought if I can bring back what I have learned to where I work, that can only be a positive thing.”

For other participants such as Jane, Sue, Viv, and Molly, commitment was professional in nature whereby reference was made to the approach and discharge of duties in the ED.

Jane: “Commitment, I just wanted to commit to being the best, one of the best nurses I could be and giving my all when I came to work and making sure that everything was done right for the patient and that they were safe and that my team knew what they were doing.”

Sue: “When I went to do the graduate diploma in emergency nursing, I was here two years and two months at the time. I knew at that stage I loved A&E, I knew I wanted to stay here, I didn’t want to go back up to the wards.”

Viv: “I’ve always liked working in A&E even from when I was a student. That’s when I first saw the learning opportunities and how A&E nurses always seemed to make a difference, you were the first people the public saw in hospital.”

Molly: “I just like how we work together no matter how busy the place can get. Even when times are tough, everyone just pulls together and that’s important. There’s also lots to learn and no two days are the same.”

### **7.1.5.2 Educational Development and Advancement**

Within this subtheme, categories such as increased knowledge and skills, the importance of higher education, the appropriateness of educational programmes, the provision of appropriate care, and educational progression were identified as being influential in decision-making. In this study, all participants cited a desire for an increased knowledge and skill base as a reason for pursuing higher education, in addition to acknowledging the importance of higher education. There was strong agreement among participants in this study that the ability to improve knowledge and clinical skills was one of the most influential influencing factors regarding the desire to pursue higher education. Within the participant group, emergency nurses stated that they ‘wanted to know’ as pursuing programmes of higher

education would provide the rationale for what they were doing in clinical practice. Similarly, participants also declared the desire to be clinically competent in ED.

Michelle: “I wanted to further my own education so that I could understand, you know, the likes of trauma. And then there’s, I suppose, if you want to further your own career, that it’s something good to have on your CV that you’ve done it.”

Molly: “I wanted to update my knowledge in emergency nursing cos I felt, although I had been involved in teaching and I had done courses in, I had probably done something every year and I was teaching on a lot of trauma courses cos by this stage I was an instructor in the advanced trauma nursing course, the pre-hospital emergency care course, eh, and the advanced cardiac life support course, so I was very involved with education and training but I felt that maybe I just, em, needed to update generally on emergency nursing so the easiest way really was to do the pg dip.”

Julie: “I suppose I wanted to gain more knowledge in what I was specialising in.”

Alison: “...I wanted to be able to have a knowledge base and know the rationale of how to deal with that trauma or, you know, issue at the time and to give the client or the patient proper quality care. Em, and I suppose professionally, develop my knowledge base.”

Whilst some participants had clear expectations in terms of knowledge and skills enhancement, Natalie also referred to the desire for ability and competence recognition as being influential.

Natalie: “...I also wanted to be perceived to be, I suppose, someone of value and like ‘oh Natalie knows what she’s doing, you know, we have great confidence in Natalie’.

### **7.1.5.3 Importance of Higher Education**

All participants considered it important for emergency nurses to engage in higher education. Participants deemed knowledge essential in appropriately dealing with varying and complex healthcare needs and the demands of service-users in general. In addition, the acquisition of this knowledge contributed to confidence and competence when dealing with patients, and for effective multidisciplinary team-working.

Olivia: “It upskills them, they gain more knowledge, em, and they’ll feel more experienced. I know I did anyway.”

Kerry: “...you are the first person the public meets, you know, em, ninety percent of the time when they come in, you have to be, I think after completing the course like that you are competent, confident, knowledgeable, calm, and confident in your own ability to deal with whatever happens.”

Yvonne: “I think emergency nursing is such a broad thing, anything can come through the doors and I think that once you start, particularly the postgrad, if you

have that you gain new skills and I just think it gives nurses that extra bit of confidence and that extra knowledge that they need.”

For participants, Alexandra and Emma, the importance of higher education for nurses went beyond the acquisition of knowledge and skills, for them higher education was important in order to demonstrate professional power and parity with other healthcare professionals.

Alexandra: “In emergency nursing everything’s quite quick and you kind of, you need to be, again best practice needs to be in place all the time and best practice is constantly changing and the only way to ensure that you’re achieving best practice, is higher education. I suppose again, it’s just that they [emergency nurses] feel like they have a voice and for me I know it is that kind of thing that knowledge is power, that you can kind of, you know, you feel more capable, you feel more competent.”

Emma: “I think that just for the fact that you can stand shoulder to shoulder with other professions but I do think they [emergency nurses] need more support, support as in through management, they don’t always, it’s hit and miss. It’s not uniform the amount of support people get, people have busy lives, people are commuting, people are working horrendously hard in emergency and then they’re expected on their days off to work and do the Masters programme on their own and I think that’s totally unacceptable, you know.”

#### **7.1.5.4 Work Context**

The influence of the work environment is a significant aspect in educational decision-making among emergency nurses. Within the context of this study, the work environment refers not only to the immediate ED work context but also refers to the broader and evolving healthcare environment. It also refers to the organisational environment which includes the immediate work organisation, the healthcare organisation as a whole, and the professional organisation that regulates nursing and midwifery practice in Ireland. I will begin by illustrating the immediate work context as an influencing force in decision-making.

All participants cited the workplace as influential in their higher education decision-making. Participants specifically referred to the influence of work colleagues regarding their decision to pursue higher education. The influence of colleagues presented itself in both direct and indirect forms. Direct forms included the active encouragement of participants by colleagues who had already undertaken postgraduate programmes of study, to the indirect general observation, admiration, and envy of colleagues’ enhanced level of knowledge and competence with the desire to be part of that group of emergency nurses who held higher education qualifications. In addition, these emergency nurses found themselves exposed to the agents of professional socialisation where the norms and expectations related to their membership of the ED were apparent. While some participants cited admiration of their

colleagues, others admitted to feeling envious of their colleagues' knowledge, skills, and competencies.

Jennifer: "There was a lot of peer pressure as well [laughs], it was more healthy pressure more so 'it's good for you to do this and it's easy to do [laughs] and it's just a year and it'll be over and done in a year'."

Alison: "...there were a few of the other girls that had done it so I suppose like observing them, their competency areas, in particular in resus, like they would have had the skills and the knowledge base to be able to deal with that particular circumstance."

Sue: "I was very intimidated and intrigued to know what they [ED nursing colleagues] knew and I thought am I ever going to be on that level and here I am now but at the same time I was in absolute awe of them."

Natalie: "People that had gone before me who had done the course, and there were a few, they were really, I could see that they had stepped up their game, you know, in their competence and their capabilities and that they were happy. I could see how it had changed them and their knowledge. I was envious of their knowledge and their ability to provide a high level of care to patients, you know, and do it quite seamlessly. I admired them greatly, envious of them of them as well and I suppose I wanted to be part of that group."

For other participants, the influence of colleagues was cultural in nature. Participants observed that the undertaking of programmes of higher education was a cultural phenomenon among staff while others cited the expectation to study. I recognised early in my emergency nursing career that there was an expectation to undertake further training and education in order to meet the demands of a specialist clinical environment. I witnessed colleagues undertaking specialist nursing programmes over the years and as more colleagues started to commit to pursue specialist programmes, the more I felt compelled to do the same. At the time I felt this was more to do with the fear of being left behind rather than the desire to expand my skills and knowledge base. The desire to be part of that group of emergency nurses who held higher education qualifications was also apparent. Additionally, participants articulated the desire to be part of that particular group of emergency nurses who attained a higher level of education. Participants wanted to be part of that particular group and did not want to experience exclusion. This sense of group belonging was important when it came to educational decision-making. These participants disclosed the importance of group belonging in their workplace. This belonging would be achieved through the pursuance of higher education.

Ellen: "I felt like, well at the time actually, it was a cultural thing. Everyone I worked with was doing the course, you know, if you were in the hospital I was in, everyone did the course."

Kerry: “I just wanted to be one of them [ED nursing colleagues who had pursued higher education], I didn’t want to be excluded from that group. I kind of wanted to be part of that group to be honest.”

Yvonne: “...it felt good that I wasn’t alone. I think and I knew that there was always someone there going through the same thing as me, there was always someone there that knew exactly what you were going through. Because you’re part of a group you can share experiences so you can kind of learn from each other a bit as well, you know.”

Olivia: “It seemed like at the time in the ED nearly everybody just about had their course done so it was another reason to go forward to do it, we all wanted to be at the one level. I suppose higher education benefited a lot of the girls, they felt they had confidence going into situations. After that, I could deal with whatever came in, I felt that I had the knowledge and skills and confidence to do my work. As well as that, I didn’t want to be left behind.”

Pauline: “It was important for me to be part of that group, you know, to be part of that group who had that education. I wanted to know what they knew.”

While a sense of group belonging was important to some emergency nurses, for others, such as Michelle, completion of higher educational programmes did not automatically entail group belonging.

Michelle: “...I suppose you could sit and talk to people who have done the course with you. The people who haven’t done the course maybe feel that they’re left out of this but I wouldn’t categorise people just because they have done the course.”

While most participants reported a positive colleague experience, some reported some challenging issues pertaining to group cohesiveness. This was particularly in relation to the pursuance of higher education programmes beyond the initial postgraduate diploma in emergency nursing. Those emergency nurses who reported issues pertaining to group cohesiveness claimed a ‘them and us’ situation as they steered towards advanced practice. They claimed a dissonance of thought surrounding the concept of nursing and the overall evolution of the profession. Issues pertaining to group cohesiveness arose as certain emergency nurses progressed towards the advanced practice route. Kim and Alexandra particularly highlighted this as an area of concern, and both spoke quite emotively about their experiences of transitioning into advanced practice. It was apparent that some of the difficulties they experienced when the roles were first introduced in the ED arose from the lack of knowledge and understanding of the advanced practice role and how the role would impact both the service and our relationships within the team.

Kim: “One of the biggest [challenges] I suppose would be nursing, how they respond to it or how they’ve reacted to it and it’s been very negative, I would feel for the most part that it hasn’t been positive. I think there’s a perception that you think you know

it all and you don't come in here and tell us how to do things because actually that was said to me on one of the first days that I worked in the hospital, 'so what are you going to do that we're not doing already' and I thought 'crikey, where do I go from here?'"

Alexandra: "...I think it was probably from a work perspective, colleagues were the biggest challenge, kind of. Em, you know, it was a very tight, cohesive team and everyone looked out for each other so you felt supported and everything, you did. I think that's the thing I found the hardest, I didn't expect to get it from your peers. I thought they'd be like more supportive but it suddenly developed into a 'them and us' kind of thing. There was a number of times where it was said, you know, it's steering away from real nursing, like, when was the last time you put your hands on a patient kind of nursing. The hands-on nursing is at the core of nursing but you also need to kind of move forward and kind of realise that there's an evolution in every profession and for nursing it needed to evolve."

Interestingly, a sense of distance was deemed necessary particularly for those progressing into the area of advanced nursing practice. While some advanced nurse practitioners claimed a lack of cohesiveness within the emergency team, this was deemed necessary by others in order to progress into their new role.

Natalie: "...when you are transitioning you have to step back from what you were doing to be able to achieve an advanced level because you can't do task-orientated stuff, you know, and then try and think at a higher level and look at all angles of your decision-making skills, you know, you have to stand back, you really have to separate...it was a slow and painful process because I didn't want to see my colleagues stuck, you know. I wanted to help them and sometimes I did step in, you know, but I knew I had to step back out very quickly because I was damaging my relationship with them even if they felt I was totally abandoning them. But also I was going to be damaging my new relationship with my collaborative practice, my medical colleagues and that's where your professional identity and vulnerability come in because you're straddling the fence of nursing and medicine. We're not as cohesive now, you know, they view me as separate, I'm in advanced practice now. They don't view me as part of the emergency department team at all even though I'm on the floor, I think it's hilarious to be honest, you know."

The ED work setting is underpinned by an evolving healthcare environment. EDs by nature are busy and often unpredictable clinical environments with high patient presentations, significant workload volumes, and varying levels of acuity. Coupled with the evolving nature of health and disease, and implementation of various governmental and professional body initiatives, it is often a factor in educational decision-making. In this thesis, most participants cited the evolving healthcare environment as influential in their decision to pursue higher education. The diverse ED work environment was a significant factor pertaining to higher education uptake and was cited as a reason by many study participants. In addition, the advanced nurse practitioners in the emergency nurse group specifically

identified the need to be responsive to the demands of the public and anticipating the potential need for new service initiatives. Interestingly, Viv was the only emergency nurse who specifically described sociopolitical influences regarding her educational decision-making and acknowledged how the evolving healthcare environment necessitated an appropriate response regarding the professional development of registered nurses.

Viv: “I suppose, eh, what would really have triggered it off was because nursing was changing at that stage and it was, the Commission on Nursing had changed it, and I was quite involved in the INMO, I was a rep, I was in the A&E section. I was very much involved in it and there was a huge emphasis on further education. I suppose as well the hospital in itself was hugely changing at that stage, it was really evolving at a huge pace, you know, are we up to speed on everything, is there something more and, you know, technology was moving so fast.”

Emily: “Things are changing all the time, you know. Your patients are changing, technology is changing, your doctors are changing, you’re getting older, the doctors are getting younger, your experiences are changing, everything is changing, it’s changing constantly so I think you need to change with it to keep up with it.”

Alison: “I wanted to keep up to date and I think in nursing and in the medical side of things, things are changing so rapidly and that.”

Jane: “...there’s so much to learn and there are so many innovative things that are happening and techniques and equipment coming into force every day and even since I’ve completed my course, there’s been a lot of changes in emergency medicine and nursing.”

Natalie: “The care that we deliver to patients is changing, you know. There’s different methods of delivering care on a daily basis, you know, evidence-based care is so important and it can change from one month to the next month, you know, with best practices that are being identified so it’s very important that as nurses you keep on top of that or else you’re giving substandard care to patients, you know.”

Additionally, Natalie described a more focused reason for pursuing higher education specifically in the area of advanced practice within the working context.

Natalie: “I enjoy looking after people but I was feeling far removed from looking after people in the post of a CNM2. My time was taken up with other things such as, you know, bed management meetings, em, trying to source staff, things like that. I was coming further and further away from the patient and it wasn’t making me happy. I didn’t want to be doing that so I decided I’d have to look at other avenues. So I saw that there was a need for a new service initiative in the area of assessment and treatment of patients with non-traumatic abdominal pain, cellulitis, things like that. They were having prolonged waiting times, you know. I could see as well that patients weren’t being managed properly by some of our doctors, our medical colleagues, em, and it frustrated me, I was very frustrated. I thought I could do as good a job if not better.”

Since the ED is a busy, dynamic, and often unpredictable environment, the patient experience and quality of care received are often directly related to the team that deliver that emergency care. As a team, healthcare professionals in the ED are often required to be responsive to an ever-changing clinical and professional environment and make prompt adjustments to new developments in clinical practice. Additionally, the changing nature of the profession requires nurses to look ahead and prepare for change as well as to respond to more immediate needs and challenges.

Jennifer: "...even with the new students coming into the hospital you like to have a background into what is actually going on and the reasons for it and everything is constantly being updated. There's a lot of new nursing coming with degrees and it's just that I feel that I've only a diploma so I needed to better myself a little bit more."

Natalie: "Well I suppose they [hospital management] see that there's a service need and also they're looking at government strategies, you know, and new initiatives..."

Emma: "I think it's to do with standards with the emergency medicine programme, there are standards there now. There should be standards and you know part of those standards is that, you know, you have staff that are trained and educated and qualified to a particular standard."

#### **7.1.5.5 Security**

The concept of security was another influencing factor in the pursuance of higher education. In this context, security referred to the security of remaining in ED, the security of not feeling left behind by others who had pursued programmes of higher education, and the security of belonging to a group. In deciding to pursue higher education, emergency nurses declared their desire to remain in ED and how completing postgraduate programmes of education would ensure that they would be enabled to remain in ED. In this case, participants highlighted their ability to remain in ED on completion of their educational programmes. Participants also stated that they pursued higher education in order to justify their position in ED.

Alexandra: I knew I wanted to stay here but I hadn't made the decision about doing the emergency nursing course or anything. I was on nights and I got a call from the then CNM3 saying that somebody had dropped out of the course and did I want to do it. And I didn't think, it was reflex [snaps fingers], it was like, yeah, no problem, I'll do it."

Emily: "I did it because I loved the whole A&E system, I loved the whole buzz of it. I loved the challenge of it, I loved the fast action, the fast pace, I loved the learning. I felt I was good at it, that it suited me. So with that in mind, you know, I felt it would secure me, that I wanted to broaden my knowledge and increase my learning."

Joy: "I had asked for a job in the A&E department. I was shown around the A&E department and on the first day I started I was moved over to the medical assessment



unit and that's not where I wanted to be and asked the question 'how do I get back over there?' and I was told 'if you want to be over in A&E, you need to do the course.' I said 'right well then that's what I'll do' and that was, em, that was basically why I went to do the postgrad."

Interestingly, while most participants articulated the notion of security in this sense, others saw it as a means of securing a position outside the ED context. In addition to the acquisition of knowledge and skills, some emergency nurses were considering future academic endeavours. I also undertook a postgraduate diploma in emergency nursing with a view to leaving ED. I knew that if I completed my postgraduate diploma that it would allow me to pursue an MSc degree and that would eventually pave my way to leave ED.

Jennifer: "I'm think about going for public health and so for that you have to have a Level 8 or higher and so that's the plan."

Gemma: "I decided I wanted to further my knowledge and it would be another avenue that I could be educating myself in really for preparation for going on to do something else further down the line."

The second aspect of security was derived from participants' fears of being left behind if they did not pursue higher education in line with their colleagues. This particular sense of security was derived from both witnessing other emergency nurses' educational achievements and the emergence of degree-prepared registered nurses.

Kim: "Partly insecurity I think initially. Insecure in that I felt that I was being judged because I didn't have a course done. I felt that I needed to educate myself and the other thing was I wanted to stay in A&E, I wanted to get some A&E expertise."

Ellen: "We knew that coming behind us, because I think in Galway by then were doing the BSc or were starting and we kind of could see that next year everyone was going to do the BSc straight away. If there's going to be people doing degrees coming up behind you and you had your diploma that you would be less qualified if you were going for a job."

Holly: "I didn't want to be left behind as education had gone towards university. I didn't want to be left behind. I mean I know I was one of the first to undertake a graduate diploma but I definitely didn't want to be left behind."

Yvonne: "Yeah, I think that would have been definitely afraid that I was going to be left behind alright, yeah, that was a big factor."

In contrast, Natalie describes an opposing viewpoint. Up to this point, her status as an emergency nurse who had not participated in higher education had not made her feel under any threat regarding being left behind.

Natalie: "I was never afraid of being left behind cos I think I had been in a stagnant position for 16 years. I was a great nurse, you know, well able to do jobs, you know,

get on with it but I was happy until it was put up to me by my CNM3 so I was never afraid of being left behind, you know.”

Emily also describes a similar perspective.

“...I still felt that I was the nurse on the ground and I always felt that my role was important and I always enjoyed my job. Nobody stayed in the same areas so the education part of it never really came into it and at the time when I did my A&E course there was no pressure and I did it on my own. I didn't apply with anyone else or anything like that. I don't think there was ever any pressure.”

#### **7.1.5.6 Opportunity for Promotion and Progression**

Within this study most emergency nurses stated that they pursued higher education with a view to increasing promotional opportunities. Participants admitted that ‘looking at the bigger picture’ was a significant factor in educational decision-making while some participants identified how higher education might ‘open doors’ for them. Participants cited the desire for increased autonomy when planning higher education uptake while other emergency nurses felt that other colleagues would have the advantage should promotional opportunities arise. Participants were aware of the need to progress and higher education was the platform through which these opportunities would be realised.

Olivia: “I suppose when I had done the A&E course I thought the advanced nurse practitioner route sounded a nice thing to do. They were autonomous in their own practice, they could make decisions, they could see their patients, treat their patients and discharge their patients. It's something that would still interest me.”

Maria: “It was the opportunity to get a promotion, you know, because I kind of started to look around, you take your head out of the sand and you see what other people are doing and you can kind of see, mainly I think in [city] hospitals, everyone is doing their masters and I was thinking to myself if I don't do the masters, if I go for a job where someone else has done their masters, they would obviously have the advantage.”

Jane: “Well I felt it was important for me to go up the ladder a bit. I just didn't want to stay static.”

Kim: “I think undertaking a Masters, part of it was I wanted the qualification. I wanted doors to open up for me. I felt that if I could undertake a Master's and complete it, other doors might open.”

#### **7.1.5.7 Ability to provide appropriate care to patients**

One of the reasons cited by emergency nurses for pursuing higher education was the ability to provide appropriate care to patients as a result of engaging in higher education programmes specific to the clinical area. It was important for these emergency nurses who spoke passionately about being able to be up-to-date with current trends and developments with others specifically making reference to using evidence-based practice in emergency

nursing care. Participants claimed to feeling out of their depth as a result of not having higher education while others wanted to be more expert in their dealings with patients. All participants claimed that higher education would provide them with a foundation from which appropriate care specific to the clinical setting could be delivered.

Maria: "I thought like if I do a postgraduate diploma I can provide better care to my patients."

Yvonne: "I really just wanted to make sure that I was providing the best care in terms of A&E and I wanted to learn more and know exactly what I was doing and if I was, you know, doing it right."

Kim: "...it was just my wanting to know and my wanting to feel secure in the area that I wanted to work in but I think a lot of it for me was always about safe practice and putting evidence, once I did the postgrad I realised there was a huge evidence base out there."

Molly: "I felt, you know, to make sure that I was delivering the best care I could and giving the best information to those that, the staff who were now under my management and, em, obviously to the patients."

Sue: "I felt like I was here a long time and I still didn't know it all. I felt out of my depth and I didn't like that and I said right I'm going to do on and I need to do this, you know, because of the line of work."

In pursuing programmes of higher education, emergency nurses specifically referred to the attractiveness of the educational programmes and modules as being influential and appropriate to their learning needs, and the needs of the patient group in the ED.

Maria: "I don't think we learned these things in the Bachelors. I know there's skills, I know they gain skills over time as well, those skills are from experience but when you do this course and learn that skill it has got a different value, you know the rationale behind it and everything, if I say an example like you look at an ECG of a patient resus and you say there is a T-wave inversion, with the Bachelor's degree I can just look and say there is an inversion but of you have an A&E course you know the reason why it is there."

Emma: "It was very practical grounded and you could kind of say 'oh my goodness, I'm doing this because it'll benefit the patient and it'll benefit my knowledge in dealing with the patient' and it's only probably later that you realise this is obviously benefiting you in relation to decision-making and analytical skills, sit back and reflect and think about what you're doing, you know."

Natalie: "So what attracted me to it was that the Master's element of it, the academic research element of it was in the second year so I thought the first is really going to be loaded with clinical, which I love, loads of clinical stuff."

### 7.1.5.8 Organisational Support

In this study organisational support referred to the support proffered by local management in the hospital and by the professional regulatory body. The perception of local management support varied among participants with some emergency nurses indicating support from management and others declaring poor management support. This support was deemed important by emergency nurses undertaking programmes of higher education.

Michelle: “Definitely the CNM3 encouraged me, she was all for me progressing and getting my postgrad.”

Sue: “I felt like the CNM3 was very encouraging and even as part of the course we had to do a condition and I did anaphylaxis and I had to make a presentation all about it, even the CNM3 came up and sat in the audience for the presentation and that means an awful lot.”

While management were deemed to be encouraging and supportive, this did not translate into tangible support as perceived by the participants particularly in terms of study leave. This was a specific constraint highlighted by the study participants. While the allocation of study leave was minimal (usually three days per annum), emergency nurses frequently undertook their educational pursuits in their own time with some utilising their annual leave time to cover studying commitments. This will be further detailed in the section addressing the challenges experienced by emergency nurses in answering the third research question. When I pursued my postgraduate diploma and Master’s programmes, I also undertook much of my study on my own time. It may be argued that nursing management took this stance due to staffing constraints and associated costs. It is worth noting, however, that hospital management did financially support all emergency nurses in full for their specialist postgraduate programmes (postgraduate diploma in emergency nursing; advanced practice pathways) but this was not acknowledged by all emergency nurses. Most of the participants only equated support in terms of study leave and, as a result, felt that management was unsupportive during their period of study.

Interestingly, when asked about the influence of the professional body in pursuing higher education, only a few participants claimed that the professional body had any influence on their educational decision-making; the majority of participants stated that the professional body bore no influence on their decisions to pursue higher education. The NMBI is the professional regulatory body for nurses and midwives in Ireland and provides support and advice in the area of education both at pre-registration and post-registration level. Despite this remit, emergency nurses were generally in agreement that the NMBI did not influence their decision to pursue higher education.

Emma: “I wouldn’t have felt that they would have encouraged me at all, in fact, I would have had no contact with them. I know it’s about setting standards for education, it’s about regulation, em, I think in a way they’re a bit removed from nurses. I think they’re attempting to kind of be more visible to us but, em, you know, I think they have a long way to go to be honest.”

Kim: “Well, the NMBI had no influence on my decision for further education. They’ve had no impact that way, no. The only influence they had was on site accreditation after I had my Master’s in advanced practice so that was the first time the NMBI were really involved.”

Gemma: “No, certainly not. I don’t think they do anything to encourage anything like that. There’s talk again of them having this portfolio, I think they do it in the UK, where you have to continually update your portfolio to kind of prove your practice development before you re-register. I was talking to the INMO recently and they were saying that it’s being discussed and I think it would be a good thing for people, you know. Some people qualified forty years ago and have never done anything since, you know.”

Kerry: “No. I just never really had any dealings particularly with them. I felt I did it all myself, you know, I asked, I applied for funding, I did it.”

While the NMBI did not directly influence educational decision-making, those emergency nurses who suggested NMBI influence higher education uptake made general reference to advanced practice pathways and proposed plans to introduce professional portfolios. These nurses did not directly refer to the influence of the NMBI regarding their own decision-making.

Holly: “I don’t see any encouragement from the NMBI, no. I think that they’re more supportive if you’re going on to do an advanced nurse practitioner course but as for a postgrad or that, I don’t think so.”

Olivia: “Em, I can’t say that they encouraged me to do my postgrad course, I’ve had very little dealings with the NMBI unless it’s to pay for my retention fee. I know that there’s things coming on stream with CPD and that they’re going to be looking more into points and making sure we are educated more.”

Julie: “I don’t think that they encourage education. I think they’ll be encouraging it more if they introduce continuous professional development for registration.”

### **7.1.6 Summary of Findings**

In ascertaining the powers that influence emergency nurses, it is evident that professional influencing forces are significant and credible forces in the higher education decision-making. All 22 participants cited professional factors which included work context, career and educational progression, and organisational support as instrumental in decision-making. While these findings are in keeping with findings from other studies regarding educational decision-making, it has now been revealed how departmental commitment is also a feature

in the decision to pursue programmes of higher education among emergency nurses. This finding has not been uncovered previously.

### **7.17 Overall Summary**

In answering the first research question ‘What powers govern the decision to pursue higher education among emergency nurses?’, it is apparent that several significant powers were at play in emergency nurses’ educational decision-making. Findings from this research question indicate that decision-making influences were multifactorial and representative of the fine and, sometimes, complex forces which feature in the lives of emergency nurses. It was evident that emergency nurses made decisions against a backdrop of significant personal, social, and professional forces. Participants described in detail the intricacies of the powers at play in the decision to pursue higher education.

These stories were significant in terms of originality, endurance, passion, and honesty. They illuminated three key powers that have not been previously uncovered regarding the decision to pursue higher education among this group of healthcare professionals. It has now been revealed that social background, timing, and departmental commitment are new findings in higher education decision-making among emergency nurses. In addition, other findings generated from this research question also reflected results from similar studies exploring decision-making regarding higher education uptake among registered nurses. It was also evident that the forces at play in higher educational decision-making were specific to the individual but, as a group, their desire, drive, and determination to achieve their goals was universal and without question. The next section will focus on the second research question ‘Does higher education inform an emergency nurse’s sense of self and identity?’

### **7.2 Research Question 2: Does higher education inform an emergency nurse’s sense of self and identity?**

Having identified the governing powers underpinning higher education decision-making and uptake in the previous section, the second research question sought to establish if the achievement of higher education informed an emergency nurse’s sense of self and identity. In addressing the governing powers which influenced higher education uptake in the first research question, it was evident that the concepts of self and identity were significant and enduring powers in educational decision-making. These powers were clearly illuminated when discussing the issue of self-worth and challenging traditional social legacies.

In exploring the impact of higher education on emergency nurses’ sense of self and identity, two main themes emerged; the impact of higher education on sense of self and identity, and

the impact of higher education on sense of professional identity. It was evident throughout participants' narratives that the pursuance and attainment of higher education informed the sense of self, identity, and professional identity. Participants described how elements such as self-worth, self-esteem, confidence, and pride enhanced their sense of self. In terms of identity, while participants predominantly identified how higher education impacted on their sense of professional identity, others referred to the impact of higher education on their sense of personal identity. In answering this research question, participants were asked at various junctures to provide further insight into their understanding of concepts such as self, personal identity, professional identity, and professionalism in order to further illuminate how these concepts were informed through the undertaking of higher education.

### **7.2.1 Impact of Higher Education on Sense of Self and Identity**

To begin, emergency nurses were asked to identify their interpretations of their sense of self. This was not an easy question for participants and all appeared to struggle with articulating their sense of self in its own right with some referring to their sense of self primarily in terms of their personal identity and, in some cases, their professional identity. This was to be expected given that, as stated in the literature review, the two terms are often linked and used interchangeably. I will begin by highlighting the interpretations of self as provided by Natalie, Yvonne, and Ellen. I will then illustrate some interpretations of the self as provided by other participants.

#### **7.2.1.1 Impact of Higher Education on Sense of Self**

In addressing this research question, I began by asking participants to firstly consider their sense of self before considering the impact of higher education on that sense of self.

Natalie: "My sense of self means the make up of me, of my mind, where I want to be in this life and in my workplace environment."

Yvonne: "Oh God. It's what you are, it's what you see yourself as, it's your identity I believe."

Ellen: "Em, I suppose who you are, who you feel you are, who people perceive you to be so my self can be all kind of different things, like being a mother, a wife, being a daughter or sister."

With the research question in mind, I then focused on how this group of emergency nurses perceived the impact of pursuing higher education on their sense of self. Despite most participants being unable to comprehensively describe their sense of self as a distinct entity, most participants did not find any difficulty in expressing how the pursuance and achievement of higher education impacted upon their sense of self. In relaying stories about

how higher education informed their sense of self, participants described their feelings in terms of self-esteem, self-worth, pride, confidence, and fraudulence.

I will begin by illuminating the concept of self-esteem where emergency nurses told stories of feelings of personal satisfaction, enhanced self-esteem, happiness, and generally feeling good about themselves as a result of higher education pursuance and attainment.

Natalie: “I think the challenge that I put myself through it and that I excelled at it to be honest, it really gave my self-esteem a great boost so it did and I felt proud of myself and I thought ‘well done’, you know.”

Jane: “It empowered me because it made me feel good the fact that I had achieved it. That I had gone from starting a course to completing a course, feeling good about myself, going to graduations, the celebrations, seeing my other colleagues and friends achieving so much and feeling so proud of them. I suppose too the challenge that Mum couldn’t get me to college so I did it for myself and I achieved it. It was a huge achievement and I was proud.”

Emily: “Eh, I absolutely didn’t anticipate the feeling of, the wonderful feeling you get when you have it done, that was great. I didn’t think that I would get such a kick out of the learning part.”

In her description, Natalie detailed in quite a heartfelt manner the impact of higher education on her sense of self. It was quite evident that the pursuance of higher education impacted on her more profoundly by not only enhancing her sense of self but also by reaffirming her professional pathway choices.

Natalie: “I blossomed again. That shroud of despair was falling away from me, you know, I really felt that it was just gone and, em, within a few weeks you know, I felt that I’d found my niche, I’m happy. It was just so empowering, it really was. After only being a week on the course, I knew. I said this is going to be for me, I’m going to be satisfied. It just, it really empowered me. It gave me back my passion for looking after people as well and wanting to do it well and to a high standard and it reconfirmed for me that my pathway is like to be at the patient’s bedside.”

Natalie further described the impact of higher education on her sense of self and identity:

“People looked at me differently because I had a Masters, you know. For me, I didn’t feel different but it empowered me definitely that I’ve done this and I challenged myself and I rose to the challenge and it gives you something, I don’t know, education definitely, you know, gives you something, definitely my sense of self-worth and my belief in myself has risen greatly without having a huge head or anything like that but no, it has definitely.”

Self-worth was another aspect that was identified by participants as a result of having undertaken programmes of higher education. The concept of self-worth was evidenced



through the descriptions offered by participants in recognising the benefit and value of higher education uptake.

Gemma: “I definitely have a sense of self-worth that I would never have had before and, like, you know, I am a nurse, I’ve worked hard to get my qualifications. I feel as though I deserve recognition for having those qualifications and they’re not easy to come by, em, a lot of work and time went into getting them, you know, I’m proud for having them. And it’s not that I think any less of any colleagues who haven’t got them, but I’m proud to have them.”

Emergency nurses cited the feelings of pride, achievement, and accomplishment as a result of having undertaken programmes of higher education.

Sue: “Well going back to college was a massive thing as well, you know. I remember telling my cousin ‘I’m going to [university]’, that was massive you know. I told everyone, everyone who would listen to me I told, you know. Mum and Dad were so proud of me on my graduation day.”

Joy: “I’ll tell you a story where I came back from [country] after I had qualified as a nurse and I met one of my primary school friends as I would put it and we were out one night and she asked me how I was getting on and what was I doing and I said ‘I work up in [hospital].’ ‘Oh, kitchen or cleaning?’ So I got a great kick out of saying ‘no, staff nurse in the emergency department, and what exactly are you doing?’ and we were just a junior secretary in Ryanair. It made me feel amazing because she thought I was going to achieve nothing. I have achieved so much more than all of them because I know what they’re all up to now and none of them have achieved what I have achieved.’

Emergency nurses also described the confidence they felt as a result of completing programmes of higher education.

Jennifer: “You’re more confident, yeah, but I wouldn’t consider that to be a, I wouldn’t be cocky confident, I’d just be more confident. I’m happy the way I am now.”

Emma: “I think just confidence, it gives you confidence to say well I’m as good as anyone else.”

Pauline: So personally, apart from professional life and having the promotion, like I feel more confident and happier I guess that I’ve done study and also the knowledge I’ve gained and the skills.”

While these participants referred to the confidence gained through the acquisition of higher education, participants like Kerry gave an honest account of her sense of fraudulence owing to her lack of higher educational attainment. Kerry was keen to highlight that this sense of fraudulence emanated from herself and was not attributable to another party.

Kerry: “I feel like if I set my mind to something now I can do it or now I’ve an idea that I can try it and hope that I can do it but I’m not getting too panicked that if it’s

not for me, it's not for me and I'm not getting too uptight about it but I feel that I've earned my place to go further whereas as last year I felt I am here by default, am I a fraud, do I belong in [university] whereas going into September, please God, em, I feel I deserve to be there. I felt like a fraud because I didn't have my nursing degree per se, I just did my portfolio to be accepted so I did feel that I was coming in on the back foot. Nobody made me feel like that only me."

Surprisingly, while most participants cited the positive and tangible impact of higher education on their sense of self, Kim revealed an interesting insight and described a feeling of indifference regarding the attainment of a higher education award:

"I didn't feel like I achieved anything to be honest, I don't, let me see, there was no difference, I just progressed along, em, over the course. It didn't make me feel any different, I didn't feel anything, em, no. I didn't feel any sense of achievement in that because this is something I pursued for myself. I got the course under my belt, I got registered and I get to treat my patients as an advanced nurse practitioner so that was it."

#### **7.2.1.2 Impact of Higher Education on Sense of Identity**

In exploring the impact of higher education upon identity, it was deemed appropriate to explore emergency nurses' insights and understandings of identity. Unlike the questions about their sense of self, participants did not struggle as much in revealing the factors which constituted or contributed to their sense of identity. However, similarly to the question about their sense of self, participants on occasion referred to their profession when disclosing their sense of identity. I will firstly highlight how emergency nurses depicted their sense of identity before revealing how higher education impacted on their identity. In uncovering their sense of identity, participant responses were varied and largely alluded to identity in terms of general demographic information, marital status, motherhood, and position in their family. Participants also referred to perceptions of others in describing their sense of identity.

Kim: "So identity is to me your name, date of birth, medical record number, em, that's your identity, who you are, your birth certificate, your passport, your driver's licence and that's what identity is."

Joy: "Identity to me is what I portray to other people and how they perceive me, alright? I'm a mum, I'm a daughter, I'm a sister, I'm a wife basically."

Gemma: "It means I suppose who I am, who and how other people see me."

In terms of how higher education impacted on their sense of identity, participants mainly referred to the impact upon their professional identity. In detailing the impact of higher education on their personal identity, participants identified how higher education gave them a role-modelling identity for family members.

Natalie: "...my niece and nephew, they've seen me go back to college and one of them has started on his college journey and they very much look up to me and they come to me for advice, even about IT which I'm useless at, you know. I know they see the value of what I've done. They've seen me get up at five in the morning and finishing at twelve and then going back to bed and they've seen that over the last two years and working as well full-time and they see well if you need something, you have to work hard."

Gemma: "I guided them [children], I tried to set a good precedent in what I was doing. They were always very aware that I had homework and assignments and exams, they were not part of it but they knew. I remember when it was my graduation, you know, it was important to me that they were part of that because it's to realise what a big thing it was and I'd hope that they'd want it for themselves, you know."

### **7.2.2 Impact of Higher on Sense of Professional Identity**

Emergency nurses were also asked in this study about the impact of higher education on their sense of professional identity. In order to fully illuminate the impact of higher education on professional identity, participants' views on various aspects associated with the concept of professional identity were first elucidated. Participants were asked to consider the concept of professional identity and their thoughts on what it means to be professional, and the characteristics associated with being professional. I will firstly highlight participants' understanding of professional identity before revealing the impact of higher education on their sense of professional identity.

#### **7.2.2.1 Sense of Professional Identity**

Emergency nurses were first asked to describe what it meant to be professional and what factors characterised their sense of being a professional. The sense of professionalism varied among them, however, and participants for the most part had different interpretations of what constituted being a professional and how they perceived their sense of professional identity. Having education was identified as the main characteristic of being a professional by participants.

Julie: "Em, to be a professional, just in all you've learned and your experience, em, to be able to implement that in your day to day work and being be the best you can be in your profession and all that you've learned and been taught through your colleagues."

Pauline: "Professional I guess is working with your own professional body to achieve, having to achieve an education and having to pass a written qualification exam in order to be in a professional body."

Jane: "That you have a better understanding of your skills and competencies and that you're learning and what you have learned you can bring to helping the patient through their illness or injury. Also, we're all registered, we're a recognised body"

within An Bord Altranais because we have to work within a scope of practice and not go outside that. We need to learn, we need to be able to say ‘yes, I know how to do that, I know why I’m doing that’ so we need to learn, we need to practice safely and not do any harm.”

Affiliation to a professional body was the next most common characteristic cited by participants which also included reference to professional standards, behavioural expectations, and community standing underpinning the profession as a whole.

Ellen: “Em, to have certain standards, a body that organises your role, the nursing board, and to have professional standards that you have to set and safety standards and to have policies. There’s guidelines and structure to what you do, you’re not just, and then you’ve got a certain level of qualification I suppose, all those aspects.”

Emily: “Well I’m part of An Bord Altranais so I’m registered with them and that stakes my claim for being a nurse and being professional.”

Gemma: “I suppose being professional means to me I’m doing a recognised worthwhile job which pays a reasonable salary and recognised as a decent human being in the community but as a worthwhile human being in the community. [laughs]”

In identifying attributes which constituted being a professional, these were varied and included references to qualities and values such as trustworthiness, honesty, respectfulness, kindness, caring, responsibility, leadership, and accountability.

Natalie: “I think to be a professional one has to, I suppose, you really have to be capable, competent, accountable, responsible, you have to be innovative as well, you know. You have to be a leader and I think everyone is a leader and everyone should be a leader, you know, em, we need more leadership, em, and I think it’s very important to put yourself as a leader and not a follower, you know, as such. And just to be courteous, em, you know, to be respectful and dignified in your dealings with your staff and your patients, with your colleagues at all times, really.”

Olivia: “Well I suppose it’s the way you are, you know, in the way you’re dealing with the situation. Em, you know, and the nature of our work is, you are dealing with people in the worst time of their, like, when they’re sick, they’re vulnerable. So obviously if you’re not professional, so if someone comes in and you’re screaming at them, that’s not very professional, you know, it doesn’t instil safety or any kind of competency in them that you are going to provide good care to them.”

Holly: “Well, it’s to carry out your duties in a caring, respectful and courteous manner. I’m talking about respect for your patient, respect for your colleagues, you know, there’s a certain manner that you would behave in.”

Participants were also asked to consider their perceptions and understandings of the term ‘professional identity’. The perceptions of professional identity varied among emergency nurses with participants describing professional identity as being what constituted their current role in the emergency department. These participants also stated that being employed

in a specialist area gave them an extra sense of professional identity due to the specialist nature of emergency nursing. Participants again made reference to various professional characteristics and values in describing what professional identity meant to them and what contributed to their sense of professional identity.

Kim: “For me to be a professional is that I can articulate at a level I suppose, that I could sit and have an intelligent conversation with like-minded people so I mean I could sit down in a group of people and somebody’s area of expertise and somebody’s area of expertise might be car racing or horse racing or something like that. I know absolutely nothing about that, em, however, my professional identity allows me to sit in a room of people, you know, of like-minded people and discuss at the level of my expertise so, em, that’s what my professional identity is.”

Gemma: “I suppose it’s recognition of the fact that you are or I am in my role as a nurse, em, and that I have a qualification, you know, that I worked hard to get.”

Jennifer: “As in nursing as a career and where you work in the department, the emergency department, so emergency nurse. That and, em, being truthful, honest, eh, doing your best and then keeping the patient, maintaining, well the, what’s the word, doing your best for the patient basically.”

Kerry: “It has several umbrellas really. Professional conduct obviously, em, to have, em, the level of knowledge and education to carry out your job in a professional manner and to treat your own colleagues as professional as well within the team.”

Emily: “My professional identity is what identifies me as a nurse and what identifies me as a nurse is my uniform, my place of work, my reputation within the local area because I’ve worked here so long, my registration, my badge.”

Michelle: “I think the fact that you wear a uniform, you know, people know that, ok, this girl, she works here. Then you wear a name badge and it says, you know, you’re a clinical nurse manager and then if somebody is going through a bad time and they want to speak to the manager, I think you stand out with your uniform and badge, em, and it’s not, you know, as part of a hierarchy in a hospital setting that, you know, you have to be able to define yourself I think between the patients, the relatives and the staff members as well that people know who to go to and it might just be the colour of your uniform.”

Participants’ sense of professional identity was sometimes problematic, particularly for those who undertook advanced practice pathways. In this context, emergency nurses, like Natalie, found that transitioning into an advanced practice role was sometimes fraught with challenges such as self-doubt and assuming a different professional identity.

Natalie: “I think I’m still grappling maybe with my identity still at this stage, you know, my professional identity, you know. Maybe I’m waiting for someone to touch me on the shoulder and say ‘really, what are you doing, are you really an advanced nurse practitioner?’, cos I’d have huge admiration for them [advanced nurse practitioners] and their experience, you know, em, I suppose really maybe I don’t value my level of competence and capabilities just yet as much as I should do so I

don't affiliate myself with them but I think it's slowly changing because now if people ask me what I do, I would normally say I'm a nurse but now I say I'm an advanced nurse practitioner."

#### **7.2.2.2 Impact of Higher Education on Professional Identity, Confidence, and Power**

Participants clearly described the impact of higher education on their sense of professional identity. The main area where the impact of education could be felt was in participants' sense of professional confidence. Within the domain of professional confidence, participants also alluded to the sense of increased professional power and professional voice. All emergency nurses in this study stated that their professional confidence had been enhanced through participation in programmes of higher education. Participants stated that higher education enabled them to think and behave differently whereby their problem-solving and critical thinking skills were enhanced. In addition, higher education afforded them the opportunity to further develop and enhance their working and collaborative relationships with other members of the multidisciplinary team.

Alexandra: "I suppose it makes me a bit more confident professionally just that, you know, if I'm doing something in my professional life that I kind of have an educational basis with which to frame reference. I feel that I can challenge things, it gives me that benefit. I think it gives me a professional voice as well, that my opinion matters. It probably has also given me confidence in I would take on things in my personal life that I wouldn't have before because I now have experience of speaking in public, you know. I wouldn't have dreamt about confronting somebody on a professional level because I wouldn't have had the confidence to do it but higher education and kind of being in that forum gave me the confidence to probably do it."

Olivia: "I like to know what I'm doing and why I'm doing it, em, the whole rationale behind things. I like to know exactly what I'm doing. Em, it was for my own self-esteem and confidence. I know I'm more knowledgeable and I've more skills and more competent with my decision-making and I suppose my problem-solving is better than it was before. I'm not worried about anything that comes in anymore. If you're in an emergency situation you don't want to be the one standing at the end of the trolley scratching your head going 'what do I do next?', you want to be able to just dive in there with everybody else and show that you can do the very same job."

Sue: "I'm hoping it has changed how the hierarchy, the ADoN and the CNM3 how they kind of see me because I'm not any old dumbo that can kind of do a set of vitals, you know the way, that I do have the knowledge to run the resus room and whatever comes in, I don't care, it doesn't bother me and I'm glad that I do have that knowledge. I'm not intimidated by the patient who comes in or the severity of their condition and I'm not intimidated by the doctors either. I think that was another thing, now I can question them properly, you know, and I know my stuff, I can query things properly."

Participants also stated that higher education impacted positively on their sense of professional power and parity with other healthcare professionals.

Emma: “I think just for the fact that you can stand shoulder to shoulder with other professions...”

Kim: “...in my mind knowledge is power so when you have the knowledge you can articulate and you can argue for something...to be able to stand over my patient’s care and say this is best practice, this is safe practice. I certainly have a confidence, I’ve a confidence now in talking to people and questioning things.”

Alison: “I felt more competent and able to challenge, you know, especially doctors, you know you had more of a voice and you could put the rationale behind the argument.”

In discussing the impact of higher education on professional identity, participants were asked if they felt higher education was important and if they felt less professional for not having pursued higher education previously. In this context six participants indicated that they felt less professional for not having undertaken programmes of higher education. Participants believed that nursing is an evolving profession and requires nurses to engage in higher education activities, and that it was important to have parity with colleagues.

Jennifer: “Yeah, I suppose I did feel less professional for not having done the postgrad. There’s always something new around the corner that has to be learned, new policies, new protocols, so you have to keep up to date.”

Olivia: “Eh, I did in the fact that I wouldn’t have had the confidence, I wouldn’t have understood things or why we were doing things whereas now I have the educational and practical side of it.”

Kerry: “...I always felt I wasn’t a graduate, I didn’t do a degree. I know like I’m a nurse but I always felt I was constantly striving to, you know, be as good as I could be but that stops at a certain point, do you know what I mean, where really you need the paper and the knowledge.”

Natalie: “Yeah, yeah, I suppose I would have felt less professional for not having education, I would have done, yeah.”

Interestingly, Jane, stated that she did not feel less professional for not having undertaken higher education originally.

Jane: “I didn’t feel less professional because I felt they [colleagues] were going to help me along the way and I could easily ask them to because they would have a little bit more knowledge than I would and they were always quite willing to help me in any area. I never felt inferior but I knew I needed to know more.”

### **7.2.3 Summary of Findings**

It has been clearly demonstrated that higher education does inform emergency nurses’ sense of self, identity, and professional identity. The significance of these three concepts was apparent in the original decision-making of emergency nurses regarding higher education uptake and, with programmes of education completed, it was appropriate to consider the

impact of education on these influencing factors. In exploring the impact of higher education on emergency nurses' sense of self, identity, and professional identity, it was evident throughout participants' narratives that the pursuance and attainment of higher education informed their sense of self, identity, and professional identity. These are not new findings and have been previously revealed in the nursing literature. While the impact of higher education was largely positive in terms of self and identity, it must be acknowledged that some participants experienced some negative effects in the domain of professional identity. Notwithstanding, higher educational attainment has been demonstrated as being a positive influence on emergency nurses' sense of self and identity overall.

### **7.3 Research Question 3: 'What are emergency nurses' experiences of higher education?'**

The final research question sought to address the experiences of higher education among emergency nurses. All participants described their experiences of undertaking programmes of higher education. In addressing this research question, two themes were identified in revealing the experiences of higher education uptake among emergency nurses. These themes are 'Challenges of higher education' and 'Factors that maintained interest in programmes of higher education'. It was evident that experiences of higher education were largely representative of the group as a whole but equally multifaceted and sometimes unique to each emergency nurse. I will begin by describing the challenges experienced by emergency nurses in pursuing programmes of higher education as this theme was the most pertinent among the participant group. I will then identify the factors that maintained their interest in programmes of higher education.

#### **7.3.1 Challenges of Higher Education**

Commencing higher education is a time of change and adjustment for any registered nurse. In this study, all emergency nurses described various challenges associated with the pursuance of higher education. Challenges were diverse and encompassed various aspects of personal, professional, and academic life. Within this theme, the main challenge associated with higher education was that of adjusting to the academic requirements of higher education programmes. This was followed by the challenge of balancing competing demands, organisational support, and university support and requirements.

##### **7.3.1.1 Adjusting to the Academic Requirements of Higher Education Programmes**

I will begin by identifying emergency nurses' experiences pertaining to academic study and specifically referring to areas such as adjusting to academic writing and computer skills and



trying to balance the demands of home and working life in meeting academic requirements and deadlines.

Emergency nurses articulated the difficulties they experienced in becoming accustomed to academic writing with some participants identifying issues with computer skills as being particularly challenging. At times this seemed to impact on their confidence leaving some to feel inadequately prepared to meet the required standards of academic writing.

Kim: “It was the academic writing that I found hard to get to grips with initially and I still do to this day. Reflection on practice is another thing that absolutely freaks me out but it’s actually, I would have to say, it depends on how it’s taught. I didn’t fully understand it, I didn’t know what it was. You’re asking me to reflect on something and I’d read the theories behind it but I just, it was something I felt I was never good at and even now I think I’m good at it in practice but writing about it I find difficult.”

Jennifer: “It was mainly all computer stuff so trying to do powerpoint presentations and trying to learn your Microsoft Office and that and trying to attach things to emails and send them back and scan them, trying to get used to that sort of thing.”

Holly: “The first day I nearly ran out of the university when I heard how many thousand words that we’d to write and I said ‘oh my God, I won’t be able for this’ cos I hadn’t written academically for a while and it just seemed at that moment that I wouldn’t be able for it but then I just, I had, eh, there were two other girls, there was one girl from here doing it and a girl from the North and they were able to calm me down and say ‘take it day by day’.”

Interestingly, not all participants viewed the academic requirements negatively. Here, Michelle described how her desire to undertake the programme of education helped her to overcome the challenges of academic writing. Kim also described how her initial struggle with reflective writing now benefits her clinical practice.

Michelle: “Em, I was terrified at the start because I kind of felt, you know, I’d been out of college for seven years and I wouldn’t know terminology and research was never one of my better topics but I have to say I really enjoyed it, it was something I wanted to do so I think maybe it’s easier to sit down and study because you’re doing something you enjoy.”

Kim: “What I found is I’m actually not disliking it anymore, I’m actually learning from it, I’ve become very self-aware.”

### **7.3.1.2 Balancing Competing Demands**

Undertaking higher education programmes has its challenges and a number of these were reported by participants. The impact of engaging in academic pursuits on home, family, and social life is significant and was a key issue among the study participants. The challenges associated with trying to balance home life and working life with the demands of their educational programmes was particularly pertinent. In addition, participants specifically

identified the need for time management skills with some participants identifying the need to be organised as a means of meeting the demands of home, professional, and academic life.

Jennifer: "...I found that the only time with family at home, the only time to get study done was either after 12 o'clock at nighttime or to get up at three in the morning and start your study then. You just used whatever free hours you had when everyone else was asleep to try and get as much done as you could."

Alison: "I suppose you hit the ground running. I remember for the first month it was a shock. I remember buying the laptop and sitting at the kitchen table and not only were you working full-time in a busy emergency department but you had a small allocation of study leave. It was about organisation basically. And you just, I had to kind of put the social life on hold for the year because, you know, I wanted to do this and you just kind of worked around it. It was all about organisation."

Emma: "I think the big challenge was kind of home life and its practicalities and, you know, trying to manage everything."

Emergency nurses clearly identified how the pursuance of higher education impacted on their home, family, and social lives.

Jane: "Sometimes it was stressful. There were times when I felt I wasn't giving enough to the family at the time, at certain times. I suppose not being able to go to certain family events because there was so much to do and involved in the course that you were giving it your all and you're missing out on a lot of social activities and social events."

Olivia: "...I just locked myself into a room and I would come out a few hours later, cup of tea or something to eat and back in again but for that whole year you saw nobody, you had no social life, it was work to study, study to work. I lost touch with friends and in the middle of it I met a guy who thought I wasn't interested in him because I was so busy studying and he didn't kind of understand the fact that I was studying, he thought it was a brush-off [laughs]. Em, I even remember our placements, we had to do our normal working week as well as our placements week all in the one week so you were doing two weeks' work in one week which was tough."

The impact of higher education participation was so significant for participants that at times they considered giving up pursuing their educational programmes.

Michelle: "I have to say my family were very good, you know. There were times where I said 'I'm giving up, I've had enough', they'd be like 'no, no, no, you're doing great'. I probably put a lot of pressure on myself, if I'm doing it, I want to do it properly."

Alison: "Now there was weeks that I thought, you know, I wanted to give up and then there was weeks where, you know, if you did well in an assignment or, you know, you got good satisfaction and you thought 'good, I did good on that but I put the effort in that'."

For some participants organisation and time management was not a specific issue as, due to the fact that they had undertaken programmes of education previously, they had strategies in place to cope with the requirements of academic study.

Alexandra: “If anything, I know it seems strange, but I actually found it easier because I had become more organised. Because of working somewhere like in ED you have to become like this organisational savant nearly to kind of have everything that sits in place and then as I said my husband worked away and I was the only one at home and I had been pregnant so I had to be super-organised so it was a case of everything had to be structured and nothing could be let slide. I didn’t have that kind of luxury when I was doing my first course and just assignments would get done, I’ve loads of time, I’ve nothing else to do, you know, just get out of bed and go to college, this was a case of ‘no, I’ve so many other things that I have to organise’ that I had to structure it so that I gave myself enough time and not give myself a nervous breakdown.”

Pauline: “With regards to time I guess, there’s more, I felt that the postgrad was more gruelling because it asks you for more, like everything is compacted into this one year, the knowledge and skills you have to learn. With the Master’s you are given enough time. I know it’s still very intense but you’re given much more time to organise it yourself within a certain timeframe.”

### **7.3.1.3 Organisational Challenges**

Organisational challenges were also experienced by emergency nurses in the uptake of higher education. Organisational challenges in this context included challenges associated with the workplace and challenges associated with higher education institutions. Responses were varied from participants when describing organisational support. Emergency nurses cited issues such as lack of organisational support, and unsupportive colleagues while pursuing higher education. In contrast, other emergency nurses declared that management were supportive when they were undertaking programmes of higher education. This support was elicited from management at local departmental level and management at the senior hospital level, and came in the form of general encouragement to pursue higher education and the provision of study leave to facilitate attendance at university. Emergency nurses cited difficulties associated with university support and their programmes of education while eight emergency nurses identified challenges in their personal lives. I will begin by illuminating the challenges associated with local organisational support as experienced by this group of emergency nurses followed by the challenges associated with HEIs.

Lack of local organisational was cited by some emergency nurses and this was in relation to general support and encouragement. In particular, the allocation of study leave for the duration of educational programmes was particularly challenging for participants. These emergency nurses utilised their annual leave entitlements in order to cover the shortfall left

by a lack of study leave so that they could meet the academic and clinical placement requirements of their programme. However, some participants were keen to acknowledge the support of management in their decision to pursue higher education.

Joy: "The hospital didn't encourage me, no. It was like if you want to be working in the department you'll have to do that course but it was almost like, it was a test to see how much you wanted it, it wasn't like 'we would love you to work in this department' and that you could give so much to this department. It wasn't encouraging, it was like putting up a boundary to say 'if you want to work there you do the course'."

Jane: "Well the [city] hospital definitely encouraged me because they wanted me to pursue the course and they, you know, if you were interested in pursuing it, you had to apply and they would go through what you needed to do, they were supportive. In this hospital, no. I pursued that myself because I had asked for funding, em, I felt that if I was going to get anywhere in this hospital, at the time it was very hard, there wasn't room for progress if you didn't have courses done."

Yvonne: "Yeah, I think they did with the postgrad, eh, the Masters, it's kind of, it was very much up to myself, it was my decision and they had very little to do with it."

Michelle: "...all my annual leave went towards my course. I pretty much used all but a week. It was also quite difficult cos we weren't released for our placements. It was quite stressful and I know I wasn't an easy person to live with at all. I used to get up very early in the mornings, study before I came into work or before I came in on night duty, em, just to make sure all my assignments were done and done properly."

Emergency nurses also cited challenges associated with the programmes of education and university support. They indicated the difficulties experienced with areas such as sudden timetable changes, the impact of these changes, and what some emergency nurses perceived as being irrelevant module and programme content. Some participants also described a lack of university support generally throughout the duration of their programme.

Olivia: "I would have found the lead lecturer challenging in the fact that she would not give you information. She would tell you to come up on a day that, we arrived at ten o'clock one morning for a maternity talk that we had at that time but as we pulled into the carpark, we drove for an hour to get there at ten o'clock that morning and there was an email there to say that she cancelled it and like people were travelling from all over and she didn't do it once, she did it three times. Em, there was a lot of that. There was a lot of bumps regarding schedules and times, it wasn't very clear. That was challenging because you've organised specific days off work and then things are cancelled at the last minute and you're already up in university for it."

Ellen: "We had some challenges with our facilitator, I have to say. For example, they would explain something to me and then, I don't know how to explain it, em, they would explain something to me and then bring someone else in and say 'now x, do you know how to do this?', knowing they hadn't taught her yet so it was nearly like

an element of bullying so it was like ‘I’m going to show her up that she doesn’t know’ and then a few things like not getting things signed off.”

Kerry: “It transpired when, as you know, you got dates for different things that were happening and I had, I kept in my diary and I wrote down my dates when I needed to be off in the request book and I would get an email from [university], the plaster of Paris day has been changed and I would go back and I would put it in and suddenly that would be questioned, you didn’t request that, why are you putting it in now, em, I felt I constantly had to justify my requests.”

#### **7.3.1.4 Sources of Support**

Despite the clear challenges identified by participants regarding organisational challenges, it was also clear that support was forthcoming from several sources. Participants were keen to highlight the sources of support which were underpinned by either personal or organisational factors.

Sue: “The CNM3 was very encouraging and, you know, we had the study leave, we had the encouragement here. I was very into it because, you know, I wanted to do it.”

Viv: “Absolutely, I felt encouraged by the hospital to go back to college. The A&E manager I have to say was also very supportive.”

Kerry: “Em, well I met with the Director of Nursing and she, I asked her what she thought and she, em, was very encouraging. The CNM3 was extremely encouraging.”

The support of family was a key theme among participants in the consideration of higher education pursuance. Once enrolled on educational programmes, family support continued to be significant for the duration of the programmes. This pertained particularly to childcare arrangements which were necessary to allow participants sufficient time and opportunity to undertake both academic assignments and clinical placements. Participants were also keen to acknowledge colleagues as a source of support.

Michelle: “I have to say my family were very good, you know. There were times where I said ‘I’m giving up, I’ve had enough’, they’d be like ‘no, no, no, you’re doing great’. I probably put a lot of pressure on myself, if I’m doing it, I want to do it properly.”

Kerry: “How did I address it? I spoke to my colleagues, I had great support from, em, when I thought about this, am I the only one that is struggling with this. I spoke to former postgraduates in work who were extremely supportive and experienced and said they experienced the same thing. They also gave me advice on what I could do to get ahead which was extremely useful and I followed every bit of advice that I was given.”

Alison: “Our ED postgrad group, they were from different EDs around the country and I suppose we kept each other going. It was good like, there was good, em, there

was good friendship. And then I suppose there was different aspects of the course I loved, like, I loved the whole practical exams, not so much the written part and I suppose whatever you learned you were putting into practice at work.”

Despite the difficulties faced by some emergency nurses, others were keen to highlight the support received from the university network. Participants described the support they received from the university itself and their university peers over the duration of their programmes.

Sue: “Well, you know, there was a lot of support from a few teachers, you know, it was very helpful and you really appreciate it. I found that [university] lecturers, they were great but there was a massive class of us and they couldn’t really help us individually even though I didn’t feel awkward in emailing or anything like that.”

Alison: “Em, I suppose our postgrad group, they were from different EDs in the country and I suppose we kept each other going. It was good like, there was good, em, there was good friendship.”

Continuing with the challenges associated with the programmes of education, emergency nurses also highlighted what they perceived as being irrelevant module and programme content. This was largely attributed to the inclusion of research methods and nursing theory as core components of the educational programmes. In contrast, however, views were expressed by participants regarding the appropriateness of module content, and this will be detailed shortly in the section highlighting the factors that maintained interest in programmes of education.

Julie: “I just found the research modules were very difficult and I wasn’t sure about how useful they were going to be to me. I think the more practical modules interested me.”

Molly: “I always struggled with research and the girls who had done the postgrad before me had warned me about the nursing theory side of it. They found it hard and to be honest I really struggled to get my head around it too. I just couldn’t see the relevance of it or how it even applied to a course like this.”

Holly: “To be honest there was very little, there was only about, there was only one module devoted to emergency nursing, the rest of it was research-based so I think I was quite shocked by it. Like ok, you had to learn research and all that but did it really make much difference to emergency nursing to learn all that?”

### **7.3.2 Factors that Maintained Interest in Programmes of Higher Education**

Undertaking postgraduate study requires significant personal and professional commitment. Given that emergency nurses invest significantly in higher educational pursuits, it was appropriate to consider if there were any factors that maintained the interest of participants throughout their programmes of study. This has not been explicitly explored previously in the literature pertaining to higher education uptake. Despite the various challenges

experienced by participants over the duration of their educational programmes, it was apparent that several factors maintained their interest in the programmes. In exploring the experiences of higher education, all participants identified various factors that maintained their interest in the pursuance and completion of their educational programmes. Factors such as appropriate programme content, knowledge application, achievement of a specialist qualification, determination, and implications of non-completion of educational programme were all cited by participants as influential in maintaining their interest in their programme of study.

### **7.3.2.1 Appropriate Programme Content**

In terms of appropriate programme content, emergency nurses cited the provision of relevant and interesting module content, and the enjoyment and satisfaction from learning, as key to maintaining their interest in their educational programme.

Alison: “We also got to do placements in other emergency departments as well so it was good to see that we weren’t the only department that was under pressure and under strain. And then I suppose there was different aspects of the course I loved, like I loved the whole practical exams, not so much the written part but I did like that part so you know I enjoyed that bit...”

Julie: “Eh, let’s see now, what kept me going, em, it was continuous assessment so that interested me, the essays, but I just found that my lecturers were really supportive and just the achievement at the end of it all and that I’ve learned.”

In acquiring knowledge and skills from their programmes of education, participants were keen to identify how this learning was brought back to ED and subsequently applied to the area of practice.

Olivia: “Em, I know I’m more knowledgeable and I’ve more skills and more competent with my decision-making and I suppose my problem-solving than I ever was before. I’m not worried about anything that comes in anymore, I deal with it as it comes.”

Michelle: “Em, my knowledge base would be a lot broader. I’m able to research a topic now if I need to. Time, like not even time management, but your problem-solving skills, we would have done a bit of that, em, and your organisation which is very important I think in a busy emergency department, your organisational skills.”

### **7.3.2.2 Qualification Achievement**

For some participants, the achievement of the qualification at the end of their programme was the incentive that maintained their interest. In this regard emergency nurses cited the achievement of their award as what inspired them to complete their programme. This incentive particularly resonated with me as I knew that once I completed my postgraduate diploma, I would be able to pursue a Master’s degree programme.

Emily: “The end result, the end goal. Getting the pass mark, knowing you were going to graduate with this next qualification and the other is I was going to prove to myself that I could do it. I also enjoyed the learning part of it as well and I liked the classroom situation and I liked the opinions of everybody else.”

Jane: “I suppose the challenge that Mum couldn’t get me to college so I did it for myself and I achieved it. It was a huge achievement and she was proud.”

### **7.3.2.3 Determination**

For other participants, it was the sheer determination to complete their programmes of education that assisted them in maintaining their interest throughout. Here, emergency nurses declared their determination as being key in maintaining their interest to complete their programmes of education.

Kerry: “Ok, well, I’m stubborn. I wasn’t going to give in.”

Joy: “It’s not in me to back down. I was going to get through this and I was literally like ‘I can come out on top of this’ and I did and that’s the way. If I can do it and it’s in me to do it, I’ll do it. If I can’t go straight up, I’ll go around.”

Natalie: “What kept me going was pure pig-headedness I’d say and stubbornness. I really enjoyed it. I could see the value of the course and I could see what I could add to the service as well and I could see that my job satisfaction was going to be huge as well. Yeah, the job satisfaction, the hours are better, you know, no shift work.”

Yvonne: “I suppose once I started, yeah, I like to finish things. Also, my boyfriend at the time, husband now, em, he has a lot of patience and he let me off to study and do my own thing while he, you know, looked after other stuff at home so he kind of gave me the year off. I did have colleagues who would help me proof-read what I wrote.”

The last factor that maintained interest in programmes of education was the implications of non-completion. For some participants, this largely alluded to the financial repercussions that would have ensued had they not completed their studies.

Kerry: “There was one day, one of my colleagues and I actually worked out that we couldn’t afford to quit cos we’d have to pay back [hospital] and we’d have to get a Credit Union loan. I said ‘I’m getting a Credit Union loan for a holiday, not this’.”

Holly: “Well I suppose my employer was paying for it so financially I didn’t want to have to pay that money back if I failed.”

### **7.3.2.4 Plans for Future Study**

Given the narrative methodology underpinning this study and with the subsequent three-dimensional space in mind, participants were asked to disclose plans for future study. Responses to this question were varied with some emergency nurses articulating plans for future educational pursuits which reflected personal circumstances, previous educational experiences, and professional aspirations.



Holly: “Give me another 12 months please [laughs] and then I’ll think about it.”

Olivia: “I’d like to complete my Master’s and finish that off. I have a year left to do, em, when and how I’ll do it, I don’t know.”

Michelle: “Yes. I started my Master’s last year and it just didn’t go according to plan but I do plan to go back and do it. Em, even, you know, a Master’s in education, em, A&E is so busy all the time, I suppose that it’s something, you know. I’m there five years now, you know, I think there’s a lifespan on it, there’s burnout so, you know, you do have to look at what else you might do even though I would like, you know, a role maybe in education in the emergency department. Em, yeah, we’ll see.”

Ellen: “I had planned to do it [further study] straight away but then I got sucked into marriage and, you know, life took over. I had planned to do my Masters. I kind of thought I’ll do a Master’s degree straight away but actually in hindsight I’m glad I didn’t because I think you need to know what you’re going to do with your career to do a Masters rather than just do it because you’re in the frame of mind for studying.”

Alison: “Yeah, I’d hope to go on and do public health nursing, yeah.”

### **7.3.3 Summary of Findings**

In answering the third research question ‘What are emergency nurses experiences of higher education?’, it was apparent that emergency nurses’ experiences varied in the pursuit and achievement of programmes of higher education. In addressing this research question, two themes were identified, challenges of higher education and factors that maintained interest in higher education, revealing the experiences of higher education uptake among emergency nurses. It was evident that the challenges associated with pursuing programmes of higher education were significant for each emergency nurse with most citing the adjustment to higher education, balancing competing demands, and issues associated with organisational support as being the most challenging. These challenges are representative of previous studies regarding higher education uptake among registered nurses and, as a result, no new findings were revealed. Emergency nurses cited appropriate programme content as the most significant factor in maintaining their interest followed by knowledge application, the achievement of a specialist qualification, determination, and implications of non-completion of their educational programme.

### **7.4 Conclusion**

This chapter has outlined and answered the three research questions underpinning this thesis. Findings have been presented through a number of key themes exploring emergency nurses’ decision-making regarding higher education participation, the impact of higher education on their sense of self and identity, and their experiences of higher education. In keeping with the narrative methodology, participants’ past, present, and future intentions pertaining to higher education were uncovered. The stories relayed by emergency nurses revealed much

insight into their approaches to higher educational decision-making and their experiences of pursuing higher education.

Participants revealed, in often very heartfelt and emotional ways, the personal and professional stories which underpinned their educational decision-making processes and experiences. Participants also described the multidimensional and often complex personal and professional issues which supported and, sometimes, challenged their higher education journeys. While findings supported previous studies in this area, three new findings have emerged. Forces such as social background, timing, and commitment to the department were highlighted by emergency nurses as influential forces in decision-making.

In considering my own reasons for higher education, I did not expect emergency nurses to describe the influence of social background in their decision-making. I became aware that I was not alone in the influence and significance of the untold story, that of social background. These previously untold stories have now contributed to the knowledge base surrounding higher education decision-making. Revelations about care of the self, and the sense of self, particularly the sense of the real self and the ideal self, and identity are significant. While engagement with the literature on the concepts of self and identity gave me some new insights into my own sense of self and identity, it was the case for me that engaging with these emergency nurses also further enhanced my own understanding of my reasons for pursuing higher education.

The impact of higher education on sense of self and identity was also explored. While most participants reported a positive impact on their sense of self and identity from both personal and professional perspectives, there were occasions where emergency nurses perceived some negative effects pertaining to their sense of professional identity as a result of engaging in programmes of higher education. I hope that the credible and honest accounts provided by these emergency nurses may instil in others the confidence to fully articulate their feelings and experiences in future studies of this area. The pursuance of higher education was not without its challenges. While the overall experience of higher education for participants was mostly positive, issues such as organisational challenges, balancing competing demands, and adjusting to the requirements of academic study were significant considerations for many participants. This chapter has now presented the study findings and the next chapter will present a discussion of these findings.

## **Chapter 8 – Discussion**

## **8.0 Introduction**

The aims of this study were to explore the decision-making strategies of emergency nurses regarding higher education uptake through the lens of self and identity, and to explore the experiences of emergency nurses who pursued higher education. The study posed three research questions; ‘What powers govern the decision to pursue higher education among emergency nurses?’; ‘Does higher education inform an emergency nurse’s sense of self and identity?’ and ‘What are emergency nurses’ experiences of higher education?’. The previous chapter presented the study findings and highlighted emergency nurses’ narratives regarding their educational decision-making, and experiences of higher education. It is apparent that decision-making is influenced by several forces based on personal, social, and professional powers. The impact of higher education on self and identity was also presented, in addition to emergency nurses’ experiences of higher education. This chapter will present a discussion on the study findings underpinned by the study objectives. In doing so, I will make appropriate reference to Foucault’s concepts of disciplinary power and governmentality as best interpretative frame in order to interpret and describe the significance of my findings in light of what is already known, and to explore the new insights that have emerged regarding higher education uptake as a result of this study. In addition, I will also make appropriate reference to the literature review chapters to further illuminate my findings.

In Chapter 1, I highlighted how Ireland has a strong reputation for delivering educational programmes which ensure that both pre-registration and post-registration nurses are fit for purpose in responding to the demands of an evolving healthcare system. These demands have been underpinned by significant reform within the nursing education system as a whole. I described how, historically, patriarchal structures shaped the education of nurses and how nurse education in Ireland preceded its links with the tertiary sector. With the integration of nurse education into the university sector in the 1990s came the growth of postgraduate educational opportunities. In addition, the development of post-registration education frameworks by the professional regulatory body and the expansion of nursing roles has both accelerated and enhanced the need for higher education. There are a range of postgraduate educational programmes which serve to improve services and standards of care, and to facilitate the professional development of the individual nurse. I also highlighted significant statistics illustrating educational attainment among emergency nurses in Ireland.

Despite recruitment embargos, reduced progression pathways and promotional opportunities, emergency nurses have continued to pursue programmes of higher education. Additionally, it is not a licensing requirement to pursue higher education in order to maintain

registration with the professional body, however, both emergency nurses and the general nursing population have consistently engaged in educational pursuits. It was, therefore, apparent that other personal and professional powers were at play regarding higher educational decision-making and uptake. The nursing literature has also not previously considered the concept of higher education among this group of healthcare professionals. In addition, previous studies pertaining to higher education uptake had not explicitly considered the factors that maintain interest in programmes of higher education, and this was also an area that warranted further exploration. With these considerations in mind, and with the research questions formulated against this background of reading and analysis of various literature, I deemed the area to be worthy of further consideration. I therefore sought to explore how personal, social, and professional powers may influence emergency nurses in pursuing higher education against a backdrop of limited personal and professional opportunities, and a non-requirement by the professional regulatory body to engage in higher education for the purposes of continuing registration.

In this chapter I will indicate the unique contribution of this study to the field under investigation by reviewing findings in light of previous research knowledge. I will reveal the new perspectives and insights offered by this group of emergency nurses regarding the pursuance and completion of programmes of higher education. It will become apparent that new findings such as the impact of social background, recognition of potential by others, timing, and departmental commitment are both significant and enduring in the decision to engage in higher education. In addition, it is also apparent that findings from this study support previous studies in the area of higher education uptake among nurses. With the research aims in mind I will begin the discussion and analysis of findings by addressing the first research objective which sought to explore emergency nurses' sense of self, identity, and professional identity and with reference to the earlier literature review chapters.

### **8.1 Research Objective 1: To explore if emergency nurses' sense of self, identity, and professional identity influenced higher education decision-making**

In the literature review it was highlighted how self and identity, while distinct concepts, are inextricably linked. The self was highlighted to be an entity that can hold value in its own right through its ability to reflect the inner personality and intentions to achieve goals and ambitions, and it may also be reflective of the values absorbed from others. Identity encompasses the characteristics by which an individual can be recognised either through the meanings and associations attached by the self or by others. Emergency nurses' sense of self and identity was prevalent throughout this study. Emergency nurses, while having some

difficulty in comprehensively articulating what ‘self’ meant to them, referred to their sense of self in terms of their identity and, in some cases, their professional identity.

Difficulties in expressing sense of self are not uncommon as Oyserman et al. (2012) explain that individuals may have multiple self-concepts with some better organised and articulated than others. Furthermore, they contend that whether individuals express their sense of self in terms of social roles, relationships or personal traits and characteristics depends somewhat on their immediate situational cues. When discussing their sense of self, some emergency nurses took an approach to description that reflected Roger’s (1959) theory of the self. Emergency nurses alluded to their ‘real’ selves in the context of their social backgrounds when particularly describing their early years and associated limited opportunities. They then described their ‘ideal’ self in terms of aspirations and potential. This continued through to their professional lives where the notions of aspirations and potential were also evident in educational decision-making.

The stories told by emergency nurses highlighted social legacy as a significant driving force in the consideration and pursuit of higher education. Within their stories, a number of finer powers including social background and family influence were evident. In the literature review it was identified that power is central to human affairs and an inescapable feature of life. It was also identified how Foucault’s concept of power incorporated the subtle feature of authority and influence. While the concept of power can often have a negative connotation, Foucault (1979) explored the notion of productive power whereby power can provide a constructive and positive platform on which opportunities may be realised. In this case, what was initially perceived by participants as a potential negative and repressive force, the areas of social background and family actually proved to be an influencing and productive power.

While only a small number of participants articulated the idea of social background and family influence, the strength of emotion was evident and worthy of consideration as a significant and original influencing factor in educational decision-making. These finer forces of power were both significant and instrumental in influencing decision-making. Social background and family influences represented what Foucault (1990) describes as ‘force relations’. These force relations consisted of the social interactions associated with social background, family, and upbringing that encouraged and compelled participants to pursue educational opportunities. The description of limited opportunities in their early years as a result of their social background and associated socioeconomic status compounded desires

and mobilised participants to excel in later life. The stories relayed by emergency nurses identified that they did not want to surrender themselves to the powers of perceived typical stereotypes associated with their social backgrounds. Some participants alluded to the notion that the expectation was to proceed into the unskilled labour market in keeping with the forces of their social background, an expectation that was at odds with their actual aspirations and perceived potential. While these force relations may be viewed as being negative and restrictive in nature, they, in fact, were productive and influential and compelled participants to strive for better opportunities. This was evident in early educational decision-making and also in post-registration educational decision-making.

The impact of lower access to capital was identified by several participants in this study who realised at a young age that higher educational opportunities would be compromised as a result of their social background. Such disadvantages were also shaped by peer interactions, and social practices in families and schools. This finding is echoed in Doveswell et al.'s (1998) study which suggests that nurses' desire to undertake further studies relates to deficits in their previous educational attainment, such as not achieving well at school, or achievements of family members. This observation was articulated by one of the participants, Sue, and is supported by Cullinan et al.'s (2012) study where the level of disadvantage experienced in neighbourhood peer groups impacted on the individual's preference ordering involving education and work choices. Flannery and O'Donoghue's (2009) survey exploring higher education decision-making found that parental educational level was one of the most significant factors in decision-making processes. Although the impact of social origin on educational choices may be less forceful at higher education level, it still exists, even if previous educational achievement is held constant (Jacob & Weiss, 2011). This thesis has clearly demonstrated that the influence of social background, underpinned by the sense of self and identity, is enduring and pertinent in higher educational decision-making, specifically among emergency nurses.

With their aspirations in mind, and against a backdrop of social and economic barriers, participants alluded to a sense of subjectivity. Participants articulated the desire for a higher and truer life and to achieve something greater than their social backgrounds would allow or even expect. It was apparent from their stories that participants did not want to repeat history and wanted to elevate themselves from their socioeconomic origins. Foucault (1988) refers to this as 'care for the self', defining our 'subjectivity' as what we make of ourselves when we do devote ourselves to taking care of ourselves. This 'care for the self' was underpinned by the desire to do well among participants and not to conform to traditional social powers

and expectations associated with predominantly working-class backgrounds. Therefore, participants exercised their own power and the decision to pursue a career in nursing would address several personal and social objectives.

The first personal and social objective it would meet would be their personal aspirations with limited resource requirements from family. Secondly, it would provide career, further educational, and travel opportunities. Finally, it would provide an enhanced sense of self and social identity while providing a sense of professional identity. When the criteria of a profession were considered in the literature review earlier, it was evident how 'Sanction of the Community' is a key characteristic, and this was highlighted by emergency nurses who referred to nursing qualifications as providing a 'good standing in the community' and 'someone who had done well for themselves.' Indeed, in exploring the impact of class on career pathways, Huppatz (2010) claims that nursing was viewed as a platform on which socioeconomic conditions could be improved. This qualitative study which sought to explore the significance of social class for women's engagement with paid care work highlighted how participants were driven by financial need rather than the desire to care.

More recently, Snee and Goswami's (2020) study on social mobility and social class in nursing, suggests that nursing provided working-class women with a route to upward social mobility and a means of combating socioeconomic inequality. This is in contrast to their observation that nursing in the 19<sup>th</sup> century was viewed as a career for middle-class women, offering high-status employment and security. While Lehmann (2013) claims that as working-class students begin to develop a middle-class habitus, they do not simply shed their working-class identity. Instead, students often to come to terms with deteriorating relationships with family and peers at home just as they develop new forms of cultural and social capital at university. Interestingly, however, some participants in this study, mainly advanced nurse practitioners, still identified as being working-class despite being engaged in occupations associated with a higher social class, standing, and pay. For these participants, relationships with family and peers have not been compromised.

Family influence was also evident regarding educational decision-making both at pre-registration and post-registration levels. Again, this was representative of Foucault's (1990) concept of force relations. While it was apparent that parental influence was quite significant in decision-making, other forces such as the influence of siblings, extended family members and own experiences of healthcare were important considerations. While Jacob and Weiss (2011) suggest that the effects of parental class, wealth, and social origin are present in later educational decisions, their investigation mainly concerned younger adults returning to



undergraduate education from the labour market. The findings from this study further contribute to this thinking by identifying that the influence of social background permeates through to later adulthood and postgraduate educational decision-making.

In terms of parental influence, some participants described how their parents were keen for them to make a better life for themselves, while other parents appeared to be indifferent to their children's aspirations. This indifference primarily arose from parents' own social background, and their lack of exposure to higher education opportunities and experiences. Interestingly, while some parents were encouraging of their children's aspirations, they demonstrated little awareness or insight into how these aspirations could be realised. Research has shown that parents can pass on their socioeconomic advantage or disadvantage to their children (Brooks-Gunn & Duncan, 1997). Hertz (2005) also contends that children's socioeconomic backgrounds can remain strongly associated with their adult income while Strand (2014) claims that such backgrounds are also linked with the level of educational attainment and educational ambitions. Furthermore, even in early childhood, social class is linked to a range of outcomes, such as health, behaviour, and, to a greater extent, education (Sullivan & Cara, 2010; Sullivan, Ketende, & Joshi, 2013).

In later life, participants described how the social and family powers which originally compelled them to seek better opportunities were retained and remained pertinent in their professional lives. This is a significant finding of this thesis and one that has not previously been articulated in the literature on discussions of higher educational decision-making. It was evident that the influence of social background in particular was still relevant among this group of healthcare professionals. The experience of having limited opportunities in their early years was enduring as was the desire to excel in later life. While participants were keen to relay through their story-telling the finer personal and social powers at play relating to their sense of self and identity regarding higher education uptake, it was clear that their 'real' and 'ideal' sense of self and identity was still prevalent and enduring in driving their desires for higher education in order to further elevate and enhance their sense of self and identity. In achieving this enhanced sense of self and identity, participants engaged in 'techniques of the self' whereby Foucault's (1990) notion of governmentality, specifically, governmentality of the self was initiated. Emergency nurses, through their story-telling, acknowledged and disclosed details about their formative years, their private feelings and experiences, and the measures they undertook in caring for 'the self' in order to enhance their sense of self and identity.

There were also broader personal forces that influenced the decision to pursue higher education among emergency nurses. In this study it was revealed that the desire for self-affirmation was an influential force among emergency nurses in their educational decision-making. Emergency nurses cited finer forces such self-worth as instrumental in their decision-making. Although not the main reasons for higher education pursuance, these forces were significant nonetheless among this group of nursing professionals. The desire for self-worth was significant among emergency nurses in this study where participants clearly expressed the need to better themselves and the need for self-fulfilment. The concept of self-worth was also an influential force in higher educational decision-making with just over half of participants citing this factor.

Within this context of this study, self-worth embraced the covert and intrinsic forces of self-fulfilment and recognition of potential by self and others. Participants identified factors such as bettering themselves personally and professionally, doing it for themselves, and having an interest in pursuing higher education which also contributed to their sense of self-worth. This is not a new finding in nurses' higher educational decision-making and the need to better or improve oneself has previously been identified in the literature (Kinsella et al., 2018; Pool et al., 2016; Richardson & Gage, 2010). Again, this is representative of the finer forces of power whereby forces that generate little conflict, can generate much in the way of influence and productivity. The need to be seen as someone of value was also an interesting finding and stemmed from those who cited disadvantaged social backgrounds. Recognition of one's own potential and recognition of potential by others also arose in these discussions. In particular, recognition of potential by others also contributed to the sense of self-worth experienced by participants. These are not new findings and the influence of personal forces have been uncovered in previous studies. Altmann's (2012) exploratory descriptive study sought to examine the attitudes of registered nurses toward continuing formal education and revealed how personal desire in addition to the need for professional growth and the influence of the working environment were significant powers in educational decision-making. Similarly, Reyes and Conde (2017) identify the interest to learn, pleasure and satisfaction in learning, and the sense of accomplishment as influential in nurses' decision-making strategies. They also highlight nurses' desires to embrace further education, develop a career identity, and to provide quality care. Pool et al.'s (2016) qualitative investigation sought to understand the factors influencing nurses' educational decision-making and revealed how the concept of self-esteem was an important consideration in the decision to undertake postgraduate study.

In order to further illuminate the influence of self, identity, and professional identity on higher educational decision-making, participants considered their sense and perceptions of professional identity. While perceptions of professional identity and the sense of professionalism varied among participants, the majority of emergency nurses cited education as being the main characteristic of being professional and this has been previously identified in studies exploring professional identity in nursing (Porter et al., 2019; Browne et al., 2018; Dikmen et al., 2016; Willetts & Clarke, 2014). While achievement of education was considered to be a significant component of being professional, affiliation to a professional body was the next most important characteristic of being professional that emerged from the stories of emergency nurses. Again, this is not a new finding and has been previously identified by Rasmussen et al. (2018) and Willetts and Clarke (2014). To a lesser extent, emergency nurses' sense of professional identity was influenced by their current role in the ED and the specialist nature of emergency nursing. However, for those emergency nurses who progressed into advance practice pathways, the sense of professional identity was problematic at times due to the impact of transitioning into a new role and assuming a new identity. This was not a new finding and is reflected in other studies exploring the transition of nurses into advanced practice (Mannix & Jones, 2020; O'Keeffe et al., 2015).

In this study, all participants identified professional influencing forces as significant factors pertaining to educational decision-making. These professional powers included educational development and advancement, career advancement, security, and the influence of the working environment. Within these areas operate some finer forces which include the ability to provide appropriate care to patients within the clinical environment, colleague influence, organisational support, perceived importance of higher education, and promotional opportunities. These forces are reflective of the disciplinary power and governmentality that is apparent within the clinical setting. In Foucault's (1978) words, disciplinary power strives to make the body 'more obedient as it becomes more useful.' Arendt (1985, p.454) claims that disciplinary power not only controls the body through the production of individual qualities but also through the amalgam of qualities that render an individual distinct from others. As a result, this form of power enhances individuals, utilises their productive potential and then makes use of their capacities.

Those emergency nurses who pursued programmes of higher education were 'distinct' from those who had not engaged in programmes of higher education. McNay (1991) states that disciplinary power allows for the creation of individuality by subjecting the body to the demand for progress towards an optimal end. In other words, by undertaking programmes

of higher education emergency nurses willingly subject themselves to a process of educational development and enhancement which will have positive benefits on both personal and professional levels. Similarly, the concept of governmentality is also relevant here. As a population, emergency nurses have capacities which, in combination with the finer personal, social, political, and disciplinary powers, are ultimately resources which can be nurtured, guided, and utilised as a means of serving personal and professional agendas in addition to wider political and professional agendas.

All participants highlighted the desire for furthering their knowledge base as being one of the most influential professional reasons for pursuing higher education. Indeed, all emergency nurses cited the importance of higher education uptake within this clinical area and deemed specialist knowledge essential when dealing with patients of high acuity and high complexity. There was strong agreement among participants that the ability to enhance knowledge and clinical skills was influential in decision-making with the desire to be clinically competent and having an evidence base to underpin their clinical roles. In addition to enhancing one's knowledge base, emergency nurses also viewed higher education as a means of securing both promotional and further educational opportunities.

A number of studies indicate the main reason for undertaking postgraduate education is improvement of professional knowledge (Clark et al., 2015; Kinsella et al., 2018; Liao et al., 2016; Mlambo et al., 2021; Shahhoseini & Hamzehgardeshi, 2015). In an earlier study, Armstrong and Adam (2002) explored the impact of a postgraduate certificate in critical care nursing on nursing knowledge using a descriptive phenomenological study. The students reported that the course had added to their knowledge of management, leadership and teaching as well as the clinical skills in the speciality. Similarly, Johnson and Copnell (2002) reported that the majority (64%) of graduates of a paediatric postgraduate course identified the ability to link theory to practice and an increase in self-confidence presumably from additional knowledge and experience as being a benefit of undertaking the course. Two studies (Adriaansen, van Achterberg, & Borm, 2005; Rassool & Oyefeso, 2007) exploring the issue of higher education, highlighted that registered nurses who completed postgraduate qualifications reported a high correlation between knowledge and quality of care which, according to Adriaansen et al. (2005), could indicate that there was an increase in the actual skills of the registered nurses who took the course. More recently, studies undertaken by Mlambo et al. (2021), Ng et al. (2016), and Walter and Terry (2021) illustrate how higher education can improve knowledge and critical thinking skills which ultimately impacts positively on patient outcomes through the provision of evidence-based care.

The work environment was also a significant influencing factor in educational decision-making. While powers such as colleague influence, organisational support, and the impact of healthcare reform has been previously identified in the literature, the notion of commitment to the department was a new finding in educational decision-making. The ED is a busy, unpredictable, and dynamic environment both nationally and internationally. The patient experience and quality of care received is directly related to the team that deliver that care, and in particular, the emergency nurse. Two characteristics required of emergency nurses are an ability to learn and adapt promptly, and an awareness of the changing healthcare environment. The changing nature of the profession requires nurses to also look ahead and prepare for change as well as to respond to more immediate needs and challenges.

In addition to being responsive to differing levels of patient acuity and clinical need in the ED, healthcare professionals are required to make prompt adjustments to new developments in clinical practice and be appropriately responsive to the changing patterns of health, illness, and disease. Challenges experienced by EDs include not only the increasing volume of patients, but also their acuity, diminishing resources and bed access within hospitals, the skills mix of staff, and country-specific key performance indicators (Jones, Shaban, & Creedy, 2015). Healthcare reform and professional body initiatives are underpinned by a governmentality approach whereby techniques, such as key performance indicators and role expansion strategies, are targeted to conduct and influence a population in a way that responds to such reforms. As has been highlighted in the literature review, governmentality makes use of knowledge and expertise to guide populations with behaviours consistent with governmental and professional body ambitions and objectives.

The majority of participants identified the influence of work colleagues regarding their decision to pursue higher education. This is not a new finding and has been identified in other studies (Mlambo et al., 2021; Price & Reichert, 2017; Watkins, 2011). The influence of colleagues presented itself in both direct and indirect forms. Direct forms included the active encouragement of participants by colleagues to consider an application for a higher education programme, to the indirect general observation and admiration of colleagues' enhanced level of knowledge and competence. In this context, Foucault's (1980) 'simple instruments' of hierarchial observation and normalising judgement are evident. In the literature review it was highlighted how hierarchial observation (surveillance) implies visibility from above, with those of a higher rank or grade observing those of a lower rank or grade. This was evident within the group of emergency nurses where some cited the influence of the departmental manager, and to a lesser extent wider hospital management, as

instrumental in their decision to pursue higher education. The departmental manager, in a senior role, observed how these emergency nurses would benefit from pursuing a specialist programme of education. In addition, some emergency nurses felt that the departmental manager noted potential in them and ability to pursue a programme of higher education.

Similarly, it may also be argued that those emergency nurses with postgraduate qualifications may be viewed as having an unofficial higher rank as opposed to those emergency nurses not in possession of such qualifications. As a result, the direct observation of the enhancement of others' knowledge base and skill set positively impacts on decision-making. This is an example of where normalising judgement comes into operation. Foucault (1995) notes that as a disciplinary practice, normalising judgement is both an instrument of control where an individual can be both an object and subject of power. This concept is also evident in relation to the affiliation with a professional body. Professional codes of conduct set out to guide professional standards and expectations. As a strategy, it allows for behaviours to be normalised should any anomalies arise, and it also identifies the degree to which individuals can claim membership to a specific homogenous group. Here the local relations of force are apparent at the micro-level within ED.

Force relations exist within the social interactions among this group of healthcare professionals. Participants identified their observations of other colleagues who had undertaken or were undertaking higher education programmes. These colleagues demonstrated knowledge and skills and the ability to competently and confidently manage various situations within the workplace. These participants desired to have that same ability and, as a result, felt compelled to pursue higher education by as they recognised the pursuance of higher education was the means by which they would achieve such ability and competence. Additionally, some participants described the influence of colleagues as cultural in nature. They sensed a cultural expectation among staff that higher educational programmes should be pursued. This is in keeping with Foucault's (1990) claim that 'power must be understood in the first instance as the multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organisation.'

In addition, participants also articulated the desire to be part of the social group of emergency nurses who pursued higher education, fearing exclusion, instead seeking that sense of enrichment that comes with being part of a particular social group. This is not a new finding and has been previously uncovered in studies exploring nurses' educational decision-making strategies (Price & Reichert, 2017; Watkins, 2011). Findings from this study reflect the premise of SIT where emergency nurses saw themselves as both individuals in their own

right and as members of a group. This group membership clearly demonstrated the ability of the group to shape educational behaviour and contribute to emergency nurses' sense of self, identity, and professional identity. Korte (2007), in reviewing how the concept of SIT impacts on workplace training and development, suggests that enhancement of self-esteem is a further tenet of the concept.

Interestingly, however, Brown (2020) claims that as a theory of identity, SIT fails to acknowledge the complexities of the individual and contemporary social groups, claiming that social identities are multifaceted, and it is often the case that single group identities cannot be assumed. In the literature review it was highlighted how the process of professional socialisation is based upon a platform of internalising and developing a professional identity through the acquisition of knowledge, skills, values, attitudes, and norms in order to fulfil a professional role. Within the ED, the agents of socialisation, including the influence of colleagues, and the acquisition of professional values, conveyed the norms and cultural expectations related to their membership of this specialist nursing group. In this study, emergency nurses not only highlighted how the transition to the ED required the learning of new skills, knowledge, and values as part of the socialisation process, but also how the desire remain part of this group was compounded by the desire for specialist higher education. For many emergency nurses, the notion of security was influential in decision-making. In this context, security referred to the security of remaining in ED once a programme of education was undertaken but also the security of not feeling left behind as others proceeded with higher educational activities.

Emergency nurses undertook higher education with a view to increasing promotional and employment opportunities. This is consistent with findings from previous studies exploring educational decision-making (Price & Reichert, 2017; Spence, 2004). This outcome is unsurprising. In the current environment where continuing education is increasingly the norm across all professions, and nurses are expected to keep their skill sets up-to-date, nurses expect that their employers will support them in seeking professional development so as to augment their skills throughout their careers (Price & Reichert, 2017). Additionally, Price and Reichert's (2017) study on continuing professional development found that the opportunity for continuing professional development and growth was regarded as an attractive feature of the nursing profession. Nurses demonstrated an awareness of the importance of evidence-based practice and expressed a desire to constantly learn new things. The acquisition of postgraduate qualifications brings added value to an individual's work history and the associated knowledge gained provides them with a deeper theoretical

underpinning which supports more effective decision-making processes (Spence, 2004). Interestingly, Murphy et al.'s (2006) study suggests that promotion is the key motivator for participating in higher education. In addressing this research objective, it is apparent that emergency nurses' sense of self, identity, and professional identity are credible powers in the decision to pursue programmes of higher education.

## **8.2 Research Objective 2: To explore if higher education informs an emergency nurse's sense of self, identity, and professional identity**

At the outset, it was a fundamental assumption of this thesis that the concepts of self and identity formed the basis of desire and were pivotal in educational decision-making. This has now been demonstrated as it has been revealed that self and identity are real and enduring powers in influencing emergency nurses' decision-making. It was, therefore, appropriate to consider if higher education informed these concepts.

In pursuing higher education, there was clear evidence of the impact on the sense of self mainly in terms of self-worth, self-esteem, self-belief, pride, and confidence among this group of emergency nurses. Participants described an enhanced self-esteem, achievement, pride, and generally feeling good about themselves having completed programmes of higher education. In addition to the impact of higher education on the sense of self, it was also apparent that higher education positively impacted on the participants' sense of identity where they described how pursuing programmes of higher education allowed them to 'rise above where you've come from', be 'individuals of note' and have that 'good standing in the community'. This reflects a particular aspect of Erikson's (1968) theory where he highlights how human growth can emerge from inner and outer conflicts. This growth represents the capacity of the individual 'to do well' according to their own standards and the standards of those who are significant to them. Reference to the term 'to do well', according to Eriksson (1968), suggests the notion of cultural relativity. In particular, some participants described in very detailed and heartfelt manners how the process and achievement of programmes of higher education not only empowered them, but also reaffirmed their professional pathway choices. The NMPDU's (2020) review of the impact of postgraduate education on nurses and midwives in Ireland revealed the personal and professional advantages of education. The review demonstrated how participating in programmes of higher education positively impacted on nurses' and midwives' level of confidence and self-esteem. This in turn had a positive impact on participants feeling more professionally competent, and more likely to gain recognition within multidisciplinary teams thus enhancing their sense of professional identity.



This study shows that higher education clearly informs an emergency nurse's sense of professional identity. It was evident that professional confidence and, more specifically, professional voice and professional power, were significantly enhanced through the pursuance and acquisition of higher education. Emergency nurses identified how skills such as critical-thinking and problem-solving were enhanced as a result of higher education. In this study participants highlighted the desire to improve not only clinical skills which would enable them to efficiently address complex situations and advanced management of care but also skills in critical thinking and problem-solving. This finding is supported by the studies of Kinsella et al. (2018), Reyes and Conde (2017), and Walter and Terry (2021), and also in earlier studies by Kutney-Lee et al. (2009) and Lucero et al. (2010) which concluded that nurses' critical thinking and clinical judgement skills are vital in ensuring quality and safety, and in the risk management of patient care. Ng et al. (2016) purport that both the uptake and value of higher education resides in this finding in that it enhances critical analysis of care, clinical judgement, and attendant progression to a new level of proactive and autonomous practice.

It is apparent that a positive relationship exists between higher education uptake and clinical nursing practice. The evidence seems to suggest that effective skills are more likely to be seen in nurses who have undertaken postgraduate study (Clark et al., 2015). For those who engage in programmes of higher education in emergency nursing, these skills are not limited to clinical skills and knowledge; they also include skills in research, leadership, and management. Drennan (2012) evaluated the leadership and management abilities of Masters' level nurses and found that there were some gains in these areas when assessed objectively compared to their skills on commencing the programme, as a result of their higher degree.

Indeed, it was the attractiveness and appropriateness of some programmes of higher education that also bore some influence on decision-making. The provision of clinical skills and knowledge, research skills, clinical decision-making, and leadership components within specialist programmes contributed to emergency nurses' decision-making. Participants in a New Zealand study identified improvement in nursing skills which benefited clients as a result of postgraduate education (Richardson & Gage, 2010). These participants described clients in the twenty-first century as 'well-read and better informed' and they felt they 'owed it to their clients' to provide quality and up-to-date information. Research has also found that students of postgraduate education report a high correlation between knowledge and quality of care (Adriaansen et al., 2005), an improvement in knowledge and skills acquisition

(Rasool & Oyefeso, 2007) and improvement in their nursing skills which benefit the clients (Richardson & Gage, 2010).

More recently, research undertaken collaboratively by the Schools of Nursing and Midwifery at Trinity College Dublin and University College Cork measuring the impact of cANPs and RANPs highlighted how postgraduate education positively impacted on the patient experience (ONMSD, 2020). This study indicated that 99.4% of patients surveyed agreed that the cANP / RANP provided high quality care. Narrative data from this study also revealed how patients acknowledged comprehensiveness of care, including the treatment and interventions provided by nurse practitioners. In this thesis, emergency nurses clearly articulated that the pursuance and completion of programmes of higher education impacted positively on their abilities to provide appropriate care in the emergency department setting while also enhancing their skills in management, leadership, and teaching. Emergency nurses also felt sufficiently prepared to meet the demands of the ED environment.

However, it must be acknowledged that the impact of increased knowledge and skills obtained from postgraduate education may not always be viewed positively. Abu-Qamar et al.'s (2020) systematic review on postgraduate nurse education and the implications for nurse and patient outcomes indicates that nurses perceive their educational attainments to impact positively on patient care outcomes. However, they note that there is limited evidence to support this notion. Abu-Qamar et al. (2020) further claim that this perception of knowledge, skills, and the subsequent impact on patient outcomes is subjective and does not provide sufficient evidence of the positive impact of postgraduate education. Similarly, Wilkinson et al. (2018) claim there is no agreement regarding the impact of higher education on the quality of nursing care provided to patients. Audet et al.'s (2018) systematic review also sought to explore the relationship between nurse education and the risk of mortality and adverse events in acute hospitals. While they acknowledge that higher levels of nurse education are associated with lower risks of failure to rescue and mortality, they highlight that few studies have considered the association between nurse education and the risk of other nursing-sensitive adverse events such as medication errors, falls, and nosocomial infections. Earlier studies, such as the Willis Commission Report (Royal College of Nursing, 2012), identified the belief by healthcare stakeholders in the UK that there was a poor connection between the level of educational achievement and the quality of nurses' practice. Similarly, in Johnson and Copnell's (2002) study, a total of 131 nurses with postgraduate diplomas in paediatric nursing were surveyed, and 8% of those nurses believed the course

had not adequately prepared them to work in the clinical area. Ewens et al. (2001) also explored the experience of 21 newly qualified community nurses to establish if the specialist course prepared them for the reality of practice. Significant findings of that study were that many nurses felt unprepared for the 'real world' of practice especially workplace demands.

Interprofessional working and collaborative practice arrangements can be enhanced as a result of higher education. In this study, emergency nurses felt more confident to challenge treatment modalities and engage in professional debate. In addition, emergency nurses also felt that they were on a par with other healthcare professionals having completed programmes of higher education. These findings are corroborated in other studies. Mlambo et al.'s (2021) study highlighted how education was perceived to be key in defining nurse professionalism. Furthermore, engagement with education was considered an important component of professionalisation in nursing. Ng et al.'s (2016) quantitative study exploring the factors affecting nurses' pursuit of higher education highlighted how higher education makes the profession more efficient, effective, and demonstrates to the wider healthcare team that the individual nurse has achieved the professional standard for practice. Ng et al. (2016) further claim that professional recognition offers the most promise for explaining the relationship between higher education and the impact on professional nursing practice. Massimi et al.'s (2017) cross-sectional study exploring the relevance of Master's degree education for the professional development of nurses and midwives revealed that nurses reported a sense of professional advancement as a result of pursuing this level of education. Furthermore, higher education confers on the nurse a level of credibility which in turn enhances influence and leadership which leads to increased professionalisation.

### **8.3 Research Objective 3: To explore other powers that influence emergency nurses' decision-making regarding higher education uptake**

It is apparent from emergency nurses' stories that there were other powers which influenced the decision to pursue programmes of higher education. These powers represent Foucault's (1990) notion of force relations. These force relations were reflective of the interactions associated primarily with family and social life. While some of these influencing factors have been previously identified in the nursing literature, a number of new findings have been uncovered pertaining to the area of higher educational decision-making, namely timing, and departmental commitment.

The concept of timing was one of the main findings within the area of self-affirmation. The findings highlighted how timing arose from two main perspectives; the right time in life personally or professionally, and distraction and escape. While personal and professional

timing has been highlighted previously in the literature regarding the decision to pursue higher education, a new finding arising from this study is that emergency nurses actively sought distraction and escape and higher education was the means by which this would be achieved. The reasons for distraction and escape were based on both personal and professional forces and included escape from family life and escape from professional life. This finding has not been previously identified in the nursing literature.

While previous studies suggest that the right time personally and professionally is significant, and how higher education provides a distraction from life in general (Cooley, 2008), none identified distraction as a direct reason or an influencing factor for the pursuance of higher education programmes. Cooley's (2008) study also identifies the notion of solace and distraction as a consequence of higher education; while studying can impact on home and family life, it can provide an escape from the routine of home life. Additionally, Illingworth et al.'s (2012) study described higher education activities as providing a 'safe haven' from clinical practice in that it allowed space and time to think. While the concept of timing was not the main cited reason for pursuance of higher education, it was a significant force for emergency nurses nonetheless.

Family issues were a significant consideration in the decision to return to study. Childcare and domestic commitments are widely recognised as being influential in decisions for post-registration education. Findings in the current study identified that for some emergency nurses, the time was right with families maturing. Up to that point, childcare and domestic commitments impacted on the ability to devote time to study. Murphy et al.'s (2006) study highlighted that nurses find trying to balance courses and home-life very difficult. The effects of working emergency nurses participating in courses tend to be felt most acutely in their personal lives, mainly in the private spheres of home and family. Thus, there appears to be some disequilibrium between professional and family life. Though the participant's professional life gains and consequently, so does the employer, the participant's family life appears to suffer.

Commitment was cited as a reason for engaging in higher education. Commitment was articulated in two forms; commitment to ED, and commitment to emergency nursing. Commitment to the ED is a new finding in higher educational decision-making. Commitment to a profession is reflected in employees' attitudes to their work and their behaviour and, according to Gould and Fontenla (2006), has a number of hallmarks. These include pride in the occupation, willingness to invest personal involvement, and to perform well. Furthermore, people demonstrating high levels of professional commitment usually

stay in their chosen field of employment for a long time. While Drey et al.'s (2009) study found no evidence of a relationship between professional and organisational commitment and the undertaking of higher education, Kamariannaki et al.'s (2011) study found a significant association between professional commitment and the uptake of higher education among registered nurses. Conversely, Gould and Fontenla (2006) report that opportunities for continuing professional education could contribute to professional and organisational commitment. In this thesis, however, commitment to the ED was uncovered as a new finding in higher educational decision-making.

#### **8.4 Research Objective 4: To explore the experiences of emergency nurses who pursue higher education**

The final research objective sought to address the experiences of higher education among emergency nurses. All participants described their experiences of undertaking programmes of higher education. In addressing this objective, a number of key areas were identified regarding the experiences of higher education uptake among emergency nurses. It was evident that experiences of higher education were representative of the group as a whole and largely reflective of previous studies relating to nurse education but also it is evident that these experiences were at times multifaceted and unique to each emergency nurse.

Commencing higher education is a time of change and challenge for any registered nurse. Adjusting to the requirements of academic study, balancing competing demands, sources of support, and challenges associated with pursuing higher education were all significant components of emergency nurses' higher educational experiences. Adjusting to the requirements of academic study was a significant experience for the emergency nurses in this study. Issues such as wanting to achieve the required academic level, IT abilities and general academic writing skills were concerns highlighted by emergency nurses. This is congruent with previous studies (Clark et al., 2015; Kinsella et al., 2018; Macaden et al., 2017; Pool et al., 2016; Webber, 2004) which suggest that mature students often doubt their academic ability. Other studies (Greenwood et al., 2014; Illingworth et al., 2012; Johansen & Harding, 2013; Richardson & Gage, 2010) highlight the apprehension associated with the return to higher education. Participants in these studies describe steep learning curves and how registered nurses felt like novices again during their academic programmes. In particular, issues such as referencing in academic work and digital competency led to a lack of confidence within study participants and a feeling of being inadequately prepared to meet the required standards of academic writing, or indeed, the academic programme.

Undertaking higher programmes of higher education has its challenges. The impact of studying on family life was a key theme among the participants in this study. Several participants identified the challenge of balancing home life and working life with the demands of their educational programmes. Balancing competing demands instilled in emergency nurses the need for time management skills in order to meet the demands of home, professional, and academic life. Almost half of the participants in Spencer's (2006) UK study of 12 registered nurses, midwives and health visitors enrolled on a Master's programme felt that there had been a negative impact on family life with expressions of guilt as study infringed on family time. While some participants identified this area as a specific challenge, for others balancing demands was easier as they learned management strategies from previous educational experiences.

Sources of support was a key area for emergency nurses when pursuing programmes of higher education. Sources of support were underpinned by either personal or professional factors among the study participants. The support of family was a key theme among participants in the consideration of higher education pursuance. Once enrolled on educational programmes, family support continued to be significant for the duration of the programmes. This pertained in particular to childcare arrangements which was deemed necessary to provide participants with sufficient time and opportunity to undertake both academic assignments and clinical placements. Consistent with Cooley's (2008) study, emergency nurses' families were supportive because nurses had discussed their plans with them and together devised strategies to facilitate entry to higher education.

In terms of professional support, the workplace was deemed to be both supportive and unsupportive among emergency nurses in this study, and this is reflected in previous studies exploring nurses' decision-making strategies and experiences of higher education. Mlambo et al.'s (2021) study indicated that a supportive working environment was essential requirement for CPD uptake. Specifically, workplace camaraderie, moral support, and a good team spirit were highlighted to be of value for those considering and participating in educational activities. In this study, participants cited their immediate peers and colleagues as a significant source of support, particularly those colleagues who had previously undertaken higher education activities. Local managers were deemed to be supportive in some cases also which is worthy of consideration as Ellis and Nolan (2005) highlight the importance of effective managerial support. While nurses in Cooley's (2008) study generally found nursing management to be unsupportive and unlikely to encourage nurses to study, financial support was a key motivator in the pursuance of higher education programmes.

Few participants in this study acknowledged the funding they received in order to undertake their programmes of higher education. From their perspective, they received little support from an organisational level and support was identified in terms of study leave allocation only. Even with the granting of minimal study leave, this was not sufficient for most participants, with some utilising annual leave entitlements in order to attend timetabled sessions in university and complete academic assignments.

Price and Reichert's (2017) study identified nurses as requiring a commitment to lifelong learning but they believe that continuing education and training are not a priority from a management perspective. Little support was provided to them in terms of securing scholarly time or funding for these educational initiatives. Nurses described continuing education as an investment in their expertise. Some felt that the shift away from continuing education as a priority for employers where increased knowledge could enhance the quality of patient care. The lack of support for continuing education seemed to further reflect management's differing priorities and a lack of respect for their contributions to patient care. There was an understanding that best practices and patient care standards were constantly evolving and there was a desire for access to information through training and education to provide the best care possible to patients.

Support was also deemed to be lacking among emergency nurses' own colleagues in this study. While most participants reported positive colleague experiences in terms of support, some emergency nurses reported issues pertaining to group cohesiveness. This was particularly evident when programmes of higher education beyond the initial postgraduate diploma were being pursued. Over recent years, the healthcare sector in Ireland has witnessed exceptional growth, expansion and demand in response to the increasing and sometimes complex needs of service-users, healthcare reform, governmental, and professional body initiatives. In keeping with the concept of governmentality, this represents the plurality of agencies and authorities. As a result, specialist and advanced nursing practice roles in nursing have expanded rapidly. Since 2010, the NMBI have statutory responsibility for the regulations and accreditation of advanced nurse practitioners and clinical nurse specialists. The core competencies of advanced nurse practitioners include autonomy in clinical practice, professional and clinical leadership, and research. Specialist and advanced practice roles are seen as enhancing service delivery and building the capacity of the nursing and midwifery professions (Coyne et al., 2016). In relation to service provision, postholders were seen as differing from non-postholders in the area of therapeutic communication, health

promotion, education of service-user and family, the use of physical and psychosocial interventions and increased patient and client satisfaction (Coyne et al., 2016).

For those emergency nurses who engaged in advanced pathway programmes, a 'them and us' phenomenon was highlighted. This is not a new finding in the nursing literature exploring the experiences of those nurses progressing into advanced practice roles. These participants described how colleagues reacted negatively to them pursuing advanced practice career pathways and stated that these experiences were more difficult than dealing with other challenges associated with pursuing higher education. While opportunities for progression should be welcomed, it may be argued that bad feeling could be attributed to a lack of understanding surrounding these advanced roles in clinical practice. Transition to advanced practice can be fraught with what is seen as the blurring of medical and nursing roles and, in addition, a reluctance to give up nursing duties. Spinks (2009) reports the obstacles to the acceptance of the ANP role which include potential negative attitudes of nursing staff; role confusion is more likely to occur when an individual has previously been known in a nursing role. MacLellan et al.'s (2016) study on nurse practitioner experiences describe many expressions of both overt and covert hostility where supportive relationships and friendships were lost and adversaries instead of allies were created. A sense of professional jealousy was often evident. Participants in MacLellan et al.'s (2016) study describe nurses who were once colleagues who became formidable opponents, highlighting passive aggressive and dismissive behaviours between nurses and newly practising nurse practitioners. Transitioning to the role of ANP is challenging and demanding with some struggling with role confusion and defining a distinct place for themselves within the healthcare team. ANPs move between the traditional models of practice and cultures of nursing and medicine to provide holistic care incorporating defined responsibilities for diagnosis, prescription, and treatment within an advanced nursing role. It is for this reason that ANPs often encounter initial resistance from both nurses and medical professionals as they transgress and blur traditional role boundaries (MacLellan et al., 2016).

Despite the numerous challenges experienced by emergency nurses in the pursuit of higher education, there were several factors that maintained their interest in completing their programmes of higher education. Factors such as the provision of appropriate content in the academic programme, knowledge application, achievement of the qualification, determination, and implications of non-completion were cited by emergency nurses in this study. Participants appreciated when appropriate, relevant, and interesting module content was delivered throughout their programmes of higher education. The provision of clinical



placement opportunities particularly in the postgraduate diploma programme was also welcomed by participants. The opportunity to bring back and apply their learning to ED was also highlighted by participants.

Other factors such as the achievement of the qualification was reason enough to maintain their interest in the programme of education. This was aided by sheer determination and, in some cases, stubbornness, among participants to ensure completion of their educational programmes. The last factor that maintained their interest in higher education was the implication of non-completion. For a small number of emergency nurses, this was largely attributable to the implication of fee reimbursement to the hospital should they have failed any component or not completed the programme. Given the experiences and challenges associated with higher education, some emergency nurses indicated their intentions for future study.

## **8.5 Conclusion**

The story of higher educational decision-making among emergency nurses within this study is powerful. Emergency nurses openly relayed their stories regarding higher educational decision-making and experiences in emotional, heartfelt, and humbling manners. The stories that have emerged are multifactorial, complex, and enormously significant in making sense of the powers that influence decision-making, strategies, and experiences of higher education among emergency nurses in Ireland. While emergency nurses' stories reflect findings from similar studies, I have uncovered three new findings in the area of higher education pursuance.

I have uncovered how emergency nurses are still influenced and shaped by the power of their social backgrounds, and experiences associated with limited opportunities in their formative years. There are clear messages regarding sociocultural influences and the impact of these influences on intention to pursue higher education. I have also revealed how the area of timing is significant particularly in relation to distraction and escape, and how this has been influential in underpinning emergency nurses' educational decision-making. I have uncovered how commitment to the ED is also a new influencing power in decision-making. I have identified the impact of higher education on sense of self and identity and it is clear that pursuing programmes of higher education does inform emergency nurses' sense of self and identity both in positive and negative terms. Overall, the aims and objectives of this study have been met. The next chapter will provide a conclusion to this thesis.

## **Chapter 9 - Conclusion**

## **9.0 Summary**

This study has contributed three new key findings to the area of higher educational decision-making and experiences among emergency nurses in Ireland. It was conducted with a small cohort of emergency nurses based in one hospital setting in the Republic of Ireland. These emergency nurses had undertaken a programme of study or studies at Level 8 and above. They are not representative of the entire emergency nurse population, or indeed the registered nurse population, but their stories reveal rich and insightful data.

My overarching aim was to explore the decision-making strategies regarding the consideration and uptake of higher education among emergency nurses through the lens of self and identity. In addition, I sought to explore the experiences of higher education among emergency nurses. In order to achieve these aims I illustrated four objectives which were underpinned by three research questions – ‘What powers govern the decision-making of emergency nurses?’, ‘Does higher education inform an emergency nurses’ sense of self and identity?’, ‘What are emergency nurses experiences of higher education?’

I began by placing the study in context, thereby setting the scene of the state of nurse education both in the past and present. In doing so, I was able to highlight how nurse education has been transformed in line with political, professional, and wider healthcare trends. I also highlighted the educational statistics pertaining to emergency nurse educational uptake in Ireland. The literature review covered three distinct areas; self, identity, and professional identity. In theoretically underpinning my study, I referred to the writings of Michel Foucault. I hoped to ascertain and explore emergency nurses’ sense of self and identity through using Foucault’s concepts of disciplinary power and governmentality. Using these concepts, I constructed a theoretical framework that was broad enough to both encompass and illuminate emergency nurse narratives as a means of understanding higher education decision-making and experiences.

I conducted 22 interviews with emergency nurses in April 2017. These interviews were then transcribed over a four-month period from May 2017. Data was then manually coded, and the research questions were answered. I have illuminated the ‘hard realities’ in keeping with the tradition of narrative inquiry. I have highlighted how both personal and professional experiences have shaped educational decision-making. In assigning meaning to experiences I have focused on participants’ life stories in revealing areas such as background, early education, and nurse training. I have shaped this landscape and I have also been shaped by this landscape. Participant narratives have assisted me in understanding my reasons for higher educational pursuance. The findings are summarised in the following section.

## **9.1 Major Findings**

This thesis uncovered three new findings pertaining to the decision-making strategies and experiences of emergency nurses. In addition to these new findings, it also supports findings from previous national and international studies pertaining to higher education uptake among the registered nurse population. The first new finding, the influence of social background in higher education decision-making, was revealed when addressing the first research objective. The issue of timing, and commitment to the ED were also new findings and were revealed when addressing the third research objective which sought to explore the other powers that influence emergency nurses' educational decision-making. It must be noted, however, that the other influencing powers cited by emergency nurses have been previously identified in the literature and are now also replicated in this thesis.

## **9.2 Contributions to the Nursing Knowledge Base**

This study offers a contribution to the understanding of higher education decision-making and experiences of emergency nurses in Ireland. As previously identified, research endeavour within this specialist area of nursing practice is limited generally, and consideration of higher education decision-making strategies and experiences among this group of healthcare professionals is lacking, both nationally and internationally. Understanding decision-making approaches and experiences pertaining to higher education uptake will be useful in developing strategies to keep students engaged and create a firm foundation for lifelong learning relationships with universities. In doing so, it is envisaged that the results of this research will be important in understanding of why and when emergency nurses engage in higher education, thus leading to a greater knowledge of how higher educational opportunities can be managed for this group of nursing professionals. Understanding decision-making strategies and experiences will also be useful in providing a platform from which further consideration can be given to the new findings arising from this study.

## **9.3 Major Recommendations**

The process of pursuing higher education as a means of personal and professional development can be a profound struggle for emergency nurses. The results of this study suggest that institutions where emergency care is delivered need to create an environment that is conducive to learning and educational needs as this may affect future relationships regarding the intention to study. Hospitals, emergency care facilities, and HEIs must be empathetic to students who find themselves in a transitional phase with some having not

engaged in educational activities for a considerable time or those who wish to engage in educational activities that lead to advanced clinical roles.

It was apparent through emergency nurses' stories that several issues arose from engaging in programmes of higher education. One of the main issues raised by emergency nurses was that of study leave allocation. Their experiences indicated that the allocation of study leave did not match the demands of the educational programmes. It was often the case that study time and course attendance was undertaken on rostered days off or annual leave which subsequently impacted on personal time and how competing demands were balanced. In addition, it was apparent that attendance at programmes further highlighted the inconsistencies among organisations in the support provided to staff to participate in programmes of higher education. Often urban hospitals provided more support in terms of study leave allocation.

A recommendation of this study would be that at local level any organisational policy statements or CPD strategies relevant to professional development should clearly be cognisant of the requirements and contributions of higher education programmes. While it is important that organisations encourage and promote the pursuit of higher education, they need to be fully aware of the commitment required and potential impact of unsupportive working environments. Having such awareness would also enable participation in CPD activities. More broadly, support offered by organisations could be standardised to alleviate the pressures on those nurses employed in non-urban areas. This study reveals that hospitals may have an increased uptake in higher education pursuits if they seek to have a better understanding of the needs of those who engage in programmes of higher education. In addition, this may also assist with recruitment and retention strategies.

Another issue arising from emergency nurses' stories was that of role transition particularly for those who pursued advanced practice pathways. It was apparent that those emergency nurses struggled with their new professional identity and their new collaborative working relationships. Additionally, it was apparent that ANPs experienced a lack of cohesiveness with their colleagues as result of their new clinical role. A further recommendation arising from this study would be that non-ANP emergency nursing staff be appropriately educated regarding the ANP role and this would assist in minimising any transitional difficulties that both ANPs and non-ANPs experience.

The professional regulatory body and trade union bodies could also advocate and promote higher education and positively influence the support systems offered at local level. In

particular, the professional regulatory body could do more to influence and support those nurses pursuing non-ANP and specialist pathways. Some emergency nurses in this study stated that the NMBI bore no influence on their decision to participate in programmes of higher education. While the support offered by the NMBI for cANPs, ANPs, and clinical nurse specialists is reasonably robust there is little evidence of their influence on or support for those nurses who do not pursue these specialised pathways.

The findings of this study also suggest that HEIs need to have a better understanding of this group of professionals in terms of job demands and limited allocation of study leave. Additionally, HEIs also could do more to assist those nurses who have not engaged with higher education for a considerable period of time particularly in the areas of IT skills and reflective practice. HEIs also need to be aware of the less well-articulated personal reasons, as well as the professional reasons, for nurses' consideration of programmes of higher education while also emphasising the personal benefits to be gained from further study in their marketing strategies. In conjunction with clinical practice partners, HEIs should encourage and support students in disseminating research findings to national and international audiences. Similarly, healthcare organisations could be more proactive in seeking out opportunities in conjunction with academic partners to promote and showcase educational and research achievements. While not an issue in this study, HEIs must also be cognisant of potential additional learning needs and support services required of those student groups from an international background. Understanding this student group will assist in developing processes, such as hybrid approaches to content delivery, to keep students engaged and create a firm foundation for lifelong learning relationship with the university.

In an evolving healthcare system in which up-to-date education, training and skills are pivotal in delivering a responsive and equitable service, against a backdrop of limited opportunities and significant personal investment, the underpinning approach to educational decision-making is worthy of consideration. The decision-making strategies, influences, and experiences of emergency nurses reveal a committed yet complex group of healthcare professionals who strive for educational achievement in uncertain times in which they view themselves as the first point of contact and who should be competent and proficient in the delivery of emergency nursing care. It is envisaged that the results of this research will be important in the understanding of why and when emergency nurses engage in higher education, thus leading to a greater knowledge of how higher educational opportunities can be focused for this group of nursing professionals.

#### **9.4 Areas of Further Research**

Having completed this small-scale qualitative investigation, I can identify further potential research areas. With the limitations of this investigation in mind, it seems obvious that a broader exploration of not only emergency nurses decision-making strategies, but also those of the wider registered nurse population would be of value in ascertaining those influencing powers which may assist in informing the approaches adopted by HEIs and hospitals in facilitating higher education opportunities for this group of healthcare professionals. Another potential area of research may involve exploring in further detail the significance and influence of social background and how it permeates through to adulthood and adulthood decision-making. It would be interesting to ascertain the influencing forces pertaining to uptake of the Certificate in Emergency Nursing programme as this programme of higher education was not available at the time of data collection. Additionally, it would also be interesting to explore if the intentions, influences, and experiences of higher education are similar or different according to the programme level. This would be of particular interest to me as I now work in a HEI and to have data of this nature would be beneficial in assisting with module, programme, and curriculum development. Since male nurses did not constitute part of the participant group, I believe it would be useful to capture the perspectives of male emergency nurses thus further illuminating the decision-making strategies and experiences pertaining to higher education uptake.

#### **9.5 Limitations**

Obviously one of the main limitations is that of sample size. While narrative accounts provided rich detail, the perspectives and experiences of 22 emergency nurses from one acute hospital are not representative of the ED nurse population in Ireland. While the sample size was appropriate for the methodology used, it is unlikely that the views and experiences of this group represent the views of the whole emergency nursing population. Another limitation of the study population may relate to gender. There were no male participants in this study and it may, therefore, be argued that the study reflected a degree of gender imbalance. As a result, it may also be argued that including the stories of male emergency nurses may have brought some unique insights and perspectives particularly in relation to sense of self, identity, and professional identity, and approaches to higher education decision-making and experiences. However, despite the lack of male nurses in the study, the participant group reflected a wide range of ages, experiences, clinical roles, and ethnicity which I feel contributed significantly to the representativeness of the study findings.

Another limitation of this thesis may relate to methodology. In conducting this study I was always cognisant that the stories emergency nurses relayed to me about their experiences of pursuing higher education were the best evidence available regarding this issue. Polkinghorne (2007) claims that often a degree of validity is granted to a statement because of the authority of the person who makes it. However, it may be argued that the methodology used may have limitations particularly in relation to validity. For example, participants may be reluctant to reveal any information that portrays them in a negative light. It may also be argued that narrative approaches to research are still evolving and may not have the same impetus as other qualitative methods. However, as I indicated earlier in this thesis, narrative research helps to illustrate the finer details of phenomena and the paradigms that both shapes individuals' identities and experiences. Using a narrative approach has enabled the discovery of deep and layered decision-making processes while acknowledging participants' experiences as dynamic entities.

#### **9.6 Have I met the aims and objectives of the study?**

This study sought to explore the decision-making strategies and experiences of emergency nurses in Ireland through the lens of self and identity. In doing so, I aimed to provide an analytical description of how emergency nurses decide to engage in higher education and how this decision is linked to their sense of self and identity. I also wished to explore emergency nurses' understanding of self and identity as learners in higher education, and to explore the connection between self and identity and higher education uptake. It is my belief that I have met the aims and objectives of this study. I have clearly set out the decision-making strategies and experiences of higher education among emergency nurses in Ireland. I have provided detailed and analytical descriptions, underpinned by an appropriate theoretical framework, of the powers that influence emergency nurses to pursue programmes of higher education. I have ascertained emergency nurses' perceptions of self, identity, and professional identity, and I have detailed the connection between these concepts and the decision to pursue higher education. I have also clearly described the experiences of higher education among this group of healthcare professionals.

#### **9.7 Have I answered the research questions?**

This study identified three research questions at the outset; 'What powers govern the decision to pursue higher education?', 'Does higher education inform an emergency nurse's sense of self and identity?', and 'What are emergency nurses' experiences of higher education?' I have answered all three questions in a clear and comprehensive manner. I have clearly identified new findings and I have also acknowledged where findings from this study



have also been replicated in previous studies. The powers underpinning emergency nurses decision-making strategies are multifaceted and unique to each individual. It is evident that the influence of social powers are both significant and enduring throughout life. Undoubtedly higher education has the ability to inform sense of self, identity, and professional identity. It appeared that the impact of higher education on sense of self and identity was also enduring and meaningful for emergency nurses. I have also described in detail the experiences of emergency nurses in pursuing higher education.

In undertaking this research, I have gained greater insight into the complexities underpinning educational decision-making. At the outset, my assumption was that there were more covert powers at play regarding emergency nurses' decision-making strategies. Given the limited opportunities surrounding promotion and progression, and in recalling my own influences, strategies, and experiences regarding higher education pursuance, I assumed there were unspoken finer forces influencing nurses to pursue programmes of higher education. Also, my belief that my position as an insider-researcher would give me some advantages in illuminating the decision-making and experiences of others. I had an extensive background in emergency nursing and I had also completed several programmes of higher education while working full-time. I had experienced first-hand the realities of higher education pursuance and I understood the politics of both the healthcare and higher educational systems. I knew how things really worked. While establishing trust and rapport with this group of emergency nurses was not problematic, I was unsure, however, as to how honest emergency nurses would be in telling their personal stories to me as I was known to them. What resulted were very honest, and frank accounts of their past, present, and future stories. Interestingly, some of their stories resonated with me and my own strategies and experiences of higher education. As a result, there were occasions where they illuminated my story and provided me with a greater understanding of my own decision-making strategies and experiences.

### **9.8 Dissemination Strategy**

A dissemination plan is a key component of any research study. Timmons (2015) states that, as nurse researchers, it is important that we recognise the value of our research across multiple audiences. Similarly, Hagan, Schmidt, Ackison, Murphy, and Jones (2017) assert that we must appreciate the potential impact of our research for study participants and other stakeholders. It is my hope that the knowledge produced as a result of this study will inform current knowledge within the scientific field, and that those stakeholders with a vested interest in my research will find some benefit from the study findings.

In 2018 I presented my research at the 3<sup>rd</sup> Global Emergency Nursing and Trauma Conference in The Netherlands. In January 2021 I presented my work at the local research showcase to fellow academic staff, and I also presented my work as part of research showcases to undergraduate and postgraduate nursing students undertaking research modules as part of their educational programmes. I have been invited to present my research findings at the next annual nursing research day at the study site. It is my intention to write a paper with my supervisor for publication in an emergency nursing journal. It is also my intention to submit an abstract for the next Trinity Health & Education International Research Conference, and the RCN International Nursing Research Conference.

## **9.9 Conclusion**

This study sought to ascertain the experiences and decision-making strategies of emergency nurses pertaining to higher education uptake through the lens of self and identity. In its findings this study supports the well-established claims of promotional and educational opportunities, and patient care outcomes as reasons for pursuing higher education. While these have been credible driving forces in the uptake of higher education, this study has also demonstrated that emergency nurses' personal mandates in terms of self and identity are more influential and enduring in the decision to participate in higher educational activities. These emergency nurses provided rich, personal, and honest accounts of the powers that underpinned their higher education decision-making coupled with frank descriptions of their educational experiences. To this end, I can say that our 'selves' and our 'identities' are rich and varied with a little hint of vulnerability at times. Most of all, however, they are unique, and enduring, and will forever form part of our personal and professional stories.

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## **Appendices**

**Appendix 1**  
**Literature Search Strategy**

#	Query	Limiters / Expanders	Run via	Results 2010-2015	Results 2016-2021
S1	self AND identity	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsycInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher’s Index	3,988	1,328
S2	sense of self	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101;	Interface – EBSCOhost; Research Databases;	427	322

		Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsycInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher’s Index		
S3	(perceptions or attitudes or opinion or experience or view or reflection or beliefs) AND self AND identity	<b>Limiters</b> - Full Text; References Available; Peer Reviewed; Published Date: 20100101-20141231; Abstract Available; English Language; Journal & Citation Subset: PubMed not MEDLINE; Language: English; Publication Year: 2010-2014; Publication Type: Peer Reviewed	Interface - EBSCOhost Research Databases Search Screen - Advanced Search. Database - MEDLINE;APA PsycInfo;AgeLine;	527	705

		Journal; English; Language: English; Intended Audience: Psychology: Professional & Research; Document Type: Journal Article; Publication Year: 2010-2014; Abstract Available; English Language; Exclude MEDLINE records; PDF Full Text; Language: English; PDF Full Text; Abstract Available; Language: English; <b>Expanders</b> - Apply equivalent subjects; <b>Search modes</b> - Boolean/Phrase	CINAHL Plus with Full Text; Academic Search Complete ;Philosopher's Index		
S4	sense of self AND (nurse or nurses or nursing)	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with	27	14



		2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher’s Index		
S5	sense of self or identity AND (nurse of nurses or nursing)	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the	180	134

			Americas; Philosopher's Index		
S6	real self	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsycInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher's Index	101	30
S7	ideal self	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published	Interface – EBSCOhost;	1,302	48

		<p>Date: 20100101 – 20150101;  Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase</p>	<p>Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher’s Index</p>		
S8	ideal self AND real self	<p><b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract</p>	<p>Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and</p>	11	2

		Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher’s Index		
S9	self AND carl rogers	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with	57	2

		Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher’s Index		
S10	identity	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search	13,565	5,845

		equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Complete; European Views of the Americas; Philosopher’s Index		
S11	self AND identity	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsycInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher’s Index	2,698	1,328

S12	identity development	<p><b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase</p>	<p>Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher’s Index</p>	723	364
S13	social identity	<p><b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English</p>	<p>Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search.</p>	287	140

		Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher’s Index		
S14	social identity theory	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015;	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA	277	140



		Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher's Index		
S15	social identity theory AND tajfel	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language:	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA	53	2

		English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher’s Index		
S16	identity AND eriksons stages of development	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the	14	5

			Americas; Philosopher's Index		
S17	symbolic interactionism	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsycInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher's Index	219	37
S18	symbolic interactionism AND	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published	Interface – EBSCOhost;	49	2

	(nurse or nurses or nursing)	Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher’s Index		
S19	social identity theory AND (nurse or nurses or nursing)	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and	8	4

		Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher’s Index		
S20	social identity theory process	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with	17	3

		Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher’s Index		
S21	social background AND (nurse or nurses or nursing)	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search	63	5

		equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Complete; European Views of the Americas; Philosopher’s Index		
S22	social background AND (nurse or nurses or nursing) AND (continuing professional development or cpd or professional development)	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsycInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher’s Index	302	18

S23	social background AND (nurse or nurses or nursing) AND education	<p><b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase</p>	<p>Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher’s Index</p>	21	3
S24	social background AND (education or school or learning or	<p><b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English</p>	<p>Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search.</p>	37	209



	teaching or classroom or education system)	Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher’s Index		
S25	professional identity	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015;	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA	541	447

		Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher's Index		
S26	professional identity AND nursing	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language:	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA	44	46

		English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher’s Index		
S27	criteria of a profession AND (nurse or nurses or nursing)	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the	269	1,816

			Americas; Philosopher's Index		
S28	knowledge AND (nurse or nurses or nursing)	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsycInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher's Index	2,028	681

S29	professional values AND (nurse or nurses or nursing)	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher’s Index	81	44
S30	personal values AND (nurse or nurses or nursing)	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search.	36	20

		Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher’s Index		
S31	professional socialisation	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015;	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA	90	80

		Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher's Index		
S32	professional socialisation AND (nurse or nurses or nursing)	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language:	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA	17	6

		English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher’s Index		
S33	professional identity development	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsychInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the	92	45



			Americas; Philosopher's Index		
S34	professional identity development AND (nurse or nurses or nursing)	<b>Limiters</b> – Full Text; References Available; Peer Reviewed; Published Date: 20100101 – 20150101; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; English; English; Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; PDF Full Text; Year of Publication 2010-2015; Language: English; Year of Publication: 2010-2015; Abstract Available; Language: English. <b>Expanders</b> – Apply equivalent subjects; <b>Search modes</b> – Boolean/Phrase	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database – AMED – The Allied and Complementary Medicine Database; MEDLINE; APA PsycInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Academic Search Complete; European Views of the Americas; Philosopher's Index	12	2
S35	(nurse or nurses or nursing) AND	<b>Limiters</b> - Full Text; References Available; Peer Reviewed; Published Date: 20100101-20150131; Abstract	Interface – EBSCOhost;	61	32

	<p>(continuing professional development or cpd or professional development) AND continuing education</p>	<p>Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; Publication Type: Peer Reviewed Journal; English; Language: English; English Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; Research Article; PDF Full Text; Open Access; Year of Publication: 2010-2015; PDF Full Text; Language: English; PDF Full Text; Publication Type: Academic Journal; Language: English; Publication Type: Academic Journal; Language: English; <b>Expanders</b> - Apply equivalent subjects; <b>Search modes</b> - Boolean/Phrase</p>	<p>Research Databases; Search Screen – Advanced Search. Database - AMED - The Allied and Complementary Medicine Database; MEDLINE; APA PsycInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles;Teacher Reference Center; Academic Search Complete; British Education Index; Education Abstracts (H.W. Wilson) Educational Administration Abstracts; ERIC; Child Development &amp; Adolescent Studies</p>		
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S36	(nurse or nurses or nursing) AND (continuing professional development or cpd or professional development) AND motivation	<p><b>Limiters</b> - Full Text; References Available; Peer Reviewed; Published Date: 20100101-20150131; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; Publication Type: Peer Reviewed Journal; English; Language: English; English Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; Research Article; PDF Full Text; Open Access; Year of Publication: 2010-2015; PDF Full Text; Language: English; PDF Full Text; Publication Type: Academic Journal; Language: English; Publication Type: Academic Journal; Language: English; <b>Expanders</b> - Apply equivalent subjects; <b>Search Modes</b> – Boolean/Phrase</p>	<p>Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database - AMED - The Allied and Complementary Medicine Database; MEDLINE; APA PsycInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Teacher Reference Center; Academic Search Complete; British Education Index; Education Abstracts (H.W. Wilson) Educational Administration Abstracts; ERIC;</p>	9	5
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			Child Development & Adolescent Studies		
S37	(nurse or nurses or nursing) AND (continuing professional development or cpd or professional development) AND (barriers or obstacles or challenges)	<p><b>Limiters</b> - Full Text; References Available; Peer Reviewed; Published Date: 20100101-20150131; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; Publication Type: Peer Reviewed Journal; English; Language: English; English Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; Research Article; PDF Full Text; Open Access; Year of Publication: 2010-2015; PDF Full Text; Language: English; PDF Full Text; Publication Type: Academic Journal; Language: English; Publication Type: Academic Journal; Language: English; <b>Expanders</b> - Apply equivalent subjects; <b>Search Modes</b> – Boolean/Phrase</p>	<p>Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database - AMED - The Allied and Complementary Medicine Database; MEDLINE; APA PsycInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Teacher Reference Center; Academic Search Complete; British Education Index; Education Abstracts (H.W. Wilson) Educational</p>	104	42

			Administration Abstracts; ERIC; Child Development & Adolescent Studies		
S38	(nurse or nurses or nursing) AND (continuing professional development or cpd or professional development) AND (barriers or facilitators)	<b>Limiters</b> - Full Text; References Available; Peer Reviewed; Published Date: 20100101-20150131; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; Publication Type: Peer Reviewed Journal; English; Language: English; English Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; Research Article; PDF Full Text; Open Access; Year of Publication: 2010-2015; PDF Full Text; Language: English; PDF Full Text; Publication Type: Academic Journal; Language: English; Publication Type: Academic Journal; Language: English; <b>Expanders</b> - Apply equivalent subjects; <b>Search Modes</b> – Boolean/Phrase	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database - AMED - The Allied and Complementary Medicine Database; MEDLINE; APA PsycInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Teacher Reference Center; Academic Search Complete; British Education Index;	27	21

			Education Abstracts (H.W. Wilson) Educational Administration Abstracts; ERIC; Child Development & Adolescent Studies		
S39	(nurse or nurses or nursing) AND (continuing professional development or cpd or professional development) AND (experiences or perceptions or attitudes or views)	<b>Limiters</b> - Full Text; References Available; Peer Reviewed; Published Date: 20100101-20150131; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; Publication Type: Peer Reviewed Journal; English; Language: English; English Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; Research Article; PDF Full Text; Open Access; Year of Publication: 2010-2015; PDF Full Text; Language: English; PDF Full Text; Publication Type: Academic Journal; Language: English; Publication Type: Academic Journal; Language: English; <b>Expanders</b> -	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database - AMED - The Allied and Complementary Medicine Database; MEDLINE; APA PsycInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Teacher Reference Center; Academic Search	190	92

		Apply equivalent subjects; <b>Search Modes</b> – Boolean/Phrase	Complete; British Education Index;  Education Abstracts (H.W. Wilson) Educational Administration Abstracts; ERIC; Child Development & Adolescent Studies		
S40	(nurse or nurses or nursing) AND higher education	<b>Limiters</b> - Full Text; References Available; Peer Reviewed; Published Date: 20100101-20150131; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; Publication Type: Peer Reviewed Journal; English; Language: English; English Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; Research Article; PDF Full Text; Open Access; Year of Publication: 2010-2015; PDF Full Text; Language: English; PDF Full Text; Publication Type: Academic Journal; Language: English;	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database - AMED - The Allied and Complementary Medicine Database; MEDLINE; APA PsycInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles;Teacher	219	179

		<p>Publication Type: Academic Journal;  Language: English; <b>Expanders</b> -  Apply equivalent subjects; <b>Search  Modes</b> – Boolean/Phrase</p>	<p>Reference Center;  Academic Search  Complete; British  Education Index;</p> <p>Education Abstracts  (H.W. Wilson)  Educational  Administration  Abstracts; ERIC;  Child Development  &amp; Adolescent Studies</p>		
S41	<p>(nurse or nurses or  nursing) AND higher  education AND  (experiences or  perceptions or  attitudes or views)</p>	<p><b>Limiters</b> - Full Text; References  Available; Peer Reviewed; Published  Date: 20100101-20150131; Abstract  Available; Language: English;  Abstract Available; English  Language; Publication Year: 2010-  2015; Publication Type: Peer  Reviewed Journal; English;  Language: English; English Abstract  Available; Language: English;  Publication Type: Academic Journal;  Publication Year: 2010-2015;  Abstract Available; English  Language; Research Article; PDF  Full Text; Open Access; Year of  Publication: 2010-2015; PDF Full  Text; Language: English; PDF Full</p>	<p>Interface –  EBSCOhost;  Research Databases;  Search Screen –  Advanced Search.  Database - AMED -  The Allied and  Complementary  Medicine Database;  MEDLINE; APA  PsycInfo;  SPORTDiscus with  Full Text; AgeLine;  CINAHL Plus with</p>	111	86



		Text; Publication Type: Academic Journal; Language: English; Publication Type: Academic Journal; Language: English; <b>Expanders</b> - Apply equivalent subjects; <b>Search Modes</b> – Boolean/Phrase	Full Text; APA PsycArticles; Teacher Reference Center; Academic Search Complete; British Education Index; Education Abstracts (H.W. Wilson) Educational Administration Abstracts; ERIC; Child Development & Adolescent Studies		
S42	(nurse or nurses or nursing) AND postgraduate education	<b>Limiters</b> - Full Text; References Available; Peer Reviewed; Published Date: 20100101-20150131; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; Publication Type: Peer Reviewed Journal; English; Language: English; English Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; Research Article; PDF	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database - AMED - The Allied and Complementary Medicine Database; MEDLINE; APA PsycInfo; SPORTDiscus with	88	70

		Full Text; Open Access; Year of Publication: 2010-2015; PDF Full Text; Language: English; PDF Full Text; Publication Type: Academic Journal; Language: English; Publication Type: Academic Journal; Language: English; <b>Expanders</b> - Apply equivalent subjects; <b>Search Modes</b> – Boolean/Phrase	Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles;Teacher Reference Center; Academic Search Complete; British Education Index;  Education Abstracts (H.W. Wilson) Educational Administration Abstracts; ERIC; Child Development & Adolescent Studies		
S43	(nurse or nurses or nursing) AND postgraduate education AND (experiences or perceptions or attitudes or views)	<b>Limiters</b> - Full Text; References Available; Peer Reviewed; Published Date: 20100101-20150131; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; Publication Type: Peer Reviewed Journal; English; Language: English; English Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015;	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database - AMED - The Allied and Complementary Medicine Database; MEDLINE; APA	47	29

		Abstract Available; English Language; Research Article; PDF Full Text; Open Access; Year of Publication: 2010-2015; PDF Full Text; Language: English; PDF Full Text; Publication Type: Academic Journal; Language: English; Publication Type: Academic Journal; Language: English; <b>Expanders</b> - Apply equivalent subjects; <b>Search Modes</b> – Boolean/Phrase	PsycInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Teacher Reference Center; Academic Search Complete; British Education Index; Education Abstracts (H.W. Wilson) Educational Administration Abstracts; ERIC; Child Development & Adolescent Studies		
S44	(nurse or nurses or nursing) AND postgraduate education AND (barriers and facilitators)	<b>Limiters</b> - Full Text; References Available; Peer Reviewed; Published Date: 20100101-20150131; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; Publication Type: Peer Reviewed Journal; English; Language: English; English Abstract Available; Language: English;	Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database - AMED - The Allied and Complementary	0	1,606

		<p>Publication Type: Academic Journal;  Publication Year: 2010-2015;  Abstract Available; English  Language; Research Article; PDF  Full Text; Open Access; Year of  Publication: 2010-2015; PDF Full  Text; Language: English; PDF Full  Text; Publication Type: Academic  Journal; Language: English;  Publication Type: Academic Journal;  Language: English; <b>Expanders</b> -  Apply equivalent subjects; <b>Search  Modes</b> – Boolean/Phrase</p>	<p>Medicine Database;  MEDLINE; APA  PsycInfo;  SPORTDiscus with  Full Text; AgeLine;  CINAHL Plus with  Full Text; APA  PsycArticles;Teacher  Reference Center;  Academic Search  Complete; British  Education Index;   Education Abstracts  (H.W. Wilson)  Educational  Administration  Abstracts; ERIC;  Child Development  &amp; Adolescent Studies</p>		
S45	(nurse or nurses or nursing) AND postgraduate education AND motivation	<p><b>Limiters</b> - Full Text; References Available; Peer Reviewed; Published Date: 20100101-20150131; Abstract Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; Publication Type: Peer Reviewed Journal; English;</p>	<p>Interface – EBSCOhost; Research Databases; Search Screen – Advanced Search. Database - AMED -</p>	2	2

		Language: English; English Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; Research Article; PDF Full Text; Open Access; Year of Publication: 2010-2015; PDF Full Text; Language: English; PDF Full Text; Publication Type: Academic Journal; Language: English; Publication Type: Academic Journal; Language: English; <b>Expanders</b> - Apply equivalent subjects; <b>Search Modes</b> – Boolean/Phrase	The Allied and Complementary Medicine Database; MEDLINE; APA PsycInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Teacher Reference Center; Academic Search Complete; British Education Index; Education Abstracts (H.W. Wilson) Educational Administration Abstracts; ERIC; Child Development & Adolescent Studies		
S46	(nurse or nurses or nursing) AND postgraduate education AND	<b>Limiters</b> - Full Text; References Available; Peer Reviewed; Published Date: 20100101-20150131; Abstract Available; Language: English; Abstract Available; English	Interface – EBSCOhost; Research Databases; Search Screen –	18	8

	(barriers or obstacles or challenges)	Language; Publication Year: 2010-2015; Publication Type: Peer Reviewed Journal; English; Language: English; English Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; Research Article; PDF Full Text; Open Access; Year of Publication: 2010-2015; PDF Full Text; Language: English; PDF Full Text; Publication Type: Academic Journal; Language: English; Publication Type: Academic Journal; Language: English; <b>Expanders</b> - Apply equivalent subjects; <b>Search Modes</b> – Boolean/Phrase	Advanced Search. Database - AMED - The Allied and Complementary Medicine Database; MEDLINE; APA PsycInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles; Teacher Reference Center; Academic Search Complete; British Education Index; Education Abstracts (H.W. Wilson) Educational Administration Abstracts; ERIC; Child Development & Adolescent Studies		
S47	(nurse or nurses or nursing) AND	<b>Limiters</b> - Full Text; References Available; Peer Reviewed; Published Date: 20100101-20150131; Abstract	Interface – EBSCOhost;	2	1,581

	<p>postgraduate education AND (facilitators or motivators or enablers)</p>	<p>Available; Language: English; Abstract Available; English Language; Publication Year: 2010-2015; Publication Type: Peer Reviewed Journal; English; Language: English; English Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; Research Article; PDF Full Text; Open Access; Year of Publication: 2010-2015; PDF Full Text; Language: English; PDF Full Text; Publication Type: Academic Journal; Language: English; Publication Type: Academic Journal; Language: English; <b>Expanders</b> - Apply equivalent subjects; <b>Search Modes</b> – Boolean/Phrase</p>	<p>Research Databases; Search Screen – Advanced Search. Database - AMED - The Allied and Complementary Medicine Database; MEDLINE; APA PsycInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles;Teacher Reference Center; Academic Search Complete; British Education Index; Education Abstracts (H.W. Wilson) Educational Administration Abstracts; ERIC; Child Development &amp; Adolescent Studies</p>		
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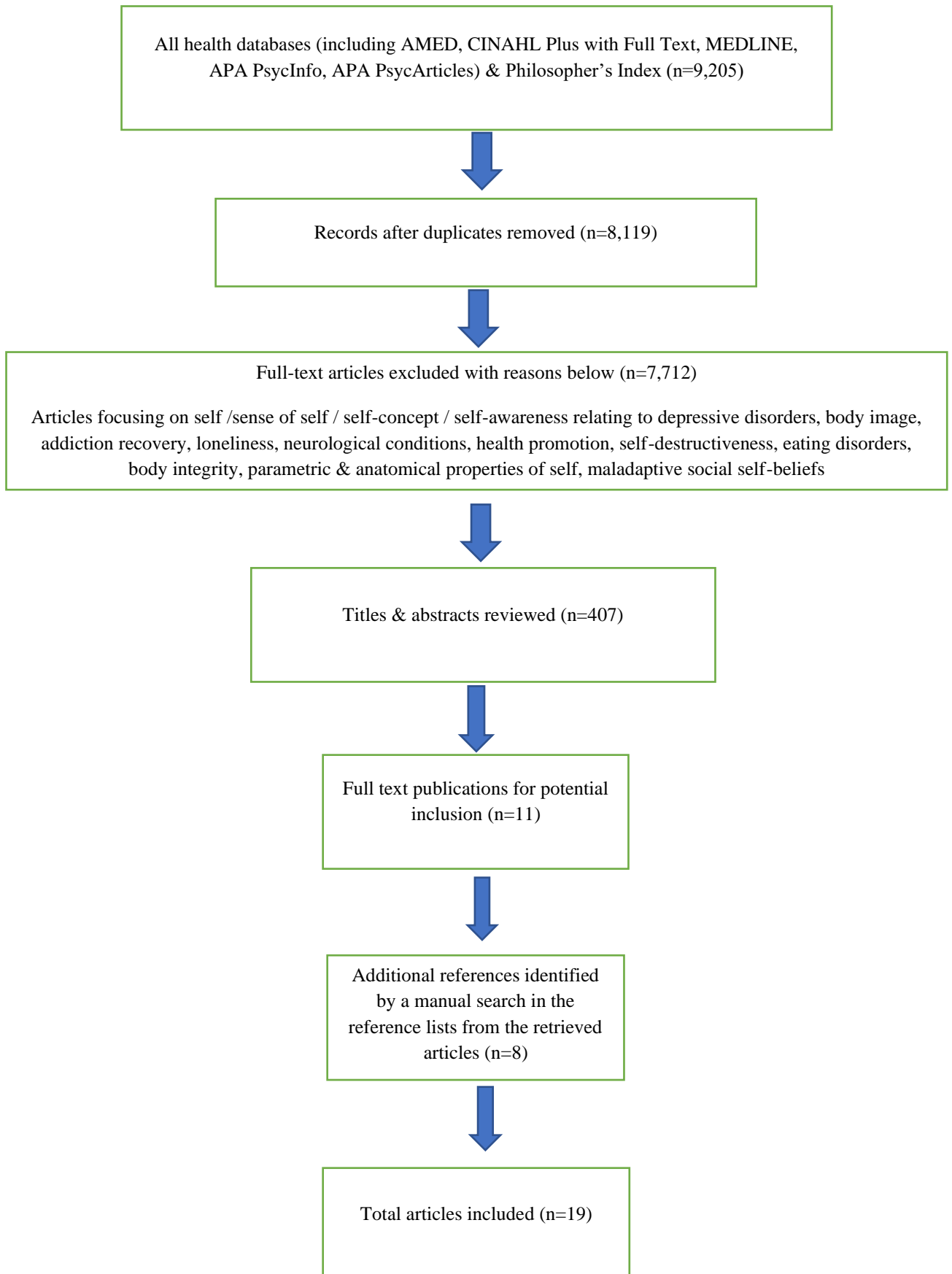
S48	Impact of education AND (nurse or nurses or nursing)	Language; Publication Year: 2010-2015; Publication Type: Peer Reviewed Journal; English; Language: English; English Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; Research Article; PDF Full Text; Open Access; Year of Publication: 2010-2015; PDF Full Text; Language: English; PDF Full Text; Publication Type: Academic Journal; Language: English; Publication Type: Academic Journal; Language: English; <b>Expanders</b> - Apply equivalent subjects; <b>Search Modes</b> – Boolean/Phrase	Database - AMED - The Allied and Complementary Medicine Database; MEDLINE; APA PsycInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles;Teacher Reference Center; Academic Search Complete; British Education Index; Education Abstracts (H.W. Wilson) Educational Administration Abstracts; ERIC; Child Development & Adolescent Studies	60	34
S49	(nurse or nurses or nursing) AND (continuing	Language; Publication Year: 2010-2015; Publication Type: Peer Reviewed Journal; English; Language: English; English Abstract	Database - AMED - The Allied and Complementary	55	41



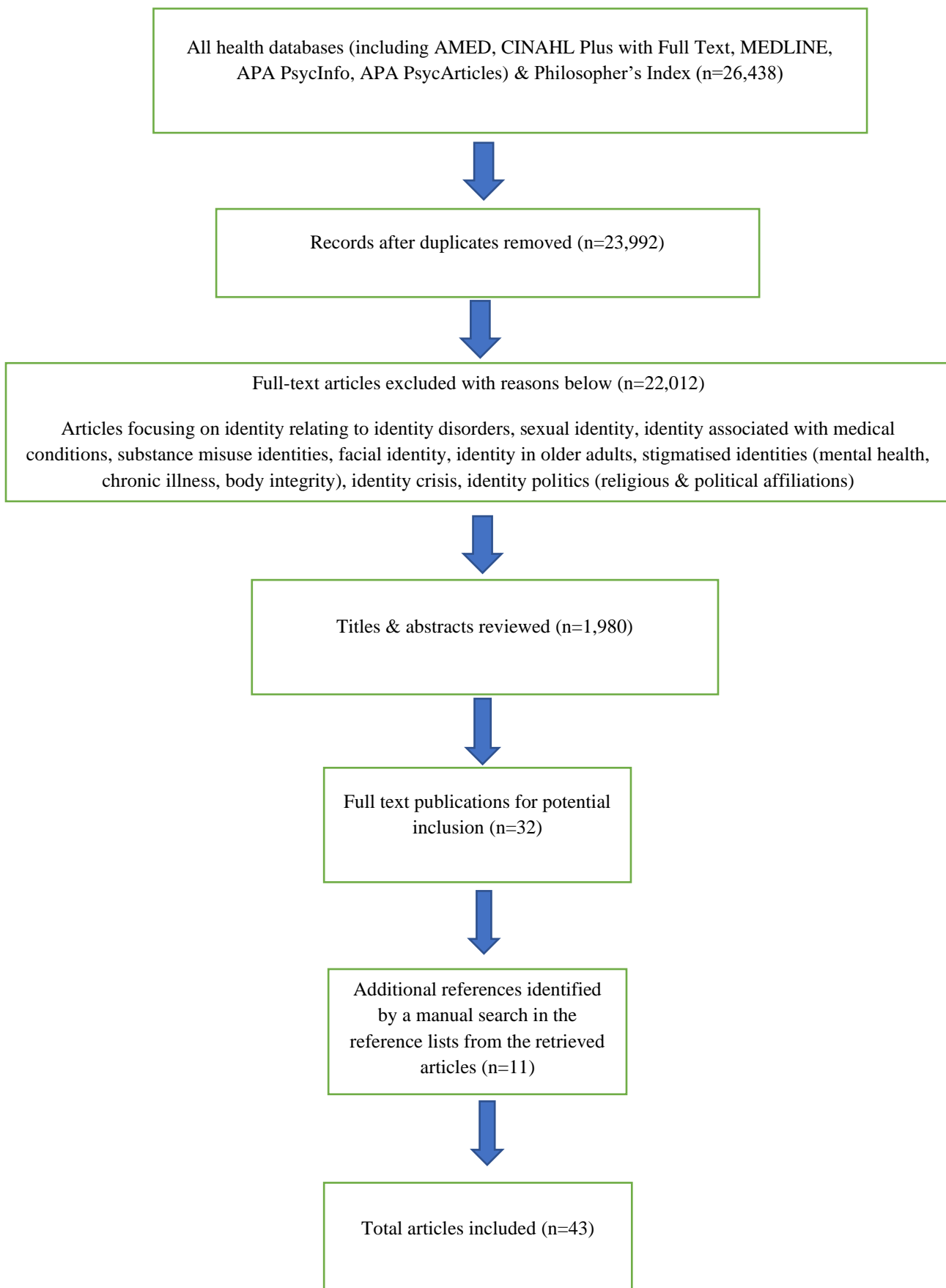
	professional development or cpd or professional development) AND (benefits or advantages or positive effects or importance or impact)	Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English Language; Research Article; PDF Full Text; Open Access; Year of Publication: 2010-2015; PDF Full Text; Language: English; PDF Full Text; Publication Type: Academic Journal; Language: English; Publication Type: Academic Journal; Language: English; <b>Expanders</b> - Apply equivalent subjects; <b>Search Modes</b> – Boolean/Phrase	Medicine Database; MEDLINE; APA PsycInfo; SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles;Teacher Reference Center; Academic Search Complete; British Education Index; Education Abstracts (H.W. Wilson) Educational Administration Abstracts; ERIC; Child Development & Adolescent Studies		
S50	(nurse or nurses or nursing) AND postgraduate education AND (benefits or advantages or positive	Language; Publication Year: 2010-2015; Publication Type: Peer Reviewed Journal; English; Language: English; English Abstract Available; Language: English; Publication Type: Academic Journal; Publication Year: 2010-2015; Abstract Available; English	Database - AMED - The Allied and Complementary Medicine Database; MEDLINE; APA PsycInfo;	26	21

	effects or importance or impact)	Language; Research Article; PDF Full Text; Open Access; Year of Publication: 2010-2015; PDF Full Text; Language: English; PDF Full Text; Publication Type: Academic Journal; Language: English; Publication Type: Academic Journal; Language: English; <b>Expanders</b> - Apply equivalent subjects; <b>Search Modes</b> – Boolean/Phrase	SPORTDiscus with Full Text; AgeLine; CINAHL Plus with Full Text; APA PsycArticles;Teacher Reference Center; Academic Search Complete; British Education Index; Education Abstracts (H.W. Wilson) Educational Administration Abstracts; ERIC; Child Development & Adolescent Studies		
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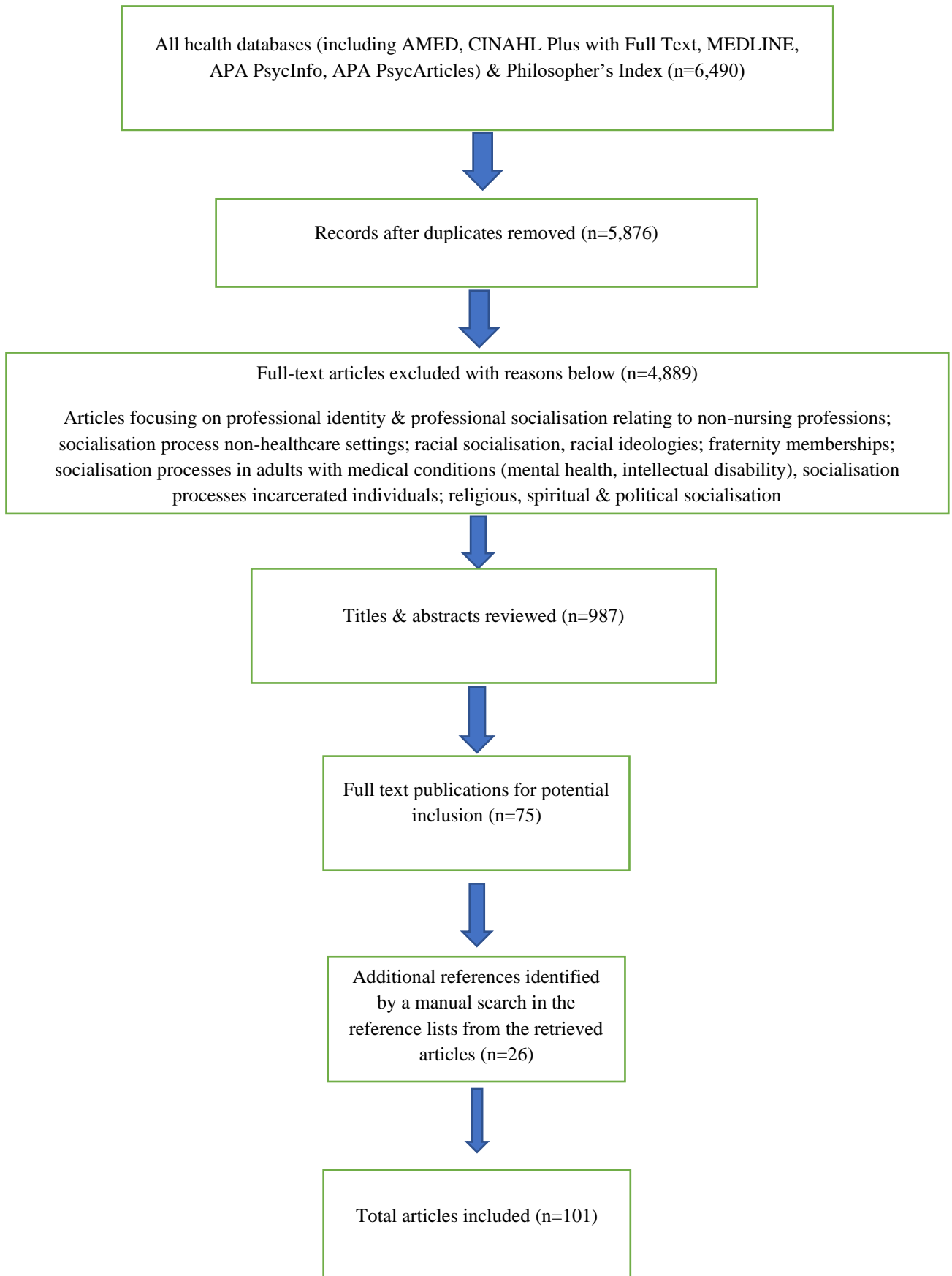
## Literature Search Flowchart – Self



## Literature Search Flowchart – Identity



## Literature Search Flowchart – Professional Identity



**Appendix 2**  
**Research Site Ethical Approval**



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive



20/12/16

Cathy Greene,

[Redacted]

[Redacted]

Co. Kildare.

**Re: Study – Self & Identity of Emergency Nurses Pursuing Higher Education**

Dear Cathy,

I am happy to inform you that the above study has been approved by the hospital's Ethics Committee.

Publications arising from research conducted in [Redacted] Hospital as approved by the Ethics Committee should include an acknowledgement to [Redacted] as a research site. The hospital supports the International Committee of Medical Journal Editors (ICMJE) criteria for authorship and contributors and expects all principle investigators to adhere to these principles.

Yours sincerely,

**Appendix 3**  
**University Ethical Approval**



**Approval Catherine Greene (PhD)**

**31 March 2017**

Dear Catherine,

The School of Education's Ethics Committee has received and considered your application for approval of your PhD research project.

It is the decision of the Committee that no additional information is needed regarding your application. Therefore, approval is granted for your research, on the condition that it is carried out as indicated on your application. Should there be a change in the design of your research project, you will need to re-apply again for approval from the School of Education's Ethics Committee.

You are required to include a copy of this letter as an appendix to your thesis.

If you have any queries regarding this decision, please contact the Chair of the School of Education's Ethics Committee and Director of Research, Dr Stephen James Minton ([mintonst@tcd.ie](mailto:mintonst@tcd.ie)).

We wish you all the very best with your research project.

Kind regards,

Fiona McKibben  
Research Officer at the School of Education  
on behalf of Professor Stephen James Minton  
Director of Research

**3088 School of Education Arts Building**  
**Trinity College Dublin, the University of Dublin**  
Dublin 2, Ireland.  
Tel | + 353 1 8963583

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3088 Scoil an Oideachais

Coláiste na Tríonóide, Baile Átha Cliath, Ollscoil Átha Cliath  
Baile Átha Cliath 2, Éire.

School of Education, Trinity College Dublin, the university of Dublin is ranked in the top 100 in the QS 2016 subject rankings.

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**Appendix 4**  
**Letter of Invitation**

## Letter of Invitation

Dear \_\_\_\_\_,

I am a part-time PhD (Education) student at Trinity College Dublin. I work as a Clinical Teaching Fellow at Keele University, and I have a background in emergency nursing.

I am writing to invite you to participate in a research study.

This study seeks to explore the decision-making strategies of emergency nurses regarding the uptake of higher education programmes. Specifically, it aims to examine the decision-making strategies using the concepts of self and identity as a basis for exploration. The study will explore the experiences of higher education participation among emergency nurses in Ireland.

You have been chosen to participate in this study as you have completed a programme or are currently completing a programme of higher education at Level 8 or above whilst employed as an emergency nurse.

Please read the enclosed participant information leaflet. This describes the nature and purpose of the study, and what participation will involve. Participation in this study is voluntary. If you decide to participate in this study, I will ask you to sign a consent form when we meet. I will discuss the research process with you further and answer any questions you may have before you sign this form.

I am undertaking this study as there has been limited research activity in this area in Ireland. I hope that the results from this research will give a voice to this group of healthcare professionals and provide a platform from which emergency nurses can tell their story. It is also envisaged that this research study will contribute to the overall body of nursing knowledge and inform higher education programme development.

Should you wish to discuss your involvement in this study, please feel free to contact me. My contact information is detailed at the end of this letter. Participation in this study is voluntary, and you may withdraw at any time up to the point of data anonymisation without penalty.

Yours sincerely,

Catherine Greene

087-274\*\*\*\* / [greeneci@tcd.ie](mailto:greeneci@tcd.ie)

**Appendix 5**  
**Participant Information Leaflet**

## **Participant Information Leaflet**

**Study Title:** Self and identity of emergency nurses who pursue higher education in Ireland

**Researcher:** Catherine Greene

### **Purpose of the Research:**

This study is being undertaken as part of a PhD (Education) programme in Trinity College Dublin under the supervision of Dr. Aidan Seery. It will explore the concepts of self and identity in relation to higher education uptake among emergency nurses. It will also explore the experiences of emergency nurses regarding higher education participation. The objective of the study is to understand the factors that influence emergency nurses to engage in higher education activities.

### **What will participation in the study involve?**

You will be asked to participate in an interview lasting approximately one hour. You will be asked a series of prepared questions in relation to your decision to pursue higher education and your experiences of participation in higher education. This meeting will take place at a time and venue most convenient for you. The researcher may ask to meet you on a second occasion in order to clarify points that were raised in the first interview. The interviews will be audio-recorded so that the researcher can make an accurate record of the discussion for her research. Your name will not be used in the recording and will not be included in the interview transcripts. A copy of the interview transcript will be provided to each research participant.

### **Who can take part in the study?**

You are invited to participate in this study if

- You are a registered general nurse
- You are employed in the Emergency Department
- You have undertaken or are currently undertaking a higher education programme of study at Level 8 or above related to nursing or healthcare on either a full-time or a part-time basis

### **Who cannot take part in this study?**

- Registered nurses who are not employed in the Emergency Department
- Registered nurses who are employed in the Emergency Department but who have not undertaken a programme of study at Level 8 or above, or who have undertaken or undertaking Level 8 or above study in non-nursing or non-healthcare programmes

### **Benefits**

There is no promise or guarantee of any direct benefit from participation in this research. However, the study will provide emergency nurses with an opportunity to describe the factors that influence their decision-making regarding higher education participation and their experiences of participation.

**Risks**

There are no anticipated risks associated with participating in this study.

**Confidentiality**

Confidentiality will be maintained throughout the research process. Your identity will be protected through the use of a pseudonym. Your name will not appear in any report, paper or publication. All information supplied during the research process will be held in confidence. All data will be securely stored. Access to data will be restricted to the researcher and to the researcher's supervisor, Dr. Aidan Seery.

**Compensation**

This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails the rights of those who take part in the study. There is no payment for participation in this study.

**Voluntary Participation**

You do not have to take part in this study but may volunteer to do so. If you agree to take part, you may withdraw at any time up to the point of data anonymisation without penalty.

**Permission**

This research has been granted ethical approval by the School of Education, Trinity College Dublin and xxxx Hospital.

**Further Information**

You can get more information about the study from the researcher at the contact details below. You can also further discuss your participation in the study with the researcher. You may contact researcher by telephone at 087-274\*\*\*\* or by email [greenecj@tcd.ie](mailto:greenecj@tcd.ie)

# **Appendix 6**

## **Participant Profile**

### Participant Profiles

Pseudonym	Professional Qualifications	Academic Qualifications
Alexandra	RGN, RANP, RNP	PG Dip Nursing (Emergency); MSc Nursing (Clinical Practice); Grad Cert (Advanced Practice) Dip Nurse Prescribing (Medicinal Products & Ionising Radiation)
Viv	RGN, RM	PG Dip Nursing (Emergency); Dip Supervisory Management
Michelle	RGN	PG Dip Nursing (Emergency)
Holly	RGN	PG Dip Nursing (Emergency)
Jennifer	RGN	PG Dip Nursing (Emergency)
Jane	RGN, RM	BSc Nursing Management; PG Dip Nursing (Emergency); MSc Nursing
Natalie	RGN, RANP, RNP	PG Dip Nursing (Emergency); MSc Nursing (Advanced Practice); Dip Nurse Prescribing (Medicinal Products & Ionising Radiation)
Kerry	RGN	PG Dip Nursing (Emergency)
Julie	RGN	PG Dip Nursing (Emergency)
Kim	RGN, RANP, RNP	PG Dip Nursing (Emergency); MSc Nursing (Advanced Practice); MSc Nursing (Preventative Cardiology); Dip Nurse Prescribing (Medicinal Products & Ionising Radiation)
Olivia	RGN	BSc Nursing Management; PG Dip Nursing (Emergency)
Yvonne	RGN	PG Dip Nursing (Emergency); MSc Nursing



Emily	RGN, RSCN	PG Dip Nursing (Emergency); Dip Infection Control; Dip Supervisory Management
Molly	RGN	PG Dip Nursing (Emergency); MSc Nursing; FFNMRC SI
Gemma	RGN, RM	PG Dip Nursing (Emergency)
Ellen	RGN	BSc Nursing; PG Dip Nursing (Emergency)
Maria	RGN	PG Dip Nursing (Emergency)
Emma	RGN, RANP, RNP	PG Dip Nursing (Emergency); MSc Nursing; Grad Cert Advanced Practice; Dip Nurse Prescribing (Medicinal Products & Ionising Radiation); FFNMRC SI
Joy	RGN	PG Dip Nursing (Emergency)
Alison	RGN	PG Dip Nursing (Emergency)
Sue	RGN	PG Dip Nursing (Emergency)
Pauline	RGN	PG Dip Nursing (Emergency); MSc Nursing (Clinical Practice)

**Appendix 7**  
**Consent Form**

<b>Name of Researcher</b>		
Catherine Greene	087-274****	greenecj@tcd.ie
<b>Title of Study</b>		
Self and identity of emergency nurses who pursue higher education in Ireland		
<b>Purpose of Study</b>		
<p>This study is being undertaken as part of a PhD (Education) programme in Trinity College Dublin under the supervision of Dr. Aidan Seery. It will explore the concepts of self and identity in relation to higher education uptake among emergency nurses. It will also explore the experiences of emergency nurses regarding higher education participation. The objectives of the study are to explore if emergency nurses' sense of self, identity, and professional identity influence higher education decision-making, and to explore if higher education informs these areas. Also, to explore other powers that influence higher education decision-making, and to uncover the experiences of emergency nurses who pursue programmes of higher education.</p>		
<b>Role of Participant</b>		
<p>As an emergency nurse, you have been asked to voluntarily participate in this research study as you have undertaken, or are currently undertaking, an educational programme of study at Level 8 or above. You will be invited to participate in an interview with the researcher, of approximately one hour's duration, where your experiences of higher education and the factors that influenced your decision to engage in higher education will be discussed and explored. Interview questioning will be conducted in a sensitive manner. Participation in this study is voluntary. You have the right to withdraw from the study at any time up to the point of data anonymisation without penalty.</p>		
<b>Management of Research Data</b>		
<p>The data generated from the interviews will be anonymous. As a participant, you will be allocated a pseudonym by the researcher; the pseudonym key will be held by the researcher only. The generated data will be stored on two password protected USB keys, one of which will be stored privately in a locked drawer at the researcher's home, the second USB key will be stored</p>		

securely by the research supervisor. The data will be retained for 13 months following completion of the PhD programme in accordance with University regulations. It is envisaged that the research findings will be disseminated through journal publications and conference presentations.

**Please read and complete this form carefully. If you are willing to participate in this study, circle the appropriate responses and sign and date the declaration at the end. If you do not understand anything and would like further information, please contact the researcher.**

1.	I have read and understood the information about the research study, as provided in the information sheet.	Yes / No
2.	I have been given an opportunity to ask questions about the research study and my participation.	Yes / No
3.	I voluntarily agree to participate in the research study.	Yes / No
4.	I understand that I can withdraw at any time and that I will not be penalised for withdrawing nor will I be questioned on why I have withdrawn.	Yes / No
5.	The procedures regarding confidentiality and anonymity have been clearly explained to me.	Yes / No
6.	The use of data in research, publications, and archiving has been explained to me.	Yes / No
7.	I understand that a research supervisor will have access to the data and will preserve the confidentiality of the data as agreed within the terms specified in this form.	Yes / No
8.	I freely give my consent to participate in this research study and have been given a copy of this consent form for my own information.	Yes / No

**Name of Participant**

\_\_\_\_\_

**Signature**

\_\_\_\_\_

**Date**

\_\_\_\_\_

**Name of Researcher**

\_\_\_\_\_

**Signature**

\_\_\_\_\_

**Date**

\_\_\_\_\_

**Appendix 8**  
**Interview Schedule**

Area of Focus	Questions / Probes
Self	<p>Tell me about your background, family, journey through school</p> <p>Why did you choose nursing as a career?</p> <p>Tell me about your nurse training</p> <p>How did you manage the transition from home to hospital / university?</p> <p>Tell me about current home life</p> <p>Tell me about your postgraduate educational achievements</p>
Identity	<p>What does the term 'identity' mean to you?</p> <p>What aspects of your personal life do you relate as being part of your identity?</p> <p>Do you see yourself as a member of a social group? If so, is it a good / accurate reflection of who you are?</p> <p>What are your feelings towards group membership?</p> <p>How do you see yourself in a group?</p> <p>Are you more energised / enriched in a group situation?</p> <p>Is it important for you to be part of a social group?</p> <p>How do you view people in a social group?</p> <p>Has your social identity changed since undertaking higher education?</p>
Professional Identity	<p>What does the term 'professional identity' mean to you?</p> <p>What does it mean to be professional?</p> <p>What attributes do you have that make you professional?</p> <p>What specific knowledge, skills, values do you have that make you a professional?</p>

	<p>What factors influence your professional identity / professional identity as a whole?</p> <p>Why did you choose a career in emergency nursing?</p>
<p>Influencing Factors (disciplinary power, governmentality)</p>	<p>What factors influenced your decision to pursue higher education?</p> <p>Did you have / do you have a long-term plan?</p> <p>Were you influenced by the decision-making of your colleagues regarding higher education?</p> <p>Did the ED work context influence your decision to pursue higher education?</p> <p>Did the hospital encourage you to engage in higher education?</p> <p>What reasons do you think the hospital had for encouraging you?</p> <p>Did you feel it was expected of you to engage in higher education?</p> <p>Did you feel that the professional regulatory body encourages participation in higher education?</p>
<p>Impact of Education on Self &amp; Identity</p>	<p>Do you think having participated in programmes of higher education that it has contributed to the development / your sense of professional identity?</p> <p>Has engaging in higher education contributed to the professional identity of nursing as a whole?</p> <p>Do you think it is important for emergency nurses to engage in higher education?</p> <p>Before you commenced your programme, how did you perceive or view your ED nursing colleagues who were engaging / had engaged in higher education?</p> <p>Has higher education expanded your knowledge base / skill set?</p>

	<p>Did you feel less professional for not engaging in higher education?</p> <p>How has higher education affected you or your role?</p> <p>Do you think or behave differently?</p> <p>Do you perceive yourself differently?</p> <p>Do others perceive you differently?</p> <p>Did you experience a sense of belonging by participating in higher education?</p> <p>Do you feel more involved in the group now that you have participated in higher education?</p>
Experiences of Higher Education	<p>How did you manage the transition back into higher education?</p> <p>How did you balance the requirements of the course with work &amp; family commitments?</p> <p>What challenges did you face while undertaking this programme of study?</p> <p>What factors maintained your interest in the programme?</p> <p>What support mechanisms did you have?</p> <p>What factors aided in your determination to complete this programme of study?</p> <p>Did you experience any unplanned, unexpected or surprise moments?</p> <p>Do you feel higher education has benefited you?</p> <p>Have you plans to engage in further programmes of education?</p>



**Appendix 9**  
**Interview First and Second-coding**

## Participant No. 7 (Natalie) First Coding

Page 1

I'm the youngest of four children  
I was born late in life to my parents, they'd married late  
My mother was 32 getting married and my father was 41  
So she was 44 having me  
We lived in a very humble house in a normal housing estate  
My father worked as a gardener  
My mother was at home all the time, also doing odd jobs as well  
She did a bit of cleaning  
Very normal  
I always liked school  
I was a very quiet child, introverted  
At the same time I enjoyed the company of others  
Always did enjoy school  
I was a small fat little thing and would be bullied  
It never bothered me to be honest  
I always enjoyed school and playing with my friends  
From primary school into secondary school I was a mediocre student  
I had the ability to do good work but not always the stamina to continue with it  
I did my leaving cert in 1990 and passed that  
Did well enough I suppose but not as well as I would have hoped  
If you don't, rubbish in, rubbish out  
That was school over and done with then  
I always wanted to be a nurse  
I always liked looking after things whether it be cats or kittens  
You'd play with your dollies pretending to be a nurse  
When I was seven I had a perforated appendix  
I think I probably had peritonitis, I was in hospital for a month  
I was very sick, I had to have daily dressings and the pain and agony of it all  
I remember thinking looking at the nurse, I'm going to grow up and be one of those and  
get my own back on them  
There were two nurses that I was particularly fond of  
They were really kind to me and I thought "I could be like them too"  
Look after someone and make sure they're not in too much pain  
I probably only realised later on when I was a teenager and you're in school getting career  
advice I thought I'd like to do nursing  
I think it would be a nice job  
Plus my sister had gone on to do nursing  
For her, it was the fact that there wasn't many options out there at the time  
Looking back now, she would say she would have preferred to have gone into business  
studies  
But there wasn't money in our house to pursue a college education

Page 2

It was get out and get something that you can work at  
Get a qualification as well  
So when she was doing her training I was envious of her  
I was like "I wanted to do it first"  
Typical sibling rivalry

At the same time, I would look up to her and think “wow, it’s fabulous”  
She had the uniforms and she’d be starching her veils so “I can’t wait to be a nurse” and  
get on that path  
And to that end then, throughout secondary school I made sure to do voluntary work with  
St. Vincent de Paul and helping traveller children to read  
I was a real goody two shoes  
I used to go out and visit the elderly on a Saturday morning on my bicycle  
I’d sit listening to the stories for three hours  
Just to have it all on your CV  
I felt it’s going to be hard to get into nursing, that was back in the eighties  
It was 1990 when I did my leaving cert  
My sister had a struggle to get in  
She had done a year and a half of interviews before she got in  
There was an element then of “are you a farmer’s daughter” or “do you know a nun” or  
“do you know someone” in the nursing training programmes  
We would have been from what they would have classed as social housing background  
No real affiliation with anything  
I was always conscious “right, I have to make sure I look committed to what I want to do”  
which is to be nursing  
So that was why I picked it really  
I had this image of myself being the caregiver and everyone smiling and thanking me,  
thinking I was great really  
You could go in and help someone and they wouldn’t be giving out to you and everything  
would be fine  
Also, it had good standing in the community  
A job that you could be perceived as being someone of that had a nice job and had done  
well for themselves  
I think I had a very idealistic vision of nursing  
I liked being a caregiver, even as a child  
I liked looking after people and helping people  
My sister would have said it as well, there was no money to go to college  
I knew that filtered down  
I was the last of four, it didn’t have to be said to me  
She went back and she has done a law degree  
She’s very much into economics and politics  
I think to her it was like “I have to do something, I need a good job and this is what I’m  
going to do”  
I actually ended up going to London to train  
I had done a few rounds of interviews in Ireland and wasn’t successful at them

Page 3

I went to London in 1991  
I remember being very impressed  
My sister actually came over with me at the interview process  
It was a day long process  
It was a whole day of being interviewed and I think there were about forty of us  
You got certain exercises to do and to interact with others  
I thought that was really good, I was quite impressed with it  
So I was accepted into London and started in May 1991  
It was apprenticeship training, that was over three years

We had block for three months in college and then we were basically let loose on the wards  
My first ward was a surgical ward, a very busy ward  
On my first day, I fainted at handover, never fainted in my life before  
Banged my head, down to A&E  
First ward was a surgical ward for a few months, then back into college  
You'd have a block of maybe two, three or four weeks and then onto your medical wards for another few months  
Then you do a bit of community and you did specialities  
I did palliative care and gynae  
I loved the surgical ward though  
In third year you did a management block of three months as preparation for becoming a qualified staff nurse  
It was very enjoyable  
You had exams at the end and you had assignments throughout it and they were fine  
Made great friends, still have lifelong friends from that training programme  
Thoroughly enjoyed it, loved the life  
Lived in the nursing home, it was like another family being away from your own family  
I don't have any negative thoughts about my training  
We worked very hard  
We were classed as employees and we were paid, albeit it wasn't a great wage  
We never had any money before that so to us it was grand  
We worked hard, we did days and nights  
But you worked extremely hard and a lot was expected of you and you were basically left to run the wards in some scenarios  
Some nurses were like "oh, let the students off and let them do it, we'll relax" if they knew you were capable of it  
How they measured that I don't know but they obviously got a feel of it  
It was very enjoyable, I thoroughly enjoyed my training  
I just turned 18 and moved over to London  
My brother brought me over and left me  
I'll always remember saying goodbye to him and I was devastated  
I was devastated he wouldn't turn back  
In years passed he said he couldn't cos he wouldn't leave me there  
He said all these different people, different ethnic minorities  
Where we're coming from back then in Ireland it was rare to see anyone but Caucasian  
There was a girl from Mayo, we were all in the same boat  
It was nerve-racking but I think I'm very good at meeting people  
I'm not pushy but at the same time I know you have to make the effort

Page 4

It was tough but we all banded together, we were very close knit  
There was a lot of Irish there and definitely looked out for one another  
We helped one another getting our little rooms ready in the nurses home  
Then you'd ring home, you would miss them alright  
I'd never know how to wash anything, my mother did everything for me  
Trying to manage your finances and then you're going out, that freedom as well  
That was never a problem for me cos I always had plenty of freedom at home  
I was never stopped from doing anything  
It was hard to manage the financial aspect  
It was really all taken care of for us

Settled in, was meant to have a holiday, we started in May and were meant to have a holiday  
The messed up our holidays in June and then half of us weren't meant to get holidays so it was going to be December  
I remember that being a huge thing thinking "oh my God, I won't get home until December"  
They said "look we've made an error, you can have holidays in June but you won't get your Christmas holidays"  
I remember speaking to my brother, he said "don't be stupid, stick it out, you'll be delighted at Christmas time, you'll be home"  
It was the best move I made so I didn't go home until Christmas  
So you have that time to settle in, it took six months and then I was flying it  
There was a huge amount in my class  
There was RGN, mental handicap, psych and some midders  
I think there was 74 for the first two weeks of block and then for some lectures you came together like legal and ethical aspects of nursing  
For general nursing, there was 24  
There was 16 Irish in the group  
16 out of 24  
My natural predilection was to go towards what you know  
There was one particular girl that was English  
You know the way you make up a story about someone  
I remember looking at her thinking "oh my God, she looks so depressed and sad and lonely"  
I had her down as a drug addict  
She wasn't a t all  
She was only from down the road

Page 5

She's actually one of my best friends now  
It took a while to get to know her  
She was like "oh those Irish girls, I hate them, they won't talk to me"  
We were thinking "oh wow, she's deep, she's dark, we better not go near her"  
We did mingle  
There was a lot of Nigerians there across the disciplines, we did mingle with them and Mauritian girls  
Actually there might have been more than 24 now that I think about it  
It took time, initially you were gravitating towards your Irish compatriots  
I think there was so many Irish that we might have excluded ourselves from mixing with them initially  
It took a while, it took a few weeks to get into the zone of like it's ok to not just sit with the Irish  
You can sit with Mohamad from Nigeria or someone from Mauritius  
We were young as well, we were only 18, we'd never been outside Ireland before  
We were very open to it but it just took time  
I think it's the similarities really even when you're gravitating towards your own nationality  
You're gravitating more towards people that are from your own social stratosphere, like from the same kind of socioeconomic background  
I just think it was just what was familiar  
That gave you a certain level of security and comfort

So I qualified in 1994  
I had done my management on a vascular surgical ward  
I got a job as a staff nurse on that ward and within six months I got a senior staff nurse position there  
I worked for two years on that ward and you had to do a few little courses like mentorship, customer care and preceptorship  
I worked there for two years and then I decided I wanted to come home because everyone was moving on  
Our tight circle of friends that we had, people were starting to move forward and move on  
Some were going travelling, some were moving in with boyfriends, some were moving back home  
You're at a crunch time, you're thinking everything is changing now, what am I going to do  
Four of us lived together for two years  
We'd moved out of the nurses home after year one  
'Anne' was moving home, she got engaged  
The other two went off travelling  
So I decided I was going to come home for six months, save up a bit of money, go travelling and meet the girls  
So I came back to Ireland at the end of 1995 and I worked in the local hospital for six months  
I saved up and went travelling, the prerequisites of a 21 year old

Page 6

I went travelling to Australia for a year and worked and travelled  
I didn't do much work to be honest but it was great to broaden my horizons and see nursing in another country  
I felt when I moved back from London to Ireland and how nursing was perceived in Ireland was totally different  
I remember being so shocked, I just thought "oh my God"  
I was so shocked because I felt they felt that they were so superior an occupation or profession to what we would have perceived ourselves to be in England  
We thought "oh yeah, we're nurses and we're proud to be nurses"  
The pride in their profession was very evident in Ireland to the point that it was a bit arrogant  
When I first came home I thought "there's no need to be like this"  
I suppose my opinion is that Irish nurses are very much perceived to be well-educated worldwide  
Irish trained nurses, I think they've been given that mantle, Irish trained nurses and there's no-one like you in the world  
A lot of it is from the nuns as well  
The nuns would very much have that superiority, that God-given complex  
Not all of them, I do feel that definitely they were  
When I moved back even my sister would say "ah, sure she's English-trained"  
That's a derogatory term "ah, she's English-trained" smiling and laughing but at the same time you'd hear it  
I think she felt her knowledge and her ability were far superior than mine given her training, that she had a better training than me  
We had actually had many discussions about it  
I said "the experience I had, I would have been exposed to situations that you're never going to get"

I would say “you’re in a small backward little hospital here, sure I’ve been in London and I’ve seen things that you’re never going to see or be exposed to”  
It was pathetic really because at the end of the day we’re still both doing the same job  
The basics and essentials of nursing are still the very same  
If you don’t have a strong foundation to go from you’re going to be hopeless  
There was definitely that “I’m better than you”  
It was a standing joke sometimes but I would get thick about it sometimes

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“What do you know, sure you’re English-trained, sure I’ll go to the real nurse”  
I’d be like “go on so, go off to the real nurse”  
Nursing afforded me the opportunity to travel  
I really thank nursing for that  
Travel opens up your mind  
It really does show that there’s different people living different lives  
Just because you’re living life in one way doesn’t mean someone else’s way is any less better than yours  
The Australian way of thinking regarding nursing was on a higher level totally  
They had it figured out  
They knew they were a force to be reckoned with  
They were large in numbers and the health service needs them  
They used their voice and used it very well to have more structure to their profession  
I remember going over there and you’d only have six patients  
You’d be used to having the whole ward with one other person and you’d be covering  
They had housekeeping doing the beds  
They looked upon themselves as collaborative practice with the medical profession as well  
They weren’t handmaidens to doctors, they didn’t view themselves as an inferior profession  
They had a voice and were respected  
They were very well respected by the medical profession  
I think there’s that kind of dominance of the medical profession that’s perceived to be elitist  
All other disciplines sometimes try to align themselves with that  
I think in Australia they did collaborate but they were very much separate as well  
They said “no, these are our roles, this is our scope of practice, this is your scope of practice, we’ll meet in the middle but we’re not any less better than you”  
They had a really strong sense of professional identity  
After I left Australia I came back to the little hick country Ireland  
I worked in a county hospital for three years  
I worked on a male medical, kind of CCU ward for three years  
I was restless, I was like “oh, I want to do something”  
I wasn’t really satisfied with it  
I loved nursing, I love looking after people but it was a busy environment  
There was a lot of unease and unrest in the nursing profession coming up to 1999  
I was like “gosh, do I want to be doing this, I’m young enough, do I want to be slogging away on nights and days and shift work”  
I didn’t feel that I was giving the best care to my patients, I felt hindered in CCU  
I didn’t have the knowledge and competence to deal with the patients  
There was no-one else to deal with them  
It was a male medical ward with a six-bedded CCU  
Back then you’d have fresh MIs coming straight in, they weren’t coming through A&E

A GP could ring up or they could just land in and you were giving Streptokinase, huge fibrinolytic agents and when you look back now, you're like "oh my God"  
I wasn't happy being back in Ireland  
I just felt I'd seen a bit of the world  
I'd been in England, I'd been in Australia, I'd seen a bit of the world  
I suppose I had a bit of dissatisfaction really  
I was searching I suppose if you really look into it  
Just away from the nursing side of things, I wanted more and I just didn't know how to go about getting it  
One of the girls I was working with said "let's do our degree"  
I was like "oh my God, I'm not very good academically, I'm a practical person, I'm logical, I'm not great with airy fairy stuff"  
She was like "you'll need it now, things are changing now, you'll have to have your degree"  
I was like "can I not just do a CCU course"  
I remember applying for the CCU course in Dublin and I didn't get it  
I decided to do the degree so I started applying and then I decided no  
I decided I'd go travelling again so I went off to Saudi Arabia  
I went there and worked in a cardiology ward for three years  
They're very much based on the American education of nurses  
They're very much into maintaining competencies and updating your professional development on a regular basis  
I was exposed to a lot of in-house study days  
That was a good learning curve for me because I thought I can do it  
I didn't believe in my ability to be academic as such  
So I thought I've managed this, I can do it and people kept supporting me  
I came back to Ireland and worked in the bigger Dublin hospitals for two years

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What brought me back from Saudi is that it's a hard environment to work in  
If you're there for too long it's lonely and it's a different culture and different lifestyle  
While it's good sometimes you're frustrated with the restriction that are placed on you when you're used to being free and being valued as a woman  
You're not really valued as a woman over there  
Their camels come first and then their cows and possibly a woman after that  
You have to be quiet and you can't be voicing any of your opinions because it's a male dominated world and it's a closed environment  
After a while you realise, ok I've made a bit of money, got a lot of experience and did a lot of travel which was important to me at the time  
I needed to love my life freely and be able to do things, like drive which women aren't allowed to do  
I wanted to be able to walk down the street without having to cover my head  
It wears on you, you think "I can't do this anymore"  
You start feeling agitated and closed in and repressed  
That was my decision to come home  
I was having more down days than high days, something had to give so I decided to move home  
I suppose as well my Dad died  
He died in 2000 just before I went to Saudi  
He had been sick for a year and a half and I'd been helping to nurse him at home  
That was probably a lot of my dissatisfaction



I was frustrated, I was like "is this going to be it now"  
I have to move on  
I had discussions with my Dad and he said "I could be here for another ten years or ten days, do what you want to do"  
So I said "that's grand, I'll go" and he actually died before I went  
That was a huge thing actually, feeling caged in  
So that would have spurred me on to get out and escape  
When I came back to Ireland I worked in Dublin and I worked in Cork and started working here  
Nothing attracted me to emergency nursing whatsoever  
I was never an emergency department nurse, I'd stay clear away  
I was like "oh Christ I can't deal with that, there's no structure, there's no order, they could have anyone coming in, I can't do it"  
The nurses always seemed quite abrasive  
When I started working here you have to go where you're put  
I was put down to the A&E department and I was doing night duty  
There was very strong characters there at that time  
I was terrified, I was absolutely terrified  
"I'm just going to keep working, I'll do whatever I have to do"  
These people were workers but they'd sit down and I'd be "I don't want to sit down"  
I'd work away and then I suppose I was a worker  
I kept getting put down there, I hated it, I hated it, I was terrified  
Then after six months I loved it, something clicked in me and I just loved it

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I think the characters are abrasive because it's a hugely challenging environment in an emergency department  
They've a lot to deal with and I turned into one of those abrasive people  
I wouldn't have been at all before that  
They're dealing with life and death  
They're very humane, not abrasive in that manner  
It's the inbetween things, prolonged waiting times, patient dissatisfaction, it's the lack of resources  
They are being bombarded by peoples' angst, anger, fear and confusion  
They can't get back to caring for people which is what they're there to do  
They're trying to deal with all of this other outside noise without the support that should be in place  
I think they have to build a wall to be able to cope and manage their day and not feel too much  
If they feel too much, they'll turn into a rock and be cold and hard  
Or else they'll dissolve into massive anger or fear and not be able to function  
They were trying to balance how to be a compassionate nurse with being 'I have to manage this department'  
For every nurse, everyone was a leader, everyone had to  
You could be in one place and it could be kicking off so everyone had to stand up to the plate  
I think that's why they were abrasive  
I realised pretty quickly that I was becoming an abrasive person  
I mired myself in it for a couple of years  
Maybe within two or three years of being there, I realised I was becoming the same  
I'm becoming short with people and a little bit nippy and it wouldn't be my way

I had to protect myself from it  
I was becoming short with my colleagues and service-users  
I knew I was changing  
I would be very soft, people don't believe that but I'd have a very soft core and I'd be quite sensitive  
I went into nursing to help people and I still want to help people  
I was changing, I could feel myself changing and I was losing aspects of myself  
I think my friends at home realised  
They would say "Oh God, you're wrecked, you're tired, you're a bit short"  
I would be like "I'm not short, I'm ok"  
It made me feel sad when I realised  
And disappointed in myself that I had turned into this person that I didn't want to be  
It wasn't all the time

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It spilled into other aspects of life  
"I want a quick response, yes, no"  
My tolerance level was very low  
I didn't suffer fools gladly  
It's very sad to be that person, I don't want to be that person  
A huge factor in influencing me to pursue higher education was the clinical nurse manager 3 at the time  
She probably recognised my potential  
She kept encouraging me to go and put me forward  
She said "you need to do your A&E course, you need to do it"  
This was sixteen years after I had been in education  
I was like "Oh my God, I really don't want to do it"  
I think she saw the potential, she did encourage me  
I felt she was badgering me at the time  
But it was encouraging and great support  
People that had gone before me had stepped up their game in their competence and capabilities  
They were happy  
I wanted to be that happy person again  
I didn't want to be "ugh, I'm coming into work"  
I suppose the encouragement and support of the CNM3 and her recognition of my ability  
And the people beforehand, I could see how it changed them and their knowledge  
I was envious of their knowledge and their ability to provide a high level of care  
I was interested and put myself forward  
Even filling out the application form was a huge process for me  
I really didn't believe in my ability to be academically bright  
My mother was alive at the time and she said "oh what are you putting yourself through that for, don't do that"  
I suppose she didn't want to see me overstretching myself  
I would have liked for her to have supported me more  
Like education is good, but no  
I got a bit stubborn then and I thought "well I'll show her as well"  
So I applied and got accepted onto the A&E postgrad  
I knew I had the ability  
I was envious of other peoples' knowledge  
I admired them actually, I had great admiration for them

I thought the health service is a bit stagnant at the moment  
I was looking at my career options and looking at the bigger picture  
I definitely wanted to be a better nurse  
A huge thing was to be able to give good care to patients  
I wanted to be perceived as being someone of value  
“Natalie knows what she’s doing, we have great confidence in Natalie”

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Looking at my career pathway then, I knew I didn’t want to be in management  
I had done managerial in Saudi and I didn’t like it  
Education increased my confidence greatly  
I didn’t feel that I was an academic person  
I think that stems back to when I was younger  
Do your schoolwork, do well at it but this is your social standing  
Don’t go rising above it  
My mother and father were grafters and I don’t think they grasped that you can rise above  
where you’ve come from  
It really gave my self-esteem a great boost  
I felt proud of myself and I thought “well done, you’ve done well for yourself, you’ve  
managed this”  
Every assignment I had to do, I was like “ok, I can do it”  
It gave me that inner fight to kind of make yourself a better person  
Educate yourself a little more  
It opened my mind to education and the importance and value of it  
It does raise your self-esteem and confidence  
It does make make you perceive to be someone of note  
My friends are like “aren’t you great”  
It’s not that you’re seeking validation from anyone  
It gives you something that’s hard to quantify  
It definitely increased my confidence and my ability to pursue education  
I knew hard work, you have to put work in  
Anything that’s worth doing will be worth doing well  
It did help my self-esteem  
My intention wasn’t to excel  
My intention was like “oh Jesus, let me get through this”  
I said Novenas, I said prayers, I said everything  
I had everyone praying for me  
It wasn’t to excel but then once I engaged in it, I wanted to excel  
I suppose the competitiveness came out in me as well  
I was competing against myself  
That little voice that was saying “oh you’re useless, don’t be doing it”  
I think that stems from your upbringing as well  
I can do it, look I have done it  
I think the plan at the time was to be a CNM2  
I was happy to go that management route as management in A&E is different to ward level  
In A&E you’re still very much clinical  
My plan was to get a CNM2

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You had to have the post grad to qualify for that post  
That was the plan at the time for a career pathway

That did transpire then after that as well  
There was various posts coming up  
I'd been working as a staff nurse and I'd went for two interviews and I didn't get them  
Then I went for a third one and got it, it was for a permanent post  
I worked as a CNM2, I was delighted, I was so happy  
I was so proud of myself and I enjoyed the leadership side of things and the nurturing of other nurses  
Because I had education  
I think my CNM3 was great in that I valued her recognition of me  
So I would look at others, recognise their abilities and encourage them  
I liked that aspect of the CNM2 role  
I took great pride in my work making sure the unit was running efficiently and everyone was happy in their jobs and got their breaks  
There was a good team spirit when you'd be on  
That's very challenging in an emergency department but you can do it  
It's hard work but you can do it  
I thoroughly enjoyed the role for maybe a year and a half  
After that I started getting burnout because I was setting myself up too high to achieve things with resources that were so depleted  
I was getting brittle again  
I was like "oh my God, here we go again, I'm getting abrasive, I've no patience"  
There was stuff going on in family life as well  
My mother was ill  
These are kind of turning points in my life  
She knew I had the CNM2 post and was delighted for me  
Then she got ill and subsequently passed away  
It was kind of an awakening for me  
I thought "right, you don't have your mother to complain about anymore"  
I had a void in my life I suppose after she died because I had looked after her as well  
It was a huge undertaking and the dynamics of family life were hard as well  
Before she died I had suffered with depression  
I got depressed and worked through that  
After she died I said "right, you have to pull yourself together now, you have to have a plan"  
I decided I want to stay in nursing  
I enjoy looking after people, I'm feeling far removed from looking after people in the post of a CNM2  
My time is taken up with other things such as bed management meetings and trying to source staff and trying to sort the dynamics between other staff members  
I was coming further and further away from the patient and it wasn't making me happy  
I didn't want to be doing that so I decided to look at other avenues  
I went back to the education board  
I could see there was a need in our ED for patients with prolonged waiting times  
There was two advanced nurse practitioners non-life non-limb threatening posts  
They were covering everything from broken bones, arms to elbows, knees to toes  
I didn't want that element of it  
I spoke with them and they told me about the advanced practice element of it and the autonomy that comes with it  
I was scared about that because the accountability and responsibility is huge  
At the same time I knew I would be well able for it because I was taking on so much responsibility as a CNM2

I saw there was a need for a new service initiative in the area of assessment and treatment of patients coming with non-traumatic abdominal pain, cellulitis, things like that  
They were having prolonged waiting times, they were turning away from ED, there were second visits and whatnot  
I could see as well that patients weren't being managed properly by some of our doctors  
It frustrated me, I was very frustrated  
I thought I could do as good a job, if not better  
I was seeing that the level of care being given to patients was substandard  
Not across the board but a lot of the time it was  
A lot of the time the nurses had done the work and the doctor just came in and said "no, you're fine, go home"  
Nothing was explained and the nurses have done all the work but not getting any of the recognition or nay of the satisfaction of doing the job well  
Seeing the patient from start to finish and knowing that everything is done properly for them  
Then you'd see these people coming back in again and you would know that this was going to happen because the doctor hasn't treated them right, hasn't given them the right instructions or right treatment  
I felt I could do this with the proper training  
I'd looked into the advanced nurse practice module and applied for it  
I went to my director of nursing and consultant and they were very much on for it  
My director of nursing said "that's fine, you're the driver of this vehicle, so drive it, I'll be here if you need support but you drive it"  
So I went and did it  
I undertook the advanced nurse practitioner in emergency nursing with ionising radiation and prescribing of medicinal products  
That was a masters over two years  
I was still questioning my academic ability  
What attracted me to it was that the Masters element of it, the academic research element, was in the second year  
I thought the first year is really going to be loaded with clinical which I love  
There were plenty of assignments as well, it was a tough year but I loved it  
I blossomed again, that shroud of despair was falling away from me  
Within a few weeks I felt I'd found my niche, I'm happy  
I loved engaging with college I have to say, I loved it

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It was just so empowering, it really was  
It was the lecturers we met, the advanced nurse practitioners  
They were so inspiring  
You could see they were happy  
It was that job satisfaction that they were getting  
I wanted that and I knew I was going to get it  
After a week I knew I was going to be satisfied  
I'm going to be able to achieve what I want to achieve for patients  
Take responsibility and be accountable  
It'll be down to me, I won't have to chase everyone else to do their job  
It really empowered me, it gave me back my passion for looking after people and wanting to do well  
It reconfirmed for me that my pathway is to be at the patient's bedside  
To be hands-on with the patient but at an advanced level

I didn't want to be doing it at the level that I had been doing it at  
I felt I had lost some of my skills because of the constraints on us  
The lack of resources and what not  
It's such a huge transition  
I was at the top of my game as an emergency nurse, I was banging out triages  
People would come to me for advice and support  
I felt bombarded at times but I was good and able to manage it  
I went from being at the top of my game from being an expert and into advanced practice  
I realised I was actually a novice, I wasn't as shit hot as I thought  
I realised there's so much I don't know and that things can go wrong  
It's that accountability and I was like "my God, I don't know anything really"  
That didn't knock my confidence but it opened up my eyes  
I realised this is what the doctors have been doing all these years  
Some of them are still not doing it right  
It didn't knock my confidence but it made me vulnerable  
I felt what could go wrong and the fear of mistreating someone was huge  
But that's drilled into you on the course, it isn't for everyone  
Everyone thinks "oh yeah, an advanced nurse practitioner, we'll see the patients we want to see"  
You're the one calling the shots, you're the one that's responsible if you send them home

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Going from novice to expert at this stage after how many years  
My vulnerability was how I was perceived by the staff I worked with  
I was still in the same department but I was in a different role  
You had to step back from the role that you had been in  
Had to get peoples' perceptions of you to change so I felt vulnerable  
I thought they are going to think I'm useless now  
I felt my professional identity was changing  
I would take some ownership of it because you have to  
When you are transitioning from that role you have to step back from what you were doing  
To achieve an advanced level you can't do task orientated stuff  
You try to think at a higher level and look at all angles of your decision-making skills  
You have to stand back, you really have to separate  
It was a slow and painful process  
I didn't want to see my colleagues stuck  
I wanted to help them and I did step in  
Whether they perceived it as help I don't know  
I knew I had to step out again very quickly because I was damaging my relationship with them  
They felt I was abandoning them  
I was going to be damaging my new relationship with my collaborative practice, my medical colleagues  
I think that's where your professional identity and where your vulnerability comes in as well  
You're straddling the fence of nursing and medicine  
Like doctors would come to me and say see this patient, see that patient  
I'm not in this area anymore, I can't help you  
They're teaching you about advanced physical assessment and critical thinking  
There is that element where you have to sit down and talk things through so they don't come to you and ask you to do other tasks that you would have done previously

You have to make a concerted effort not to go back to do those tasks  
They'll think Natalie is not too interested now  
I've wasted my time giving her my knowledge, she's back doing whatever  
I'll just tell her to do this urinalysis or do this or do that and it'll be fine  
It was straddling both disciplines, it was tough initially but I had great support from the  
other ANPs  
They said it was going to be tough but you have to persevere  
I did persevere and it was fine  
Nursing management want you in a role and they want all the glory associated with it  
At the same time they want to pull you out of it and you can't be doing two jobs  
You're either employed for one job or the other job

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You have to remember I went through depression  
I'd lost my mother and I was so sad  
I always wanted to be a nurse and I was happy doing it but I found my niche  
I'm good at this and I've got huge job satisfaction from being able to care for a patient  
from post-triage to discharge  
It's a great responsibility and I'd wake up at night worried, did I do the right thing  
You're looking at the system for weeks after to make sure if they were coming back in  
Did I do the right thing  
I'd accomplished the Masters side of things  
I did very well in that and the research, I was thrilled with myself  
People looked at me differently, I knew people looked at me differently because I had a  
masters  
I didn't feel different but I felt empowered  
I've done this and I've challenged myself, I rose to the challenge, it gives you something  
My sense of self-worth and my belief in myself has risen greatly without having a huge  
head  
I still feel very vulnerable and exposed but I think it's good to feel like that  
You reflect on your practice and you reflect on your capabilities and competencies  
You can never be too blasé in that role  
One mistake and it could someone's life or my career  
I was so nervous about the whole thing  
I remember going with my niece and nephew to get highlighters and things  
I remember her giving me a pencil case and getting my school bag ready  
I was so nervous about it all  
And I'm IT challenged, I'm much better now  
The expense of it too, I had to buy a laptop  
That was really frightening, the IT side of things  
There's so much support out there from education institutions and your colleagues  
My colleagues were great but it was still nerve-wracking and I was questioning myself, my  
ability  
Am I good enough, it's like these two people talking, I must be bipolar maybe  
It was this constant battle and you just had to steady herself  
I gravitated to two lovely people in the course, we were all of a similar ilk  
They were much younger but we got on great  
We travelled up together and shared that expense as well

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I suppose family commitment was my mother

She was the main thing and a great support at that time  
She's have dinner ready, I would just have to block off time and say to people that I  
wouldn't be available  
I managed it ok but it was stressful looking back  
That was a very stressful time trying to manage all that  
It was very rewarding and I got on great with others on the course  
We supported one another, you get one another through it  
The academic writing was a huge challenge for me  
I didn't understand it  
We had a research component, there wasn't enough of it  
I didn't really understand the referencing  
It was only when I was doing the masters and ANP that it was like driving a car, you get it  
It kind of came together but that was a huge challenge, the academic side  
Writing, critical thinking, doing assignments was a challenge  
Whereas clinically, I'm pretty good, I'm excellent I suppose  
I can learn algorithms  
It was that higher level of critical thinking  
When you're doing an assignment, that's a huge skill and it takes time  
You have to nurture it, you have to keep at it  
It was just the volume you had to read and expose yourself to  
I think it's invaluable, it's definitely an essential component  
What kept me going was pure pig-headedness and stubbornness  
I really enjoyed it, I could see the value of the course and I could see that I was going to  
add to the service  
I could see that my job satisfaction was going to be huge as well  
There's not much remuneration for it and I've sacrificed a lot for it monetary wise  
But there's remuneration at the end so your wage will go up  
The job satisfaction, the hours are better, no shift work  
The opportunities that will be available to me because emergency nursing and nursing in  
general is evolving so quickly  
We have a huge workforce that we're going to have to meet the demands that are on the  
health service  
They're exploring that avenue at the moment  
I know I want to be at that table, I want to be involved

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I want to be able to continue at a high level  
High quality care to patients when they need it, in the right time & setting  
I think nursing is a great job and I think it should be advocated  
We see the bad side of it, we hear about the bad stories too often  
But there's huge positives to the nursing profession and we should be proud to be nurses  
There was group work with people that we didn't know  
There was six of us in the group and there was a huge issue with plagiarism  
I got embroiled in that, that had a huge impact on me because I was so annoyed  
I was made that someone had done that and had jeopardised my grade with their  
thoughtless ness  
It soured me actually towards the education institution because they didn't deal with it very  
fair  
I suppose they did looking back, their hands were tied but it worked out fine for me in the  
end



It's interesting when new people come in and they don't know you when you were a CNM2 or staff nurse  
Your relationship with them is so free and easy in comparison to your relationships with your colleagues  
They're a bit wary of me, my older colleagues whereas the newer colleagues they'll ask my opinion  
They consult me about certain cases and they'll ask me about information  
They know I've a good grasp of the mechanics of A&E and certain protocols and the proper way to do things  
They'll turn to me for guidance  
My older colleagues are a bit wary, don't let her see you doing this or that  
I would stand up and say that's not the right way to do things  
Definitely my relationships with them have changed totally  
We're not as cohesive, they view me as separate  
I'm in advanced practice now, they don't view me as part of the emergency department team  
I think it's hilarious

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I think that's the transition process  
It's your professional identity you're trying to grapple with  
You're changing that so you have to stand back  
When you're standing back from your colleagues, you're still there but that's their transition  
It's how they perceive it  
I think some of them would be a little wary of me, some of them then are very accepting  
Part of the role of an advanced nurse practitioner is research, education and leadership so I would be continually engaging in further education  
I'm doing research at the moment and will publish the results of the research  
I don't feel part of a particular social group  
There is a group for advanced nurse practitioners and midwives and there is that association  
I don't feel part of that group  
I don't know to be honest  
I think I'm still grappling with my professional identity  
Maybe I'm waiting for someone to touch me on the shoulder  
What are you doing, are you really an advanced nurse practitioner  
I'd have huge admiration for them and their experience  
Maybe I don't value my level of competence and capabilities as much as I should do  
I don't yet affiliate myself with them  
I think that's slowly changing now because if people ask what I do, I say I'm an advanced nurse practitioner  
Identity means your sense of self, your ego, your beliefs, your values  
My sense of self is the make up of me, my mind, where I want to be and my workplace environment

Page 19

I've a great relationship with my friends, they're like family to me  
My family is quite small  
I walk a lot, trying to get fit, hill-walking

Professional identity means I want to be seen as an excellent nurse, advanced nurse practitioner  
Capable of giving high-quality care to patients  
I want to be identified as a resource that is cornerstone of the emergency department  
There to provide support and to provide encouragement for future role development and the development of the nursing profession  
I think to be professional you have to be capable, competent, accountable and responsible  
You have to be innovative as well  
You have to be a leader, we need more leadership  
I think it's very important to put yourself as a leader and not a follower  
To be proud of your nursing profession  
I don't think you have to keep your professional identity separate, we can happily co-exist  
Be courteous, respectful and dignified in your dealings with your staff and patients and colleagues  
I suppose I have a higher level of expert skills that I use like advanced physical assessment  
Consultation with patients, critical thinking, clinical decision-making  
You have your competencies as well, my ability to perform certain procedures and to perform them well  
Suturing, incision and drainage  
The advanced physical assessment thing and the attributes, I'm steady, I'm consistent  
And pride, you have to take pride in your work  
If you lose pride what are you doing it for at the end of the day  
Participating in higher education has enhanced my sense of professional identity  
I think it's the exposure to other academics, it has definitely enhanced

Page 20

I've come from a certificate and doing nothing for sixteen years  
You're gaining your skills and your competencies  
It definitely has enhanced the professional identity of nursing  
I think they do wonderful work in colleges and universities, they've so much resources  
It's important for emergency nurses to engage in higher education because the care we deliver to our patients is changing  
There's different methods of delivering care, evidence-based care is so important  
It can change from one month to the next month  
With best practices being identified it's very important to keep on top of that  
Or else you're giving substandard care to patients  
I admired them greatly, envious of them  
I perceived them to be really intelligent  
I really admired them  
They were aspirational, I really admired them and was envious of them as well  
I wanted to be part of that group  
I was never afraid of being left behind as I had been in a stagnant position for sixteen years  
I was a great nurse, well able to do jobs  
I was happy until it was put up to me by my CNM3  
I was never afraid of being left behind  
I would have felt less professional for not having done higher education  
For social identity I want to be perceived in a nice way, I don't want people to think that I'm not a nice person  
I would value what other people, people that I care about, how they would perceive me  
I'm not too bothered as a whole if people that I don't know perceive me to be something that I am or am not

That's everyone's prerogative  
Nobody has to like everyone else  
I would value other peoples' opinion of me

Page 21

I've great friends, my friends have been friends since we were teenagers  
I know from a social standing that we'd be viewed that way  
They're so and so's friends  
I like to be part of a group  
I don't like to be the follower  
I would be classed more as a leader but I like to be able to move in and out of a group  
I like to be fluid  
My friends say I need my quiet time  
When we were training she would say that  
I need time, I need time for me  
I need time to reflect, I like my own company  
I don't really feel energised by being in a group, may be sometimes  
I find my own motivation energises me  
I find the encouragement and support of my friends really good and spurs you on, gives you motivation  
My friends say I'm a mini doctor, I'm not, I'm an advanced nurse practitioner  
You have to say it over and over again, sometimes they laugh at me  
Not in a nasty way, I just let it go  
I'm delighted that I have my masters but that's not what it is all about  
It's the job satisfaction really  
I know my brother perceives me as being different  
My niece and nephew have seen me go back to college  
One of them has started their own college journey and they look up to me  
They come to me for advice  
I know they can see the value of what I've done  
They've seen me get up at five in the morning and finishing at twelve  
They've seen that over the last two years and working full-time  
They see if you need something, you have to work hard  
I think my social identity has changed in how people perceive me

Page 22

The hospital encourage me very much for both of my courses, I didn't find any obstacles  
They were obliging and I didn't encounter any obstacles  
For the postgrad I did feel it was expected to engage in higher education but not for the advanced nurse practice  
They see a service need and they're also looking at government strategies  
They're supportive and they like to have a new service initiative  
Nursing as a profession is really at the forefront of trying to change the service that we provide to patients  
They want the glory of a new service  
I do think nursing management want that as well  
They don't understand the role in its full capacity  
I don't think anyone can understand the role until you're working in it  
They're looking at ways to meet the demands of the health service and it's challenging  
But they do want the glory as well

The professional body does encourage nurses, they're always encouraging and the newsletters that go out  
I think they could play a bigger role  
I thoroughly enjoyed it, especially the ANP and masters  
It's really opened my eyes to the value of education and continuing education  
I think it's important that we push ourselves  
Education for me gives you that sense of higher self-esteem and confidence in your ability  
It's very important

**Participant No. 7 (Natalie) First Coding (Peer-debriefer)**

Pg. 1

I'm the youngest of four children, older sister and brothers  
I was born late in life to my parents, they'd married late  
My mother was 32 and my father was 41 when they got married  
She was 44 having me  
We lived in a normal housing estate  
My father worked as a gardener  
My mother was at home all the time, also doing odd jobs as well  
I always liked school  
I was a very quiet child  
I enjoyed the company of others  
I enjoyed school  
I would be bullied  
It never bothered me  
I always enjoyed school and playing with my friends  
I was a mediocre student in primary and secondary school  
I had the ability to do good work but not always the stamina  
I did my leaving cert in 1990  
Did well enough but not as well as I would have hoped  
I always wanted to be a nurse  
I always liked looking after things  
You'd play with your dollies pretending to be a nurse  
I had a perforated appendix when I was seven  
I was in hospital for a month  
I was very sick, I had to have daily dressings  
I remember the nurse, I'm going to grow up and be one of those and get my own back on them  
There were two nurses that I was fond of  
They were really kind to me, "I could be like them too"  
Look after someone  
I probably only realised later on when I was a teenager I'd like to do nursing  
I think it would be a nice job  
Plus my sister was doing nursing  
For her, there wasn't many options out there at the time  
She would say she would have preferred to have gone into business studies  
There wasn't money in our house to pursue a college education

Pg. 2

Get something that you can work at  
Get a qualification as well  
I was envious of my sister doing her training

“I wanted to do it first”  
Typical sibling rivalry  
At the same time, I would think “wow, it’s fabulous”  
She had the uniforms and so “I can’t wait to be a nurse” and get on that path  
Throughout secondary school I did voluntary work with St. Vincent de Paul and helping  
traveller children to read  
I was a goody two shoes  
I used to go out and visit the elderly on a Saturday morning on my bicycle  
I’d sit listening to the stories for hours  
Just to have it on my CV  
It was hard to get into nursing, back in the eighties  
I did my leaving cert in 1990  
My sister struggled to get in  
She had done a year and a half of interviews before she got in  
“Are you a farmer’s daughter” or “do you know a nun” or “do you know someone” to get  
into nursing training programmes  
We would have been from social housing background  
No real affiliation with anything  
I was always conscious to look committed to do nursing  
So that was why I picked it really  
I had this image of myself being the caregiver and everyone smiling and thanking me  
You could go in and help someone  
Also, it had good standing in the community  
A job that you could be perceived as being someone who had a nice job and had done well  
I had a very idealistic vision of nursing  
I liked being a caregiver  
I liked looking after and helping people  
There was no money to go to college  
I knew that filtered down  
I was the last of four  
My sister has done a law degree  
She’s very much into economics and politics  
For her it was “I have to do something, I need a good job and this is what I’m going to do”  
I went to London to train  
I had done a few rounds of interviews in Ireland and wasn’t successful

Pg. 3

I went to London in 1991  
My sister actually came over with me at the interview process  
It was a whole day of being interviewed  
There were certain exercises to do  
I thought that was good, I was quite impressed with it  
I was accepted in London and started in May 1991  
It was apprenticeship training over three years  
We had block for three months in college and then we were basically let loose on the  
wards  
My first ward was a surgical ward  
On my first day, I fainted at handover  
Banged my head, went down to A&E  
First ward was a surgical ward for a few months, then back to college  
You’d have a block of maybe two, three or four weeks and then onto your medical wards

Then you did community and you did specialities  
I did palliative care and gynae  
In third year you did a management block in preparation for becoming a staff nurse  
You had exams at the end and you had assignments throughout  
Made great friends, still have lifelong friends  
Lived in the nursing home, it was like another family being away from your own family  
I don't have any negative thoughts about my training  
We worked very hard  
We were employees and we were paid, it wasn't a great wage  
We never had any money before that so to us it was grand  
We worked hard  
A lot was expected of you and you were basically left to run the wards in some scenarios  
Some nurses were like "oh, let the students off and let them do it, we'll relax" if they knew  
you were capable of it  
I don't know how they measured that but they obviously got a feel of it  
It was very enjoyable, I thoroughly enjoyed my training  
My brother brought me over and left me  
I'll always remember saying goodbye to him and I was devastated  
I was devastated that he wouldn't turn back  
He said he couldn't  
He said all these different people, different ethnic minorities  
In Ireland it was rare to see anyone but Caucasian  
There was a girl from Mayo  
We were all in the same boat  
It was nerve-racking but I'm very good at meeting people  
I know you have to make the effort

Pg. 4

It was tough but we were very close knit  
There was a lot of Irish there, looked out for one another  
We helped one another  
You would ring home, you would miss them  
My mother did everything for me  
Trying to manage your finances, that freedom as well  
That was never a problem for me, I always had plenty of freedom at home  
I was never stopped from doing anything  
It was hard to manage the financial aspect  
We started in May and were meant to have a holiday  
The messed up our holidays in June so it was going to be December  
I remember that being a huge thing  
I remember speaking to my brother, he said "stick it out, you'll be delighted at Christmas  
time, you'll be home"  
I didn't go home until Christmas  
It took six months to settle in and then I was flying it  
The class was big, there was RGN, mental handicap, psych and some midders  
For general nursing, there was 24  
There was 16 Irish in the group, 16 out of 24  
My natural predilection was to go towards what you know  
There was one particular girl that was English  
I remember thinking "oh my God, she looks so depressed and sad and lonely"  
I thought she was a drug addict

She wasn't, she was only from down the road

Pg. 5

She's one of my best friends now  
It took a while to get to know her  
She was like "oh those Irish girls, I hate them, they won't talk to me"  
We did mingle  
There was a lot of Nigerians there, we did mingle with them and Mauritian girls  
Initially you were gravitating towards your Irish compatriots  
There was so many Irish that we might have excluded ourselves from mixing  
It took a few weeks to get into the zone  
You can sit with someone from Nigeria or someone from Mauritius  
We were young as well, we were only 18, never been outside Ireland before  
It just took time  
You're gravitating more towards people that are from your own social stratosphere  
The same kind of socioeconomic background  
It was just what was familiar  
That gave you security and comfort  
I qualified in 1994  
I did my management on a vascular surgical ward  
I got a job as a staff nurse on that ward and within six months I was a senior staff nurse  
I worked for two years on that ward and did courses like mentorship, customer care and preceptorship  
I worked there for two years and then I decided I wanted to come home  
People were starting to move forward and move on  
Some were going travelling, and others were moving in with boyfriends and moving back home  
Four of us lived together for two years  
I decided to come home for six months, save up a bit of money, and go travelling  
So I came back to Ireland at the end of 1995 and I worked in the local hospital for six months  
I saved up and went travelling

Pg. 6

I went travelling to Australia for a year and worked  
It was great to broaden my horizons and see nursing in another country  
When I moved back from London to Ireland nursing perceived differently in Ireland  
I remember being so shocked  
I felt they felt that they were so superior to what we would have perceived ourselves to be in England  
We thought "we're nurses and we're proud to be nurses"  
The pride in their profession was very evident in Ireland, it was a bit arrogant  
There's no need to be like this  
My opinion is that Irish nurses are very much perceived to be well-educated worldwide  
Irish trained nurses, there's no-one like you in the world  
A lot of it is from the nuns as well  
The nuns would very much have that superiority  
Not all of them  
When I moved back my sister would say "she's English-trained"  
That's a derogatory term and laughing but at the same time you hear it  
I think she felt her knowledge and her ability were far superior than mine

We had many discussions about it  
I would have been exposed to situations that you're never going to get  
I would say "you're in a small backward little hospital here, sure I've been in London and I've seen things that you're never going to see or be exposed to"  
At the end of the day we're still both doing the same job  
The basics and essentials of nursing are still the very same  
It was definitely that "I'm better than you"  
It was a standing joke but I would get thick about it sometimes

Pg. 7

Nursing afforded me the opportunity to travel  
I thank nursing for that  
Travel opens up your mind  
It really does show that there's different people living different lives  
The Australian way of thinking regarding nursing was on a higher level totally  
They knew they were a force to be reckoned with  
They were large in numbers and the health service needs them  
They used their well to have more structure to their profession  
You'd be used to having the whole ward with one other person  
They had housekeeping doing the beds  
They looked upon themselves as collaborative practice with the medical profession  
They weren't handmaidens to doctors, they didn't view themselves as an inferior profession  
They had a voice and were respected  
They were very well respected by the medical profession  
There's a kind of dominance of the medical profession that's perceived to be elitist  
All other disciplines sometimes try to align themselves with medicine  
I think in Australia they did collaborate but they were very much separate as well  
These are our roles, this is our scope of practice and this is your scope of practice  
They had a really strong sense of professional identity  
After I left Australia I came back to Ireland  
I worked in a county hospital for three years  
I worked on a male medical, kind of CCU ward for three years  
I was restless  
I wasn't really satisfied with it  
I loved nursing, I love looking after people, it was a busy environment  
There was a lot of unease and unrest in the nursing profession coming up to 1999  
I didn't feel that I was giving the best care to my patients, I felt hindered in CCU  
I didn't have the knowledge and competence to deal with the patients  
Back then you'd have fresh MIs coming straight in, they weren't coming through A&E  
A GP could ring up or they could just land in and you were giving Streptokinase, huge fibrinolytic agents and when you look back now, you're like "oh my God"  
I wasn't happy being back in Ireland  
I'd been in England, I'd been in Australia, I'd seen a bit of the world  
I suppose I had a bit of dissatisfaction really  
I was searching I suppose if you really look into it  
I wanted more and I just didn't know how to go about getting it  
One of the girls I was working with said let's do our degree  
I'm not very good academically, I'm a practical person, I'm logical  
She said things are changing now, you have to have your degree  
I applied for the CCU course in Dublin and I didn't get it



I decided to do the degree so I started applying and then I decided not to do it  
I decided I'd go travelling again, I went off to Saudi Arabia  
I worked in a cardiology there for three years  
They're based on the American education of nurses  
They're very much into maintaining competencies and updating professional development  
That was a good learning curve for me because I thought I can do it  
I didn't believe in my ability to be academic as such  
I've managed this, I can do it and people were supporting me  
I came back to Ireland and worked in the bigger Dublin hospitals for two years

Pg. 8

Saudi is that it's a hard environment to work in  
It's lonely and it's a different culture and lifestyle  
While it's good sometimes the restrictions that are placed on you when you're used to  
being free and being valued as a woman  
You're not really valued as a woman over there  
Their camels come first and then their cows  
You have to be quiet and you can't be voicing any of your opinions because it's a male  
dominated world  
I've made a bit of money, got experience and did a lot of travel which was important to me  
at the time  
I needed to live my life freely and be able to do things  
I wanted to be able to walk down the street without having to cover my head  
It wears on you  
You start feeling agitated and repressed  
I was having more down days than high days, something had to give so I decided to move  
home  
I suppose as well my Dad died  
He died in 2000 just before I went to Saudi  
He had been sick for a year and a half and I'd been helping to nurse him at home  
That was probably a lot of my dissatisfaction  
I was frustrated, I have to move on  
I had discussions with my Dad he actually died before I went  
That was a huge thing actually, feeling caged in  
When I came back to Ireland I worked in Dublin and Cork and started working here  
Nothing attracted me to emergency nursing whatsoever  
I was never an emergency department nurse  
I was like "oh Christ I can't deal with that, there's no structure, there's no order, they could  
have anyone coming in, I can't do it"  
The nurses always seemed quite abrasive  
When I started working here you have to go where you were put  
I was put down to the A&E department and I was doing night duty  
There was very strong characters there at that time  
I was terrified  
These people were workers but they'd sit down and I didn't sit down  
I suppose I was a worker  
I hated it, I hated it, I was terrified  
Then after six months I loved it, something clicked in me and I just loved it

Pg. 9

I think the characters are abrasive because it's a hugely challenging environment in an  
emergency department

They have a lot to deal with and I turned into one of those abrasive people  
I wouldn't have been at all before that  
They're dealing with life and death  
They're very humane, not abrasive in that manner  
It's the prolonged waiting times, patient dissatisfaction, and lack of resources  
They are being bombarded by peoples' anxst, anger, fear and confusion  
They can't get back to caring for people which is what they're there to do  
They're trying to deal with all of this other outside noise without support  
I think they have to build a wall to be able to cope and manage their day  
If they feel too much, they will be cold and hard  
They'll dissolve into massive anger or fear and not be able to function  
They were trying to balance how to be a compassionate nurse with managing the department  
For every nurse, everyone was a leader  
Everyone had to stand up to the plate  
I think that's why they were abrasive  
I realised I was becoming an abrasive person  
I mired myself in it  
Within two or three years I realised I was becoming the same  
I was becoming short with people and it wouldn't be my way  
I had to protect myself  
I was becoming short with my colleagues and service-users  
I would be very soft, people don't believe that but I'd be quite sensitive  
I went into nursing to help people and I still want to help people  
I could feel myself changing and I was losing aspects of myself  
I think my friends at home realised  
I would be like "I'm not short, I'm ok"  
It made me feel sad and disappointed in myself when I realised that I had turned into this person

Pg. 10

It spilled into other aspects of life  
My tolerance level was very low  
I didn't suffer fools gladly  
I didn't want to be that person  
A huge factor in influencing me to pursue higher education was the clinical nurse manager  
3  
She recognised my potential  
She kept encouraging me and put me forward  
She said "you need to do your A&E course"  
This was sixteen years after I had been in education  
I was like "Oh my God, I really don't want to do it"  
I think she saw the potential, she did encourage me  
I felt she was badgering me at the time but it was encouraging and great support  
People that had gone before me had stepped up their game in their competence and capabilities  
They were happy and I wanted to be that happy person again  
The encouragement and support of the CNM3 and her recognition of my ability  
I could see how it changed people beforehand and their knowledge  
I was envious of their knowledge and their ability to provide a high level of care  
I was interested

Filling out the application form was a huge process  
I really didn't believe in my ability to be academically bright  
My mother was alive at the time and she said "oh what are you putting yourself through that for, don't do that"  
She didn't want to see me overstretching myself  
I would have liked for her to support me  
Education is good, but no  
I got a bit stubborn then and I thought I'll show her  
I applied and got accepted onto the A&E postgrad  
I knew I had the ability  
I was envious of other peoples' knowledge  
I had great admiration for them  
I thought the health service is a bit stagnant  
I was looking at my career options and looking at the bigger picture  
I definitely wanted to be a better nurse  
A huge thing was to be able to give good care to patients  
I wanted to be perceived as being someone of value  
"Natalie knows what she's doing, we have great confidence in Natalie"

Pg. 11

I knew I didn't want to be in management  
I had done managerial in Saudi and I didn't like it  
Education increased my confidence greatly  
I didn't feel that I was an academic person  
I think that stems back to when I was younger  
Do your schoolwork, do well at it but this is your social standing  
Don't go rising above it  
My mother and father were grafters and I don't think they grasped that you can rise above where you've come from  
It really gave my self-esteem a great boost  
I felt proud of myself and I thought "well done, you've done well for yourself, you've managed this"  
Every assignment I had to do, "ok, I can do it"  
It gave me that inner fight to kind of make yourself a better person  
Educate yourself a little more  
It opened my mind to education and the importance of it  
It does raise your self-esteem and confidence  
It does make make you to be someone of note  
My friends think I'm great  
You're not seeking validation from anyone  
It gives you something that's hard to quantify  
It increased my confidence and my ability to pursue education  
You have to put work in  
Anything that's worth doing will be worth doing well  
It did help my self-esteem  
My intention wasn't to excel but just to get through it  
I said Novenas, I said prayers, I said everything  
I had everyone praying for me  
It wasn't to excel but once I engaged in it, I wanted to excel  
I suppose the competitiveness came out in me as well  
I was competing against myself

That little voice that was saying “oh you’re useless, don’t be doing it”  
I think that stems from your upbringing as well  
I can do it, look I have done it  
I think the plan at the time was to be a CNM2  
I was happy to go that management route as management in A&E is different to ward level  
In A&E you’re still clinical  
My plan was to be a CNM2

Pg. 12

You had to have the post grad to qualify for that post  
That was the plan at the time  
There was various posts coming up  
I’d been working as a staff nurse and I’d went for two interviews, I didn’t get them  
Then I went for a third interview and got it  
I was delighted, I was so happy  
I was so proud of myself, I enjoyed the leadership and the nurturing of other nurses  
Because I had education  
I think my CNM3 was great, I valued her recognition of me  
I would look at others, recognise their abilities and encourage them  
I took great pride in my work making sure the unit was running efficiently and everyone  
was happy in their jobs  
There was a good team spirit  
That’s very challenging in an emergency department  
It’s hard work but you can do it  
I thoroughly enjoyed the role for maybe a year and a half  
I started getting burnout because I was setting myself up too high to achieve things with  
resources that were so depleted  
I was getting brittle again  
I was getting abrasive, no patience  
There was stuff going on in family life  
My mother was ill  
These are kind of turning points in my life  
She knew I had the CNM2 post and was delighted for me  
Then she got ill and subsequently passed away  
It was kind of an awakening for me  
I didn’t have my mother to complain about anymore  
I had a void in my life I suppose after she died because I had looked after her  
It was a huge undertaking and the dynamics of family life were hard  
Before she died I had suffered with depression  
I got depressed and worked through that  
After she died I said I had to pull myself together and have a plan  
I wanted to stay in nursing  
I enjoy looking after people, I’m feeling far removed from looking after people in the post  
of a CNM2  
My time is taken up with things such as bed management meetings and trying to source  
staff and trying to sort the dynamics between other staff  
I was coming further and further away from the patient and it wasn’t making me happy  
I decided to look at other avenues  
I could see there was a need in our ED for patients with prolonged waiting times  
There was two advanced nurse practitioners non-life non-limb threatening posts  
They were covering broken bones but I didn’t want that element of it

They told me about the advanced practice element of it and the autonomy  
I was scared about that because the accountability and responsibility is huge  
At the same time I knew I would be well able for it  
I saw there was a need for a new service initiative in the area of assessment and treatment  
of patients coming with non-traumatic abdominal pain, cellulitis  
They were having prolonged waiting times, there were second visits and whatnot  
I could see that patients weren't being managed properly by some of our doctors  
It frustrated me  
I thought I could do as good a job, if not better  
I was seeing that the level of care being given to patients was substandard  
The nurses had done the work and the doctor just came in and said "no, you're fine, go  
home"  
Nothing was explained and the nurses have done all the work but not getting any of the  
recognition or any of the satisfaction of doing the job well  
Seeing the patient from start to finish and knowing that everything is done properly for  
them  
Then you'd see these people coming back in again and you would know that this was  
going to happen because the doctor hasn't treated them right or given them the right  
instructions or treatment  
I felt I could do this with the proper training  
I looked into the advanced nurse practice module and applied for it  
I went to my director of nursing and consultant and they were very much on for it  
My director of nursing said that was fine and that she would support me  
So I went and did it  
I undertook the advanced nurse practitioner in emergency nursing with ionising radiation  
and prescribing of medicinal products  
That was a masters over two years  
I was still questioning my academic ability  
What attracted me to it was that the masters element of it  
I thought the first year is really going to be loaded with clinical which I love  
There were plenty of assignments as well, it was a tough year but I loved it  
I blossomed again, that shroud of despair was falling away from me  
Within a few weeks I felt I'd found my niche, I'm happy  
I loved engaging with college I have to say, I loved it

Pg. 13

It was empowering  
It was the lecturers we met and the advanced nurse practitioners  
They were inspiring  
They were happy  
They had job satisfaction  
I wanted that, I knew I was going to get it  
I knew I was going to be satisfied  
I'm going to achieve what I want for my patients  
I wanted to take responsibility, be accountable  
I wouldn't have to chase everyone else to do their job  
It empowered me, gave me back my passion for looking after people  
It reconfirmed for me that I wanted to be at the patient's bedside, at an advanced level  
I didn't want to be doing it at the level I had been doing it at  
I felt I had lost some of my skills, constraints of resources  
It's a huge transition

I was at the top of my game  
People would come to me for advice and support  
I felt bombarded at times but I was good and able to manage  
I went from being at the top of my game from being an expert into advanced practice  
I realised I was a novice, I wasn't as shit hot as I thought  
I realised there's so much I don't know, things can go wrong  
It's that accountability and I don't know anything really  
That didn't knock my confidence but it opened up my eyes  
I realised this is what the doctors have been doing  
Some of them are still not doing it right  
It didn't knock my confidence but it made me feel vulnerable  
The fear of mistreating someone was huge  
But that's drilled into you on the course, it isn't for everyone  
Everyone thinks the advanced nurse practitioner sees the patients they want to see  
You call the shots, you're the one responsible

Pg. 14

Going from novice to expert  
My vulnerability was perceived by the staff I worked with  
I was still in the same department but in a different role  
You have to step back from the role that you had been in  
Peoples' perceptions of you to change so I felt vulnerable  
I felt my professional identity was changing  
I would take some ownership of it  
When you are transitioning from that role you have to step back  
To achieve the advanced level you can't do task orientated stuff  
You try to think at a higher level and look at your decision-making skills  
You have to stand back, have to separate  
It was a slow process  
I didn't want to see my colleagues stuck  
I wanted to help them  
I knew I had to step out again very quickly  
They felt I was abandoning them  
I would be damaging my new relationship with my medical colleagues  
That's where your professional identity and vulnerability comes in  
Straddling the fence of nursing and medicine  
Like doctors would come to me and say see this patient  
I'm not in this area anymore  
They teach you about advanced physical assessment and critical thinking  
You have to make a concerted effort not to do those tasks  
They'll think Natalie is interested now  
I've wasted my time giving her my knowledge  
I'll just tell her to do this urinalysis or and it'll be fine  
It was straddling both disciplines, it was tough but I had great support from the other ANPs  
They said it was going to be tough, persevere  
I did persevere, it was fine  
Nursing management want you in that role and they want all the glory associated with it  
They also want to pull you out of it and you can't do two jobs  
You're either employed for one job or the other

Pg. 15

I went through depression  
I'd lost my mother, I was so sad  
I always wanted to be a nurse but I found my niche  
I'm good at this and have huge job satisfaction from being able to care for a patient from  
post-triage to discharge  
It's a great responsibility but I'd wake up at night worried, did I do the right thing  
Did I do the right thing  
I'd accomplished the masters  
I did very well in that, I was thrilled with myself  
People looked at me differently because I had a masters  
I didn't feel different but I felt empowered  
I've done this and I've challenged myself, I rose to the challenge  
My sense of self-worth and my belief in myself has risen greatly  
I still feel very vulnerable and exposed but I think it's good to feel like that  
You reflect on your practice and you reflect on your capabilities  
You can never be too blasé in that role  
One mistake and it could someone's life or my career  
I was so nervous about the whole thing  
I remember going with my niece and nephew to get things  
I remember her giving me a pencil case and getting my school bag ready  
I was so nervous about it all  
I was IT challenged, I'm much better now  
It was expensive too, I had to buy a laptop  
That was really frightening, the IT  
There's so much support out there from education institutions and your colleagues  
My colleagues were great but I was questioning myself and my ability  
Am I good enough, it's like these two people talking, I must be bipolar maybe  
It was this constant battle and you just had to steady yourself  
I gravitated to two people in the course, we were all of a similar ilk  
They were younger but we got on well  
We travelled up together and shared expenses

Pg. 16

Family commitment was my mother  
She a great support at that time  
She would have dinner ready  
I would just have to block off time and say to people that I wouldn't be available  
I managed it ok but it was stressful  
That was a very stressful time trying to manage  
It was rewarding and I got on great with others on the course  
We supported one another, you get one another through it  
The academic writing was a huge challenge for me  
I didn't understand it  
We had a research component  
I didn't really understand the referencing  
It was only when I was doing the masters and ANP, you get it  
It kind of came together but that academic side was a huge challenge  
Writing, critical thinking, doing assignments was a challenge  
I'm pretty good clinically, I'm excellent I suppose  
I can learn algorithms

It was that higher level of critical thinking  
It takes time to do an assignment, that's a huge skill  
You have to nurture it, you have to keep at it  
It was just the volume you had to read  
I think it's invaluable, it's definitely an essential  
What kept me going was pure pig-headedness and stubbornness  
I really enjoyed it, I could see the value of the course and what I was going to add to the service  
I could see that my job satisfaction was going to be huge  
There's not much remuneration for it and I've sacrificed a lot for it monetary wise  
But there's remuneration at the end  
The job satisfaction, the hours are better and no shift work  
Opportunities will be available to me because emergency nursing and nursing in general is evolving quickly  
We have a huge workforce, we have to meet the demands on the health service  
They're exploring that avenue  
I know I want to be at that table and I want to be involved

Pg. 17

I want to continue at a high level  
High quality care to patients when they need it  
I think nursing is a great job and it should be advocated  
We see the bad side of it, we hear about the bad stories too often  
There's huge positives to the nursing profession and we should be proud to be nurses  
There was group work with people that we didn't know  
There was a huge issue with plagiarism  
I got embroiled in that and it had a huge impact on me, I was so annoyed  
I was mad that someone had done that and had jeopardised my grade with their thoughtlessness  
It soured me actually towards the education institution because they didn't deal with it fairly  
Their hands were tied but it worked out fine for me in the end  
It's interesting when new people come in and they don't know you when you were a CNM2 or staff nurse  
Your relationship with them is so free in comparison to your relationships with your colleagues  
My older colleagues are a bit wary of me whereas the newer colleagues will ask my opinion  
They consult me about certain cases  
They know I've a good grasp of A&E and certain protocols and the proper way to do things  
They turn to me for guidance  
My older colleagues are a bit wary, don't let her see you doing this or that  
I would stand up and say that's not the right way to do things  
Definitely my relationships with them have changed  
We're not as cohesive, they view me as separate  
I'm in advanced practice now, they don't view me as part of the team  
I think it's hilarious

Pg. 18

That's the transition process



It's your professional identity you're trying to grapple with  
You're changing so you have to stand back  
When you're standing back from your colleagues, you're still there  
I think some of them would be a little wary of me and some are very accepting  
Part of the role of an advanced nurse practitioner is research, education and leadership so I  
would be continually engaging in further education  
I'm doing research at the moment and will publish the results of the research  
I don't feel part of a particular social group  
There is a group for advanced nurse practitioners and midwives  
I don't feel part of that group  
I think I'm still grappling with my professional identity  
Maybe I'm waiting for someone to touch me on the shoulder  
Are you really an advanced nurse practitioner  
I'd have huge admiration for them and their experience  
Maybe I don't value my level of competence and capabilities  
I don't yet affiliate myself with them  
I think that's slowly changing now, I'm an advanced nurse practitioner  
Identity means your sense of self, your ego, your beliefs, your values  
My sense of self is the make-up of me, my mind, where I want to be and my workplace  
environment

Pg. 19

I've a great relationship with my friends, they're like family to me  
My family is quite small  
I walk a lot, trying to get fit  
Professional identity means I want to be seen as an excellent nurse and advanced nurse  
practitioner  
Capable of giving high-quality care to patients  
I want to be identified as a resource in the emergency department  
Provide support and encouragement for future role and profession  
To be professional you have to be capable, competent, accountable and responsible  
You have to be innovative as well  
You have to be a leader, we need more leadership  
It's very important to be a leader and not a follower  
Be proud of your profession  
Be courteous, respectful and dignified in your dealings with your staff and patients  
I have a higher level of expert skills that I use like advanced physical assessment  
Consultation with patients, critical thinking and clinical decision-making  
You have your competencies as well, my ability to perform certain procedures well  
Suturing, incision and drainage  
I'm steady and consistent with advanced physical assessment thing  
You have to take pride in your work  
If you lose pride what are you doing it for  
Participating in higher education has enhanced my sense of professional identity  
It's the exposure to other academics, it has definitely enhanced

Pg. 20

I've come from a certificate and doing nothing for sixteen years  
I'm gaining skills and competencies  
It definitely has enhanced the professional identity of nursing  
They do wonderful work in colleges and universities, they have many resources

It's important for emergency nurses to engage in higher education because the care delivered to patients is changing  
There's different methods of delivering care, evidence-based care is so important  
It can change  
It's very important to keep on top of best practices  
Or else you're giving substandard care to patients  
I admired them greatly, envious of them  
I perceived them to be really intelligent  
They were aspirational, I really admired them and was envious of them  
I wanted to be part of that group  
I was never afraid of being left behind as I had been in a stagnant position for sixteen years  
I was a great nurse  
I was happy until it was put up to me by my CNM3  
I would have felt less professional for not having done higher education  
I want to be perceived in a nice way, I don't want people to think that I'm not a nice person  
I would value how other people perceive me, people that I care about  
I'm not too bothered as a whole how other people that I don't know perceive me  
That's their prerogative  
Nobody has to like everyone else  
I would value other peoples' opinion of me

Pg. 21

I've great friends, friends since we were teenagers  
I know from a social standing that we'd be viewed that way  
I like to be part of a group  
I don't like to be the follower  
I would be classed more as a leader but I like to be able to move in and out of a group  
My friends say I need quiet time  
I need time for me  
I need time to reflect, I like my own company  
I don't always feel energised by being in a group  
My own motivation energises me  
The encouragement and support of my friends gives you motivation  
My friends say I'm a mini doctor, I'm an advanced nurse practitioner  
You have to say it over and over again, sometimes they laugh at me  
Not in a nasty way  
I'm delighted that I have my masters  
It's the job satisfaction really  
I know my brother perceives me differently  
My niece and nephew have seen me go back to college  
One of them has started their own college journey, they look up to me  
They come to me for advice  
They can see the value of what I've done  
They've seen that and working full-time  
They see if you need something, you have to work hard  
I think my social identity has changed in how people perceive me

Pg. 22

The hospital encouraged me for my courses, I didn't find any obstacles  
They were obliging

For the postgrad I did feel it was expected to engage in higher education but not for the advanced nurse practice  
They see a service need and government strategies  
They're supportive and they like to have a new service initiative  
Nursing as a profession is really at the forefront of trying to change the service we provide to patients  
They want the glory of a new service  
They don't understand the role  
I don't think anyone can understand the role until you're working in it  
They're looking at ways to meet the demands of the health service, it's challenging  
But they want the glory as well  
The professional body does encourage nurses, they're always encouraging  
They could play a bigger role  
I enjoyed it, especially the ANP and masters  
It opened my eyes to the value of education and continuing education  
I think it's important that we push ourselves  
Education gives you that sense of higher self-esteem and confidence in your ability  
It's very important

# **Appendix 10**

## **Coding Template**

Raw Data	Preliminary Codes	Codes	Category	Theme
<p>So at the time it was a good time in my life. My children were at an age where I could devote time to study. Em, I didn't have a postgraduate diploma and I liked emergency nursing. I didn't want to be left behind. I mean, I know I was one of the first to undertake a postgraduate diploma but I didn't want to be left behind (Holly)</p> <p>The timing was good as they weren't little tiny tots running around the place and then I was mature as well. You're a little bit more secure in your life as well, you're more mature and you've done a lot in life. You come to a stage where this is my time, it's your space, it's yours to make what you want out of it, like that was my time to do what I wanted to do (Viv)</p> <p>Well I suppose when I started in ED, I suppose I was there two or three years before I'd undertaken it [postgraduate diploma] and part of that, there were a few other girls</p>	<p>It was a good time in my life I could devote time to study as my children were older I liked emergency nursing I didn't want to be left behind</p> <p>Timing was good as my children were older I was mature I was secure This was my time to do what I wanted</p> <p>I was in ED two or three years before I undertook the postgraduate diploma Others had done it</p>	<p>Right time in life personally &amp; professionally</p> <p>Feeling left behind</p> <p>Right time in life personally</p> <p>Right time in life professionally Influence of other colleagues</p>	<p>Timing</p> <p>Security</p> <p>Timing</p> <p>Timing Colleague Influence</p>	<p>Desire for Self-Affirmation</p>

<p>that had done it so I suppose like observing them, their competency areas, I wanted to be able to have that knowledge base and know the rationale of how to manage things (Alison)</p>	<p>I liked observing their competency areas I wanted that knowledge base</p>	<p>Admiration for others' competencies Desire for further knowledge</p>	<p>Educational Development &amp; Advancement</p>	
<p>I knew it was going to take me from the stress of work life and the stress of home life (Jennifer)</p> <p>I had a void in my life I suppose after she [mother] died because I had looked after her as well and even though she was in hospital the last three months, it was a huge undertaking and the dynamics of family were hard as well at the time. I think after she died, before she died I suffered with depression, I got depressed and worked through that and then after she died I said 'right, you have to pull yourself together, you have to have a plan' (Natalie)</p>	<p>It was going to take me away from the stress of work and home life</p> <p>I had a void in my life when my mother dies Family dynamics were hard at the time I suffered from depression before she died I worked through my depression I needed to pull myself together and have a plan</p>	<p>Distraction</p> <p>Distraction</p> <p>Right time in life personally</p>	<p>Timing</p> <p>Timing</p>	
<p>I think, yeah, I think coming from a working-class family and I went as a day pupil to a boarding school where I suppose they were all well-to-do and this feeling of being told,</p>	<p>I came from a working-class family I was a day pupil at a boarding school</p>	<p>Social background Recognition of own potential</p>	<p>Challenging Traditional Social Legacies</p>	

<p>I remember my Mum being told that I was too laxadazical. I got grinds at one particular time and the grinds teacher told my Mum ‘God, it’s hopeless’ so it’s, you know, self-driven learning now, maybe I have a point to prove to myself now, you know (Kim)</p>	<p>My Mum was told I was laxadazical The grinds teacher told my Mum I was hopeless It’s self-driven learning now I have a point to prove to myself now</p>	<p>Self-worth  Social background Parental influence</p>		
<p>I didn’t feel that I was an academic person and I think that probably stems back to when I was younger, you know. Like, do your schoolwork, do well at it but, you know, maybe this is your social standing, you know, don’t go rising above it and my mother and father, they were grafters and I don’t think they grasped that you can rise above where you’ve come from, em, and definitely I think the challenge that I put myself through it and excelled at it to be honest, it gave me that inner fight to make yourself a better person, you know. That little voice was saying ‘oh you’re useless, don’t be doing it.’ And I think that stems from your upbringing a little bit as well, you know, ‘I can do it, look I have done it.’ (Natalie)</p>	<p>I didn’t feel I was an academic person That stems from when I was younger Do well at your schoolwork This is your social standing Don’t go rising above it My parents didn’t grasp that you can rise above where you came from I put myself through that challenge I excelled at it It gave me the inner fight to be a better person That little voice said ‘you’re useless, don’t be doing it’ That stems from your upbringing</p>	<p>Better myself Self-worth Self-esteem  Social background Better myself Parental influence Self-worth Recognition of own potential  Pride Parental influence  Parental influence</p>		

<p>It is for me, I wanted to do it. I suppose it's to do with my upbringing. I'm the oldest. When my Dad died we didn't have any money. All my friends were either going to be teachers or doctors or accountants or whatever. There was nothing there and I knew I had to achieve something. I knew I had to better myself. I suppose it empowered me to go ahead and just find what I could be best at (Jane)</p> <p>Well going back to college was a massive thing as well, you know. I remember telling my cousin 'I'm going to University', that was massive, you know. I told everyone, everyone who would listen to me I told, you know. Mum and Dad were so proud of me on my graduation day, you know (Sue)</p> <p>My mother would have said, em, my mother would have said 'do your general and go on and do something else' so it wasn't acceptable that I just had one</p>	<p>I can do it, I have done it</p> <p>I wanted to do it It's to do with my upbringing When my Dad died we didn't have money I knew I had to achieve something I had to better myself It empowered me to go ahead and find what I could be best at</p> <p>Going back to college was a massive thing I told everyone My parents were so proud of me on my graduation day</p> <p>My mother said I should do something else after my general training</p>	<p>Parental influence Self-belief Recognition of own potential</p>		
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<p>course done so I suppose I was influenced that way (Holly)</p> <p>I really didn't believe in my ability again, you know, to be academically bright, em, and my mother was alive at the time and she was like 'oh, why are you putting yourself through that for, don't do that', you know. I suppose she didn't want to see me overstretching myself but I would have liked for her to have supported me more and encourage, you know. Like education is good, but no. So I suppose I got a bit stubborn then and I thought 'well, I'll show her as well' (Natalie)</p>	<p>It wasn't acceptable that I just had one course done I was influenced that way</p> <p>I didn't believe in my ability to be academic My mother asked why I was putting myself through it She didn't want to see me overstretching myself I would have liked her support and encouragement Education is good I got stubborn I thought 'I'll show her'</p>			
<p>I knew there was something more in me, you know, self-fulfilment I suppose. I felt as though, I'm not regretting that I hadn't done it sooner, I felt it was in me, I wanted to do it. I think for me, I think it, I suppose I was, not stuck in a rut but, you know, but to me kind of, not opened up the world to me again but it gave me a new lease of</p>	<p>There was something more in me I wanted to be fulfilled I felt it was in me I wanted to do it It gave me a new lease of life and an interest outside my four walls</p>	<p>Recognition of own potential Self-esteem</p>	<p>Self-worth</p>	

<p>life, an interest outside my four walls I suppose (Gemma)</p> <p>For me, I didn't feel different but I felt empowered definitely, that I've done this and I challenged myself and I rose to the challenge and it gives you something, you know, definitely my sense of self-worth and my belief in myself has risen greatly (Natalie)</p>	<p>I felt empowered I challenged myself I rose to that challenge My sense of self-worth and self-belief has risen greatly</p>	<p>Empowerment Recognition of own potential Self-esteem</p>		
<p>I think a huge factor was the clinical nurse manager 3 at the time. She probably recognised my potential, em, and she kept encouraging me to go and put me forward, you know, she said 'you need to do your A&amp;E course, you need to do it, you need to do it' (Natalie)</p>	<p>The CNM3 recognised my potential She encouraged me and put me forward for the A&amp;E course</p>	<p>Recognition of potential by others</p>		<p>Desire for Self-Affirmation</p>
<p>People that had gone before me had done the course and there was a few, they were really, I could see that they had stepped up their game, you know, in their competence and their capabilities and that they were happy. I wanted to be that happy person again (Natalie)</p>	<p>People had done the course before me I could see they had stepped up their game They were happy I wanted to be happy again</p>	<p>Increased knowledge and skills Colleague influence Personal satisfaction</p>	<p>Educational Development &amp; Advancement Self</p>	<p>Professional Influencing Forces  Impact of Higher Education on Sense of Self and Identity</p>

<p>I was envious of their knowledge and their ability to provide a high level of care to patients, you know, and to do it quite seamlessly (Natalie)</p>	<p>I was envious of their knowledge and ability to provide a high level of care to patients</p>	<p>Colleague influence Increased knowledge and skills Provision of appropriate care</p>	<p>Educational Development &amp; Advancement</p>	
<p>Em, I thought, right, well there's, the health service is a bit stagnant at the moment but I suppose I was looking at my career options as well and looking at the bigger picture, like, I definitely wanted to be a better nurse and a more qualified nurse, em, and a huge thing at that time I think I wanted to be perceived, I suppose, someone of value and like 'oh Natalie knows what she's doing, you know, we have great confidence in Natalie', yeah, definitely that and, I suppose, looking at your career pathway then (Natalie)</p>	<p>The health service is a bit stagnant I was looking at the bigger picture and my career options I wanted to be a better and more qualified nurse I wanted to be perceived as someone of value I was looking at my career pathway</p>	<p>Increased knowledge and skills Provision of appropriate care Recognition of potential Promotional opportunities</p>	<p>Educational Development &amp; Advancement Career Advancement</p>	<p>Professional Influencing Forces  Impact of Higher Education on Sense of Self &amp; Identity</p>
<p>Em well I suppose I started working then in the ED and I suppose I was there two to three years before I'd undertaken it and part of that, there were a few of the other girls that had done it so I suppose like observing them, their</p>	<p>I was in ED two or three years before I did the course Others had done it I liked observing their competencies</p>	<p>Colleague influence Increased knowledge and skills Provision of appropriate care</p>	<p>Educational Development &amp; Advancement Career Advancement</p>	

<p>competency areas, in particular resus. I found that like when you were working in the Emergency Department like, you know, any situation was coming in and I wanted to be able to have the knowledge base and know the rationale of how to manage that trauma or, you know, issue at the time and to give the client or the patient proper quality care (Alison)</p>	<p>I wanted to have that knowledge base to deal with any situation I wanted to know the rationale of how to manage trauma and give proper care</p>			
<p>I suppose, em, not that I was bored, I just, I suppose I was eager and hungry to learn, you know, like if something came in I used to find like if I didn't know something I'd go home at night and I'd be looking it up or trying to find out more about it and things like that and then the opportunity came up that I could do a post grad in the emergency nursing and I thought I'm going to apply for that (Alison)</p>	<p>I was eager and hungry to learn If I didn't know something I would look it up later at home The opportunity came to do the postgrad I applied to do it</p>	<p>Colleague influence Increased knowledge and skills Provision of appropriate care</p>	<p>Educational Development &amp; Advancement Career Advancement</p>	
<p>Well, I wanted to learn a lot more about what I was doing in work at the hospital. A lot of peer pressure as well, colleagues and, em, family as well pushing me to try and do my best, to go further, felt if I was</p>	<p>I wanted to learn more There was peer pressure from my colleagues to do the course My family was pushing me too</p>	<p>Colleague influence Increased knowledge and skills Parental influence Promotional opportunities</p>	<p>Educational Development &amp; Advancement Career Advancement</p>	

<p>to progress anywhere I'd need to have this course done (Jennifer)</p>	<p>I needed to have the course done in order to progress</p>			
<p>Just for myself as well, I wanted to better myself (Jennifer)</p>	<p>It was for myself I wanted to better myself</p>	<p>Personal satisfaction Recognition of own potential</p>		
<p>It was the opportunity to get promotion, you know, because I kind of started to look around, you take your head out of the sand and you see what other people are doing and you can kind of see everyone is now doing their Masters and I was thinking to myself if I don't do the Masters, if I go for a job someone else who has done the Masters and goes for it, the same job, they would obviously have, you know, the advantage, so that was really the main reason for me to do the Masters. Then I was kind of looking at where my career was going, like, you know, was I going to be working on the floor all the time or not, em, and I think the Masters kind of opens doors a bit, you can either do your ANP or go on to do management but it just</p>	<p>It would give me promotional opportunities You see what others are doing Everyone is doing a Masters Anyone who had the Masters would have the advantage That was the main reason for me doing the Masters I was looking at where my career was going The Masters can open doors You can do management or ANP It opens doors and gives you more options</p>	<p>Colleague influence Promotional opportunities</p>		

opens doors so it gives you more options to decide (Yvonne)				
I felt like, well at the time actually, it was a cultural thing, everyone I worked with was doing the course, you know, if you were in the hospital I was in, everyone did the course if you were going to be in resus or triage, that was it (Ellen)	It was a cultural thing Everyone was doing the course Everyone did the course if you were working in triage or resus	Colleague influence Increased knowledge and skills		
Insecure in that I felt that I was being judged because I didn't have the course done, that would be the first thing and secondly I realised that there were things, there were things happening or there was a delay in treatments so I felt that I needed to educate myself (Kim)	I felt insecure as I thought I was being judge for not having the course done There were things happening in treatments so I needed to educate myself	Colleague influence Increased knowledge and skills Security		
I suppose I am a little bit driven. Like, for example, somebody once said to me 'you must love ECGs' and I said, when in actual fact I don't love them, I hate them but I didn't want them to better me so there's always a part of me that's a little bit driven (Kim)	I am driven Somebody once said that I must love ECGs I don't love them but I didn't want them to better me I am driven	Determination Increased knowledge and skills		
Number one I had to get the support of my family first to make	I had to get the support of my family	Timing		

sure that I would have enough time and support at home first (Jane)				
First of all I had decided that I was committed to the unit. I wasn't looking to move out of the unit so I thought if I'm committed to the unit, why not be the best I can be in the unit (Kerry)	I was committed to the unit I wasn't looking to move Why not be the best I can be if I'm committed to the unit	Commitment Increased knowledge and skills		
My colleagues also inspired me. I just wanted to be one of them, I didn't want to be excluded from that group, I kind of wanted to be part of that group to be honest. And my age came into it as well. I thought if I don't do it now I might never do it and I'll be a staff nurse in A&E, why not be a postgraduate (Kerry)	My colleagues inspired me I wanted to be one of them I wanted to be part of that group My age came into it If I don't do it now I might never do it I'll be staff nurse Why not be a postgraduate	Colleague influence Security Group belonging Timing Increased knowledge and skills		

Raw Data	Preliminary Codes	Codes	Category	Theme
<p>It gives me opportunity, it gives me the chance to kind of diversify into something else and not kind of feel like I'm stagnating and staying in the same position. I suppose that's what education is, it's just about opportunity, gives you a chance to kind of, you know, not stay in the one thing forever, if you don't want to. It gives you a chance to kind of do something different, be something different (Alexandra)</p>	<p>It gives me the opportunity to diversify I'm not stagnating Education gives the opportunity to do or be something different</p>	<p>Promotional opportunities Professional power</p>	<p>Career Advancement Professional Identity</p>	<p>Impact of Higher Education on Sense of Self &amp; Identity  Professional Influencing Forces</p>
<p>I feel accomplished in some way, you know. In the house I have three diplomas on the wall and I had a friend stay there like a couple of weekends ago and she hadn't been to the house before and she was sitting there at breakfast and she was like 'I feel so grand sitting at breakfast with all these', and I was like 'God, I forgot they were there' and she was 'God, that's so amazing' and I'd forgotten because when you're just kind of doing it and going through it you forget that it's a pretty big deal, it's great, it's an achievement. It's not everybody</p>	<p>I feel accomplished I have three diplomas on the wall My friend said 'I feel so grand sitting here with all these' I forgot they were there You forget it's a big deal It's an achievement Not everybody can do it If I put my mind to it I can do great things I can make a difference</p>	<p>Achievement Pride Professional voice Professional confidence Professional power Perceptions of others</p>	<p>Self Identity Professional identity</p>	<p>Impact of Higher Education on Sense of Self &amp; Identity</p>



<p>can do it. It's that feeling about, you know, I am able if I put my mind to something I have the ability to do good things. I have the ability to kind of progress and make a difference, you know, yeah (Alexandra)</p>				
<p>I suppose it makes me more confident professionally just that, you know, if I'm doing something in my professional life that I kind of have an educational basis with which to frame reference, that it's not a case, you know, if I was here and it's not a disrespect to somebody who hasn't pursued higher education but if they were suggesting a plan of care for a patient and I was kind of going, 'well ok, from an evidence-based practice that wouldn't be the right way to go', I'd have something, I feel that I'd be able to challenge that whereas if I didn't, it may be inappropriate care a patient was receiving. I think it gives me that benefit. I think it gives me a professional voice as well, that my opinion matters (Alexandra)</p>	<p>It makes me more confident professionally I have an educational basis with which to frame reference I can suggest a plan of care based on evidence I am able to challenge the care a patient receives It gives me that benefit It gives me a professional voice My opinion matters</p>	<p>Professional confidence Professional voice Professional power</p>	<p>Professional identity</p>	<p>Impact of higher education on sense of self &amp; identity</p>

<p>It probably has given me confidence in I would take on things in my personal life that I probably wouldn't have before because I now have experience of kind of speaking in public and, you know, dealing with people on a professional level that probably ten years ago I wouldn't even have dreamt about confronting somebody on a professional level because I wouldn't have had the confidence to do it but higher education and kind of being in that forum gave me the confidence to probably do it (Alexandra)</p>	<p>It has given me confidence I can take on things in my personal life because I have experience in public speaking I can confront people on a professional level I didn't have the confidence Higher education has given me that confidence</p>	<p>Personal confidence Professional confidence Professional power Professional voice</p>	<p>Identity Professional Identity</p>	
<p>I suppose, you know, in work you would probably be classified as either a senior staff nurse or a junior staff nurse and I suppose the junior staff nurses are probably the ones who wouldn't have the knowledge base and education behind them, so yeah, I suppose we could consider ourselves, you know, senior staff that have that education (Michelle)</p>	<p>In work you are classed as either a junior or senior staff nurse The junior staff nurses wouldn't have the knowledge base We would consider ourselves senior if we have that education</p>	<p>Seniority Professional confidence Importance of education Increased knowledge and skills</p>	<p>Professional identity Educational development and advancement</p>	<p>Impact of Higher Education on sense of self and identity  Professional Influencing Forces</p>

<p>I think even other medical professionals will come to you and ask you a question that maybe they're not sure about and especially I think in an emergency department it is quite nurse-led but only because of the education and skills of the nurses who have undertaken, you know, higher graduate courses. I think once you can show your knowledge and people see you using that knowledge, it then changes your identity (Michelle)</p>	<p>Other professionals will come and ask you a question The emergency department is quite nurse-led because of the education and skills of the nurses Once you can show your knowledge it then changes your identity</p>	<p>Professional power Professional voice Professional confidence Perceptions of others Individuals of note</p>	<p>Professional Identity Identity Educational development and advancement</p>	<p>Impact of Higher Education on sense of self and identity  Professional Influencing Forces</p>
<p>It empowered me because it made me feel good the fact that I had achieved it. That I had gone from starting a course to completing a course, feeling good about myself, going to graduation, the celebrations, seeing my other colleagues and friends achieving so much and feeling so proud of them (Jane)</p>	<p>It has empowered me It feels good that I have achieved something I feel good about myself I feel proud of my friends and colleagues</p>	<p>Empowerment Achievement Pride</p>	<p>Professional Identity Self Identity</p>	<p>Impact of Higher Education on sense of self and identity</p>
<p>It gives you confidence to say well I'm as good as anyone else because I think historically as nurses we undervalue ourselves and I think we were looked at as the</p>	<p>It gives you confidence I'm as good as anyone else I think nurses undervalue themselves</p>	<p>Professional power Professional Voice Professional parity Professional confidence</p>	<p>Professional identity Identity Self</p>	<p>Impact of Higher Education on sense of self and identity</p>

<p>handmaiden and I think, you know, we are now on a par with physios and other therapies, with medics, you know (Emma)</p>	<p>I think we are looked at as the handmaiden We are on a par with other professionals</p>	<p>Self-esteem Pride Perceptions of others</p>		<p>Professional Influencing Forces</p>
<p>I hope I would be perceived as being a bit more knowledgeable, look it, I mean I think at home I would be a little more respected because I am a nurse, an emergency nurse, you know, my family, this is our local hospital for my family. I see an awful lot of aunts and uncles here, em, and I like being able to help them, you know, or even comfort or phone them at home, you know, a few weeks later, that is nice, you know (Sue)</p>	<p>I hope I would be perceived as being more knowledgeable At home I'm respected more This is our local hospital for my family I like being able to help them</p>	<p>Personal confidence Professional confidence Respect Perceptions of others Individuals of note Recognition Increased knowledge and skills</p>	<p>Professional identity Identity Self Educational development and advancement</p>	<p>Impact of Higher Education on sense of self and identity  Professional Influencing Forces</p>
<p>I know it sounds stupid but I think I'm more senior, look it, I've been here a long time as well, so maybe that's it too but I would be more senior and I like being able to help newbies because at the same time I was here, I was one of them eight years ago and it is nice to be able to do that (Sue)</p>	<p>I think I'm more senior I've been here a long time I like being able to help new staff I was one of them and it's nice to be able to do that</p>	<p>Seniority Role model Increased knowledge and skills Colleague influence Professional confidence</p>	<p>Career advancement Work context Professional identity</p>	<p>Impact of Higher Education on sense of self and identity  Professional Influencing Forces</p>

<p>It has benefited me in my practice and in my personal achievements I guess. So personally apart from professional life and having the promotion, like I feel more confident and happier I guess that I've done study and also the knowledge I've gained and the skills (Pauline)</p>	<p>It has benefited my practice and personal achievements I have been promoted I feel more confident and happy that I have studied and gained skills</p>	<p>Achievement Professional confidence Increased knowledge and skills</p>	<p>Work context Professional identity Educational development and advancement</p>	<p>Impact of Higher Education on sense of self and identity  Professional Influencing Forces</p>
<p>Like our doctors in the A&amp;E department definitely would respect us in the sense that when we're coming to them, we're genuinely coming to them, we have a sick patient, you need to see them now and they will always come with us. Now we do have doctors who question our category two and they'll make you justify why you've categorised a patient as a two because they have to be seen more or less within ten minutes. Em, it's the very odd doctor that would do that to you but generally they do respect your decision-making (Olivia)</p>	<p>The A&amp;E doctors would respect us When we're coming to them it's because we have a sick patient Some doctors will question the triage category They make you justify why you have categorised the patient It's the very odd doctor who would do that but generally they respect your decision-making</p>	<p>Professional confidence Respect Perceptions of others Individuals of note Recognition Increased knowledge and skills Professional voice Professional power ED environment</p>	<p>Professional identity Identity Self Educational development and advancement Work context</p>	<p>Impact of Higher Education on sense of self and identity  Professional Influencing Forces</p>
<p>More confidence and to feel more competent and, you know, really to challenge as well, you know, if</p>	<p>I have more confidence and feel more competent I can challenge as well</p>	<p>Professional confidence Respect Perceptions of others</p>	<p>Professional identity Identity Self</p>	<p>Impact of Higher Education on sense of self and identity</p>

<p>there was a doctor there that hadn't seen this before, you know, you had more of a voice, you know, and you could put the rationale behind the argument (Alison)</p>	<p>You have a voice You can put the rationale behind the argument</p>	<p>Individuals of note Recognition Increased knowledge and skills Professional voice Professional power ED environment</p>	<p>Educational development and advancement Work context</p>	<p>Professional Influencing Forces</p>
<p>Well I can only speak for myself and I would say it has empowered me, it's given me confidence and it's allowed me to progress into that kind of group where I have a voice and I suppose when I sit in a group of nurses sometimes I wish they would stand up and say more for themselves, em, and I often wonder why don't they (Kim)</p>	<p>It has empowered me It has given me confidence It has allowed me to progress into that group where I have a voice Sometimes I wish nurses would stand up for themselves more I often wonder why they don't</p>	<p>Empowerment Professional confidence Respect Perceptions of others Individuals of note Recognition Professional voice Professional power Group belonging Increased knowledge and skills</p>	<p>Professional identity Identity Self Educational development and advancement Work context</p>	<p>Impact of Higher Education on sense of self and identity  Professional Influencing Forces</p>
<p>Like this is my area. This is where I have, this is my home, it's my expertise and I get great pleasure out of teaching different aspects of what I have learned and to other new staff that arrive and even going through policies and pathways. And that gives me, em, that gives me what do you call it, fulfilment. I feel like I'm doing my job, what I'm meant to be doing. It makes me</p>	<p>This is my area It's my expertise and I get great pleasure out of teaching different aspects of what I have learned to other new staff It gives me fulfilment I feel like I'm doing my job It makes me feel happy and confident</p>	<p>Role model Increased knowledge and skills Professional confidence Achievement Self-esteem Personal confidence Satisfaction</p>	<p>Work context Professional identity Educational development and advancement</p>	<p>Impact of Higher Education on sense of self and identity  Professional Influencing Forces  Desire for Self-Affirmation</p>

feel, it actually, it impacts on my, on me as a person, as in my happiness, in my confidence, in the person that I am. Like I get great joy and happiness and contentment (Joy)	I get great joy, happiness and contentment			
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Raw Data	Preliminary Codes	Codes	Category	Theme
<p>It was mainly all computer stuff so trying to do powerpoint presentations and trying to learn your Microsoft Office and that and trying to attach things to emails and send them back and scan them, trying to get used to that sort of thing (Jennifer)</p> <p>It was the academic writing that I found hard to get to grips with initially and I still do to this day. Reflection on practice is another thing that absolutely freaks me out but it's actually I would have to say it depends on how it's taught (Kim)</p>	<p>It was a challenge trying to get used to computer software and emails</p> <p>I found it difficult to get to grips with academic writing I still do I find reflection difficult but it depends on how its taught</p>	<p>Academic writing and language</p> <p>IT skills</p> <p>Academic writing and language</p> <p>IT skills</p> <p>Teaching methods</p>	<p>Adjusting to the requirements of higher education</p> <p>Challenges</p>	<p>Experiences of higher education</p>
<p>I think the big challenge was kind of home life and its practicalities and, you know, trying to manage everything (Pauline)</p> <p>I found that the only time with family at home, the only time to get study done was either after 12 o'clock or to get up at three in the morning and start your study then. You just used whatever free hours you had when everyone else was</p>	<p>The practicalities of managing home life was a challenge</p> <p>I found the only time I could get study done was late at night or early in the morning You used any free hours you had to get as much done</p>	<p>Balancing competing demands</p> <p>Balancing home and working life Balancing competing demands</p>	<p>Adjusting to the requirements of higher education</p> <p>Challenges</p>	



<p>asleep to try and get as much done as you could (Jennifer)</p> <p>All my annual leave went towards my course. I pretty much used all but a week. It was also quite difficult cos we weren't released for our placements. It was quite stressful and I know I wasn't an easy person to live with at all. I used to get up very early in the mornings, study before I came to work or before I came in on night duty, em, just to make sure all my assignments were done and done properly (Michelle)</p> <p>Sometimes it was stressful. There were times when I felt I wasn't giving enough to the family at the time, at certain times. I suppose not being able to go to certain family events because there was so much to do and involved in the course that you were giving it your all and you're missing out on a lot of social activities and social events (Jane)</p> <p>I just locked myself into a room and I would come out for a few hours, cup of tea or something to</p>	<p>Most of my annual leave went towards my course It was difficult as we were not released for placements It was stressful and I wasn't an easy person to live with I used to get up early in the mornings or before I started night duty to get my assignments done properly</p> <p>It was stressful sometimes I felt I wasn't giving enough to the family I missed out on a lot of social activities and events because there was a lot involved in the course</p> <p>I just locked myself in a room</p>	<p>Impact of higher education on family and social life Study leave allocation Commitment to study Stressful</p> <p>Commitment to study</p> <p>Stressful Impact of higher education on family and social life</p> <p>Commitment to study Commitment to study</p>	<p>Challenges Adjusting to requirements of higher education</p>	
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<p>eat and back in again but for that whole year you saw nobody, you had no social life, it was work to study, study to work (Olivia)</p>	<p>I came out for a few hours' break I saw nobody for that whole year I had no social life It was work and study</p>	<p>Impact of higher education on family and social life</p>		
<p>Em, well for the pgdip everything was a surprise, it was all new, you know. One of the biggest I suppose, another surprise would be nursing, how they responded to it or how they've reacted to it and it's been very negative, I would feel for the most part it hasn't been positive (Kim)</p> <p>We're not as cohesive, you know, they view me as separate. I'm in advanced practice now, they don't view me as part of the emergency department team at all even though I'm on the floor. I think it's hilarious to be honest, you know (Natalie)</p> <p>You know there is a level of respect that you've kind of gone through all that so, you know, you must be good at what you do or the fact that 'God, you were able to go and do</p>	<p>Everything was a surprise for the pgdip It was all new One of the biggest surprises was how nurses reacted to it It's been very negative</p> <p>We're not cohesive I'm viewed as separate They don't view me as part of the emergency department team I think it's hilarious</p> <p>There is respect for going through higher education You must be good at your job</p>	<p>Surprises</p> <p>New</p> <p>Perceptions of others</p> <p>Negativity</p> <p>Not cohesive Separate Not viewed as part of ED</p> <p>Respect for pursuing higher education Good at job</p>	<p>Challenges</p>	

your Masters' and, you know, there's a respect for that. But that's not true of everybody (Alexandra)	That's not true of everybody	Disrespect		
I spoke to my colleagues, I had great support from, em, when I thought this, am I the only one struggling with this. I spoke to former postgraduates in work who were extremely supportive and experienced and said they experienced the same thing. They also gave me advice on what I could do to get ahead which was extremely useful and I followed every bit of advice that I was given (Kerry)	I had great support from my colleagues I thought I was the only one struggling I spoke to former postgraduates who were supportive and experienced They gave me useful advice I followed that advice	Colleague support  Struggle  Colleague support  Colleague support	Sources of support  Challenges	
I have to say my family were very good, you know. There were times where I said 'I'm giving up, I've had enough', they'd be like 'no, no, no, you're doing great'. I probably put a lot of pressure on myself, if I'm doing it, I want to do it properly (Michelle)	My family were very good There were times where I wanted to give up They said I was doing great I put a lot of pressure on myself I wanted to do it properly	Family support Giving up  Family support Putting pressure on oneself Commitment to study		
I had a buddy here that was doing it at the same time as me and the two of us just gelled, we got on great,	My friend was doing it at the same time We gelled and got on great	Colleague support		

kept each other going through the whole lot of it (Jennifer)	We kept each other going through it			
<p>What kept me going was pure pig-headedness I'd say and stubbornness. I really enjoyed it. I could see the value of the course and I could see what I could add to the service as well and I could see that my job satisfaction was going to be huge as well (Natalie)</p> <p>The end result, the end goal. Getting the pass mark, knowing you were going to graduate with this next qualification and the other is I was going to prove to myself that I was going to do it. I also enjoyed the learning part of it as well and I liked the classroom situation and I like the opinions of everybody else (Emily)</p> <p>Eh, let me see now, what kept me going, em, it was continuous assessment so that interested me, the essays, but I just found that my lecturers were really supportive and</p>	<p>What kept me going was stubbornness I really enjoyed it I could see the value of the course I could see what I could add to the service I could see that my job satisfaction was going to be huge</p> <p>Getting the pass mark and knowing you were going to graduate I wanted to prove to myself that I could do it I enjoyed the learning part I liked the classroom situation and the opinions of others</p> <p>Continuous assessment interested me I found the lecturers to be supportive</p>	<p>Determination</p> <p>Enjoyment of learning Value of course</p> <p>Job satisfaction</p> <p>Achievement</p> <p>Determination</p> <p>Enjoyment of learning part</p> <p>Enjoyment of learning</p> <p>University support</p>	Factors that maintained interest	

<p>just the achievement at the end of it all and that I've learned (Julie)</p>	<p>The achievement at the end and what I had learned</p>	<p>Achievement</p>		
<p>I'd like to complete my Masters and finish that off. I have a year left to do, em, when and how I'll do it, I don't know (Olivia)</p> <p>I had planned to do it straight away but then I got sucked into marriage and, you know, life took over. I had planned to do my Masters straight away but actually in hindsight I'm glad I didn't because I think you need to know what you're going to do with your career to do a Masters rather than just do it because you're in the frame of mind for studying (Ellen)</p> <p>I think I'll always be doing courses. I like to be kept busy and I like knowing new things and always knowing, you know, what's coming out, what's new, new treatments, you know. I'm not sure I would go any higher than the Masters (Yvonne)</p>	<p>I would like to complete my Masters I don't know how or when I'll do it</p> <p>I had planned to do the Masters straight away but then I got married Life took over I'm glad I didn't do it straight away as I think you need to know what you're going to do with your career Or because you're in the frame of mind for studying</p> <p>I'll always be doing courses I like to be kept busy I like knowing new things I like knowing about new treatments</p>	<p>Future educational plans</p> <p>Future educational plans</p> <p>Family commitments</p> <p>Future career plans</p> <p>Studying frame of mind</p> <p>Future educational plans Busy Enjoyment of learning Knowledge acquisition</p>		

	I wouldn't go any higher than the Masters	Future educational plans		
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**Appendix 11**  
**Supervision Meetings**

5

2

19/01/15

Historical approaches to identity

→ Enlightenment (self)

→ Structuralist

→ Post-modern

} (others)

views & influences

Introduction to each section + perhaps an overview of what is coming in the section (content / rationale)

Critically evaluate after each section

Aristotle - types of knowledge - Charles Taylor

Sources of Self.

Structuralist - SI + SIT.

Next Meeting 23/02/15 10<sup>30</sup>am



④ 15/12/14

Sub-headings, 3-5 K  
Discussion of tensions - be aware of tensions/conflicts

① Definitions - take 4/5 from literature - compare / contrast

② Knowledge Sources - what is meant by knowledge of affect / subject matter etc  
- is subject matter scientific / research based  
- rather than replication of practice  
\* Approximation of Practice \*

③ Criteria of Profession - systematic body of knowledge  
↳ what happens when it becomes too systematic  
- professional autonomy  
↳ what is professional autonomy  
↳ not much autonomy due to regulations  
- autonomy/decisions: nursing / critical thinking  
- deprofessionalisation literature  
↳ due to quality mechanisms / policies etc, professional identity & autonomy is undermined  
- pull apart code of ethics nursing vs teaching code of ethics vs solicitors. Teaching council website

④ 'Getting above their station' - ? need for semi-professional group  
- MCHs  
- what is their 'station'?

⑤ Safety & Quality - accountability  
- does a nurse account for their time  
- RNP / CNS accountability mechanisms  
- Patient caseload

⑥ Contexts (Recognition of Contexts) - HE vs Psych vs social  
- possible identity issues  
- context of maternity, midwifery as special group  
- is identity of prenat nurses different from psych / general etc

⑦ Public Image

Next meeting 19/01/15 10:30am  
Sub-headings 1-3 (3-5k)  
Referencing - apa601

⑬ 16/12/15

Key dimensions / decision-making for HBI

Self is bigger than identity - fundamental ontological me is my being "case"  
So there a core self surrounded by types of identities, one of which is professional identity

Education can impact & affect identity

Interested in decision-making & experience of higher education. We suspect that it is connected with self & identities Taylor, Foucault "self" - ways of thinking about self.

Identify key message in each section

In summary - this knowledge is of complex nature... formed & shaped in social interactions

- Conclusions - here is what we mean by professional identity
- Comment on References
- Introductions for each section

Next meeting - 13/01/16

⑭ 13/01/16

Research Design

- Research Question - informed by literature review & theoretical frame  
- influencing (motivating) decision-making, experience  
- motivation (forces of government)  
- experience & consequences (specified in terms of plans)  
- agency, freedom (decision-making)  
- experiences (reflect formal & transformative experience of self)
- Design Approach  
- Case Study → one particular case of a general phenomenon → professionally making decisions about higher education within emergency nursing based by the fact that it is emergency nurses in Stocked, case is a very specific context.
- Methods  
- Narrative
- Sample Frame → 20-30 (where, when)
- Frame of Analysis  
- How to analyse narrative documents  
→ discourse analysis  
→ thematic analysis  
→ memetic analysis
- Timeline

Next Meeting - 23/02/16 4pm

11

14

07/10/15

Refine chapter on governmentality

Choose definition of governmentality that is most relevant/  
appropriate to the proposed study

? use headings such as "Forging an Understanding of..."

Refer to power as being productive + positive

Next chapter on Sociology of Nursing + Nurses

→ Sociology of Nursing

→ Socialisation of Nurses.

What are key themes?

Gendered nature of socialisation, historical/cultural  
eg. semi-religious

Theoretical ideas of Foucault, Giddens, Habermas to  
understand socialisation

Historical training of nurses → self + identity formation

Classical v Practice theory

Wormann, Foucault + Habermas' view of the state

Power + influence - Foucault, Habermas' view of power.

5K words

RCSI poster abstract.

**Appendix 12**  
**Codes & Themes**

<b>Research Question 1 - What powers govern the decision to pursue higher education among emergency nurses?</b>				
<b>Codes</b>	<b>Frequency (Participants)</b>	<b>Categories</b>	<b>Subthemes</b>	<b>Theme</b>
Social background	1,6,7,10, 21	Social background influences	Challenging Traditional Social Legacies	<b>Desire for Self-Affirmation</b>
Parental influences Family support	1,5,6,7,19,21 1,2,6,10	Family influences		
Right time in personal life	2,4	Right time in life	Timing	
Right time in professional life	7,8,21 12,16			
Now or never	6,7,10,13			
Distraction	5,6	Distraction & Escape		
Recognition of own potential	6,7,10,14,15,21	Recognition of potential by self & others	Self-worth	
Recognition of potential by others	1,5,7,14,21			
Being driven	10			
Having a point to prove	10			
Self-belief	1,6,7,15			
Self-worth	7,11,15,21	Self-fulfilment		
Bettering myself	5,6,7,15,16,21			
Genuine interest	6,15,16,21			
Doing it for myself	5,6,11,15,18			



Desire to use evidence based practice	1,7,10,14,19			<b>Professional Influencing Forces</b>
Further educational opportunities	1,4,5,6,7, 8,10,11,12,13,14,15,17,18,20,22	Educational progression		
Education is important for emergency nurses	1,3,6, 7,9,12, 14,15,16,17,18,19,21,22	Importance of education		
Attractiveness of programmes	7,17,18	Appropriateness of educational programme		
Influence of professional body in pursuing higher education	2,5,6,7,16,17	Professional body influence		
Feeling left behind Not wanting to remain static	2,4,8,11,12,13,16,17,19 4,5,6,16	Fear of being left behind	Security	
Justify my place in ED	3,13	Ability to remain in ED		
Security in ED	1,2,3,5,10,13,16,19,21			
Desire to remain in ED	1,7,10,19,21			
Opportunity to specialise	9,16,20			

Desire to work in a stimulating environment	1,19			<b>Professional Influencing Forces</b>
Sense of belonging to a group	8,13,15,19,20	Group belonging		
Opportunity for promotion & progression	1,2,3,4,5,6,7, 8,9,10,11,12,13,14,15,16,17,20, 21,22	Promotional opportunities	Career Advancement	
Others may have the advantage	12,22			
Looking at bigger picture	1,7,8,11,14,15,21			
Career progression opportunities	2,5,12,14			
Desire for increased autonomy	1,7			
Open doors	4,10,12,20			
Feeling less professional for not having higher education	5,8,11,19,20,21	Professional identity		
Evolving nursing profession	1,2,7,10,14			
Parity with colleagues	1,11,20			
Professional development	6,18,19			

Improve decision-making & problem-solving ability	11,14,18	Enhanced problem-solving ability		<b>Professional Influencing Forces</b>
Opportunity to teach others	6,11,14,20,21	Role model		
Cultural practice Expectation to study	5,7,10,11,16,19,20 1,2,6,12,16	Cultural expectation to study	Work Context	
Influence of work colleagues	1,2,3,4,5,6,7,8,9,12,13,15,16,17,18,19,20, 21,22	Colleague influence & support		
Admiration for others' competencies	1,2,3,5,6,7,8,10,11,15,16,17,18,19,20,21,22			
Support & encouragement from colleagues	1,2,5,6,7, 8,9,14,17,20,21			
Envy of others' knowledge & skills	7,8,10,20			
Commitment to ED Time already worked in ED	1,8,10,16,19 9,10,11,20,21	Commitment		
A liking for emergency nursing	1,4,5,7,8,9,10,14,19,21			
Diverse clinical environment	2,3,4,5,6,7,9,10,11,12,13,14,16,17,18,19, 20,21,22	Evolving healthcare environment		



Perceived need for new initiatives in ED	1,7,10			
Meeting demands of health service & public	1,7,10			
Support from management & organisation	1,2,3,6, 7,10,13,14,18	Organisational support		
Provision of funding	3,5,6,10			
<b>Research Question 2 - Does higher education inform an emergency nurse's sense of self and identity?</b>				
<b>Codes</b>	<b>Frequency (Participants)</b>	<b>Categories</b>	<b>Subtheme</b>	<b>Theme</b>
Sense of self-esteem	6,7,15,21	Self-esteem	Self	<b>Impact of Higher Education on Sense of Self &amp; Identity</b>
Personal satisfaction	2,4,5,6,7,8,13,15,16,18,19,21,22			
Happiness	4,6,19,22			
Did it for myself	6,10,22			
Feeling good about myself	6,11,13,18			
Self-fulfilment	15,19	Self-worth		
Opened my mind up to education	4,7			
New lease of life	15			
Feeling proud	1,2,6,7, 15, 17,21	Pride		<b>Impact of Higher Education on</b>
Achievement	4,6,9,10,12,13,22			

Sense of accomplishment	1,8,18			<b>Sense of Self &amp; Identity</b>
Increased sense of personal confidence	1,2,12,19,20	Confidence		
Opened up a new world	15			
Feeling fraudulent	1,7,8	Sense of impostorism		
Feeling important	7,21	Individuals of note	Identity	
Role model	8,12,15,21			
Being looked at differently	11,12	Perceptions of others		
Pursuing promotional opportunities	1,2,3,7,10,11,14,15, 21,22	Professional confidence	Professional Identity	
Enhanced professional confidence	1,3,4,5,6,7,8,9,10,11,12,13,14,16,17,18,19,20,22			
Thinking & behaving differently	3,4,8,11,12,14,16,18,19,20,21,22			
Trusting own judgement	1,16			
Grappling with a new professional identity	1,7			
Sense of professional power	1,10,11,14,18,19	Professional power		

Seniority Empowerment Professional parity Recognition Group belonging ‘Them and us’ New roles as a result of higher education Ability to challenge  Enhanced professional voice Different relationships with colleagues Authority to question	1,3,4,7, 8,15,16,19 6,7,8,10,12 1,6,10,18,22 7, 8,12,13,15,19, 21 8,10,15,19,20,22 1,7,19 1,7,19  1,10,19  1,10,11,12,14,18,19 1,7,10,12,14,16,18,19  10	Professional voice	<b>Impact of Higher          Education on          Sense of Self &amp;          Identity</b>
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<b>Research Question 3 - What are emergency nurses' experiences of higher education?</b>				
<b>Codes</b>	<b>Frequency (Participants)</b>	<b>Categories</b>	<b>Subthemes</b>	<b>Theme</b>
Adjusting to academic writing & language	2,3,4,5,6,7,9,10,11,12,13,14,16,17,19,21,22	Academic writing & language	Adjusting to the Requirements of Higher Education	<b>Experiences of Higher Education</b>
Learning IT skills	5,6,7,9,13,21	IT skills		
Trying to balance competing demands	1,2,3,4,5,8,10,11,13,15,18,20, 21,22	Balancing competing demands		
Balancing home & working life	1,2,4,5,10,13,15, 17,18,20,21			
Time management	1,2,3,4,5,6, 7, 8,10,11,12,13,15, 20,21,22			
Being organised	1,2,3,4,5,6,10,11,12,13,15, 18,20,21,22			
Meeting deadlines	4,11,12,20			
Struggle	8,13,20			
Giving up	2,3,16,20			
Academic workload	12,16			
Sacrifices	7,10			
Determination	5,6,7, 8,10,14,18,19,20,21	Commitment to study	<b>Experiences of Higher Education</b>	
Studying frame of mind	12,13,21,22			
Worked hard	4,7, 11,15, 21			
Perseverance	7,8,20			
Desire to do well	4,5,6,7,10,13			
Ambition & desire to finish programme	3,5,10,14,17,20			

Discipline	1,7,10,13			<b>Experiences of Higher Education</b>
Competing with self	10,13			
Periods of stress	1,6,7,10,16,20	Unexpected events		
Vulnerability	7			
Hit the ground running	20			
Perceptions of others	1, 7, 15, 19,21	Unsupportive colleagues	Challenges	
Negativity	1,7,10,19			
Lack of colleague support	1, 7,10,19			
Disrespect	1, 7,10,19			
Not cohesive	1,7,10	Cohesiveness		
Viewed as separate	1,7,10			
Not viewed as part of ED nursing team	1,7,10			
Insecurities of others	1,7,10			
Short notice for timetable changes	8,11,16	Educational programme challenges		
Programme inconsistencies	16,19			
Irrelevant content	4,9,11			
Lack of university support	11,12,16,19,20			
Impact of education programmes on home & social life	5,11,20,21	Impact on family & social life		

Impact of transitioning to a new role	1,7,10	Role transition		
Lack of support from hospital	8,11,19	Lack of organisational support		
Using annual leave to cover study time	3,5,6,11,22			
Time from work to study	1,5,6,10,11,20,22			
Having to justify roster requests	8			
Enjoyment of learning	5,6,7,11,13,14,15,21	Appropriate programme content	Factors that Maintained Interest	<b>Experiences of Higher Education</b>
Satisfaction from learning	11,12,13,20			
Perception of programme value	7,11			
Subject & module interest	2,4,5,7,9,12,17,21,22			
Interesting module & programme content	4,5,9,11,12,14,16,17,22	Knowledge application		
Applying knowledge & skills learned	3,8,9,11,14,20			
Bringing back learning to ED	3,14,19			
Ability to teach others	3,8,9,14,17,20			

Sense of achievement	1,2,6,7,8,9,10,12,13,14,15, 21	Achievement of qualification		
Committed to achieve	6,7,14,20			
Knowledge & skills acquisition	3,5,7, 8,9,11,12,14,15,16			
Support from lecturers	4,6,7, 8,9,13,17,19,20,21	University support		
Support from university peers	1,3,4,5,6,7,9,11,20,21,22			
Reimburse organisation if fail or discontinue programme	4,8,10	Implications of non-completion		
Support from ED colleagues	1,2,3,4,5,6,9,11,14,15,16,17,20,22	Colleague support	Sources of Support	
Support from hospital to pursue higher education	1,2,4,7, 10,11,12,13,16,21	Organisational support		
Support received from family	6,10	Family support		
Plans for further education	5,8,10,13,15,16,17,19,20	Future educational & career plans	Future Plans	

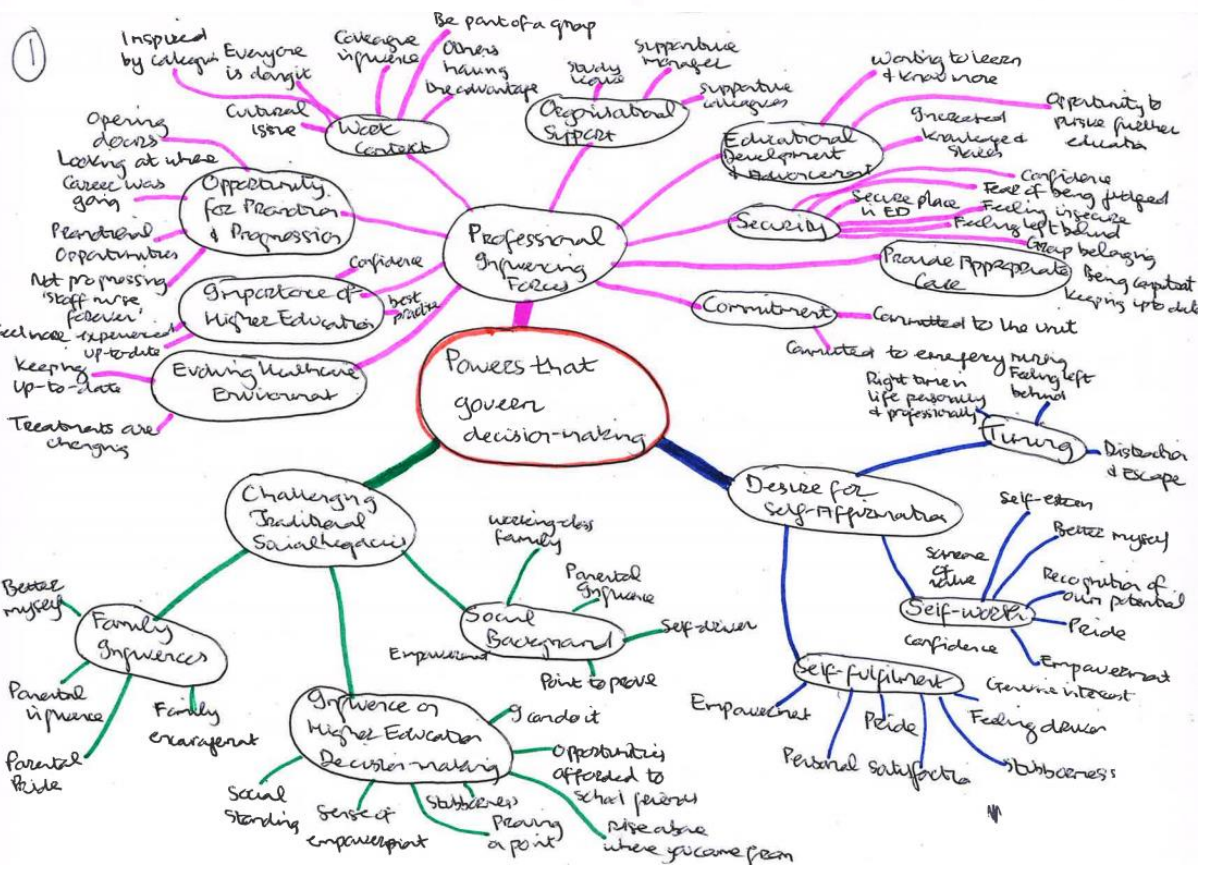
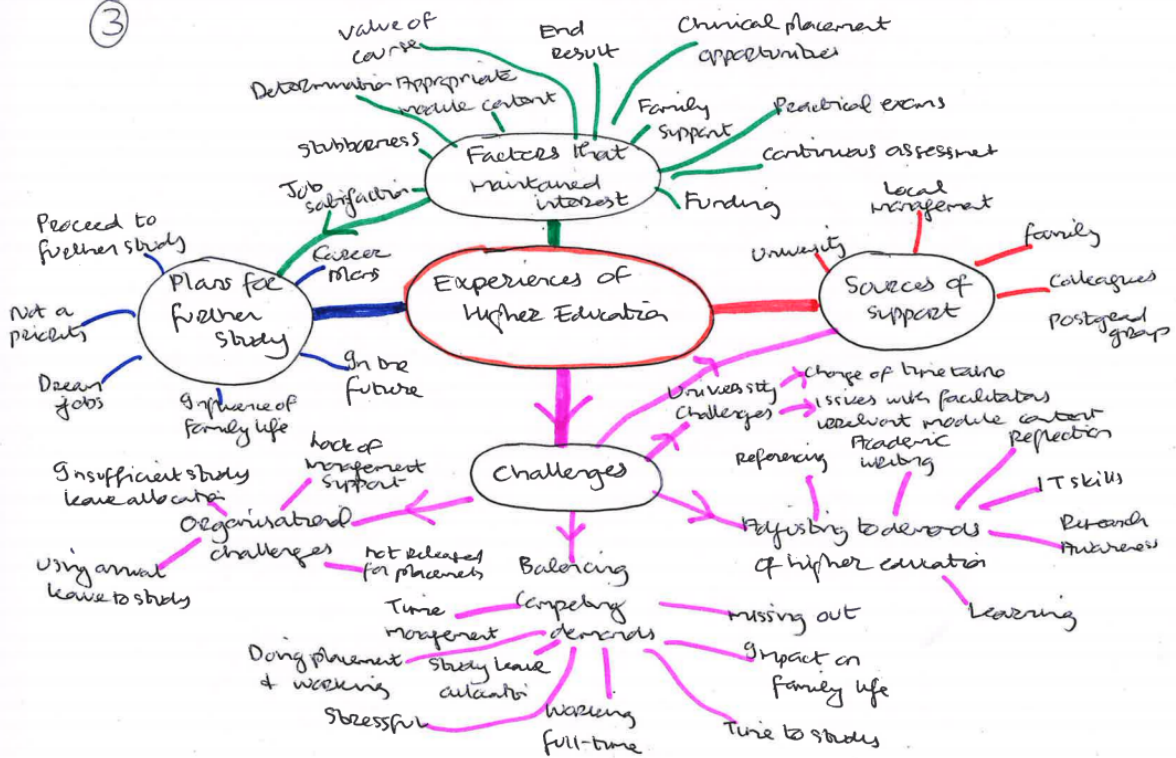
# **Appendix 13**

## **Mind Maps**





③



**Appendix 14**  
**Themes & Subthemes Table**

<b>Research Question 1 – ‘What forces govern the decision to pursue higher education?’</b>	
<b>Themes</b>	<b>Subthemes</b>
<ul style="list-style-type: none"> <li>• Challenging traditional social legacies</li> </ul>	<ul style="list-style-type: none"> <li>• Social background</li> <li>• Family influences</li> <li>• Influence of social background and family on higher education decision-making</li> </ul>
<ul style="list-style-type: none"> <li>• Desire for self-affirmation</li> </ul>	<ul style="list-style-type: none"> <li>• Timing</li> <li>• Self-worth</li> </ul>
<ul style="list-style-type: none"> <li>• Professional influencing forces</li> </ul>	<ul style="list-style-type: none"> <li>• Commitment</li> <li>• Educational development and advancement</li> <li>• Importance of higher education</li> <li>• Work context</li> <li>• Security</li> <li>• Opportunity for promotion and progression</li> <li>• Ability to provide appropriate care to patients</li> <li>• Organisational support</li> </ul>
<b>Research Question 2 – ‘Does higher education inform an emergency nurse’s sense of self and identity?’</b>	
<b>Themes</b>	<b>Subthemes</b>
<ul style="list-style-type: none"> <li>• Impact of higher education on sense of self and identity</li> </ul>	<ul style="list-style-type: none"> <li>• Impact of higher education on sense of self</li> <li>• Impact of higher education on sense of identity</li> </ul>
<ul style="list-style-type: none"> <li>• Impact of higher education on sense of professional identity</li> </ul>	<ul style="list-style-type: none"> <li>• Sense of professional identity</li> <li>• Impact of higher education on professional identity, professional confidence and power</li> </ul>

<b>Research Question 3 – ‘What are emergency nurses’ experiences of higher education?’</b>	
<b>Themes</b>	<b>Subthemes</b>
<ul style="list-style-type: none"> <li>• Challenges of higher education</li> </ul>	<ul style="list-style-type: none"> <li>• Adjusting to the academic requirements of higher education programmes</li> <li>• Balancing competing demands</li> <li>• Organisational challenges</li> <li>• Sources of support</li> </ul>
<ul style="list-style-type: none"> <li>• Factors that maintained interest in programmes of higher education</li> </ul>	<ul style="list-style-type: none"> <li>• Appropriate programme content</li> <li>• Qualification achievement</li> <li>• Determination</li> <li>• Plans for future study</li> </ul>